



State of California—Health and Human Services Agency
Department of Health Care Services



**California Advancing & Innovating Medi-Cal (CalAIM)
Proposal**

January 2021

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1. Executive Summary

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 targets 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 with the goal of improving outcomes for all Californians. Attaining such goals will have significant impact on an individuals' health and quality of life and, through iterative system transformation, will ultimately reduce the per-capita costs over time. DHCS intends to work with the Administration, Legislature and our other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are updated proposals based on extensive stakeholder feedback. Implementation will ultimately depend on the availability of funding and the requisite federal approvals.

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.

1.1 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, 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 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 the Medi-Cal program and allow the critical successes of waiver demonstrations such as Whole Person Care Pilots, the Health Homes Program, the Coordinated Care Initiative, and the public hospital system delivery transformation, that advance the coordination and delivery of quality care to continue and be expanded to 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 the 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 the 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.

1.2 Guiding Principles

In 2018, the 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, 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 toward common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities and inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve the plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

1.3 Key Goals

To achieve these 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.

Below is an overview of the various proposals and recommendations that make up CalAIM. See **Appendix A: 2021 and Beyond: CalAIM Implementation Timeline** for more information.

1.4 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 that would better identify and manage member risk and need for beneficiaries who may be challenged with medical and behavioral conditions, access to care, chronic illnesses and disabilities, and require multidisciplinary care to regain health and function.

To achieve these 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.

- Develop 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 to build appropriate enhanced care management and in lieu of services capacity statewide.
- Pursue participation in the **Serious Mental Illness/Serious Emotional Disturbance 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 whole system, person-centered population health management 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 provide, 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 services 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 Institution 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 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 high 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 demonstration 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 that these types of care 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 a county inmate Medi-Cal application process by January 2023. Additionally, DHCS is proposing to mandate 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 issues such as eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial considerations due to the current 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 full integration plans would 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.

1.5 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 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 Benefits

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 (FFS) 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 substance use disorder 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.

Drug Medi-Cal Organized Delivery System (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.

1.6 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 through, 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 transition 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: Under 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 the California’s Master Plan for Aging.

1.7 From Medi-Cal 2020 to CalAIM

Through CalAIM, DHCS is undertaking a more targeted approach to consolidating its Medi-Cal benefit package 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 transformation 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 the 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.

1.8 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.

1.9 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 substance use disorder 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 transition 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.

2. Identifying and Managing Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health

This section will walk through proposals to identify and manage member risk and need:

- Population Health Management Program
- Enhanced Care Management
- In Lieu of Services
- Shared Risk, Shared Savings, and Incentive Payments
- SMI/SED Demonstration Opportunity
- Full Integration Plans
- Long-Term Plan for Foster Care

2.1 Population Health Management Program

2.1.1 Background

DHCS currently does not have a specific requirement for Medi-Cal managed care plans to maintain a population health management (PHM) program, which is a model of care and a plan of action designed to address member health needs at all points along the continuum of care. Many Medi-Cal managed care plans have a population health management program – often in the context of meeting National Committee for Quality Assurance (NCQA) requirements – but some do not. In the absence of a population health management program, beneficiary engagement is often driven by a patchwork of requirements that can lead to gaps in care and a lack of coordination.

The goal of this proposal is to improve health outcomes and efficiency through standardized core population health management requirements for Medi-Cal managed care plans, including NCQA requirements and additional DHCS requirements. The population health management program will be comprehensive and address the full spectrum of care management – including assessing population level and individual member health risks and health-related social needs, creating wellness, prevention, case management, care transitions programs to address identified risks and needs, and using stratification to identify and connect adult and pediatric members to the appropriate programs. Additionally, Medi-Cal managed care plans will develop predictive analytics about which members, communities or populations are emerging as high risk as well as identify and address the needs of outliers with more specific services and supports.

2.1.2 Proposal

All Medi-Cal managed care plans shall develop and maintain a whole system, person-centered population health management program, where the plan will partner with contracted health care providers and community-based partners to identify and address members' health and health-related social needs. Medi-Cal managed care plans shall consult with their local public health department and county behavioral health department during the development of the population health management program.

The population health management program shall meet NCQA standards for population health, regardless of whether the plan is NCQA accredited. In addition to the NCQA accreditation processes, the population health management program description must be filed with the state via the population health management template (forthcoming). After the initial program description submission, the Medi-Cal managed care plan will submit certain portions of the program description, including any changes, to DHCS annually, but significant portions of the program description will only be required to be submitted to DHCS once every three years.

Each Medi-Cal managed care plan shall include, at a minimum, a description of how it will meet the core objectives to:

- 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;
- Identify and mitigate social determinants of health; and
- Reduce health disparities or inequities.

The population health management program shall:

- Include the goal to improve the health outcomes of communities and groups;
- Utilize data to analyze community and population level health and health-related social needs and set measurable goals for improvement;
- Utilize initial and ongoing assessments of data to analyze individual member's needs and identify groups and individuals within groups for targeted interventions;
- Provide assistance for members to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, slow the progression of

disease or disability, and support members with serious illness as their disease progresses;

- Coordinate care across the continuum of medical, behavioral health, developmental, oral health, and long-term services and supports, including tracking referrals and outcomes of referrals;
- Deploy strategies to address individual needs and mitigate social determinants of health;
- Deploy strategies to drive improvements in health for specific populations proactively identified as experiencing health disparities;
- Partner with appropriate community-based providers to support individual members, families, and caregivers in managing care.
- Utilize evidence-based practices in screening and intervention;
- Utilize a person-centered and family-centered approach for care planning; and
- Continually evaluate and improve on the population health management program strategy on an ongoing basis through meaningful quality measurement.

Assessment of Risk and Need

1. Initial Data Collection and Population Risk Assessment

As reflected in the NCQA Population Health program requirements and the [DHCS Population Needs Assessment All Plan Letter \(APL\)](#), the Medi-Cal managed care plan shall collect electronically available data sources in order to analyze data that capture the information on member health status and utilization (including physical, behavioral, and oral health), health-related social needs, and linguistic, racial, and cultural characteristics. As part of the population health management requirements, DHCS will continue to apply the existing Population Needs Assessment (PNA) APL requirements to hold the Medi-Cal managed care plans accountable for a PNA, which include requirements for analyzing health disparities and engaging external stakeholders as part of the process. DHCS will consult with NCQA to ensure the PNA APL data requirements meet NCQA data requirements for the population assessment.

The PNA requires that Medi-Cal managed care plans collect and analyze this data across the plan's entire Medi-Cal member population to identify opportunities at a population level to improve health. One example of how this might be done is through a type of analysis commonly known as "hot spotting." As noted in the PNA and NCQA

requirements, key issues Medi-Cal managed care plans must analyze in the assessment include:

- Acute, chronic, and prevention/wellness health needs;
- Areas of clinically inappropriate, over and under-utilization of health care resources;
- Opportunities for better care management and quality improvement;
- Health disparities by race, ethnicity, language, and functional status; and
- Health-related social needs at the community or local level.

The results of the PNA will inform the development of programs and strategies that the Medi-Cal managed care plan will use to address the needs of specific populations. Determining which individuals have access to these specific programs and strategies will be driven by the subsequent member-level risk stratification, population segmentation, and case management activities. Consistent with the PNA APL, Medi-Cal managed care plans must use the assessment to develop and implement an action plan to address community and population needs. DHCS does not currently plan to provide more specific requirements regarding community and population-level program development, but in the population health management template, Medi-Cal managed care plans will be asked indicate what they will be doing in this area, which also may be a focus of future learning collaborative best practice work.

2. Initial Risk Stratification, Segmentation and Tiering

Risk stratification or segmentation will enable Medi-Cal managed care plans to identify specific members who may benefit from wellness, prevention, and disease management activities; members who can benefit from case management; and members who are at risk for developing complex health issues. Consistent with NCQA Population Health program requirements, Medi-Cal managed care plans will be required to risk stratify and segment members into groups that it will use to develop and implement case management, wellness, and health improvement programs and strategies. Medi-Cal managed care plans will also be required to use DHCS-defined criteria to tier its members into four risk tier categories and report that information to DHCS.

Consistent with the NCQA Population Health program requirements, Medi-Cal managed care plans shall conduct the risk stratification and segmentation and DHCS risk tiering using an integrated data and analytics stratification process that considers at least the following sources:

- Previous screening or assessment data;
- Disengaged member reports;
- Claims or encounter data, including all fee-for-service data provided by DHCS;

- And to the extent available:
 - Available social needs data, including housing status ICD-10 data; and
 - Electronic health records.

Risk Stratification or Segmentation: Medi-Cal managed care plans will analyze each individual's data based on the minimum, mandatory list of data sources described above and will then risk stratify and segment members into meaningful sub-populations. The Medi-Cal managed care plan will use risk stratification and segmentation to identify specific members who may benefit from targeted interventions and programs designed to meet identified member needs. Risk stratification and segmentation must occur within 44 days of the effective date of plan enrollment.

The Medi-Cal managed care plan may use its own algorithm to risk stratify or segment its population or it may use the DHCS-defined risk tiers described below as a starting point for further stratification and segmentation. The design of the algorithm, including how the data is stratified and segmented as part of the algorithm, should be informed by the health needs identified through the population assessment and designed so that the Medi-Cal managed care plan can group individual members into meaningful categories and subsequently outreach to individual members within those categories for tailored interventions and programs designed to achieve specific health outcomes. Medi-Cal managed care plans will incorporate enhanced care management into their segmentation in accordance with DHCS enhanced care management target population guidance and Medi-Cal managed care plan flexibility afforded for the enhanced care management benefit. When risk stratifying its member population, Medi-Cal managed care plans must use a validated risk grouper.

Risk stratification or segmentation algorithms shall include past medical and behavioral health service utilization but must also incorporate other data such as health conditions, risk factors, and disease progressions, in order to avoid exacerbating underlying biases in utilization data that may drive health disparities. Medi-Cal managed care plans must analyze the results of its stratification/segmentation algorithm to identify and correct any biases the algorithm may introduce based on race, ethnicity, language, functional status, or other sources of health disparities. In the population health management program description, the Medi-Cal managed care plan will submit to DHCS its list of stratification/segmentation data sources, the risk stratification/segmentation algorithm (or the name of the tool if it is proprietary), and also the method of bias analysis. To promote transparency and best practices, these three pieces of information will be made available for public viewing on DHCS' website and will also be a focus of continuing Medi-Cal managed care plan learning collaborative activities.

Based on the risk stratification/segmentation and the findings from Individual Risk Assessment (IRA) described below, the Medi-Cal managed care plan will link the member with the appropriate services including, but not limited to, wellness and prevention, general case management, complex case management, enhanced care management, in lieu of services (as available) external entity coordination, and transition coordination. Specific minimum requirements for each of these categories are listed in their own sections below.

DHCS Risk Tiering Requirements. This risk tiering process, including the IRA described below, will satisfy federal Medicaid Managed Care Final Rule requirements for initial risk assessment. Medi-Cal managed care plans will use DHCS-defined criteria to assign each member into one of four risk tiers: (1) low risk; (2) medium and rising risk; (3) high risk; and (4) unknown risk. The criteria for these tiers will be developed by DHCS.

The types of criteria used will be similar (but not the same) as the DHCS criteria for risk stratifying seniors and persons with disabilities (SPDs) into low- and high-risk groups. The criteria will align with the questions that DHCS will develop for the IRA survey tool, which is addressed in the next section. “High risk” members are those who are at increased risk of having an adverse health outcome or worsening of their health status. “Medium and rising risk” members are those that are stable at a medium risk level and those whose health status suggest they have the potential to move into the high-risk category.

Members at the medium/rising and high risk levels likely require additional provider-level assessment, care coordination, and/or possibly case management, or other specific services, which will be determined by the Medi-Cal managed care plan’s population segmentation strategy and coordination with providers. “Low risk” members are those who, in general, only require support for wellness and prevention. “Unknown risk” members are those who do not have sufficient data to stratify into a risk tier and for whom the Medi-Cal managed care plan is unable to complete a member-contact screening risk assessment. The IRA survey tool will be designed to have enough information to allow for risk tier assignment on its own if there is insufficient available historical data for the member.

DHCS will develop a process to validate Medi-Cal managed care plans’ implementation of the DHCS risk tier criteria to ensure consistent application and output statewide.

3. Individual Risk Assessment Survey Tool

DHCS will develop a standardized, 10-15 question Individual Risk Assessment (IRA) Survey Tool. There will be two versions, one for children and one for adults. Medi-Cal managed care plans will use the IRA to: (1) confirm or revise the initial DHCS risk tier to which the member was assigned; (2) gather consistent information for members without sufficient data; and (3) add information that will be used as part of its own stratification/segmentation algorithms and population health management strategy.

DHCS' goal in the development of the IRA questions will be to ensure they are validated and can be used with a scoring mechanism so that the IRA information can be integrated into the Medi-Cal managed care plan's risk stratification/segmentation process. DHCS will translate the questions into the threshold languages. Medi-Cal managed care plans will have the flexibility to add questions of their choosing to the IRA and would then also translate those additional questions into all threshold languages. It is expected that Medi-Cal managed care plans will conduct subsequent and separate screenings (or add supplemental questions) to identify specific issues and priorities to address.

The IRA will replace the assessments below:

- Staying Healthy Assessment/Individual Health Education Behavioral Assessment (SHA/IHEBA)
- Health information form/member evaluation tool (HIF/MET)
- Health risk stratification and assessment survey for SPDs
- Whole Child Model Assessment
- The Initial Health Assessment (IHA) provider visit (within 120 days of enrollment) will remain a requirement, but DHCS contracts and policies will not specify provider requirements for that visit.

Medi-Cal managed care plans will continue to be required to ensure the provision of preventive and other services in accordance with contractual requirements and accepted standards of clinical care.

Members assigned to the DHCS medium/rising, high, and unknown risk tiers must be contacted within 90 (medium/rising) and 45 (high and unknown) calendar days respectively to assess their needs. The IRA may be done via multiple modalities, including phone, in-person, electronic, or mail, as long as the screening responses can be transposed into an electronic format that allows for data mining and data exchange of key elements with DHCS. Data exchange of IRA elements with DHCS is not required at this time. Medi-Cal managed care plans should use this modality flexibility to maximize successful contact. Medi-Cal managed care plans shall make at least three (3) attempts to contact a member using available modalities.

If the Medi-Cal managed care plan is unable to obtain a completed IRA from a member, it has the option to create a process for working with the member's assigned primary care provider to: 1) have the member complete the assessment with them; and 2) transfer the resulting information to the Medi-Cal managed care plan.

Medi-Cal managed care plans will use the IRA information to assign or revise the member's DHCS risk tier. Once that process is complete, Medi-Cal managed care plans will be responsible for reporting the member's assigned risk tier to DHCS in an electronic format to enable better tracking and assessment of the impacts of the population health

management program. The Medi-Cal managed care plan will also share information regarding the assigned member's risk tier to the member's assigned PCP in an electronic format. If the member transfers to another Medi-Cal managed care plan, DHCS will provide the member's risk tier to the new Medi-Cal managed care plan.

The IRA questions will align with the DHCS-specified criteria for high, medium/rising, and low risk tiers. It is DHCS's intent that the structure of the IRA will meet NCQA requirements for a Health Appraisal.

- The IRA will include 10-15 questions, which seek to identify preliminary risk information for the following elements: Behavioral, developmental, physical, Long Term Services and Supports, and oral health needs;
- Emergency department visits within the last six months;
- Self-assessment of health status and functional limitations;
- Adherence to medications as prescribed;
- Assessment of health literacy and cultural and linguistic needs;
- Desire or need for case management;
- Ability to function independently and address his/her own health needs;
- Access to basic needs such as education, food, clothing, household goods, etc.;
- Use or need for long-term services and supports;
- Availability of social supports and caregiver;
- Access to private and public transportation;
- Social and geographic isolation; and
- Housing and housing instability assessment;

4. Reassessment

At a minimum, the Medi-Cal managed care plan shall reassess risk and need, including rising risk, of all members annually both the DCHS risk tiering and its own risk stratification/segmentation process. Individual members' risk and need may need to be re-evaluated throughout the year based on a change in condition or level of care, such as an inpatient admission or new diagnosis, the availability of new data, or a case management interaction.

Medi-Cal managed care plans must describe what events or data trigger the re-evaluation process for individual members. In the population health management program description, the Medi-Cal managed care plan must inform DHCS what minimum risk groups would require regular assessment in between the annual risk stratification process. However, this does not limit the Medi-Cal managed care plan from conducting additional assessments beyond what is defined as required by DHCS.

5. Provider Referrals

Medi-Cal managed care plans must establish a process by which providers may make referrals for members to receive case management or services for other emerging needs. Referrals for case management should lead to a re-evaluation of risk stratification and DHCS risk tier assignment. Medi-Cal managed care plans must consider and integrate information received through referrals when determining members' risk stratification.

Actions to Support Wellness and Address Risk and Need

1. General Requirements and Services

The Medi-Cal managed care plan shall integrate required activities with the population health management program as appropriate including, but not limited to member services, utilization management, referrals, transportation, health/plan/benefit education, appointment assistance, warm-handoffs to community-based organizations or other delivery systems, system navigation, primary care provider member assignment, community outreach, preventive services, and screenings for all members.

The Medi-Cal managed care plan shall provide a toll-free line for primary care providers and specialists who seek technical and referral assistance when any physical or behavioral condition requires further evaluation or treatment. Available information shall include assistance in arranging for referrals, including mental health and SUD treatment referrals, developmental services referrals, dental referrals, referrals to home-based medical/social services for people with serious illness, and referrals to long-term services and supports. Communication about the availability of this consultation service shall be found on the front-page of the Medi-Cal managed care plan's website and in materials supplied to providers.

The Medi-Cal managed care plan shall provide a 24-hours-a-day, 7-days-a-week, toll-free nurse advice line for members who seek technical, clinical, and referral assistance for physical, oral, and behavioral health services to address urgent needs.

The Medi-Cal managed care plan shall demonstrate how they support practice change activities, the deployment of evidence-based tools for providers, and models of service delivery that optimize health care and coordinated health care and social services. Finally, the Medi-Cal managed care plan shall develop or provide access to a current and updated community resource directory for case managers and contracted providers.

2. Wellness and Prevention Services

The Medi-Cal managed care plan shall provide wellness and prevention services in accordance with NCQA and contractual requirements. The population health management program shall integrate wellness and prevention services for all members, regardless of risk tier, according to the benefits outlined in the managed care contract including, but not limited to, the following:

- Provide preventive health visits, developmental screenings, and services for:
 - All children (under 21 years of age) in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule.
 - All adults in accordance with US Preventive Services Task Force Grade “A” and “B” recommendations.
- Monitor the provision of wellness and preventive services by primary care providers as part of the Medi-Cal managed care plan Facility Site Review process.
- Provide health educational materials about topics such as disease management, preventive services, Early and Periodic Screening, Diagnostic, and Treatment services, how to access benefits, and other managed care plan health promotion materials.

3. Managing Members with Medium/Rising Risks

The population health management program shall:

- Provide screening for Adverse Childhood Experiences (ACEs) for children and adults, based on the recommended periodicity schedule as specified in the Medi-Cal managed care contract.
- Ensure members receive appropriate follow-up for behavioral, developmental, physical, and oral health needs including preventive care, care for chronic conditions, and referrals to long-term services and supports, as appropriate;

- Refer members identified, through assessment or re-assessment, as needing care coordination or case management to the member’s case manager for follow-up care and needed services within 30 calendar days; and
- Assess individual social care needs and deploy appropriate community resources and strategies to mitigate the adverse childhood experiences (ACEs) toxic stress and impacts of social determinants of health in partnership with providers and community organizations.

Additionally, Medi-Cal managed care plans will be required to use predictive analytics to inform them about which patients, communities or populations are emerging as high risk as well as identify and address the needs of outliers with more specific services and supports. To address this focus, Medi-Cal managed care plans shall incorporate the DHCS Population Needs Assessment and NCQA Population Health program requirements on this topic into their population health management strategy. Identifying and addressing the needs of specific high-risk communities and populations – sometimes referred to as “hot spotting” – will be a focus of the population health management learning collaborative and DHCS will continue to assess best practices in this area.

4. Case Management

Case management services actively assist at-risk members in navigating health delivery systems and acquiring self-care skills to improve functioning and health outcomes, slow the progression of disease or disability or prepare for the progression of a serious illness. Case management services are intended for members who are medium- or high-risk or may have rising risks that would benefit from case management services. Members determined to be low risk should continue to receive wellness and prevention services as well as other medically necessary services.

Case management services include the following, as needed and appropriate:

- Screening beyond the IRA to identify and prioritize goals and needs for case management, including both health issues, ACEs and toxic stress, and health-related social needs
- Documentation in an electronic format of the individual care plan and assigned case manager for each member (required for all case management).
- Utilization of evidence-based practices in screening and intervention.
- Ongoing review of the member’s goals and care plan as well as identifying and addressing gaps in care.
- Support from an inter-professional team with one primary point of contact for the member.

- Access to person-centered planning, including advanced care planning regarding preferences for medical treatment, and education and training for providers and families.
- Continuous information sharing and communication with the member and their providers.
- Ensuring a person-centered and family-centered approach by identification of member's circle of support or caregiver(s).
- Coordination and access to medically necessary health services and coordination with entities that provide mental health, substance use disorder services, and developmental and oral health services.
- Ensuring coordination and access to community-based services, such as home care, personal care services, and long-term services and supports.
- Developing relationships with local community organizations to implement interventions that address social determinants of health (e.g. housing support services, nutritional classes, etc.).
- Coordinating authorization of services including timely approval of and arranging for durable medical equipment, pharmacy, private duty nursing, palliative care, and medical supplies.
- Promoting recovery using community health workers, peer counselors, and other community supports.
- Requesting modifications to treatment plans to address unmet service needs that limit progress.
- Assisting members in relapse and/or crisis prevention planning that includes development and incorporation of recovery action plans, and advance directives for individuals with a history of frequent mental health readmissions or crisis system utilization.
- Assisting members in care planning related to cognitive impairment, traumatic brain injury, Alzheimer's disease, and dementia.
- Performance measurement and quality improvement using feedback from the member and caregivers.
- Delivery of services in a culturally competent manner that addresses the cultural and linguistic needs by interacting with the member and his or her family in the member's primary language (use of interpreter allowed), with appropriate consideration of literacy and cultural preference.
- If the Medi-Cal managed care plan assigns a case manager outside the plan, written agreements shall define the responsibility of each party in meeting case management requirements to ensure compliance and non-duplication of services. If situations arise where a member may be receiving care coordination from multiple entities, the Medi-Cal managed care plan shall identify a lead care coordinator.

If a member changes enrollment to another Medi-Cal managed care plan, the Medi-Cal managed care plan shall coordinate transition of the member to the new plan's case management system to ensure services do not lapse and are not duplicated in the transition. The Medi-Cal managed care plan must also ensure member confidentiality and member rights are protected.

Members may be assigned to one of three types of case management based on assessment of risk and need.

The three types of case management include:

- **Basic Case Management:** Basic case management would be appropriate for members who require planning and coordination that is not at the highest level of complexity, intensity, or duration. These services are provided by the Medi-Cal managed care plan, clinic-based staff, or community-based staff, and may be provided by non-licensed staff. These services may include assignment to a certified patient-centered medical home, participation in a Medi-Cal managed care plan disease management program or participation in another Medi-Cal managed care plan population health management program.
- **Complex Case Management:** The Medi-Cal managed care plan shall provide complex case management in accordance with NCQA requirements. NCQA defines complex case management as “a program of coordinated care and services for members who have experienced a critical event or diagnosis that requires extensive use of resources.” NCQA allows organizations to define “complex.” Complex case management generally involves the coordination of services for high-risk members with complex conditions.
- **Enhanced Care Management:** The proposed Enhanced Care Management benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals. Through collaborative leadership and systematic coordination among public and private entities, the enhanced care management benefit will serve target populations, benefit from data sharing between systems, and coordinate care in real time for beneficiaries. DHCS will evaluate individual and population progress — all with the goal of providing comprehensive care and achieving better health outcomes.

The population health management program description shall describe how and when the services are utilized in conjunction with the risk stratification process, as members with changing risk and needs may require changing levels of case management. If the Medi-Cal managed care plan delegates or contracts with a provider for case management or transition of care services, it must do so in accordance with the NCQA's population health management delegation requirements.

5. In Lieu of Services

“In lieu of services” are flexible wrap-around services that the Medi-Cal managed care plan will integrate into their population health management programs. These services are provided as a substitute or to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. In lieu of services should be integrated with case management for members at medium-to-high levels of risk and may fill gaps in Medi-Cal State Plan benefits to address medical or other needs that may arise due to social determinants of health. DHCS is proposing the initial use of in lieu of services to serve as a transition of the work done through existing pilots (e.g. Whole Person Care, the Health Homes Program, the Coordinated Care Initiative, etc.), as well as inform the development of future potential statewide benefits that may be instituted.

Examples of the in lieu of services that DHCS proposes to cover include many of the services currently provided in the Whole Person Care Pilot program that are not covered as Medi-Cal State Plan benefits. Some of these include, but are not limited to, respite, recuperative care, medically tailored meals, supplemental personal care services, housing tenancy navigation and sustaining services, and sobering centers. Medi-Cal managed care plans will develop a network of providers of allowable in lieu of services with consideration for which community providers have expertise and capacity regarding specific types of services. See **Appendix J: In Lieu of Services Options** for more detail.

6. Coordination between Medi-Cal Managed Care Plans and External Entities

The Medi-Cal managed care plan shall describe in the population health management program description how they will coordinate with, and refer members to, health care and social services/programs including, behavioral health services, dental, and home and community-based services. Referrals must be culturally and linguistically appropriate for the member. The Medi-Cal managed care plan must coordinate with competent external entities to provide all necessary services and resources to the member. These entities should be listed as part of the population health management program description identifying specific services each named entity will provide plan members. The Medi-Cal managed care plan's population health management

program description shall include assurance of payment to Indian Health Care Providers.

7. Transitional Services

The Medi-Cal managed care plan shall ensure transitional services are provided to all members who are transferring from one setting, or level of care, to another. The Medi-Cal managed care plan shall work with appropriate staff at any hospital that provides services to its members, whether contracted or non-contracted in the case of emergency services, to implement a safe, comprehensive discharge plan. The plan must provide continued access to medically necessary covered services that will support the member's recovery and prevent readmission.

The Medi-Cal managed care plan shall have in place operational agreements or shall incorporate transitional language into existing network arrangements with the Medi-Cal managed care plan's contracted community physical and behavioral health hospitals, residential treatment facilities and long-term care facilities, as applicable, to ensure smooth transitions. Transition services shall include tribal consultation/outreach for protections involving American Indians and Indian Health Clinic providers. The operational agreements shall define the responsibility of each party in meeting the following requirements:

- Completion of a standardized discharge risk assessment tool. The tool shall assess risk for re-institutionalization, re-hospitalization, and/or substance use disorder treatment recidivism. Each Medi-Cal managed care plan's discharge screening tool must be approved by DHCS;
- Development of a written discharge plan, shared with the beneficiary and all treating providers, to mitigate the risk of readmission and other negative health outcomes;
- Obtain the member's permission to share information with clinical and non-clinical providers to facilitate care transitions;
- Develop discharge planning policies and procedures in collaboration with all hospitals;
- Process all hospital prior authorization requests for clinic services within two business days. Such services shall include authorizations for therapy, home care services, equipment, medical supplies, and pharmaceuticals;
- Educate hospital discharge planning staff on the clinical services that require pre-authorization to facilitate timely discharge from the hospital; and
- Prevent delayed discharges from a hospital due to Medi-Cal managed care plan authorization procedures or transition to a lower level of care.

8. Skilled Nursing Facility Coordination

The Medi-Cal managed care plan shall coordinate with hospital or other acute care facility discharge planners and nursing facility case managers or social workers to ensure a smooth transition to or from a skilled nursing facility or nursing facility. The Medi-Cal managed care plan shall coordinate with the facility to provide case management and transitional care services and ensure coverage of all medically necessary services not included in the negotiated daily rate. This includes, but is not limited to, prescription medications, durable medical equipment, intravenous medications, and any other medically necessary service or product.

- If the Medi-Cal managed care plan, in coordination with the nursing facility or skilled nursing facility, anticipates the member will be in the facility after a member no longer meets criteria for medically necessary skilled nursing care or rehabilitative care, the Medi-Cal managed care plan shall assist the member in exploring all available care options. This includes potential discharge to a home or community residential setting, or to remain in the skilled nursing facility for long-term services and supports.
- If the member is discharged to a home or to a community residential setting, the Medi-Cal managed care plan shall coordinate with the facility to ensure the member is in a safe location. The plan shall ensure medically necessary services are available including, but not limited to, home health services, durable medical equipment and supplies, outpatient rehabilitation services, and any other services necessary to facilitate the member's recovery. The Medi-Cal managed care plan shall also ensure follow-up care is provided consistent with the transitional service requirements listed above.

Population Health Management Oversight

The Medi-Cal managed care plan shall have internal monitoring processes in place to ensure compliance with the population health management program requirements. Quality assurance reviews of documented population health management activities shall include:

- Case identification and assessment according to established risk stratification system;
- Electronically documented treatment plans and care plans with evidence of periodic revision as appropriate to emerging member needs;
- Referral management;
- Effective coordination of care, including coordination of services that the member receives through the fee-for-service system; and

- Identification of appropriate actions for the case manager to take in support of the member, and the case manager's follow-through in performing the identified tasks.

The Medi-Cal managed care plan shall document quality assurance reviews on an annual basis or upon DHCS' request and submit them to DHCS for review. Medi-Cal managed care plans are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including All Plan Letters, Policy Letters, and Dual Plan Letters. These requirements must be communicated by each Medi-Cal managed care plan to all delegated entities and sub-Medi-Cal managed care plans. The Medi-Cal managed care plan must submit a population health management oversight plan in accordance with NCQA requirements for any entities to which they delegate population health management functions. Such plans would need to be reviewed and approved by the state.

Health Information Technology to Support Integrated Care and Care Coordination

The Medi-Cal managed care plan will work to implement health information technology to support population health principles, integrated care, and care coordination across the delivery system. Examples of health information technology include, but are not limited to, electronic health records, emergency department information exchange, clinical data repositories, registries, decision support and reporting tools that support clinical decision-making, and case management. An overarching goal of the population health management program is to expand interoperable health information technology and health information exchange infrastructure, so that relevant data (including clinical and non-clinical) can be captured, analyzed, and shared to support provider integration of behavioral health and medical services, case management oversight and transitional planning, value-based payment models, and care delivery redesign.

The Medi-Cal managed care plan shall develop data exchange protocols, including member information sharing protocols, before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination including, but not limited to, sharing of claims and pharmacy data, treatment plans or care plans, and advance directives necessary to coordinate service delivery and care management for each member in accordance with applicable privacy laws.

Improved data collection, specifically of encounter data at the provider level, is a critical component of achieving the goals of this proposal, and DHCS will be working with plans and providers to achieve this goal.

Accountability and Oversight of Medi-Cal Managed Care Plans

In order to hold Medi-Cal managed care plans accountable for the activities proposed here, DHCS will increase its oversight and assessment of the plans to include changes

to its audit procedures and the imposition of corrective action plans and financial sanctions, when appropriate. DHCS recognizes that, through this and the other CalAIM proposals, the responsibility of Medi-Cal managed care plans will increase over time, and therefore DHCS' approach to oversight and accountability must also grow and change in conjunction with these proposals. DHCS is committed to providing Medi-Cal managed care plans technical assistance to support the smooth adoption of these changes.

Future Policy Development and Technical Assistance

As technical assistance for Medi-Cal managed care plans in development of their population health management programs, DHCS will provide submission templates and best practice examples of Medi-Cal managed care plan population health management programs from California and other states. DHCS will also create a DHCS-operated learning collaborative for Medi-Cal managed care plans to share information and promising practices. The learning collaborative will foster information sharing and address promising practices in all the DHCS-required population health management activities. The following topics that have been identified by stakeholders:

- Medi-Cal managed care plan coordination and partnerships with external entities that provide carved-out services, such as specialty mental health, Drug Medi-Cal, Regional Centers, schools, public health departments, and community-based organizations that provide social services;
- Engaging with consumers who have health and social needs but are unidentified, unengaged, and are underutilizing services, including methods to engage with these members, build trust, and obtain information from the member about their needs;
- Care transition coordination including sharing discharge risk assessment tools;
- Incorporating social determinants of health and health-related social care needs into case management and community-level population improvement activities;
- Collection of social determinants of health information for risk stratification and segmentation, and for state-level data collection for strategic planning purposes;
- Best practices in how to use population health management programs to support specific populations of interest, such as children and pregnant women, in ways that align with other DHCS initiatives;
- Use of population data for “hot spotting” and other population analysis promising practices;

- Use of general beneficiary medical record release consent to allow Medi-Cal managed care plans and providers to share data broadly for the purposes of care coordination;
- Learning best practices from California Accountable Communities for Health Initiative activities, including opportunities for partnership and elements that may be appropriate to integrate into the population health management strategies;
- Data exchange protocols and the development of health information technology/health information exchange policies; and
- Submission of housing status data to DHCS via ICD-10 coding, in alignment with the current DHCS Value-Based Payment incentive program for these codes.

The best method to advance promising practices in these areas may be to allow them to emerge through a learning collaborative and assessment of Medi-Cal managed care plan outcomes. DHCS may also standardize certain requirements after further research and consultation with stakeholders.

Continuing areas of DHCS policy development will include:

- DHCS Risk Tiering criteria;
- DHCS IRA to gather individual member information for risk tiering and stratification;
- Detailed review of alignment with NCQA Population Health program requirements, in coordination with NCQA and Medi-Cal managed care plans;
- Continued exploration into what guidance DHCS can provide regarding what can be allowed for different types of information sharing between providers and Medi-Cal managed care plans to facilitate care coordination;
- Voluntary guidance from DHCS regarding Medi-Cal managed care plan collection of social determinants of health data from ICD-10 encounter coding. The guidance, and Medi-Cal managed care plan collection of this data in accordance with the guidance, will become mandatory on January 1, 2024; and
- Setting prospective, prioritized goals to improve Medi-Cal managed care population health management over five years from the implementation date. To do this, DHCS will review of population health management program outcomes goals and measures, and their relation to the broader DHCS managed care quality metric strategy, which may be used to assess each Medi-Cal managed care plan's population health management program.

2.1.3 Rationale

The population health management program requirement will ensure that there is a cohesive plan to address beneficiary needs across the continuum of care, from prevention and wellness to complex case management. This proposal will work in conjunction with other CalAIM proposals to meet the overarching CalAIM goals of improving coordination and quality, while reducing unnecessary administrative burden and redundancy. The following CalAIM elements of the population health management program will magnify the positive impact on member outcomes:

- **NCQA Accreditation** will provide a foundation of quality best practices and an oversight structure for the population health management program and other Medi-Cal managed care plan activities;
- The new **enhanced care management** benefit will provide a critical new set of services as well as an effective case management tool to integrate within the population health management program;
- The adoption of a menu of **in lieu of services** – flexible wrap-around services designed to fill medical and social determinants of health gaps – will similarly integrate within the population health management program; and
- Making **shared risk/savings and incentive payments** available to Medi-Cal managed care plans and providers will maximize the effectiveness of the population health management program and new service options.

2.1.4 Proposed Timeline

The population health management program would be implemented as part of the new Medi-Cal managed care plan contracts, with an effective date of January 1, 2023. The date for the first population health management program description submission and other required submissions from Medi-Cal managed care plans to DHCS is to be determined.

2.2 Enhanced Care Management Benefit

2.2.1 Background

Depending on the needs of the beneficiary, some individuals may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, developmental, dental, In Home Supportive Services, etc.). Given the similarities in target populations across Medi-Cal delivery systems, beneficiaries are likely to be eligible for multiple programs that include some level of care management, depending on the efforts that are underway in their county of residence.

Additionally, 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. The Health Homes Program and many of the Whole Person Care pilots provide such services. DHCS is proposing the implementation of a single, comprehensive enhanced care management benefit within Medi-Cal managed care. Lessons learned from the Whole Person Care pilots and the Health Homes Program will be incorporated to ensure that the new enhanced care management benefit is designed to meet the clinical and non-clinical needs for the highest cost/highest need beneficiaries in Medi-Cal and is available as a statewide benefit.

2.2.2 Proposal

The proposed enhanced care management benefit will replace the current Health Homes Program and elements of the Whole Person Care pilots, building on positive outcomes from those programs over the past several years. Based on extensive stakeholder engagement, DHCS will require that beneficiaries receiving Health Homes or Whole Person Care services are seamlessly transitioned to continue receiving care coordination services by way of the new enhanced care management benefit. Medi-Cal managed care plans will be mandated to contract with all existing local providers offering Health Homes and Whole Person Care services, with a few contractual exceptions. Medi-Cal managed care plans will be required to contract with community-based providers that have experience serving the enhanced care management target populations, and who have expertise providing the core enhanced care management services. Further, to allow non-Whole Person Care or Health Homes Program counties additional time to develop an adequate local infrastructure, a phased-in approach for implementing enhanced care management will be adopted.

It is the state's intention to implement this new initiative in a complementary, rather than duplicative manner that will build upon the strengths and foundations of these existing programs. DHCS recognizes the significant investment the Whole Person Care entities made over the past five years in building the capacity for these services. The intention is to build on those investments and infrastructure to continue the positive outcomes achieved by the Whole Person Care pilots. Additionally, as a result of extensive stakeholder feedback, DHCS has determined that Medi-Cal managed care plans will be required to coordinate enhanced care management services with county Targeted Case Management programs to ensure non-duplication of services and provide a holistic approach to care for Medi-Cal's most vulnerable beneficiaries.

The proposed enhanced care management benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Enhanced care management is a collaborative and interdisciplinary approach to

providing intensive and comprehensive care management services to targeted individuals.

Medi-Cal managed care plans will proactively identify members who meet the target population criteria and can benefit from enhanced care management services. The enhanced care management providers will be taking on the responsibility for coordinating services across all delivery systems. They are the primary responsible entity for coordinating across multiple medical and social service domains of care. Authorized members will be assigned a lead care manager that will have responsibility for interacting directly with the member and coordinating all primary, behavioral, developmental, oral health, and long-term services and supports, any in lieu of services, and services that address social determinants of health needs, regardless of setting.

Through collaborative leadership and systematic coordination among public and private entities, the enhanced care management benefit will serve target populations, benefit from data sharing between systems, and coordinate care in real time for beneficiaries. DHCS will evaluate individual and population progress — all with the goal of providing comprehensive care and achieving better health outcomes.

The overarching goals for enhanced care management are:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Improving health outcomes;
- Addressing social determinants of health; and
- Decreasing inappropriate utilization.

The enhanced care management target populations include: (see **Appendix I: Enhanced Care Management Target Population Descriptions** for more detailed definitions):

- Children or youth with complex physical, behavioral, developmental, and/or 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.

Enhanced Care Management Design and Services

The enhanced care management benefit, which will be delivered by community-based providers (“ECM Providers”) contracting with Medi-Cal managed care plans, will provide multiple opportunities to engage beneficiaries by stratifying risk and need, developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Enhanced care management services extend beyond standard care coordination and disease management activities and are concentrated on the coordination and monitoring of cost-effective, quality direct care services for the individual, as well as connections to needed community supports for indirect care needs.

The enhanced care management benefit is fundamentally person-centered, goal-oriented, and culturally relevant to assure that, as a primary goal of the program, members receive needed services in a supportive, effective, efficient, timely, and cost-effective manner. Enhanced care management will emphasize prevention, health promotion, continuity and coordination of care to link members to services as necessary across providers and settings and with emphasis on identifying the least restrictive and most integrated setting that will meet the needs of the beneficiary.

The role of enhanced care management is, through face-to-face visits, to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the member, including participating in the care planning process, regardless of setting. Enhanced care management activities shall become integrated with other care coordination processes and functions and shall assume primary responsibility for coordination of the member’s physical health, behavioral health, oral health, developmental, and long-term care needs.

Enhanced care management will be provided at a level dictated by the complexity of the health and social needs of the member. The approach to enhanced care management will be high-touch, on-the-ground, and face-to-face, with frequent contacts for persons residing in community settings and nursing facilities. Enhanced care management care managers are expected to develop relationships with members and their families, engage

members and families in needs assessment and care planning processes, and work with the primary care provider to address the member's needs in coordinating physical and behavioral health care.

The enhanced care management care managers will operate within the member's community, serve as the members' primary point of contact and are responsible for ensuring that applicable physical, behavioral, long-term care, developmental, oral, social, and psychosocial needs are met in the safest, least restrictive way possible while considering the most cost-effective way to address those needs. Care managers meet members where they are, both literally, and from a medical management and plan of care perspective. Community health workers can also be used to improve outreach and provide care coordination services for beneficiaries.

Required programmatic elements to be implemented include, but are not limited to, care coordination, health promotion, comprehensive transitional care, member and family supports and referral to community and social services. These elements include helping beneficiaries navigate, connect to and communicate with providers and social service systems; coaching beneficiaries on how to monitor their health and identify and access helpful resources; identifying and coordinating available in lieu of services such as housing services; helping beneficiaries move safely and easily between different care settings and reducing avoidable hospital admissions and readmissions; educating beneficiaries and their family/support system about their conditions to improve treatment adherence and medication management; providing referrals to community and social services; and follow-up to help ensure that beneficiaries are connected to the services they need.

Program Administration

Enhanced care management will be administered by the Medi-Cal managed care plans, who will have direct responsibility for establishing the enhanced care management benefit and criteria for their members, subject to contractual requirements and programmatic guidance provided by DHCS. DHCS intends for Medi-Cal managed care plans to build upon the expertise and infrastructure of the existing Whole Person Care pilots and Health Homes Program to achieve these outcomes and, with some exceptions, to contract directly with existing Whole Person Care providers and Health Homes Program community-based care management entities, as well as other necessary contracting with public and private providers to deliver such services.

In addition, DHCS expects that plans will work in coordination and collaboration, and even contract when appropriate, with county behavioral health systems who often are the primary providers of services to a subset of Medi-Cal beneficiaries. This proposal requests that managed care plans determine the service design and intensity based on the parameters established by DHCS. DHCS will build enhanced funding into the

capitation rates to enable Medi-Cal managed care plans to successfully provide enhanced care management benefit. The Medi-Cal managed care plans will have strong oversight and will perform regular auditing and monitoring activities to ensure that all requirements are met. If a plan proposes to keep some level of enhanced care management in-house instead of contracting with direct providers, the plan will need to demonstrate to the state that their enhanced care management benefit is appropriately community-based and provide a rationale for not contracting with existing WPC and HHP providers (per the exceptions outlined in the enhanced care management and in lieu of services Model of Care Template and managed care plan contract language.)

For individuals with a primary SMI diagnosis, SUD, children with SED, or children involved in child welfare, county behavioral health staff should be considered to serve as the enhanced care management provider through a contractual relationship, provided they agree to coordinate all the services (physical, developmental, oral health, long-term care and social needs) needed by those target populations, not just their behavioral health needs. These staff will focus on the behavioral health needs and interventions for the Medi-Cal beneficiary, act as a resource for the Medi-Cal managed care plan in managing the needs of this population and ensuring that beneficiaries are linked to appropriate county resources; as well as other resources that have more experience and documented success in working with those living with these conditions.

Targeted Case Management

Furthermore, Medi-Cal managed care plans will be expected to work with Local Governmental Agencies to ensure that members receiving enhanced care management services do not receive duplicative Targeted Case Management services; this approach will also help support the Department's goal of strengthening the connections across California's delivery systems. The Targeted Case Management program is an optional Medi-Cal Program funded by federal and local funds. See **Appendix B: Targeted Case Management** for which counties currently participate in the Targeted Case Management program.

DHCS may need to review and discuss other potential county funding interactions with this benefit to ensure there is no duplication of services or funding.

Transition and Coordination Plan

Medi-Cal managed care plans currently operating a Health Homes Program or operating in a county with a Whole Person Care pilot or Targeted Case Management program, will be required to submit a transition and coordination plan to DHCS by July 1, 2021. Through the transition and coordination plan, managed care plans will demonstrate how they will translate the existing programs into the enhanced care management benefit and in lieu of services and coordinate with existing Targeted Case Management programs. The

plans must also demonstrate a good faith effort to contract for enhanced care management and in lieu of services with existing Health Homes providers and Whole Person Care entities already providing such services. If the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS information as to why such entities were not able to come to a contractual agreement.

Medi-Cal managed care plans in counties with Targeted Case Management programs will be required to submit information in the transition and coordination plan describing how they will work with the Local Government Agency to ensure that members receiving enhanced care management services do not receive duplicative Targeted Case Management services.

A transition and coordination plan will not be required for Medi-Cal managed care plans in counties that do not have Whole Person Care pilots, Health Homes Programs, or Targeted Case Management.

Implementation

January 1, 2022: All Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will begin implementation of the enhanced care management benefit, for those target populations currently receiving Health Homes Program and/or Whole Person Care services.

July 1, 2022:

- Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will implement additional mandatory enhanced care management target populations.
- All Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs must begin implementation of select enhanced care management target populations.

January 1, 2023: All Medi-Cal managed care plans in all counties must implement enhanced care management for all target populations.

Medi-Cal managed care plans that begin implementing on January 1, 2022 will submit an enhanced care management Model of Care proposal to DHCS for review by July 1, 2021. Draft contract provisions will be shared with plans in February 2021. Medi-Cal managed care plans that will implement enhanced care management on July 1, 2022, will submit an enhanced care management Model of Care by January 1, 2022. All plans must complete readiness activities for the mandatory target populations. Medi-Cal managed

care plans can submit to DHCS additional optional target populations, in addition to the mandatory target populations.

Federal regulations require that Medi-Cal managed care plan implementation activities shall include tribal consultation/outreach for protections involving American Indians and Indian Health Clinic providers. Through the enhanced care management Model of Care, managed care plans must demonstrate that there are sufficient Indian Health Clinics participating in their provider network to ensure timely access to services available under the contract from such providers for American Indian enrollees who are eligible to receive services. Medi-Cal managed care plans will provide a description of their coordination with tribal partners within the enhanced care management transition and coordination plan.

By July 1, 2022, all Medi-Cal managed care plans will need to submit to DHCS an enhanced care management Model of Care proposal for serving individuals transitioning from incarceration for implementation on January 1, 2023 in all counties. Re-entry transitions involve working closely with corrections departments, including probation, courts and the local county jail system to ensure connections to care once individuals are released from jail. While there is some infrastructure in place for this enhanced care management target population due to Whole Person Care Pilots, these types of arrangements require significant planning and coordination between the managed care plan, counties, sheriff, probation, and other key stakeholders.

DHCS is also looking to leverage the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act provisions that may make it possible to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release.

This aspect of enhanced care management will support the scaling of diversion 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. In this case, Medi-Cal managed care plans can contract with county and non-profit entities that work to meet the health care needs of those who are involved in pre- or post-booking diversion behavioral health and criminogenic treatment programs and, thus, are at risk for incarceration and could, through care coordination and service placement, have a treatment plan built to avoid incarceration and get into community-based care and services.

Furthermore, to complement this enhanced care management benefit, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023.

Mandated County Inmate Pre-Release Application Process

In 2004, the Centers for Medicare & Medicaid Services (CMS) issued a [State Medicaid Director letter](#), entitled “Ending Chronic Homelessness,” that encouraged states to ensure that applications for Medicaid are processed in a timely manner so that individuals can receive Medicaid-covered services immediately upon release from a public institution.

On May 6, 2014, DHCS provided guidance in All-County Welfare Directors Letter #14-24, on the pre-release application process for state inmates who apply for Medi-Cal coverage. Subsequently, on June 25, 2014, DHCS clarified in All County Welfare Directors Letter #14-24E, that the guidance issued in the May 2014 letter is also applicable to county inmates. However, a specific pre-release process to facilitate the applications for county inmates was not defined and implementation of such process was voluntary.

The current pre-release application process varies from county to county. From a survey of some counties, DHCS learned that relatively larger counties with pre-release programs, such as Orange County and Stanislaus County, have agreements with third-party entities (e.g., community-based organizations or vendors) to streamline the pre-release application process and to provide dedicated application intake staff that visit individuals at the county jail while still in custody. Of the smaller counties surveyed, Yolo County has an agreement with the Sheriff’s Department to establish communication channels and set up physical stations at the correctional facility, as well as security clearances for designated county staff to speak with the county inmate applicant directly. **Appendix C: County Inmate Pre-Release Application Process sample contracting Models** includes the three main models currently being used for various county inmate pre-release application programs.

DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023, which would include juvenile facilities. The goal of the proposal is to ensure the majority of county inmates/juveniles that are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to Medi-Cal services upon release from incarceration.

Additionally, DHCS is proposing to mandate that all county jails and juvenile facilities implement a process for facilitated referral and linkage from county release to county specialty mental health, Drug Medi-Cal, Drug Medi-Cal Organized Delivery Systems, and Medi-Cal managed care providers when the inmate was receiving behavioral health services while incarcerated to allow for continuation of behavioral health treatment in the community. DHCS will look to counties to implement medical record release processes that would allow medical records to be shared with the county behavioral health and Medi-Cal managed care providers, prior to or upon release from jail or county juvenile facility.

The mandated county inmate pre-release application process will standardize policy, procedures, and collaboration between California’s county jails, county sheriff’s departments, juvenile facilities, county behavioral health and other health and human services entities. This collaboration will ensure that eligible individuals are enrolled in Medi-Cal prior to release and will establish a continuum of care and ongoing support that may ultimately help to reduce the demand for costly and inappropriate services.

2.2.3 Rationale

DHCS continues to strengthen integration within the state’s health care delivery system and is working with health promotion partners to achieve better care and better health outcomes at lower cost to the Medi-Cal program. Creating a statewide enhanced care management benefit with required target populations is consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need. The benefit will comprise an intensive set of services for Medi-Cal members who require coordination at the highest levels. Targeted individuals are beneficiaries who may be challenged with medical and behavioral conditions, access to care issues, chronic illnesses, disabilities, multiple social determinants of health, and require multidisciplinary care to regain health and function.

The enhanced care management benefit will provide Medi-Cal managed care plans with opportunities to help beneficiaries achieve improved health and well-being through stratifying risk and need and developing care plans and strategic interventions. Enhanced care management services will extend beyond standard care coordination and disease management activities. They will be concentrated on the coordination and monitoring of cost-effective, high quality, direct care services, as well as connections to needed community supports for non-direct care needs.

2.2.4 Proposed Timeline

DHCS is proposing a phased statewide implementation of the enhanced care management benefit and inclusion in Medi-Cal managed care contracts. Medi-Cal managed care plans in counties with Whole Person Care Pilots and/or Health Homes Programs will implement enhanced care management on January 1, 2022 for those target populations currently receiving Health Homes and/or Whole Person Care services. On July 1, 2022, Medi-Cal managed care plans in those counties will implement additional required target populations and counties without Whole Person Care pilots and/or Health Homes Programs will begin implementing select populations on July 1, 2022. The benefit must be implemented for in all counties all target populations, including individuals transitioning from incarceration, by January 1, 2023.

DHCS is proposing an effective date of January 1, 2023 for counties to implement a county inmate/juvenile pre-release application process. To ensure the necessary data

sharing agreements and communication plans are in place, below is detailed timeline for planning and implementation of this proposal:

- **March 1, 2021:** Establish workgroup with County Welfare Director's Association and counties to develop and vet implementation plan
- **May 1, 2021:** All county guidance development
- **November 1, 2021:** County and stakeholder feedback process
- **January 1, 2022:** Publish All County Welfare Director Letter
- **January – December 2022:** County implementation planning and technical assistance
- **January 1, 2023:** Implementation of county inmate pre-release application process

2.3 In Lieu of Services

2.3.1 Background

The Whole Person Care pilots and Health Homes Program built a foundation for an integrated approach to coordinating medical care, behavioral health, and social services to improve beneficiary health outcomes. The implementation of these programs, however, has varied across California and did not provide a statewide platform to comprehensively address the needs of beneficiaries with the most complex health challenges.

According to federal Medicaid program rules, “in lieu of services” are medically appropriate and cost-effective alternatives to services that can be covered under the State Plan. They are typically delivered by a different provider or in a different setting than traditional State Plan services. An in lieu of service can only be covered if:

- The state determines that the service is a medically appropriate and cost-effective substitute or setting for the State Plan service;
- The services are optional for the managed care plan to provide;
- The services are optional for beneficiaries and they are not required to use the in lieu of service; and
- The in lieu of services are authorized and identified in the state's Medi-Cal managed care plan contracts.

Once adopted, Medi-Cal managed care plans will integrate in lieu of services into their population health management plans – often in combination with the new enhanced care

management benefit – to address gaps in State Plan benefit services. In lieu of services may be focused on addressing combined medical and social determinants of health needs to avoid higher levels of care. For example, in lieu of services might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays, and emergency department use. Based on extensive stakeholder feedback, DHCS has updated the in lieu of services menu of services. The feedback enhanced the overall design of in lieu of services, allowing beneficiaries receiving Health Homes or Whole Person Care services to continue receiving optional plan services. Furthermore, the additional feedback optimized the depth and capacity for serving eligible beneficiaries.

2.3.2 Proposal

DHCS is proposing to include the following fourteen (14) distinct services as in lieu of services under Medi-Cal managed care. Details regarding each proposed set of services are provided in **Appendix J: In Lieu of Services Options**:

- 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 and Adult Residential Facilities
- 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 Medi-Cal managed care plans and beneficiaries have the option to accept the in lieu of services or receive the State Plan services instead. Each service will have defined eligible populations, code sets, potential providers, restrictions, and limitations. However, individual in lieu of services may be used

together with other complementary in lieu of services based on individual needs and may be combined with enhanced care management services for high-risk, complex-need individuals. ILOS can be offered as an appropriate EPSDT service. Other appropriate EPSDT services should be offered in conjunction with any ILOS.

Transition and Coordination Plan

Since DHCS is building on the infrastructure developed for the Health Homes Program and parts of the Whole Person Care pilots, Medi-Cal managed care plans in counties with these programs will be required to submit a Transition and Coordination Plan to the state by July 1, 2021 demonstrating how they will transition existing programs into their enhanced care management benefit and in lieu of services. The plans must also demonstrate a good faith effort to come into agreement with and contract for enhanced care management and in lieu of services with Health Homes providers and Whole Person Care entities providing such services. DHCS recognizes the significant investment in infrastructure, as well as the existing expertise in providing these types of services, by our local county and other public/private partners and expects Medi-Cal managed care plans to partner with these entities to continue providing these critical services. If the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS a justification as to why the plan has not contracted with such entities.

2.3.3 Rationale

Adoption of this set of in lieu of services will provide additional support to beneficiaries with complex medical and behavioral health needs who experience socio-economic conditions that impede their ability to achieve their health goals. These circumstances put them at risk of hospitalization, institutionalization, and/or in need of other higher cost services.

Currently, Medi-Cal strategies to address beneficiaries' social determinants of health vary across the state, depending on the initiatives underway in different regions. Consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need, establishing coverage of a set of in lieu of services will make a statewide offering of these critical interventions for Medi-Cal beneficiaries.

The in lieu of services framework allows for regions that do not currently have a sufficient infrastructure to provide the full array of services to build network capacity in a way that meets the unique needs of their residents. This may include partnerships to develop physical infrastructure, as well as collaborations with new provider types who have not historically worked with Medi-Cal. This will also set the stage for Medi-Cal managed care

plans to be prepared to have long-term services and supports integrated into their care program by 2027.

The stakeholder feedback was critical to ensuring that the identified services will adequately address the critical needs of beneficiaries. The final policy incorporates feedback received regarding strategies for building the necessary service infrastructure in a cost-effective manner, finalizing the eligible populations, potential restrictions and limitations, and appropriate provider types to deliver this new set of services.

2.3.4 Proposed Timeline

January 1, 2022: DHCS is proposing statewide implementation and inclusion of in lieu of services in Medi-Cal managed care plan contracts. DHCS will provide technical assistance to plans as they prepare to implement this new set of services.

2.4 Shared Risk, Shared Savings, and Incentive Payments

2.4.1 Background

The combination of carving in long-term care statewide, enhanced care management and in lieu of services provides a number of opportunities, including an incentive for building an integrated, managed long-term services and supports program by 2027 and building the necessary clinically-linked housing continuum for our homeless population.

In order for the state to be equipped with the needed MLTSS and clinically linked housing continuum infrastructure, it is important to consider potential incentives and shared savings/risk models that could be established to encourage Medi-Cal managed care plans and providers to fully engage. Incentive funding will be focused on building a pathway for Medi-Cal managed care plans to invest in the necessary delivery and systems infrastructure, build appropriate and sustainable enhanced care management and in lieu of services capacity, and achieve improvements in quality performance that can inform future policy.

2.4.2 Proposal

DHCS proposes to create a series of incentives through a multi-pronged risk strategy. Potential approaches include:

- A blended capitation rate to account for the addition of seniors and persons with disabilities and long-term care beneficiaries into managed care. The rate will be subject to a blend true-up, which will provide financial protections in case of significant differences between actual long-term care beneficiary enrollment and assumptions used during capitation rate development.

- A time-limited, tiered, and retrospective shared savings/risk financial calculation performed by DHCS. This tiered model would be available for three calendar years – 2023, 2024 and 2025.
- A prospective model of shared savings/risk incorporated via capitation rate development. DHCS proposes to implement this approach 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.

DHCS will establish plan incentives linked to delivery system reform through an investment in enhanced care management and in lieu of services infrastructure. The incentive payments will also be based on quality and performance improvements and reporting in areas such as LTSS and other cross-delivery system metrics. The target of incentive payments is to drive change at the managed care plan and provider levels. DHCS anticipates managed care plans will partner and share the incentive dollars with on-the-ground providers, including our critical partners that operate Federally Qualified Health Centers, Rural Health Centers, Indian Health Service clinics, public hospital safety net systems, and county behavioral health systems and providers to work collaboratively to meet the defined targets of incentive program.

2.4.3 Rationale

In recognition of the financial uncertainties that accompany the implementation of enhanced care management, in lieu of services, and MLTSS statewide, DHCS is committed to implementing strategies that will limit excessive financial risk (losses) for Medi-Cal managed care plans, as well as for the state and federal governments. At the same time, DHCS supports the use of strategies that will result in financial gains that can be shared between Medi-Cal managed care plans and the state and federal governments. DHCS' goal is to establish financial mechanisms that will ensure a mutual commitment to the success of the proposed short- and long-term reforms and innovations within the Medi-Cal managed care program.

DHCS' proposed risk approaches are intended to strengthen financial incentives for Medi-Cal managed care plans to:

- Divert or transition beneficiaries from long-term institutional care to appropriate home and community-based alternatives, supported by the availability of in lieu of services and enhanced care management;
- Make the necessary infrastructure investments to support the goal of transitioning to an integrated long-term services and supports program; and

- Improve quality, performance measurement, and data reporting as a pathway toward realizing better health outcomes for Medi-Cal beneficiaries.

2.4.4 Proposed Timeline

Rate setting, including associated risk strategies, is a dynamic process. Therefore, DHCS will engage and collaborate with Medi-Cal managed care plans and make future refinements as determined appropriate.

- **January – December 2021:** Develop shared savings/risk and plan incentive methodologies and approaches with appropriate stakeholder input.
- **January 1, 2022:** Begin implementation of managed care plan incentives.
- **No sooner than January 1, 2023:** Begin implementation of a seniors and persons with disabilities/long-term care blended rate.

2.5 Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity

2.5.1 Background

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

This SMI/SED demonstration opportunity allows states to receive federal matching funds for services provided to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as an institution for mental disease (IMD) (e.g., psychiatric hospitals or psychiatric health facilities that have more than 16 beds), as long as it is part of a broader effort to build a robust continuum of care allowing care in the least restrictive, community-based settings. Due to the long-standing federal exclusion of Medicaid matching funds for services provided in these settings, California's counties have historically paid the full cost of inpatient mental health services provided to Medi-Cal beneficiaries in these settings.

2.5.2 Proposal

DHCS proposes that California pursue this SMI/SED demonstration opportunity to receive federal financial participation for services provided to Medi-Cal beneficiaries in an IMD. DHCS heard from stakeholders both positive and negative feedback regarding this proposal. Stakeholders in favor of the demonstration opportunity stated the additional federal funds could provide opportunities to improve service delivery and outcomes

across the continuum of care from inpatient to community-based settings, and the availability of additional matching funds would free up other local resources that counties could reinvest in strengthening other mental health services and further build the continuum of care in the community.

Proponents suggested that the demonstration opportunity is a critical component of solutions for the state hospital crisis (with long wait lists for people found incompetent to stand trial, as the state hospitals are full) and for achieving health equity, since increasing the number of short-term, crisis stabilization resources can divert people with mental illness to treatment instead of entering the justice system. People of color are disproportionately placed in justice settings instead of in mental health treatment, and lack of bed availability is a contributing factor. Stakeholders also expressed opposition based on concerns that the presence of the existing IMD exclusion is the primary safeguard in inhibiting county mental health departments from expanding the use of institutional settings and an important incentive to develop alternatives to those settings, and that using federal dollars to fund IMDs could divert resources from community-based services, undermining progress toward increased community integration and a community-based continuum of care.

On balance, DHCS believes the benefits outweigh the risks, and proposes that California submit an application to CMS using the usual process for submitting a Section 1115 waiver demonstration application. Similar to the state's existing 1115 demonstration to provide residential and other SUD treatment services under Medi-Cal, county participation would be voluntary.

2.5.3 Rationale

If California is approved to participate in the SMI/SED demonstration opportunity, federal financial participation would become available for mental health services provided to Medi-Cal beneficiaries in an IMD if all requirements are met. This additional funding would provide opportunities to improve service delivery and outcomes across a well-developed and robust continuum of care from inpatient to community-based settings, which is a requirement of this waiver. Availability of additional federal matching funds would free up other local resources, such as realignment funds, that counties may then reinvest in strengthening other mental health services and further build the continuum of care in the community.

The SMI/SED demonstration opportunity comes with many federal milestones and requirements. As of October 2020, Washington DC, Vermont, Indiana, and Idaho have approved applications, and Massachusetts, Oklahoma and Utah have pending 1115 waiver application to CMS. Below is a summary of key requirements, some of which may pose feasibility challenges:

- **Average Length of Stay:** The state would be required to achieve a statewide average length of stay of no more than 30 days for beneficiaries residing in IMDs. CMS developed guidance regarding calculations of average length of stay, clarifying that a short-term stay for acute care is limited to no more than 60 consecutive days, as long as the state continues to meet the statewide average length of stay of 30 days or less, and that states may not claim for *any* part of a stay (days 0 to 60) that exceeds 60 days.
- **Improving Community-based Services:** States participating in the SMI/SED demonstration opportunity will be expected to commit to taking several actions to improve community-based mental health care. These actions are linked to a set of goals for the SMI/SED demonstration opportunity and will milestones for ensuring quality of care in IMDs, to improve connections to community-based care following stays in acute care settings, to ensure a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries, to provide a full array of crisis stabilization services, and to engage beneficiaries with SMI/SED in treatment as soon as possible.
- **Maintenance of Effort:** According to the guidance, CMS will be examining the commitment to ongoing maintenance-of-effort on funding outpatient community-based mental health services and states must provide an assessment of current availability of mental health services. The purpose of the maintenance-of-effort requirement is to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.
- **Data Collection & Required Measures:** The state would need to report on a common set of measures and agree to additional measures and concepts specific to the state's demonstration parameters.
- **Health Information Technology:** The state would be required to develop and submit a health information technology plan that describes the ability to leverage technology, advance health information exchange(s), and ensure interoperability in support of the demonstration's goals. The health information technology plan would address electronic care plan sharing, care coordination, and behavioral and physical health integration.
- **Staffing and Resource Considerations:** Since DHCS does not currently pay for IMD services for this target population, pursuing the demonstration and ensuring compliance with requirements would require additional staffing and resources. Similarly, counties would likely need additional resources to implement and comply with elements required by the demonstration.

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

2.5.4 Proposed Timeline

The SMI/SED demonstration proposal would be developed no sooner than July 1, 2022. If the waiver proposal is approved by CMS, DHCS would work with interested counties to develop a formal implementation plan, with expected launch of the demonstration in 2023-24.

2.6 Full Integration Plans

2.6.1 Background

Currently, Medi-Cal beneficiaries must navigate multiple complex managed care and fee-for-service delivery systems to meet all of their health care needs. Beneficiaries enrolled in Medi-Cal managed care plans receive physical health care and treatment for mild-to-moderate mental health conditions from their Medi-Cal managed care plan, care for SMI/SED and SUD from the county delivery system, and dental care from a separate fee-for-service delivery system or a dental managed care plan. This fragmentation can lead to gaps in care and disruptions in treatment, cost inefficiencies, and generally fails to be patient-centered and convenient for most beneficiaries. The longevity gap among individuals with serious and persistent mental illness, and the fact that this group suffers and dies from un-or under-treated chronic physical health conditions, demonstrates the need to pilot the concept of a fully integration delivery system.

2.6.2 Proposal

DHCS would like to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. Multiple Medi-Cal delivery systems (Medi-Cal managed care, county mental health plans, county Drug Medi-Cal and DMC-ODS programs) would be consolidated under one contract with DHCS. To further develop this concept, DHCS will be engaging in stakeholder conversations to inform the development of the various components associated with fully integrating health care services. Topics will include contractor selection criteria, strategies for consolidating contract requirements, subcontracting and network requirements, and delivery system administration issues such as care coordination, utilization management, quality monitoring, and external quality review organization functions.

2.6.3 Rationale

In alignment with CalAIM, fully integrating all or most of the Medi-Cal health care delivery systems under one contract would improve the beneficiary experience as well as health outcomes by eliminating fragmentation, duplication, and the need to navigate multiple systems. In addition, integration will improve access to health data/data sharing among providers and between the plan and DHCS. Full integration would also result in overall administrative simplification by consolidating and streamlining system infrastructure. An integrated delivery system would allow for more efficient coordination of care and create opportunities to identify and manage the risks and needs of the beneficiaries in a more holistic way.

As part of the CalAIM workgroup process, DHCS sought stakeholder feedback to understand the benefits, risks and considerations for plans and counties interested in participating in a full integration model. Discussion included realignment (county behavioral health participation would need to be voluntary), how non-Medi-Cal funding streams would be managed (such as MHSA), criteria for participation, the need for adequate planning and preparation, the importance of clearly defined outcome measures, and other considerations.

2.6.4 Proposed Timeline

DHCS acknowledges the complexity of this proposal, and for this reason, is proposing a go-live of no sooner than January 2027, to allow sufficient time for planning and preparation, in partnership with counties, plans and other stakeholders.

2.7 Long-Term Plan for Foster Care

2.7.1 Background

Children and youth in foster care often present with complex medical, behavioral, oral and developmental health problems rooted in their history of childhood trauma and adverse childhood experiences (ACEs) Navigating multiple systems of care can create inherent challenges. Under the Medi-Cal program, beneficiaries receive services through various delivery systems, including Medi-Cal managed care, fee-for-service, California Children's Services, regional centers, dental county mental health plans, Drug Medi-Cal, and DMC-ODS programs. While children and youth in foster care typically have a comprehensive team to help facilitate and oversee their care including social workers, public health nurses, and the judicial system; many challenges remain in navigating Medi-Cal delivery systems, especially if there are multiple placements that may result in the child moving from one county to another or between homes in a single county.

In recent years, California has placed a greater emphasis on the behavioral health care needs of child welfare-involved children and families through major reforms such as the

Continuum of Care Reform, Family Urgent Response System, development of short-term residential treatment providers and coordinated efforts to implement the new federal Family First Prevention Services Act in California.

2.7.2 Proposal

In assessing the challenges foster care children and youth face, in June 2020 DHCS launched a workgroup of interested stakeholders to consider whether DHCS should develop a different model of care for children and youth in foster care, including the former foster youth and youth transitioning out of foster programs and services. To facilitate this discussion and develop meaningful recommendations, DHCS invited participation from key partners including but not limited to: the Department of Social Services, the Department of Education, child welfare county representatives and state-level associations, Medi-Cal managed care plans, behavioral health managed care plans, juvenile justice and probation, foster care consumer advocates, regional centers, and judicial entities involved with matters pertaining to children who are placed into the foster care system. DHCS also commissioned focus groups with foster youth and foster parents, to hear directly from those most affected by the challenges in the current system.

2.7.3 Proposed Timeline

DHCS launched the workgroup in June 2020, and will meet every other month through June 2021. DHCS and CDSS then will take lessons learned from the workgroup and the input from stakeholders and develop a comprehensive set of recommendations and plan of action, which may involve budget recommendations, waiver amendments, State Plan changes or other activities.

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

This section will walk through the proposals aimed at standardizing and reducing complexity across all delivery systems.

Managed Care

- Managed Care Benefit Standardization
- Mandatory Managed Care Enrollment
- Transition to Statewide Long-Term Services and Supports, Long-Term Care & Duals-Special Needs Plans
- NCQA Accreditation of Medi-Cal Managed Care Plans
- Regional Managed Care Capitation Rates

Behavioral Health

- Behavioral Health Payment Reform
- Medical Necessity Criteria and Other Related Changes
- Administrative Integration of Specialty Mental Health and Substance Use Disorder Services
- Behavioral Health Regional Contracting
- DMC-ODS Renewal and Policy Improvements

Dental

- New Dental Benefits and Pay for Performance

County Partners

- Enhancing County Eligibility Oversight and Monitoring
- Enhancing County Monitoring and Oversight: California Children's Services and Child Health and Disability Prevention
- Improving Beneficiary Contact and Demographic Information

Managed Care

3.1 Managed Care Benefit Standardization

3.1.1 Background

Medi-Cal delivers services through a variety of delivery systems today including fee-for-service, managed care, county mental health, Drug Medi-Cal Organized Delivery System, and Drug Medi-Cal. Most full-scope Medi-Cal beneficiaries receive their physical health

services through a Medi-Cal managed care plan. While Medi-Cal managed care exists statewide, it is operated under six different model types that currently differ based on whether certain benefits are part of the Medi-Cal managed care plan's responsibility or provided through a different delivery system.

3.1.2 Proposal

Under CalAIM, DHCS is proposing to standardize the benefits that are provided through Medi-Cal managed care plans statewide. Regardless of the beneficiary's county of residence or the plan they are enrolled in, they will have the same set of benefits delivered through their Medi-Cal managed care plan as they would in another county or plan.

DHCS is proposing the following changes:

Carved Out Benefits

- Effective April 1, 2021, all pharmacy benefits or services by a pharmacy billed on a pharmacy claim will be carved out from Medi-Cal managed care plans (pursuant to the Governor's Executive Order N-01-19 from January 7, 2019). This applies to all Medi-Cal managed care plans, including AIDS Healthcare Foundation, but does not apply to SCAN Health Plan, Programs of All-Inclusive Care for the Elderly (PACE) organizations, Cal MediConnect health plans, and Major Risk Medical Insurance Program (MRMIP).
- Effective January 1, 2022, the following benefits that are currently within the scope of some or all the Medi-Cal managed care plans will be carved out:
 - Specialty mental health services that are currently carved in for Medi-Cal members enrolled in Kaiser in Solano and Sacramento counties; and
 - The Multipurpose Senior Services Program which is currently included in the Medi-Cal managed care plans in the seven Coordinated Care Initiative counties.

Carved In Benefits

- Effective January 1, 2022, all major organ transplants, currently not within the scope of many Medi-Cal managed care plans, will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.
- Effective January 1, 2023, institutional long-term care services (i.e. skilled nursing facilities, pediatric/adult subacute care, intermediate care facilities for individuals with developmental disabilities, disabled/habilitative/nursing services, specialized rehabilitation in a skilled nursing facility or intermediate care facilities), currently

not within the scope of many Medi-Cal managed care plans will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.

In order to provide a smooth transition from fee-for-service to managed care, promote access and maintain affordability, DHCS proposes to require that long-term care and transplant providers accept as payment in full and require the Medi-Cal managed care plan to pay the applicable Medi-Cal fee-for-service rate, unless the provider and plan mutually agree upon an alternative payment. This is consistent with how these transitions to managed care have occurred in the past, such as with the Coordinated Care Initiative and the Whole Child Model.

3.1.3 Rationale

The standardization of benefits delivered through Medi-Cal managed care plans statewide has two main purposes and benefits:

- Beneficiaries will no longer have to deal with the confusion that may arise when moving counties/plans and to find that different benefits are covered by their new plan or that they need to access another delivery system; and
- DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.1.4 Proposed Timeline

The benefit standardization will be effective and included in Medi-Cal managed care plan contracts by January 2023, according to **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage**.

3.2 Mandatory Managed Care Enrollment

3.2.1 Background

Currently, the Medi-Cal program provides benefits through both a fee-for-service and managed care delivery system. Enrollment into the fee-for-service delivery system or the managed care delivery system is based upon specific geographic areas, the health plan model, and/or the aid code that the beneficiary is determined to qualify for. In some cases, enrolling in managed care is optional for beneficiaries. However, more than 80 percent of Medi-Cal beneficiaries are currently served through the managed care delivery system.

3.2.2 Proposal

In an effort to enhance coordination of care, increase standardization, and reduce complexity across the Medi-Cal program, DHCS is proposing to standardize which aid code groups will require mandatory managed care enrollment versus mandatory fee-for-service enrollment, across all models of care and aid code groups, statewide. Under this proposal, beneficiaries in a voluntary or excluded from managed care enrollment aid code that are currently accessing the fee-for-service delivery system, would be required to choose a Medi-Cal managed care plan and will not be permitted to remain in fee-for-service. DHCS completed extensive data analytics to inform this proposal, for example, 73% of beneficiaries with other health coverage are already enrolled in managed care today and of non-long-term care share of cost beneficiaries, on average only 5.4% of beneficiaries meet their monthly share of cost.

DHCS is proposing implementation of this change in two phases, transitioning non-dual eligible populations in 2022 and dual eligible populations in 2023. A non-dual member is defined as a Medi-Cal member without any Medicare coverage. A dual beneficiary is defined as a Medi-Cal member with any Medicare coverage. This would include Medi-Cal members with Medicare A only or Part B only (partial duals) and members with Medicare Part A and B (full duals) regardless of enrollment in Medicare Part C or Part D. See below for a summary of changes and **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage** for more details.

Given the ability and directive of Medi-Cal managed care plans to provide case and care management not available in a fee-for-service environment, DHCS firmly believes that Medi-Cal managed care is a delivery system we should continue to invest in and rely upon. In conjunction with these new and increased responsibilities, DHCS plans to increase oversight of the plans and their delegated entities to ensure that current requirements being met but also that the additional benefits and requirements contained in CalAIM are truly being provided statewide.

Mandatory Managed Care Enrollment

Below are the populations that currently receive benefits through the fee-for-service delivery system that would transition to Medi-Cal managed care upon implementation of this proposal in 2022:

- Trafficking and Crime Victims Assistance Program (except share of cost)
- Individuals participating in accelerated enrollment
- Child Health and Disability Prevention infant deeming
- Pregnancy-related Medi-Cal (Pregnant Women only, 138-213% citizen/lawfully present)
- American Indians
- Beneficiaries with other health care coverage

- Beneficiaries living in rural zip codes

Below are the populations that currently receive benefits through the fee-for-service delivery system except in COHS and CCI counties that would transition to the Medi-Cal managed care system upon implementation of this proposal in 2023:

- All dual and non-dual individuals eligible for long-term care services (includes long-term care share of cost populations)
- All partial and full dual aid code groups, except share of cost or restricted scope, will be mandatory Medi-Cal managed care, in all models of care starting in 2023

Mandatory Fee-for-Service Enrollment

This proposal would also move the following populations from mandatory managed care enrollment into mandatory fee-for-service enrollment upon implementation of this proposal in 2022:

- Omnibus Budget Reconciliation Act (OBRA): This population was previously mandatory managed care in Napa, Solano, and Yolo counties.
- Share of Cost: beneficiaries in county organized health systems (COHS) and Coordinated Care Initiative counties excluding long-term care share of cost.

Therefore, beneficiaries in the following aid code groups will have mandatory fee-for-service enrollment:

- Restricted scope
- Share of cost (including Trafficking and Crime Victims Assistance Program share of cost, excluding long-term care share of cost)
- Presumptive eligibility
- State medical parole, county compassionate release, and incarcerated individuals
- Non-citizen pregnancy-related aid codes enrolled in Medi-Cal (not including Medi-Cal Access Infant Program enrollees)

DHCS recommends keeping enrollment requirements for foster care children and youth in place until the Foster Care Workgroup makes recommendations on the future delivery system for foster care children and youth.

3.2.3 Rationale

Moving to mandatory managed care enrollment will standardize and reduce the complexity of the varying models of care delivery in California. Populations moving between counties will have the same experience when it comes to receiving services through a managed care plan. Transitioning current populations to mandatory managed care enrollment will also allow for Medi-Cal managed care plans to provide more

coordinated and integrated care and provide beneficiaries with a network of primary care providers and specialists.

Additionally, DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.2.4 Proposed Timeline

- **January 1, 2022:** Non-Dual and pregnancy related aid code group, and population-based transitions, except for LTC aid codes.
- **January 1, 2023:** Dual aid code group transition, including LTC aid codes for both non-dual and dual beneficiaries.

3.3 Transition to Statewide Long-Term Services and Supports, Long-Term Care, & Dual Eligible Special Needs Plans

3.3.1 Background

Under CalAIM, DHCS is proposing to transition CMC and the CCI to a statewide MLTSS and dual eligible special needs plan (D-SNP) structure. This policy is intended to help meet the statewide goals of improved care integration and person-centered care, under both CalAIM and the California Master Plan for Aging.

The Coordinated Care Initiative has been underway in seven California counties and is comprised of two parts: 1) Cal MediConnect, a demonstration project that combined acute, primary, institutional, and home and community-based services into a single benefit package for individuals who are fully or partially eligible for Medicare and Medicaid; 2) mandatory Medi-Cal managed care enrollment for dual eligibles for all Medi-Cal benefits, including managed long-term services and supports.

The Governor's 2017-2018 budget determined that the Coordinated Care Initiative was not cost-effective due to the financing of the In-Home Supportive Services benefit, which was carved out to fee-for-service effective January 1, 2018. DHCS will carve out Multipurpose Senior Services Program services to fee-for-service effective January 1, 2022 for all Medi-Cal members. CMS approved an extension for the remaining program elements – Cal MediConnect and mandatory managed long-term services and supports enrollment – until December 31, 2022.

While the Coordinated Care Initiative and Cal MediConnect offer the promise of better integrated care for California's dual eligibles, the program is only available in seven out of 58 counties. Additionally, Cal MediConnect has been a complex program to administer.

DHCS is implementing a new approach to take the key lessons learned and innovative strategies from these programs and make them more broadly available across the State.

3.3.2 Proposal

Aligned Enrollment

DHCS will use selective contracting to move toward aligned enrollment in D-SNPs; beneficiaries will enroll in a Medi-Cal managed care plan and D-SNP operated by the same parent company to allow for greater integration and coordination of care.

- In CCI counties, aligned enrollment will begin in 2023. Cal MediConnect members will transition to aligned D-SNPs and managed care plans operated by the same organization as their Cal MediConnect product.
- Aligned enrollment will phase-in in non-CCI counties as plans are ready. DHCS will require managed care plans to apply for aligned D-SNPs to be effective no later than contract year 2025.
- Dual eligible beneficiaries already enrolled in a non-aligned D-SNP (a D-SNP that is not affiliated with their managed care plan) when aligned enrollment takes effect in their county will be in that D-SNP (allowing the beneficiary to stay in the non-aligned D-SNP). New enrollment in those non-aligned D-SNPs will be closed.

In conjunction with the aligned enrollment approach, starting in 2022 CMS will limit enrollment into Medicare Advantage (MA) plans that are D-SNP “look-alikes.” These are MA 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, such as risk assessments or care plans.

As outlined in the CMS Contract Year 2021 Medicare Advantage and Part D Final Rule:

- CMS will not enter into contracts with new MA plans that project 80 percent or more of the plan's enrollment will be entitled to Medicaid starting in 2022; and
- CMS will not renew contracts with MA plans (except SNPs) that have enrollment of 80 percent or more enrollees who are entitled to Medicaid (unless the MA plan has been active for less than one year and has enrollment of 200 or fewer individuals).

DHCS will also allow plans in CCI counties with managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans to transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP in 2022, prior to the end of CCI. This will provide better coordination of care, without reducing enrollment in Cal MediConnect plans, and is in alignment and preparation for the CMC transition to D-SNP aligned enrollment in 2023.

D-SNP Integration Requirements

DHCS will require that all D-SNPs use a model of care addressing both Medicare and Medi-Cal services to support coordinated care, high-quality care transitions, and information sharing. DHCS will work with CMS to incorporate new CalAIM model of care requirements into the D-SNP model of care, as appropriate.

As DHCS implements aligned enrollment, DHCS will require D-SNPs to:

- Develop and use integrated member materials.
- Include consumers in their existing advisory boards.
- Work with CMS to establish quarterly joint contract management team meetings for aligned D-SNP and managed care plans.
- Include dementia specialists in their care coordination efforts.
- Coordinate carved-out LTSS benefits including IHSS, MSSP, and other HCBS waiver programs.

Additionally, DHCS will work with CMS to coordinate audit timing, to avoid a D-SNP/managed care plan being audited by both agencies at the same time.

Long-Term Care Carve In

In conjunction with mandatory Medi-Cal managed care enrollment, DHCS will require statewide integration of LTC into managed care for Medi-Cal populations by 2023. This means that full- and partial-benefit duals in LTC facilities in counties or plans that do not already include LTC will be enrolled in Medi-Cal managed care by 2023.

D-SNP Transitions and Enrollment Policies

DHCS will encourage aligned enrollment of dual eligibles into matching managed care plans and D-SNPs to promote more integrated care. During all transitions, DHCS will work with CMS to ensure beneficiaries receive continuity of care protections.

Mandatory Enrollment into Medi-Cal Managed Care Plans

DHCS is committed to providing beneficiary and provider education, as well as technical assistance around Medi-Cal managed care plan requirements, for mandatory enrollment of dual eligibles into Medi-Cal managed care. As part of this work, DHCS will:

- Review and make any needed updates to education and enrollment materials used to assist dual eligibles in enrolling into a managed care plan or PACE for their Medi-Cal benefits.

- Help educate providers about necessary billing practices as well as the processes that will not change, building on materials and best practices previously developed under CCI.

3.3.3 Rationale

Individuals dually eligible for Medicare and Medi-Cal are among the highest need populations. However, lack of coordination between Medicare and Medi-Cal can make it difficult for individuals enrolled in both programs to navigate these separate systems of care. California has made significant progress in building integrated systems through the implementation of CCI and CMC in seven counties (Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino and Santa Clara). As part of the CalAIM initiative, DHCS is leveraging the lessons and success of CCI to develop policies to promote integrated care through D-SNPs and MLTSS across California. This includes mandatory enrollment for dual eligibles into managed care plans for their Medi-Cal benefit and increasing the availability of aligned D-SNPs. This will allow duals to voluntarily enroll for their Medicare benefits into the D-SNP that is aligned with their managed care plan.

In addition, to promote integrated, person-centered care, the D-SNP and MLTSS policies will rely on California's robust and diverse array of HCBS providers across the state who serve older Californians and people with disabilities. In support of this effort, DHCS plans to submit a request for supplemental funding through the federal Money Follows the Person grant to accelerate LTSS system transformation design and implementation, and to expand HCBS capacity. The one-time supplemental funding would be used to develop a multi-year roadmap for implementing strategies and solutions for strengthening HCBS and MLTSS programs and provider networks. DHCS' intent is that the roadmap will provide a unified vision to integrate CalAIM MLTSS, D-SNP policy and the related in lieu of services policy, other components of the Master Plan on Aging, and all of HCBS, to expand and better link those HCBS to Medi-Cal managed care and D-SNP plans.

3.3.4 Proposed Timeline

- **January 1, 2021:** All existing D-SNPs must meet new regulatory integration standards effective 2021.
- **January 1, 2022:** Voluntary in lieu of services in all Medi-Cal managed care plans and CMC plans. Multipurpose Senior Services Program (MSSP) carved out of managed care in CCI counties. Plans in CCI counties with existing managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans may transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP.
- **December 31, 2022:** Discontinue CMC and CCI.

- **January 1, 2023:** Statewide mandatory enrollment of full- and partial- benefit dual eligible beneficiaries into managed care plans for Medi-Cal benefits, including dual and non-dual eligible LTC residents and statewide integration of LTC into Medi-Cal managed care. Aligned enrollment begins in CCI counties and managed care plans in those counties must stand up D-SNPs. All CMC members cross-walked to matching D-SNP and managed care plans, subject to CMS and state requirements.
- **January 1, 2025:** Aligned enrollment begins in non-CCI counties; All managed care plans required to begin operating D-SNPs (voluntary enrollment for dual eligibles' Medicare benefit).
- **January 1, 2027:** Implement MLTSS statewide in Medi-Cal managed care.

3.4 NCQA Accreditation of Medi-Cal Managed Care Plans

3.4.1 Background

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization that offers accreditation to health plans and other health care-related entities (e.g., accountable care organizations) in the areas of quality improvement, population health management, network management, utilization management, credentialing and re-credentialing, and member experience. NCQA also develops quality performance measures known as the Healthcare Effectiveness Data and Information Set (HEDIS) measures, which provide a standardized method for comparing health plan performance. Currently, 26 states require NCQA accreditation for their contracted Medicaid managed care plans.

DHCS conducts annual medical audits of all Medi-Cal managed care plans, but does not currently “deem,” or use information obtained from a national accreditation review, to satisfy mandatory external quality review activities, with the exception of the credentialing requirement of the annual medical audit. Federal regulations permit the state to deem this information for credentialing purposes.

DHCS does not currently require Medi-Cal managed care plans to be accredited by NCQA. Out of 24 full scope Medi-Cal managed care plans in the state, 17 health plans currently have NCQA accreditation. Medi-Cal managed care plans that provide private coverage through Covered California are required to be accredited by either NCQA, the Utilization Review Accreditation Commission (URAC), or the Accreditation Association for Ambulatory Health Care (AAAHC).

3.4.2 Proposal

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 be NCQA accredited by 2026. DHCS may use NCQA findings to certify or deem that Medi-Cal managed care plans meet particular state and federal Medicaid requirements. However, numerous stakeholders have shared with DHCS their concerns around DHCS deeming any elements of its current oversight of the managed care plans. Before DHCS recommends deeming of elements of its annual medical audits of the plans, DHCS will solicit feedback on the proposed deemable elements. If deeming does occur, DHCS will post information on the deeming elements and the corrective action plan for NCQA oversight findings on its website. DHCS will not accept accreditation from entities other than NCQA (e.g. URAC). Additional information on proposed deeming is below.

DHCS will also require Medi-Cal managed care plan NCQA accreditation to include the LTSS Distinction Survey subsequent to all health plans operating a D-SNP by 2027; the exact effective date for the LTSS Distinction Survey will be determined at a later date. Requiring the LTSS Survey will align with the state's effort to carve-in long-term care services and expand in lieu of services to make MLTSS a statewide benefit.

While DHCS is interested in the potential future addition of the Medicaid (MED) module to routine NCQA health plan accreditation, as it could potentially maximize the opportunity for streamlining state compliance and deeming, DHCS has determined that it is premature to require the MED module at this point, given how new it is for NCQA.

Finally, DHCS had considered requiring Medi-Cal managed care plans to ensure any non-health plan subcontractors to whom certain contractual elements are delegated are NCQA accredited for that function. DHCS will not require this in its contracts with the Medi-Cal managed care plans at this time; Medi-Cal managed care plans will need to determine if they will require any accreditation of their non-health plan subcontractors. If DHCS decides to deem particular elements of NCQA health plan accreditation standards, and any Medi-Cal managed care plans elect to require NCQA accreditation of their subcontractors, the Medi-Cal managed care plans will have the option to offer deeming on those same elements, if applicable, with their subcontractors.

3.4.3 Rationale

One of the three objectives of CalAIM is to reduce variation and complexity across Medi-Cal delivery systems, including standardization of the Medi-Cal managed care benefit. requiring NCQA accreditation of its managed care plans and following the NCQA framework, DHCS can potentially increase standardization throughout the state and reduce redundancies in various processes and assessments, in areas such as care coordination, which DHCS currently requires. Further, NCQA accreditation can assist in streamlining DHCS monitoring and oversight of managed care plans, particularly with regard to the annual medical audits, by increasing the number of elements in which DHCS may consider deeming Medi-Cal managed care plans. This would allow the annual medical audits to focus on other DHCS priority areas not reviewed by NCQA.

The addition of the LTSS Distinction Survey aligns with DHCS' goal of making LTSS a statewide benefit. DHCS recognizes that the addition of this survey to routine NCQA accreditation may be difficult for Medi-Cal managed care plans that are not already NCQA accredited, so DHCS will determine a timeframe for requiring the LTSS Distinction Survey that falls after all managed care plans have achieved routine NCQA plan accreditation.

3.4.4 Proposed Timeline

DHCS will require all Medi-Cal managed care plans and their health plan subcontractors to be NCQA accredited by 2026.

- DHCS will review and consider elements of NCQA health plan accreditation standards for deeming in relation to the annual A&I compliance audits.
 - DHCS will ensure that a complete crosswalk of federal and state Medicaid requirements and NCQA health plan accreditation standards is available online for comment prior to finalizing any deeming decisions.
 - DHCS will ensure that any NCQA health plan accreditation elements selected for potential deeming are vetted with stakeholders prior to finalizing any deeming decisions.
- DHCS may consider implementing deeming of the select elements sooner than 2026 for Medi-Cal managed care plans that already have NCQA accreditation. DHCS will align all applicable processes in its Medi-Cal managed care plan contract and All Plan Letters with the following six NCQA health plan accreditation categories to correspond with the requirement for accreditation by 2026:
 - Quality Improvement;
 - Population Health Management;
 - Network Management;
 - Utilization Management;
 - Credentialing; and
 - Member Experience.

3.5 Regional Managed Care Capitation Rates

3.5.1 Background

DHCS currently develops, certifies, and implements managed care capitation rates on an annual basis for contracted Medi-Cal managed care plans. DHCS develops distinct rates for each contracted managed care plan by county/region and population group. Due to the complexities of the Medi-Cal managed care program, which includes varied and intricate financing mechanisms, DHCS calculates multiple rating components for each capitation rate for a total of more than 4,000 rating components on an annual basis as of

state fiscal year 2018-19. The excessively large number of rating components DHCS must develop on an annual basis is administratively burdensome and contributes to lengthy annual federal review and approval timeframes. It also limits DHCS' ability to advance value-based and outcomes-focused rate setting methodologies. With the changes contemplated in CalAIM, DHCS views the need for simplified methodologies with a reduced number of components as necessary to achieving our broader goals of improving care delivery, access, quality and outcomes for our Medi-Cal beneficiaries.

3.5.2 Proposal

A regional rate-setting methodology provides a pathway toward simplification of the rate-setting process for the Medi-Cal managed care program. The proposed simplification will afford DHCS the flexibility to continue to pursue strategies that support advancements and innovations within the program.

To ensure a successful transition, DHCS proposes a two-phased approach:

Implement Regional Rates in Targeted Counties (Phase I)

- DHCS would implement Phase I for calendar years 2022 and 2023 (at a minimum) for targeted counties and Medi-Cal managed care plans;
- DHCS would advance new regional rate-setting approaches and streamline rate processes and methodologies;
- DHCS would utilize Phase I as a means of identifying strategies and further improvements that will support a seamless transition to regional rate setting statewide; and
- DHCS would engage and collaborate with contracted Medi-Cal managed care plans and industry associations as part of this process.

Fully Implement Regional Rates Statewide

- DHCS proposes to fully implement regional rates statewide no sooner than calendar year 2024, to align with the end of Phase I; and
- DHCS will consider health care market dynamics, including but not limited to health care cost and utilization data, across counties when determining regional boundaries.

3.5.3 Rationale

The proposed transition to regional rates statewide offers four main benefits:

- Regional rates would reduce the number of distinct rating components that DHCS must develop on an annual basis, and thereby permit DHCS to utilize a more flexible rate structure model. This flexibility is essential to DHCS' ability to pursue

advancements and innovations in the Medi-Cal managed care program, including CalAIM, and to explore new, innovative ideas.

- Regional rates would simplify the presentation of rates to CMS, which may expedite federal review and approval of the Medi-Cal managed care capitation rates. DHCS could implement rate-setting approaches that promote efficiency, including cost-averaging processes, across Medi-Cal managed care plans.
- These approaches would continue to incentivize Medi-Cal managed care plans to operate efficiently as rates will be based upon costs across the multi-county region. In effect, each Medi-Cal managed care plan will be incentivized to compete to be more efficient than other plans in their region.
- Regional rates would provide a larger, multi-county base for averaging, and thereby alleviate some of the criticisms regarding the process currently used by DHCS.

3.5.4 Proposed Timeline

Rate setting is a dynamic process. Therefore, DHCS will proceed methodically, engage and collaborate with Medi-Cal managed care plans, and make future refinements as determined actuarially appropriate.

- **Calendar Year 2020 and 2021:** Develop regional rate-setting methodologies and approaches with appropriate stakeholder input.
- **January 1, 2022:** Implement Phase I for targeted counties and Medi-Cal managed care plans.
- **Calendar Year 2023:** Evaluate and continue to refine the rate-setting process prior to the implementation of regional rates statewide.
- **No sooner than January 1, 2024:** Fully implement regional rates statewide.
- **Post-implementation:** Continue to evaluate and refine the rate-setting process and regions.

Behavioral Health

3.6 Behavioral Health Payment Reform

3.6.1 Background

Through realignment efforts in 1991 and 2011, funding for the majority of the non-federal share of costs associated with the specialty mental health and substance use disorder (SUD) services became the responsibility of the counties. Currently, counties are reimbursed for the federal and state portion of costs for services and administration of these programs via Medicaid Certified Public Expenditure (CPE) methodologies. Under

CPE methodologies, reimbursements to counties are limited to costs incurred by the counties and are subject to a lengthy and labor-intensive cost reconciliation process.

For specialty mental health services, counties pay with non-federal funds at the time of service and when incurring costs to administer the programs. The counties then submit CPEs to DHCS so that the state can draw down eligible federal Medicaid matching funds. In accordance with the CMS-approved CPE protocol, mental health plans receive interim reimbursement of federal financial participation on a fee-for-service basis, pursuant to interim rates approved by the state on an annual basis for approved units of service for allowable procedure codes. The state completes the interim reconciliation of interim Medicaid payments no later than 24 months after the close of each state fiscal year. The final cost reconciliation of mental health plan interim Medicaid payments occurs within 36 months after the certified, reconciled, state-developed cost reports are submitted.

The Drug Medi-Cal portions of the State Plan establishes the interim payment methodology for both Narcotic Treatment Program and non-Narcotic Treatment Program services. Generally, this methodology requires an interim reimbursement at the statewide maximum allowable or uniform statewide daily dosing rate. DHCS also provides an interim reimbursement to counties for costs incurred to administer DMC-ODS or DMC programs. After the fiscal year ends, DHCS performs a settlement with counties for the cost of administering the SUD services (either through DMC State Plan or through DMC-ODS). These cost reconciliations occur years after the close of the state fiscal year to allow time for claims run out as well as for DHCS to complete its cost reconciliation audits.

To incentivize additional investment in the delivery systems and reduce overall burden on counties and the state, DHCS is proposing to reform behavioral health payment methodologies for counties. Under the current CPE methodology, counties are not able to retain revenue when implementing cost-reduction efforts, thereby limiting the ability to fully invest in the delivery system to improve access and quality. These reforms will allow not only for more timely review and final payment, but will enable the county behavioral health system, for the first time, to participate in and design true outcomes and value-based reimbursement structures that reward better overall results and quality of life for Medi-Cal beneficiaries.

3.6.2 Proposal

The state is proposing to reform its behavioral health payment methodologies via a multi-phased approach with the goal of increasing available reimbursement to counties for services provided and to incentivize quality objectives. This proposal would move reimbursement for all inpatient and outpatient specialty mental health and substance use disorder services from CPE-based methodologies to other rate-based/value-based structures that instead utilize intergovernmental transfers to fund the county-supplied non-federal share. DHCS proposes to implement the shift in methodology in two initial phases:

- In order to establish appropriate payment rates, DHCS proposes to transition specialty mental health and SUD services from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, known as Current Procedural Terminology (CPT) coding, when possible; and
- DHCS will establish reimbursement rates, as well as an ongoing methodology for updating rates, for the updated codes with non-federal share being provided by counties via intergovernmental transfer instead of CPEs, eliminating the need for reconciliation to actual costs.

Transition from HCPCS Level II Coding to CPT Coding

DHCS is proposing 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.

For specialty mental health services, DHCS would identify a mix of HCPCS Level II codes and CPT codes for the following service functions: therapy, assessments, treatment planning, rehabilitation, prescribing medication, administering medication, patient education, and crisis intervention. DHCS would establish a rate for each of the HCPCS Level II codes and CPT codes identified within each service function. Counties would receive payment for each service rendered based upon the rate established for the specific HCPCS Level II code or CPT code. Services that currently receive a bundled rate, such as psychiatric inpatient hospital services, adult residential treatment, crisis residential treatment, psychiatric health facility services, crisis stabilization, day treatment, and day rehabilitation, would continue to be reimbursed using a bundled rate.

For SUD services, DHCS would identify a mix of HCPCS Level II codes and CPT codes for the following service functions: assessment, case management, crisis intervention, discharge planning, group counseling, individual counseling, medical psychotherapy, prescribing medication, administering medication, recovery services, and treatment planning. DHCS would establish a rate for each of the HCPCS Level II codes and CPT codes identified within each service function. Counties would receive payment for each service rendered based upon the rate established for the specific HCPCS Level II code or CPT code. Narcotic Treatment Programs would continue to be reimbursed a daily rate for each encounter.

Rate Setting Methodology

For the establishment of reimbursement rates, DHCS is proposing to set rates by peer grouping. Each peer group would be made up of counties with similar costs of doing business to best reflect local needs. 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. Additionally,

DHCS is proposing to establish a methodology to provide, at a minimum, an annual update to established rates to ensure that reimbursement continues to reflect the cost of providing services, administration, and required utilization management/quality assurance activities.

To start, DHCS is proposing to process intergovernmental transfers and make payments to counties on a monthly basis. Eventually, DHCS plans to transition to quarterly intergovernmental transfers and payments to reduce the administrative burden tied to processing intergovernmental transfers and payments for 58 counties on a monthly basis. The state will discuss with the counties the appropriate time to transition from monthly to quarterly payments.

3.6.3 Rationale

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 intergovernmental transfer-based methodologies will allow DHCS, in collaboration with county partners, to:

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

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

3.7.4 Proposed Timeline

Given the need to ensure county readiness for this change in approach, DHCS is looking forward to working with counties and stakeholders to establish the timeline for adoption of the HCPCS Level I. DHCS proposes to work with counties and stakeholders to evaluate county readiness and develop a strategy to support them in making this transition. However, the earliest date the shift would occur would be July 1, 2022.

The transition from cost-based reimbursement to an established rate schedule would take place concurrently with the adoption of the HCPCS Level I coding. DHCS would, initially, establish separate rate schedules for specialty mental health and substance use disorder services, with the goal of aligning rate schedules when these services are administratively integrated into a single behavioral health managed care program. DHCS would begin the intergovernmental transfer-based reimbursement at the start of a state-county fiscal year to ease the transition.

3.7 Medical Necessity Criteria

3.7.1 Background

Current medical necessity criteria for specialty mental health services are outdated and confusing and can lead to challenges for beneficiaries in accessing appropriate care. Current diagnosis requirements can prevent beneficiaries from receiving urgently needed care, especially for children, who are entitled to care before developing a mental health condition, or for people with a co-occurring substance use disorder whose diagnosis may not be immediately clear. DHCS requirements for provider documentation are confusing and may lead to provider burden and risk of payment disallowance during audits.

Currently, DHCS does not standardize screening practices to determine where a beneficiary should initially seek mental health care. As a result, counties and plans have a variety of approaches to determine where beneficiaries should initially access care, whether with county Mental Health Plans (for specialty mental health services) or with Medi-Cal Managed Care or Fee for Service delivery systems (for beneficiaries not meeting criteria for specialty mental health services). DHCS does not currently standardize how beneficiaries transition across these delivery systems when their status changes, leading to inconsistent practices. In addition, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) protection for beneficiaries under age 21 is inconsistently interpreted and leads to confusion and variation in practice.

3.7.2 Proposal

With the CalAIM initiative, DHCS aims to design a coherent plan to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes. The goal is to ensure beneficiary access to the right care in the right place at the right time.

In CalAIM, DHCS 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.

DHCS 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.

DHCS 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. In addition, DHCS 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.

DHCS proposes to implement a “no wrong door” policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system where they seek care. This policy would allow beneficiaries who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services, even if the beneficiary is ultimately transferred to the other delivery system due to their level of impairment and mental health needs. In certain situations, beneficiaries may receive non-duplicative services in multiple delivery systems, such as when a beneficiary has an ongoing therapeutic relationship with a therapist or psychiatrist in one delivery system while requiring medically necessary services in the other.

DHCS also proposes to simplify and streamline mental health documentation requirements, to align with medical provider requirements, improve efficiency, and decrease provider burnout.

With respect to inpatient specialty mental health services, DHCS proposes to update the criteria for psychiatric inpatient medical necessity currently provided in Title 9 of the California Code of Regulations. To facilitate improved communication between mental health plans and hospitals, and to decrease variation in clinical documentation requests across counties, DHCS will develop, in consultation with hospital and county stakeholders, documentation standards and concurrent review protocols to allow efficient and streamlined communication of clinical information during concurrent review.

Division of Services Between Mental Health Plans and Medi-Cal Managed Care Plans

To ensure beneficiaries with behavioral health needs are guided to the most appropriate delivery system to address their needs, DHCS is proposing to update its medical necessity criteria and processes, which would be organized as described below:

California provides Medi-Cal mental health services through Managed Care Plans, Fee for Service (FFS), and county mental health plans. The delivery system responsible to provide the mental health service depends on the degree of a beneficiary's impairment from the mental health condition and other criteria described below. Beneficiaries may receive mental health services prior to diagnosis in any of these delivery systems under certain conditions, even if ultimately the beneficiary is determined not to have a mental disorder. Beneficiaries may initiate medically necessary mental health services in one delivery system and receive ongoing services in another system. Beneficiaries whose degree of impairment changes may transition between the delivery systems, or under some circumstances may receive medically necessary mental health services in more than one delivery system. Care shall be coordinated between the delivery systems and services shall not be duplicated.

Medi-Cal Managed Care Plan responsibilities:

The following nonspecialty mental health services are covered by managed care plans:

- a) Individual and group mental health evaluation and treatment (including psychotherapy and family therapy);
- b) Psychological testing, when clinically indicated to evaluate a mental health condition;
- c) Outpatient services for the purposes of monitoring drug therapy;
- d) Psychiatric consultation; and,
- e) Outpatient laboratory, drugs, supplies and supplements (note: the pharmacy benefit will be carved out of managed care plans contracts and transitioned to fee for service delivery under Medi-Cal Rx as of 4/1/2021).

Medi-Cal managed care plans are responsible to provide the above nonspecialty mental health services to adult beneficiaries with mild to moderate distress or mild to moderate impairment of mental, emotional or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders. Managed care plans are also required to provide non-specialty mental health services to children under the age of 21. Managed care plans are also responsible to provide mental health services to beneficiaries with potential mental health disorders

These services are also available in the FFS mental health delivery system for beneficiaries not enrolled in Medi-Cal managed care.

County Mental Health Plan responsibilities:

For beneficiaries 21 years and over, Mental health plans are responsible to provide specialty mental health services for beneficiaries who meet (A) and (B) below:

(A): The beneficiary must have one of the following:

- (i) Significant impairment (“impairment” is defined as distress, disability or dysfunction in social, occupational, or other important activities), OR
- (ii) A reasonable probability of significant deterioration in an important area of life functioning.

(B): The beneficiary’s condition in (A) is due to:

- (i) A diagnosed mental health disorder (according to the current Diagnostic and Statistical Manual of Mental Disorders and International Statistical Classification of Diseases and Related Health Problems criteria), OR
- (ii) A suspected mental disorder that has not yet been diagnosed.

For beneficiaries under age 21¹,

Mental health plans are responsible to provide specialty mental health services to beneficiaries who meet either Criteria 1 **or** Criteria 2:

Criteria 1: The beneficiary is at high risk for a future mental health disorder due to experience of trauma, evidenced by: scoring in the high-risk range on a DHCS-approved trauma screening tool, or involvement in the child welfare system, or experience of homelessness.

Criteria 2: The beneficiary must meet both (A) and (B), below:

(A): The beneficiary must have at least one of the following:

- I. Significant impairment, or
- II. A reasonable probability of significant deterioration in an important area of life functioning, or
- III. iii. A reasonable probability a child will not progress developmentally as appropriate, or
- IV. Less than significant impairment, but requires mental health services that are not included within the mental health benefits that managed care plans are required to provide.

(B): The beneficiary's condition in (A) is due to:

- I. A diagnosed mental health disorder (according to the current Diagnostic and Statistical Manual of Mental Disorders and International Statistical Classification of Diseases and Related Health Problems criteria), or
- II. A suspected mental disorder that has not yet been diagnosed.

Mental health plans provide the following specialty mental health services

1. Crisis Residential Treatment Services
2. Adult Residential Treatment Services
3. Crisis Interventions
4. Crisis Stabilization
5. Day Rehabilitation
6. Day Treatment Intensive
7. Medication Support Services
8. Psychiatric Health Facility Services

¹ The Early and Periodic Screening, Prevention and Treatment protection entitles beneficiaries under age 21 to services necessary to correct or ameliorate a mental illness and condition recommended by a qualified provider operating within his or her scope of practice, whether or not the service is in the state plan.

9. Psychiatric Inpatient Hospital Services
10. Targeted Case Management/Intensive Care Coordination
11. Mental Health Services and Intensive Home-Based Services (including the following service interventions: Assessment, Plan Development, Therapy, Rehabilitation, and Collateral)
12. Therapeutic Behavioral Services
13. Therapeutic Foster Care Services

Substance Use Disorder Services

As with the current SMHS medical necessity criteria, the current Section 1115 waiver for SUD services requires beneficiaries to be diagnosed with a SUD to meet criteria for reimbursement, preventing the provision of treatment services prior to a definitive diagnosis.

As for mental health, DHCS proposes that substance use disorder treatment services may be provided and reimbursed prior to the determination of a diagnosis, including providing services to beneficiaries with co-occurring mental health disorders.

In addition, DHCS heard many comments from stakeholders about how to improve the Drug Medi-Cal Organized Delivery System, which are reflected in the “DMC-ODS Program Renewal and Policy Improvements” section of this proposal.

Documentation Requirements for Specialty Mental Health and Substance Use Disorder Services

Documentation requirements for SUD and SMHS are currently stringent. Stakeholders report that concern about disallowances result in providers spending an excessive amount of time “treating the chart instead of treating the patient.” With the goal of aligning standards across physical and behavioral health programs, DHCS is proposing to update documentation requirements for specialty mental health and substance use disorder treatment to simplify and streamline requirements. For example, DHCS proposes to eliminate the requirement for a point-in-time treatment plan signed by the client, with progress notes tying to the treatment plan. Evidence does not show that shared decision-making is achieved through signature requirements, and the requirement that every note and every intervention must tie to a treatment plan is inefficient and inconsistent with documentation requirements in the medical (physical health) system. DHCS proposes to align behavioral health and medical documentation requirements in Medi-Cal by requiring problem lists and progress notes to reflect the care given and to align with the appropriate billing codes. DHCS also proposes to revise the clinical auditing protocol, to use disallowances when there is evidence of fraud, waste, and abuse, and to use quality improvement methodologies (such as oversight from the External Quality Review Organization) for minor clinical documentation concerns. These documentation changes will align with behavioral health payment reform, as the use of Level 1 HCPCS codes comes with national documentation standards and expectations.

Technical Corrections

DHCS proposes to make other technical corrections to address outdated references to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), rather than the more current DSM-V, and reflect federal diagnostic coding requirements related to use of International Classification of Diseases (ICD) code sets.

3.7.3 Rationale

Updates to medical necessity criteria for specialty mental health and SUD services, and related policy proposals, are required to achieve more up-to-date clinical practices and better clarity for oversight.

3.7.4 Proposed Timeline

DHCS recommends making changes to the specialty mental health and substance use disorder medical necessity criteria and related processes, as applicable, effective January 1, 2022 with the approval of the Section 1115 and 1915(b) waivers.

3.8 Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

3.8.1 Background

California's mental health plans operate under the authority of a Section 1915(b) waiver, while DMC-ODS plans operate under the authority of a Section 1115 demonstration, and Drug Medi-Cal fee-for-service programs are authorized through California's Medicaid State Plan.

For mental health plans and DMC-ODS plans, DHCS contracts with counties to act as prepaid inpatient health plans to provide, or arrange for the provision of, specialty mental health services and DMC-ODS treatment services to beneficiaries. While the specialty mental health services program is a statewide benefit, the DMC-ODS managed care program is only covered in counties that have "opted-in" and are approved to participate by DHCS and CMS.

Fifty-six mental health plans administer the SMHS program, including two joint arrangements in Sutter/Yuba and Placer/Sierra. For SUD services, 37 counties administer the DMC-ODS program, covering more than 90 percent of the Medi-Cal population. Seven of these counties contract with a local Medi-Cal managed care plan to provide an alternative regional model for DMC-ODS. The remaining 21 counties provide SUD treatment services through Drug Medi-Cal.

Medi-Cal specialty mental health and SUD treatment services are currently administered through separate, unique structures at the county level. Beneficiaries with co-occurring mental health and SUD treatment needs must navigate multiple systems to access care.

Beneficiaries must review multiple handbooks and provider directories, navigate separate intake and assessment processes, and often travel to multiple locations to receive care. Counties and providers face challenging documentation and coding requirements, especially for beneficiaries with both SUDs and mental health conditions.

At the system level, counties must demonstrate compliance with two sets of requirements and are subject to multiple reviews. For DMC-ODS counties, administering two distinct prepaid inpatient health plans must demonstrate compliance with federal managed care requirements twice, essentially running two almost entirely separate managed care programs with duplicative processes for quality improvement and performance measurement, beneficiary appeals, and program integrity.

3.8.2 Proposal

DHCS is proposing administrative integration of specialty mental health and SUD services into one behavioral health managed care program. This proposal is distinct from the Full Integration Plan which will integrate physical, behavioral and oral health care into comprehensive managed care plans. The goal is to improve outcomes for beneficiaries through coordinated treatment across the continuum of care. An additional goal and benefit would be to reduce administrative and fiscal burdens for counties, providers, and the state.

For counties participating in DMC-ODS managed care, DHCS is interested in working toward integrating the two behavioral health programs/prepaid inpatient health plans into a single behavioral health plan structure. The result would be a single prepaid inpatient health structure in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD treatment services for all Medi-Cal beneficiaries in that county or region. Participating counties would benefit from streamlined state requirements and the elimination of redundancy. Consolidating operations and resources into one behavioral health managed care plan would allow counties to successfully meet state and federal requirements and significantly decrease their administrative burden.

Additionally, Drug Medi-Cal fee-for-service counties will also be able to integrate such services; however, slight variations may apply due to the differences of federal requirements for fee-for-service verses prepaid inpatient health plans.

Clinical Integration

1. Access Line

Counties are required to have a 24-hour access line for mental health plans and for DMC-ODS. Some Drug Medi-Cal counties may also have 24-hour access lines, although it is not a requirement. Many counties already use their access lines in an integrated manner to triage, screen, and refer beneficiaries for both specialty mental

health and SUD treatment services; however, some counties maintain separate lines. Under an integrated model, the goal would be for all counties to have an integrated, 24-hour access line for beneficiaries seeking either specialty mental health and/or SUD services.

2. Intake/Screening/ Referrals

Processes for intake, screening, and referral vary by county. Optimally, counties would have standardized and streamlined intake processes that are timely, emphasize a positive beneficiary experience, and use a “no wrong door” approach to help beneficiaries access mental health and substance use disorder services. While assessments are performed by clinicians and tailored to the needs of the client, and may vary based on setting, DHCS proposes to move forward with a standardized statewide screening tool for beneficiaries 21 and over, and one for beneficiaries under 21, to ensure beneficiaries receive prompt care in the right delivery system.

3. Assessment

Assessment processes and tools for specialty mental health and SUD services also vary by county. For example, the American Society of Addiction Medicine placement tool is used to make level of care determinations DMC-ODS. However, an assessment tool is not required in Drug Medi-Cal counties. For SMHS, the Child and Adolescent Needs and Strengths tool is required for children and youth; however, there is not a required tool for adults. More research will be needed to determine which aspects, authorities, or requirements need to be addressed to integrate clinical assessments for mental health and SUDs.

4. Treatment Planning

Currently, treatment planning for specialty mental health and SUD treatment services is conducted separately and is not integrated. Beneficiaries receiving both types of services can have multiple treatment plans that include different documentation requirements. To improve efficiency, counties would integrate treatment planning for both specialty mental health and substance use disorder services with simplified and aligned documentation requirements. The goal would be to develop a new, simplified, more client-centered and strength-based approach to behavioral health treatment planning and to align treatment planning and documentation standards with physical health care. Additionally, DHCS will provide counties with relevant Medi-Cal services data, which may include managed care encounter and pharmacy claims data, to allow for better coordination of care and treatment planning.

5. Beneficiary Informing Materials

Currently, beneficiaries who receive services through mental health plans and DMC-ODS receive two beneficiary handbooks. The handbooks are not the same, but both

address elements that are required by federal managed care regulations, such as language regarding the grievance, appeals and state fair hearing processes. The goal is to consolidate beneficiary information materials to streamline them into one user-friendly handbook, reduce confusion, increase access, and achieve administrative efficiencies.

Consideration would need to be given to implementing this element in Drug Medi-Cal counties, since they are not currently required to have a beneficiary handbook.

Administrative Integration

1. Contracts

Currently, there are three separate contract types between DHCS and counties: mental health plans, DMC-ODS and Drug Medi-Cal counties. Under an integrated system, the goal would be to have only one contract in every county that would cover both all Medi-Cal specialty mental health and SUD treatment services.

2. Data Sharing / Privacy Concerns

Counties are responsible for managing data-sharing at two levels: within and across county plans, and at the provider level. Data sharing and privacy concerns need to be explored to determine what areas can be addressed, since there are different considerations and regulations pertaining to data sharing for SMHS and SUD services. Addressing these concerns will be critical in determining whether and when counties can integrate assessments, treatment plans, and electronic health records, among other processes. A thorough assessment of the various barriers and solutions to stringent patient privacy protections will be required. There will need to be a thorough assessment by the state and counties to identify the various barriers and solutions to stringent patient privacy protections built into federal regulations.

3. Electronic Health Record Integration and Re-Design

Many counties currently operate separate electronic health records (EHRs) or maintain differently configured and separate records for specialty mental health and substance use disorder services. This is largely in response to federal regulations, but also due to historical bifurcation of the two programs and different documentation and data-reporting requirements for the specialty mental health and substance use disorder programs. Timelines for integrating different components of administrative integration will depend on counties' ability to arrive at a record design that is compliant and then collaborate with their vendors to make multiple, timely modifications to their electronic health records.

4. Cultural Competence Plans

Mental health plans are required to have a plan for culturally responsive care for specialty mental health services. DMC-ODS plans are also required to have a culturally responsive care plan. Under an integrated system, counties would have only one integrated plan for culturally responsive care instead of two, separate plans.

Considerations would need to be given to how this element would be implemented in Drug Medi-Cal counties since they are currently not subject to these same requirements.

Integration of DHCS Oversight Functions

1. Quality Improvement

Some counties have integrated quality improvement and performance measurement programs for specialty mental health and substance use disorder services. However, most programs – or components of them – are still separate. Under an integrated system, counties would develop and operationalize a consolidated quality improvement plan, have a single quality improvement committee, and develop a comprehensive list of performance measures for specialty mental health services and substance use disorder services.

2. External Quality Review Organizations

Pursuant to federal Medicaid managed care requirements, an external quality review is required for both mental health plans and DMC-ODS. Currently, Behavioral Health Concepts is the contractor that acts as the External Quality Review Organization for both programs. However, there are separate contracts, review processes, timelines, and protocols. In addition, counties must develop separate performance improvement plans for each program. The goal is to implement a combined external quality review process, which would result in one external review and integrated performance improvement plans, and ultimately having one single External Quality Review Organization (EQRO) report for each county. Since an external quality review is not required for Drug Medi-Cal counties, further exploration will be needed to determine the extent to which these elements would play a role under an integrated model.

3. Compliance Reviews

Current compliance reviews conducted by DHCS for mental health plans, DMC-ODS, and Drug Medi-Cal counties are separate. Under an integrated model, the goal would be to consolidate compliance reviews into a single review with an integrated protocol. A particular focus of this effort will be on streamlining documentation requirements for behavioral health providers to allow integrated behavioral health care.

4. Network Adequacy

Network adequacy certification processes are separate for specialty mental health plans and DMC-ODS. Under an integrated model, DHCS would certify one network for specialty mental health and substance use disorder managed care services for each county, instead of certifying two networks as currently required.

5. Licensing & Certification

Existing requirements and processes for licensing and certification are different and separate for specialty mental health and substance use disorder providers. The goal is to streamline licensing and certification requirements, processes, and timeframes across the behavioral health managed care system, where appropriate. Successful implementation of integrated care models would also necessitate a discussion on non-administrative changes that may be needed, such as workforce development, cross-training of existing providers, and adoption of new evidence-based practices.

3.8.3 Rationale

About half of individuals with a SMI have a co-occurring substance use and those individuals benefit from integrated treatment. Since the state provides Medi-Cal-covered substance use disorder and specialty mental health services through two separate county-operated delivery systems, it is difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties with both DMC-ODS and mental health plans are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. The purpose of this proposal is to make changes to streamline the administrative functions for SUD and SMHS.

3.8.4 Proposed Timeline

The goal would be 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 in 2027. Both state-level and county-level activities will be required to achieve this goal. Successful implementation will require careful sequencing and planning and a phased-in approach where cohorts are considered.

3.9 Behavioral Health Regional Contracting

3.9.1 Background

State law allows two or more counties acting jointly to deliver or subcontract for the delivery of specialty mental health services. Furthermore, participating DMC-ODS counties are permitted to develop regional delivery systems for required modalities or to act jointly to deliver covered services, with approval from DHCS and CMS, as applicable.

3.9.2 Proposal

DHCS encourages counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (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 County Medical Services Program or the local Medi-Cal managed care plan, to create administrative efficiencies across multiple counties.

Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. DHCS is interested in discussing how counties not currently seeking DMC-ODS participation may be more interested in doing so through a regional approach and/or how services provided under Drug Medi-Cal might also be provided through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

3.9.3 Rationale

Acting jointly through regional contracts would allow counties to pool their resources, which can improve access and availability of services for Medi-Cal beneficiaries in their region and allow for increased county administrative efficiencies. Although regional contracting is currently allowed under state law, only a few counties have taken advantage of this opportunity. Regional contracting would give counties opportunities to share workforce and jointly invest in administrative infrastructure such as electron health records, billing and claiming systems, and oversight/quality assurance and improvement.

Regional contracts offer numerous potential advantages. For example, network adequacy certification requires significant administrative infrastructure to develop and maintain policies and procedures for tracking network resources, and counties must identify and contract with additional qualified providers when network gaps are identified. Both functions (tracking and finding new providers) can prove challenging in some counties that may have fewer local providers. Through regional contracts, counties could reduce duplication and standardize administrative processes, such as beneficiary handbooks, provider directories, and grievance and appeal processes.

For Drug Medi-Cal counties, regionalization could potentially enable smaller counties to participate in DMC-ODS, providing a broader set of services to their residents when it would not be otherwise feasible. By participating in DMC-ODS, these counties could then create a single, integrated behavioral health plan, as described in the CalAIM Administrative Integration of Specialty Mental Health and Substance Use Disorder Services proposal.

In addition, Medi-Cal managed care plans, mental health plans, and DMC-ODS plans must meet the full array of state and federal requirements applicable to prepaid inpatient health plans under the federal Medicaid managed care regulations. Among these are network adequacy, quality assessment and performance improvement, beneficiary rights and protections, and program integrity. For individual counties, entering into regional contracting agreements would reduce the administrative burden of meeting Medicaid managed care requirements. Counties could better utilize resources to focus on improving access, quality of care, and beneficiary outcomes, while mitigating the risk of audit exceptions and administrative and financial sanctions.

3.9.4 Proposed Timeline

DHCS seeks input from county partners and other stakeholders regarding an estimated timeframe for establishing regional contracting agreements.

3.10 Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements

3.10.1 Background

One of the key goals of the Drug Medi-Cal Organized Delivery System (DMC-ODS) was to treat more people more effectively by reorganizing the delivery system for substance use disorder (SUD) treatment through Medi-Cal. California's Drug Medi-Cal Organized Delivery System (DMC-ODS) was the nation's first SUD treatment demonstration project under Section 1115, approved by CMS in 2015. Since then, more than 20 other states have received approval for similar substance use disorder treatment demonstrations. The program has established a continuum of care modeled after the American Society for Addiction Medicine (ASAM) criteria. These criteria are the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with addiction.

The benefits under the DMC-ODS, which counties administer as pre-paid inpatient health plans (PIHPs), include all of the standard SUD treatment services covered in California's Medicaid State Plan (outpatient, intensive outpatient, perinatal residential, narcotic treatment programs and naltrexone), plus case management, multiple ASAM levels of residential substance use disorder treatment, withdrawal management services, recovery services, physician consultation and if the county chooses, additional medication assisted treatment, and partial hospitalization.

Also included in the current program is the expenditure authority to allow federal Medicaid reimbursement for short-term residential SUD treatment stays in an Institution for Mental Disease (IMD). The IMD exclusion has historically prohibited federal reimbursement for residential and inpatient mental health and SUD treatment for Medicaid enrollees age 21-64, in facilities with more than 16 beds. This exclusion deterred most providers in the State who found it financially unviable to operate facilities with so few beds. Allowing for reimbursement of residential SUD treatment services through the Medi-Cal program, with

no limitation on the number of beds, means that counties can receive federal matching funds for services that were previously unavailable.

Currently, DMC-ODS is not a statewide benefit since the program operates only in counties that “opt in” to participate and are approved to do so by both DHCS and CMS. There are currently 37 counties participating in the DMC-ODS demonstration, providing access to SUD treatment services for 96 percent of the Medi-Cal population. Seven of these counties are working with a local managed care organization to implement a regional model. Medi-Cal beneficiaries in the 21 counties not participating in the program provide their SUD treatment services through fee-for-service as authorized through the Drug Medi-Cal State Plan. The fee-for-service benefit is more limited than the DMC-ODS benefit in terms of covered services and that it is not a managed care program.

3.10.2 Proposal

DHCS proposes to update and improve the DMC-ODS, based on experience from the first several years of implementation. Accordingly, DHCS proposes to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency.

DHCS aims to design a cohesive plan to address beneficiaries’ SUD treatment needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and to promote long-term recovery. This requires developing new approaches to care delivery and system administration that will improve the beneficiary experience, increase efficiency, ensure cost-effectiveness, and achieve positive health outcomes.

The 37 counties that have implemented the DMC-ODS have made tremendous strides in improving the continuum of care for Medi-Cal beneficiaries with SUD treatment needs. Implementation across 37 California counties has also yielded lessons learned and opportunities to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency. DHCS also acknowledges that for many counties, the DMC-ODS model of care is still very new since implementation was phased in over several years.

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

DHCS also intends to provide counties with another opportunity to opt-in to participate in the DMC-ODS in hopes of promoting DMC-ODS participation across the state. While participation in DMC-ODS will not be mandatory for counties, DHCS would like to work with counties not currently participating in the DMC-ODS to explore ways to encourage the remaining counties to opt-in.

Residential Treatment Length-of-Stay Requirements

Currently, within a 365-day period, adult residential SUD treatment services may be authorized for two non-continuous stays, for up to 90 days for each stay, with one 30-day extension permitted for one of the stays. Similarly, within a 365-day period, adolescent residential treatment services may be authorized for two non-continuous stays; however, stays for adolescents are limited to 30 days each stay, with one up to 30-day extension allowed for one of the stays.

Residential length-of-stay should be determined based on the individual's condition, medical necessity, and treatment needs. Given that the two-episode limit is inconsistent with the clinical understanding of relapse and recovery from SUDs, DHCS proposed in the 12-month extension request to remove this limitation and base treatment on medical necessity.² DHCS will further propose that there be no distinction between adults and adolescents for these particular requirements.

Note: DHCS must obtain approval from CMS regarding all components of the Section 1115 extension and renewal. CMS is currently only approving SUD 1115 demonstrations with a residential benefit average length-of-stay of 30 days. While some states may show average lengths of stay that are close to the 30-day target, these are likely to include numerous treatment episodes that may have terminated prematurely, before the client achieved positive clinical outcomes. Including these shorter stays in the calculation may lower the average and give the impression that shorter lengths of stay are universally feasible and appropriate.

As such, DHCS will examine the possibility of tracking and documenting the average length-of-stay for only those DMC-ODS enrollees that achieve positive treatment outcomes. Furthermore, with the substantial rise in methamphetamine usage and overdose deaths in California, DHCS will work closely with CMS to negotiate a residential treatment benefit that accounts for the increased clinical needs of individuals utilizing stimulants.

² Proposed changes to the DMC-ODS program included in the Medi-Cal 2020 12-month extension request: 1) Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period, 2) Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis, 3) Clarify that recovery services benefit, 4) Expand access to MAT, and 5) Increase access to SUD treatment for American Indians and Alaska Natives.

Residential Treatment Definition

The current definition of residential treatment in California does not clearly define the amount, duration, and scope of covered services, and there are different treatment standards and limitations for adults and adolescents.

DHCS proposes that the definition of residential treatment be updated to remove the adolescent length-of-stay limitations, and to add mandatory provisions for referral to medication assisted treatment. DHCS would also propose to remove the distinction between adults and adolescents for these requirements, with the exception of Early and Periodic Screening, Diagnostic, and Treatment services.

Recovery Services

As part of Dimension 6 (Recovery Environment) of the ASAM criteria, during the transfer/transition planning process, beneficiaries shall be linked to applicable recovery services. Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed, or as a preventive measure to avoid relapse.

DHCS proposed in the 12-month extension to clarify the following policies related to recovery services:

- Specify the services included in the benefit (e.g., group, education sessions, and assessment);
- Establish when and how beneficiaries may access these services, including language to encourage the use of recovery services for justice-involved individuals: and
- Define the term “after completing their course of treatment,” to not inadvertently prohibit beneficiaries receiving long-term medication assisted treatment from having access to recovery services.

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.

Additional Medication Assisted Treatment

Counties are required to cover opioid treatment program services, also called Narcotic Treatment Programs. Currently counties may elect to cover additional medication assisted treatment, which includes the ordering, prescribing, administering, and monitoring of all medications for SUD treatment.

DHCS proposed in the 12-month extension request to keep the additional medication assisted treatment (MAT) services as an optional benefit but clarified the coverage provisions to require that all substance use disorder managed care providers demonstrate that they either directly offer, or have referral mechanisms to medication assisted treatment. The goal is to have a county-wide multi-delivery system of coverage.

Clinician Consultation Services

Currently, physician consultation services cover time spent by the DMC-ODS physicians consulting with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists. The name of the benefit will change to Clinician Consultation Services and be expanded to include consultation services for, and by, licensed clinicians including Nurse Practitioners and Physician Assistants. Coverage of consultation services is designed to help clinicians seek expert advice on designing treatment plans for beneficiaries. Clinician consultation services can only be billed and reimbursed by providers in DMC-ODS provider sites.

DHCS proposes to clarify the terms of clinician consultation, particularly with regard to how and who can claim this activity. DHCS proposes to remove the limitation that clinician consultation services can only be billed by certified Drug Medi-Cal providers. Counties may contract with SUD clinicians not certified by Drug Medi-Cal. DHCS' [telehealth policy](#) will be used to guide this effort.

Evidence-Based Practice Requirements

Currently, providers are required to implement at least two of the following evidence-based treatment practices based on a timeline established in the county implementation plan: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho Education. The two evidence-based practices are a per-provider per-service modality.

DHCS proposes to retain the five (5) current evidence-based practices and add Contingency Management to the renewal proposal. Providers are not limited to providing only the six evidence-based practices.

DHCS Provider Appeals Process

Following a county's protest procedure, a provider may currently appeal to DHCS if it believes that the county erroneously rejected the provider's solicitation for a contract.

DHCS proposes removing this process from as it is convoluted, has rarely been used, and it is already addressed by the network adequacy requirements. All providers have a right to appeal under the federal 438 requirements.

Tribal Services

DHCS proposed in the 12-month extension to take several actions to increase access to SUD treatment for American Indians and Alaska Natives, including:

- Providing an allowance for specific cultural practices for Tribal 638 and Urban clinics, reimbursement, and definitions of scope of practice for the workforce of traditional healers and natural helpers, and culturally specific evidence-based practices.
- Requiring Indian health care providers to use at least two evidence-based practices as defined in the DMC-ODS and/or from a list developed by DHCS in consultation with Tribal and Urban partners.

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

Treatment after Incarceration

The current language requiring the ASAM criteria, may be underestimating the level of care necessary to serve individuals being released from incarceration, since their substance use was either not possible during incarceration or because individuals under parole/probation supervision are likely hesitant to admit to substance use.

Because inmates are at a high risk of relapse and overdose upon release from incarceration, whether or not there was active use in the last 12 months, DHCS plans to clarify access language for individuals leaving incarceration who have a known substance use disorder.

Billing for Services Prior to Diagnosis

Currently, counties may not begin billing for SUD services until a beneficiary has been diagnosed (i.e., counties may not bill for time spent conducting substance use disorder assessments). Since it takes time for clinicians to evaluate a beneficiary for a substance use disorder, and sometimes presenting symptoms are due to a combination of mental illness, substance use disorder, or both, DHCS proposed in the Medi-Cal 2020 extension to clarify the waiver Special Terms and Conditions to allow reimbursement for SUD assessments (even if it takes multiple visits) before a final diagnosis is determined, which aligns with requirements around assessments for specialty mental health services.

Medical Necessity for Narcotic Treatment Programs (NTPs)

DHCS proposes to update and align the STCs with best practices to allow a physician's history and physical to determine medical necessity for NTP services as required by

federal licensing laws. In addition, DHCS would clarify requirements for the initial assessment and medical necessity determinations in other settings.

Early Intervention (Level 0.5)

DHCS proposes to add ASAM 0.5 level of care for beneficiaries under 21, to allow early intervention as an organized service that may be delivered in a wide variety of settings. This service is designed to explore and address problems or risk factors related to substance use, and to help the individual recognize the harmful consequences of high-risk substance use. This includes engagement activities (including screening, assessment, brief interventions such as motivational interviewing and counseling) for beneficiaries at high-risk for developing substance-related or addictive behavior problems, or those for whom there is not yet sufficient information to document a substance use disorder.

3.10.3 Proposed Timeline

The following changes would go into effect on January 1, 2021, subject to federal approval of the Medi-Cal 2020 12-month extension request:

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

The remaining changes outlined above would go into effect January 1, 2022, subject to federal approval.

Dental

3.11 New Dental Benefits and Pay for Performance

3.11.1 Background

DHCS is committed to improving the accessibility of Medi-Cal dental services and improving oral health outcomes for Medi-Cal members. To demonstrate that commitment, three initiatives and policy changes have been implemented in recent years:

- The Dental Transformation Initiative under the current Medi-Cal 2020 Section 1115 demonstration;
- Proposition 56 supplemental provider payments; and

- Restoration of the optional adult dental benefit under Medi-Cal.

These efforts have been successful in increasing preventive dental service utilization for children, as well as increasing adult utilization of dental care. While two of the initiatives share a common theme – financial incentives for positive outcomes – they are time-limited. DHCS has included a chart (see **Appendix H: Dental in Proposition 56 vs. CalAIM**) that reflects the dental codes with financial incentives available under CalAIM and Proposition 56.

3.11.2 Proposal

The Department set a goal to achieve at least a 60 percent dental utilization rate for Medi-Cal eligible children. In order to progress toward achieving that goal and based on lessons learned from the Dental Transformation Initiative, DHCS proposes the following reforms for Medi-Cal dental be made statewide provide better care and align with national dental care standards. The proposed new benefits include:

- Caries Risk Assessment Bundle for young children; and
- Silver Diamine Fluoride for young children; and specified high-risk and institutional populations; and
- 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 expanded initiatives would be available statewide for children and adult enrollees.

These expanded initiatives would be available statewide for children and adult enrollees.

New Dental Benefits

DHCS proposes adding coverage of a Caries Risk Assessment Bundle for children ages 0 to 6 years. The Caries Risk Assessment bundle would include nutritional counseling (D1310) to educate and influence behavior change. Based on risk level associated with each individual Medi-Cal beneficiary ages 0 to 6, the benefit would allow the following frequency of services:

- Low – comprehensive preventive services 2x/year (D0601)
- Moderate – comprehensive preventive services 3x/year (D0602)
- High – comprehensive preventive services 4x/year (D0603)

Additionally, DHCS proposes to add coverage of Silver Diamine Fluoride for children ages 0 to 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 (SNF/ICF) or part of the Department of Developmental Services (DSS) population. The Silver Diamine Fluoride benefit would provide two visits per member per year, for up to ten teeth per visit, at a per tooth rate and a maximum of four treatments per tooth.

Pay for Performance

To increase statewide preventive service utilization for children and adults, DHCS is proposing to provide a flat rate performance payment for each paid preventive service rendered by a service office location.

Additionally, the state proposes to provide 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.

3.11.3 Rationale

These policy proposals align with the legislature's charge to achieve at least a 60 percent dental utilization rate for Medi-Cal eligible children, CMS Oral Health Initiative goals for Medicaid (increase by ten percentage points the proportion of Medicaid and CHIP children ages one to 20 who receive a preventive dental service), and our lessons learned from the Dental Transformation Initiative (DTI).

For example, in the DTI - Domain 1, incentive payments were made to service office locations that increased the utilization of the top eleven preventive services available to children. As a result, not only has utilization of preventive services continued to increase year after year, but since the baseline year of 2014, the number of services has increased eight percent and the number of services per member has also increased by seven percent.

Furthermore, data comparing a control group of children in Dental Transformation Initiative counties who did not receive Caries Risk Assessment with children who did receive Caries Risk Assessment over two calendar years yielded staggering results. The Medi-Cal children who had a Caries Risk Assessment received over 300 percent more preventive services compared to 189 percent for non-Caries Risk Assessment children. Additionally, in this same period, the number of restorative services was almost half that of the control group. Medi-Cal children receiving Caries Risk Assessment had a 263 percent increase in restorative services while the control group with no Caries Risk Assessment had a 475 percent increase in restorative services.

3.11.4 Proposed Timeline

DHCS is currently evaluating a timeline for implementation as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration.

County Partners

3.12 Enhancing County Eligibility Oversight and Monitoring

3.12.1 Background

The implementation of the Affordable Care Act (ACA) marked a monumental overhaul of the Medi-Cal program by financing a coverage expansion to populations that previously did not qualify, in addition to streamlining eligibility requirements for some populations. County social service agencies strived to acclimate to the vast changes in regulations while managing an unprecedented surge in Medi-Cal applications submitted statewide. To afford counties the opportunity to modify business processes to effectively administer the Medi-Cal program post Affordable Care Act, counties were held harmless by DHCS for performance standards.

Federal, state, and DHCS audits of Medi-Cal eligibility determinations conducted since the implementation of the Affordable Care Act in 2014 have identified several issues that must be addressed and resolved. Audit findings include performance issues related to timeliness of application processing and timeliness of annual eligibility renewal processing. Discrepancies between the Medi-Cal Eligibility Data System (MEDS), and the county Statewide Automated Welfare System (SAWS) also resulted in audit findings, which in part were caused by system-related issues connected to the implementation of the California Healthcare, Eligibility, Enrollment and Retention System (CalHEERS).

Audit findings, recommendations, and corrective action plans imposed upon DHCS require the State to implement additional oversight activities needed to increase the administrative integrity of the Medi-Cal program. Federal audit findings have also levied fiscal penalties upon DHCS, requiring the state to repay the federal matching funds that were claimed because of erroneous Medi-Cal eligibility determinations.

3.12.2 Proposal

DHCS recommends a phased-in approach to working with the counties to increase program integrity with respect to eligibility and enrollment.

- **Reinstate County Performance Standards:** In response to audit findings, DHCS will reinstate the county performance standards required under state law as a means of addressing and correcting error rates and issues which may have a future impact on the timeliness and accuracy of Medi-Cal eligibility determinations. DHCS plans to implement a series of oversight programs throughout the course of the next 24 months. This includes the implementation of a statewide MEDS alerts monitoring program.
- **Develop an Updated Process for the Monitoring and Reporting of County Performance Standards:** In collaboration with CWDA, SAWS and the counties, DHCS will define roles, responsibilities, and develop an updated written process for the monitoring and reporting of the existing county eligibility performance standards. This process will clearly outline DHCS' performance expectations, taking into consideration the issues that are beyond the counties' control, but including potential consequences if standards are not met.
- **Ensure DHCS/County Partnership through Regular Meetings and Open Lines of Communication:** DHCS will work collaboratively with CWDA, counties, and SAWS to develop a communications plan that articulates a process for receiving and responding to county requests for technical guidance and assistance as necessary and appropriate to support counties through this transition. DHCS will look at leveraging existing meetings, and/or developing dedicated meetings to further open lines of communication related to county oversight and monitoring. DHCS will continue to encourage county feedback in identifying gaps or needed clarifications in policy guidance and automation issues. DHCS will also work closely with counties, SAWS and CalHEERS to identify and pursue needed automation changes to support counties in the effective administration of the Medi-Cal program.
- **Develop a Tiered Corrective Action Approach:** DHCS will work with county partners to establish a tiered corrective action approach that would require the submission of a Corrective Action Plan for counties that do not meet established performance expectations. DHCS remains committed to supporting counties and providing timely policy guidance, along with technical assistance, as needed, in addressing and correcting error trends.
- **Incorporate Fiscal Penalties as Part of the Tiered Corrective Action Approach:** For counties that do not demonstrate sufficient improvement in performance, DHCS will take disciplinary action that could range from technical assistance to requiring corrective action plans to imposing financial penalties on counties that fail to show significant improvement and/or are unresponsive to CAPs.

- **Incorporate Findings/Actions in Public Facing Report Cards:** DHCS will work with CWDA, counties and the SAWS to further develop county performance reports that are publicly posted on the California Health and Human Services (CHHS) Open Data Portal and increase accountability by issuing annual public-facing report cards to all 58 counties.

3.12.3 Rationale

This proposal is envisioned to be a crucial step toward achieving DHCS' larger vision for CalAIM by ensuring Medi-Cal enrollment processes are applied in a standardized and consistent manner statewide. 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 is compliant with federal and state requirements.

3.12.4 Proposed Timeline

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 for 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.

- **June 1 – August 31, 2021:** DHCS will reinstate County Performance Standards, including incorporation of MEDS alert monitoring statewide.
- **September 1 – December 30, 2021:** DHCS will develop and publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CAPs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties.
- **January 1 – March 31, 2022:** DHCS will begin assessing County Performance Standards, in keeping with the aforementioned updated process.
- **April 1 – June 30, 2022:** DHCS will implement the county performance monitoring dashboard (a public facing report card). The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.

- **July 1 – September 30, 2022:** DHCS will begin publishing the county performance monitoring dashboard on the CHHS Open Data Portal.
- **July 1 – December 31, 2023:** DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.

3.13 Enhancing County Oversight and Monitoring: CCS and CHDP

3.13.1 Background

The California Children’s Services program serves as a proxy of Medi-Cal for case management services and provides diagnostic and treatment services, physical and occupational therapy services to children and youth with eligible medical conditions. The Child Health and Disability Prevention program delivers periodic health assessments and services to low-income children and youth; and provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

California Children’s Services and Child Health and Disability Prevention beneficiaries are best served when their care is delivered in a standardized and consistent manner. It is the State’s responsibility to ensure that the same high-quality standard of care is compliant with federal and State guidelines for all beneficiaries. To remain proactive with emerging trends, technology, medical advances, and interventions, it is essential the State continue to evolve its efforts accordingly.

3.14.2 Proposal

DHCS intends to provide enhanced monitoring and oversight of all 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach) to ensure continuous, and unwavering optimal care for children. To implement the enhanced monitoring and oversight of California Children’s Services and Child Health and Disability Prevention in all counties, DHCS will develop a robust strategic compliance program. Effective compliance programs begin with ascertainable goals, performance measures, and metrics capturing all federal and State requirements. Ongoing quality assurance and data reviews are fundamental to ensuring compliance and continued improvements in program operations and beneficiary care.

Initial efforts will entail a review of all current standards and guidelines for both programs. Once the internal policy review is complete, DHCS will develop initial auditing tools to assess current county/city operations and compliance. DHCS will then evaluate and analyze the findings gathered during audits to identify gaps and vulnerabilities across the State within the programs. The information gathered will be the cornerstone for future efforts, and the basis for the development of the strategic compliance program.

County/City variances in program operations and compliance with federal and State laws are also identified by tracking trends. DHCS will refine and update oversight policies and procedures and implement best practices. DHCS, along with input from our county partners and other stakeholders, will establish goals, metrics, performance measures, and milestones to ensure counties/cities are providing the necessary provider oversight and medical/ dental care for beneficiaries. DHCS will provide training and technical assistance with internal and external partners to achieve statewide consistency of the compliance requirements and goals. In addition, DHCS will conduct ongoing quality assurance reviews, develop, and create county/city program specific dashboards, as necessary to meet internal and external reporting needs.

In alignment with technology trends, the State plans to shift counties/cities from annual hardcopy submission of Plan and Fiscal Guidelines budgets to a more efficient and streamlined automated electronic submission process. Training and overview of the electronic submission process conducted for the counties ensures understanding prior to implementation of the automated system. More rigorous annual review of all county budgets will further efficiencies, contain costs, and improve outcomes.

To better manage this population's health care and ensure targeted interventions are implemented, each county/city and state will enter into a Memorandum of Understanding (MOU) with DHCS. The MOU, in conjunction with other supportive policies (information notices, numbered letters, etc.), will detail how the state will monitor county/city activities, policies and procedures, conduct audits, and implement corrective action plans. This MOU will be developed utilizing information obtained during the audits with the intent of having signed agreements with all counties/cities.

After initial deployment of the enhanced monitoring and oversight, DHCS will continue to conduct ongoing audits, stay proactive with emerging developments, and monitor trends to ensure high-quality consistent care. DHCS will allow sufficient time for counties to implement and adjust to this new structure prior to engaging in any sort of progressive action. DHCS will continue compliance oversight to preserve and improve the overall health and well-being of these vulnerable populations.

3.13.3 Rationale

Enhancing monitoring and oversight will eliminate disparities in care to beneficiaries and reduce vulnerabilities to the state, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

3.13.4 Proposed Timeline

- **Phase I: August 2020 – June 2021**
 - Review of current standards, policies, and guidelines

- Development of goals, performance measures, and metrics
- Revision of current Plan and Fiscal Guidelines guidance document
- Continuation of the establishment of an electronic submission portal for the annual county/city budgets.
- **Phase II: July - September 2021**
 - Development of auditing tools
- **Phase III: October 2021 – September 2022**
 - Shift to an electronic automated PFG submission by the counties/cities
 - Develop training documents
 - Evaluate and analyze findings and trends
 - Identify gaps and vulnerabilities
- **Phase IV: October 2022- Ongoing**
 - Initiate Memorandum of Understanding between State and counties
 - Continuous monitoring and oversight
 - Continuous updates to standards, policies, and guidelines

3.14 Improving Beneficiary Contact and Demographic Information

3.14.1 Background

Medi-Cal has approximately 13 million enrolled beneficiaries; approximately 80 percent are enrolled in the managed care delivery system and 20 percent are enrolled in the fee-for-service delivery system. County social services departments are delegated by DHCS to process Medi-Cal applications and renewals, as well as to generally provide case management services. Counties use Statewide Automated Welfare Systems (SAWS_ to support and maintain Medi-Cal enrollment processes. The SAWS, of which there are currently three, contain contact and demographic information on enrolled individuals. The systems maintain electronic interfaces with the state-level eligibility and enrollment system (California Healthcare Eligibility, Enrollment, and Retention System) and the state-level eligibility database, the Medi-Cal Eligibility Data System. The Medi-Cal Eligibility Data System is the system of record for purposes of Medi-Cal eligibility information, claims payment, and health plan assignment, among other things.

When a beneficiary has a change in circumstances that affects their eligibility, the beneficiary is required to report changes to their county eligibility worker within ten calendar days of the change. Such changes include but are not limited to address and contact information updates, family size (increases or decreases), access to other health insurance, changes in income, and death. County eligibility workers are then responsible

for ensuring the data maintained in the local county eligibility system is accurate and up to date. Under current state law, Medi-Cal managed care plans have the ability to report updated contact information to the county when they have obtained consent from the beneficiary for such reporting.

Accurate contact and demographic information is critical for purposes of ongoing program enrollment and care management for beneficiaries. This information is used by Medi-Cal fee-for-service providers and Medi-Cal managed care plans, as well as other providers of care, for purposes of effective communication and interaction with Medi-Cal beneficiaries, including deploying care management strategies based on individual needs.

Given the substantial volume of individuals in the process of enrolling in or renewing Medi-Cal coverage, it is critical that DHCS, counties and plan and provider partners have accurate contact and demographic information. A more effective and efficient process for keeping this information up to date in California's systems is needed.

3.14.2 Proposal

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

3.14.3 Rationale

As DHCS seeks to make improvements in its approach to population-based health care and drive innovation in health care delivery, it is critical that our Medi-Cal providers, managed care plans, county partners, and others have access to accurate, up-to-date contact and demographic information for beneficiaries. County eligibility workers play a key role in ensuring contact information is current; however, there are other entities that interact with Medi-Cal beneficiaries on a regular basis who may have access to more current information. As a result, DHCS would like to leverage and explore the possibility of other entities having the opportunity to also update contact and demographic information about Medi-Cal beneficiaries.

3.14.4 Proposed Timeline

DHCS proposes to engage with key partners during 2022-23 to develop thoughtful and realistic recommendations for implementing improvements in how contact and demographic information can be updated by other entities in addition to county eligibility

workers. Such changes may be effectuated through updates to the Medi-Cal application, use of eligibility online portals and/or other means. As part of the workgroup effort, DHCS will also seek input in terms of timing of implementation, taking into consideration current system migrations, consolidations and/or modernization efforts.

4. Conclusion

DHCS developed these CalAIM proposals with a view toward the future and what will be necessary to more effectively and positively impact Medi-Cal beneficiaries' quality of life. These proposals were drawn from more than a year-long effort by DHCS leadership and staff, as well as engagement with critical partners and experts across the State and the nation. These ambitious proposals represent a long-term vision for advancing and improving the Medi-Cal program in fundamental ways that build upon the foundations established in prior waivers and expansion efforts. The success of the thinking behind CalAIM will fundamentally rest on the collaboration and coordination of DHCS, our plan, provider, county, and legislative partners, and the entire stakeholder community. DHCS recognizes that these proposals will likely require significant time and fiscal investment and look forward to working with our partners and through the budget process to most effectively implement the concepts proposed in this initiative. These efforts are not limited to a single year, but represent DHCS' current vision for what Medi-Cal might be able to achieve over the next five to ten years, and beyond.

5. From Medi-Cal 2020 to CalAIM: A Crosswalk

California is embarking on a new and system-wide initiative to transform how beneficiaries' access Medi-Cal services. As the Medi-Cal program has expanded under the Affordable Care Act and through other state-led initiatives, and with over 80% of beneficiaries now being served through managed care plans, it is an opportune time to consider the patient experience from an even more global perspective. Currently, beneficiaries may need to access six or more separate delivery systems (managed care, fee-for-service, specialty mental health, substance use disorder, dental, In Home Supportive Services, etc.) in order to receive the care they need. This combination of system fragmentation and clinical complexity, and the likelihood of decreased beneficiary capacity, makes access to effective care coordination even more critical.

As such, the state is undertaking a more targeted approach to consolidating its Medi-Cal benefit package to achieve better alignment across the system. While Section 1115 waiver authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating budget neutrality for waivers. CMS, in recent

guidance, has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools. These factors, combined with new federal managed care regulations, have encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for innovation in the Medi-Cal program.

In the spring of 2020, in response to the COVID-19 public health emergency, DHCS determined that additional time would be needed to prepare Medi-Cal managed care plans, counties, and a wide array of stakeholders for the transition from the Section 1115 waiver to the CalAIM structure. 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.

The following table outlines the proposed approach under CalAIM for each of the key Medi-Cal 2020 waiver elements:

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals				
Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Medi-Cal Managed Care	X	Transition to new 1915(b) waiver.	The general authority for various Medi-Cal managed care will be shifted from 1115 to 1915(b). This would include PACE models needing waiver approval and Whole Child Model.	January 1, 2022
Whole Person Care Pilots	X	Transition to new 1915(b) waiver and managed care plan contract authority.	Medi-Cal managed care plans would provide a new enhanced care management benefit. Additionally, Medi-Cal managed care plans will have the option to provide a menu of approved in lieu of services. The majority of Whole Person Care services will continue to be available as both enhanced care management and in lieu of services via Medi-Cal managed care plans, and ultimately will be expanded to Medi-Cal managed care plans in non-Whole Person Care counties.	January 1, 2022
PRIME		Transition to managed care directed payment under the Quality Incentive Pool (QIP) Program.	The existing PRIME funding structure was transitioned into QIP directed payments effective July 1, 2020. Network Designated Public Hospital (DPH) systems and the District/Municipal Public Hospitals (DMPHs) will have the opportunity to participate in and receive directed QIP payments from their contracted Medi-Cal managed care plans for reporting on a set of quality improvement measures through the QIP program.	Phase I: July 1 – December 31, 2020 Phase II: January 1, 2021
Health Homes Program	X	Transition to new 1915(b) waiver as Enhanced Care Management.	Medi-Cal managed care plans would provide a new enhanced care management benefit similar to the benefits included in the Health Homes Program. Medi-Cal managed care plans will have the option of providing a menu of approved in lieu of services. Services currently provided to populations with complex health needs under the HHP will become available under the managed care delivery system structure.	January 1, 2022

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Coordinated Care Initiative and Cal MediConnect	X	Managed care authority to new 1915(b) waiver; Extension of 1115A demonstration for Cal MediConnect through 2022; eventual Medicare-Duals Special Needs Plans (D-SNPs).	Transition to standardized mandatory enrollment of dual eligibles into Medi-Cal managed care plans. Multipurpose Senior Services Programs will be carved out; long-term care will be carved in statewide. All Medi-Cal managed care plans will be required to offer coverage through D-SNPs for care coordination and integration of benefits.	CCI program with end date of December 31, 2022
Drug Medi-Cal Organized Delivery System (DMC-ODS)	X	Expenditure authority for residential SUD treatment remains in 1115 waiver; Services and delivery system move to new 1915(b) waiver.	The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care for substance use disorder treatment.	Implementation continues January 1, 2022
Global Payment Program	X	1115 waiver renewal.	Continuation of existing program, with discontinuation of Safety Net Care Pool funds, using only Medicaid Disproportionate Share Hospital (DSH) allotment funds.	January 1, 2022.

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Dental Transformation Initiative	X	Transition authority to Medi-Cal State Plan.	<p>New dental benefits and provider payments:</p> <ul style="list-style-type: none"> • Caries Risk Assessment Bundle for ages 0-6; • Silver Diamine Fluoride for ages 0-6, and specified high-risk and institutional populations <p>Pay for Performance incentives for preventive services and establishing continuity of care through dental homes</p>	January 1, 2022
Community-Based Adult Services (CBAS)	X	1115 waiver renewal.	Services for eligible older adults and those with disabilities to restore or maintain their optimal capacity for self-care. The goal is to delay or prevent inappropriate or personally undesirable institutionalization.	January 1, 2022
Eligibility Authorities	X	1115 waiver renewal.	Full Scope Benefit for Pregnancy Related Beneficiaries with FPL 109-138% and Out of State Former Foster Care Youth.	January 1, 2022
Rady CCS Pilot	X	Not included.	The demonstration project tested two healthcare delivery models for children enrolled in the California Children’s Services (CCS) Program.	Expires December 31, 2021
Designated State Health Programs (DSHP)	X	Not included.	Financing mechanism under 1115 waiver which has permitted federal funding for certain State health programs not traditionally allowed for federal funding	Expires December 31, 2020
Tribal Uncompensated Care	X	Not included.	The state makes supplemental payments to Indian Health Service (IHS) and tribal 638 facilities to take into account their responsibility to provide uncompensated care. DHCS will work to implement Tribal FQHCs by January 1, 2021, which will account for the remaining services being billed for under Tribal Uncompensated Care.	Expires December 31, 2021

5.1 Transition of PRIME to Quality Incentive Program

5.1.1 Background

The California Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program built on other delivery system transformation efforts focused on strengthening patient-centered primary and specialty outpatient care, improving care coordination, and providing the right care in the most appropriate settings. A total of 17 Designated Public Hospitals and 34 District and Municipal Public Hospitals participated in PRIME. PRIME was designed to accelerate efforts by participating entities to change care delivery, maximize health care value, and strengthen their ability to successfully perform under risk-based alternative payment models. PRIME was intentionally designed to be ambitious in scope and time limited. Using evidence-based quality improvement methods, the initial work required the establishment of performance baselines followed by target-setting, and the implementation and ongoing evaluation of quality improvement interventions.

In 2017, California created a Quality Incentive Program (QIP) – a managed care directed payment program – for the state’s Designated Public Hospitals. The state directs Medi-Cal managed care plans to make QIP payments tied to designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The QIP measures do not directly overlap with any of the quality measures being used in PRIME, rather they are designed to be complementary. The QIP promote access to care, value-based purchasing, and to tie funding to quality outcomes, while at the same time further aligning state, Medi-Cal managed care plan, and hospital system goals. The QIP also creates incentives to build data and quality infrastructure and ties funding directly to these goals, allowing the state to pay for quality and build capacity.

5.1.2 Proposal

DHCS is in the process of transitioning the quality improvement work and funding that has been available through PRIME into the QIP and permitting the District and Municipal Public Hospitals to begin participating in the program, which has enabled hospitals to continue quality improvement efforts underway at all 51 PRIME entities after PRIME expired on June 30, 2020. This transition promotes value-based purchasing, ties funding to quality outcomes, and aligns PRIME entities’ transition to the QIP with California’s transition to the calendar year rating period for Medi-Cal managed care plans.

There are two key phases in the PRIME-to- QIP transition:

- **Phase I:** Alignment with the calendar year health plan rating period, July 1, 2020 through December 31, 2020

- **Phase II:** Merge to QIP, January 1, 2021 through December 2021, and beyond.

Phase I: Alignment with Calendar Year Rating Period

All 51 PRIME entities transitioned into a six-month transitional program on July 1, 2020 to calibrates the new program to end on the same date as Bridge Period 2019-20, an 18-month rate year for Medi-Cal managed care plans that ended on December 31, 2020. For performance on both the original QIP quality metrics (for Designated Public Hospitals) and the PRIME transition metrics (for Designated Public Hospitals and 34 District and Municipal Public Hospitals) during this period, the 51 entities will be paid through Medi-Cal managed care plans, via state-directed Medi-Cal managed care plan payments. CMS approval for this six-month program was obtained on September 14, 2020.

To earn funds for PRIME transition metrics, all 51 PRIME entities will continue to report to DHCS on quality improvement projects and measures from PRIME. The six-month transition will use a twelve-month measurement period to ensure that performance can be fairly compared to benchmarks set by DHCS. Due to the [COVID-19 public health emergency](#), entities will use the March 1, 2019 to February 29, 2020 measurement period and be held to achieving the minimum performance benchmark established by DHCS from PRIME Demonstration Year 15. The Designated Public Hospitals will also continue activities on the original QIP quality metrics during this six-month period, utilizing the same [modifications due to the COVID-19](#) public health emergency outlined for PRIME above.

Phase II: Merge to QIP

Subject to obtaining the necessary federal approvals, January 1, 2021 will be the start of QIP Year 4 and will include the Designated Public Hospitals and 34 District and Municipal Public Hospitals, totaling 51 QIP entities. Similar to Phase I, payments to the 51 QIP entities will be directed payments through the Medi-Cal managed care plans. Program Year 4 will align with Rate Year 2021, corresponding to calendar year 2021.

PRIME Policy Letters and associated PRIME reporting guidance will no longer apply to QIP. DHCS will review all prior PRIME Policy Letters and QIP Policy Letters for relevance and issue updated Policy Letters and reporting guidance to Designated Public Hospitals and District and Municipal Public Hospitals.

DHCS worked with stakeholders to develop a revised metric set for Program Year 4 that prioritizes CMS Adult and Child Core Set measures, HEDIS measures, other nationally vetted and endorsed measures, and measures in wide use across Medicaid quality initiatives. The measures align with well-established benchmarks and State, Medi-Cal managed care plan, and hospital system goals. The Program Year 4 metric set meaningfully reflects the goals and priorities of CalAIM.

5.1.3 Rationale

The QIP Program is intended to promote access to care, value-based payments, and tie funding to quality outcomes, while at the same time further aligning state, Medi-Cal managed care plan, and hospital system goals. The PRIME to QIP transition will engage both Designated Public Hospitals and 34 District and Municipal Public Hospitals to continue quality improvement work for select priority metrics in QIP As such, this proposal will help achieve the following goals of CalAIM:

- Enhance coverage expansion to address health disparities among vulnerable populations;
- Drive delivery transformation across Designated Public Hospitals and District and Municipal Public Hospitals toward value-based care and away from volume-based care, and
- Reduce variation and complexity across hospital systems through alignment of quality measures with those required of health plans.

5.1.4 Proposed Timeline

January 1, 2021: Complete transition from PRIME to QIP for Designated Public Hospitals and District and Municipal Public Hospitals using new CMS Adult and Child Core Set measures, HEDIS measures, and other nationally-vetted and endorsed measures

5.2 Global Payment Program Extension

5.2.1 Background

The Global Payment Program is a five-year pilot program included in California's Medi-Cal 2020 Section 1115 demonstration waiver. The Global Payment Program establishes a statewide pool of funding by combining a portion of California's federal Disproportionate Share Hospital (DSH) allotment with available uncompensated care funding. These funds support public health care system efforts to provide health care for California's uninsured population and promotes the delivery of more cost-effective and higher-value care to the uninsured.

Global budgets are allocated to public health care systems based on available funding and service point thresholds to be achieved. Public health care systems can achieve their hospital specific global budget by meeting a service point threshold that incentivizes movement from high cost, avoidable services to providing higher value and preventive services in the most appropriate setting.

The Global Payment Program's requirements are established in the Special Terms and Conditions for California's Medi-Cal 2020 Section 1115 demonstration and the program

funding is authorized December 31, 2021 under the one year Medi-Cal 2020 extension proposal, submitted to CMS on September 16, 2020.

5.2.2 Proposal

DHCS proposes to extend the Global Payment Program under CalAIM through a renewal of the Medi-Cal Section 1115 waiver demonstration. The Global Payment Program will operate under the following assumptions:

- The start date of Program Year 7 will begin on January 1, 2022, and end on December 31, 2022. The Global Payment Program was originally approved through June 30, 2020. On August 3, 2020, the Centers for Medicare and Medicaid Services (CMS) approved a waiver amendment extending the program and authorizing Program Year 6A for the period of July 1, 2020 through December 31, 2020. The Medi-Cal 2020 one-year extension proposal extended the program through December 31, 2021.
- The Global Payment Program under CalAIM will be funded solely by a portion of the State's Designated Public Hospital Disproportionate Share Hospital allotment allocation and will no longer incorporate uncompensated care funding;
- The percentage of Designated Public Hospital Disproportionate Share Hospital allotment funds to be split amongst University of California hospitals and Global Payment Program public health care systems will remain constant for the entirety of the waiver with 78.104% allocated to the Global Payment Program and 21.896% allocated to University of California hospitals;
- The Global Payment Program will include an evaluation to continue to assess whether the program is achieving its stated goals;
- The Global Payment Program will continue the shifting of point values for specific services to incentivize the provision of care in the most appropriate and cost-effective settings;
- DHCS may recalibrate the initial point thresholds for each hospital. Some public health care systems consistently exceed their thresholds, while others do not. Recalibration of the initial point thresholds will serve to minimize payment adjustments; and
- All other facets of the Global Payment Program in the CalAIM period will operate per the Medi-Cal 2020 waiver Special Terms and Conditions.

5.2.3 Rationale

The Global Payment Program was established to accomplish the following goals:

- To improve health of the remaining uninsured through coordination of care and to move away from the cost-based payment methodology restricted to mostly hospital settings to a more risk-based and/or bundled payment structure;
- To encourage public healthcare systems to provide greater primary and preventive services, as well as alternative modalities such as phone visits, group visits, telemedicine, and other electronic consultations; and
- To emphasize the value of coordinated care and alternative modalities by recognizing the higher value of primary care, ambulatory care, and care management as compared to the higher cost, avoidable emergency room visits and acute care hospital stay.

DHCS collaborated with the RAND Corporation to conduct an evaluation of the Global Payment Program from the onset of the program through March 2019. The evaluation assessed whether and to what extent, changing the payment methodology resulted in a more patient-centered system of care. Results show that there has been an increase in outpatient services, an increase in access to care for the uninsured, an improvement in the coordination of care, advancements in data collection and tracking, and an appropriate allocation of resources to effectively tailor care to more appropriate settings.

These findings provide strong support for the argument that the Global Payment Program is a powerful catalyst in helping the public health care systems deliver more cost-effective and higher-value care to the State's remaining uninsured individuals and will continue to move in this direction over the next five years.

5.2.4 Proposed Timeline

DHCS proposes to extend the Global Payment Program for the next five years according to the schedule in **Attachment G**.

6. Appendices

Appendix A: 2021 and Beyond: CalAIM Implementation Timeline³

Date	Implementation Activity
July 1, 2020	PRIME transitions to Quality Incentive Program
January 1, 2021	12-month extension of Medi-Cal 2020 demonstration
April 2021	Submission of Section 1915(b) and 1115 waiver requests Pharmacy Carve-Out Effective
June 2021	County Oversight⁴ : DHCS will engage with counties by forming a working group that will focus on developing new county performance standards monitoring and reporting mechanism. The reinstatement of County Performance Standards will include incorporation of MEDS alert monitoring statewide County oversight (CCS, CHDP) : Development of auditing tools. Foster Care Model of Care Workgroup completed
October 2021	County oversight (CCS, CHDP) : Shift to automated Plan and Fiscal Guideline submission process, develop training documents, evaluate and analyze findings and trends, and identify gaps and vulnerabilities.
November-2021	County Inmate Pre-Release Application Process : Stakeholder process
December 2021	County Oversight : DHCS will publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CPAs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties. Goal approval date of Section 1915(b) and 1115 waiver requests
2022	

³ Implementation date TBD: IMD SMI/SED waiver, regional contracting (will vary), improving beneficiary contact and demographic information

⁴ 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 for 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.

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL PROPOSAL

Date	Implementation Activity
January 1, 2022	<p>Managed Care Authority: Shifts to 1915(b) authority</p> <p>Implementation of the following CalAIM proposals:</p> <ul style="list-style-type: none"> • Enhanced care management/In lieu of services (existing WPC and/or HHP target populations) • Incentive payments • Dental benefits and pay for performance (implementation date TBD as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration) • Managed care benefit standardization continues • Mandatory managed care • Regional Rates Phase I • DMC-ODS renewal and policy improvements • Changes to behavioral health medical necessity • Multipurpose Senior Services Program carved-out of managed care • D-SNP look-alike enrollment transition in CCI counties <p>County Inmate Pre-Release Application Process: Publication of guidance and begin Technical Assistance (through December 2022)</p>
March 2022	<p>County Oversight: DHCS will begin assessing County Performance Standards, in keeping with the aforementioned updated process.</p>
June 2022	<p>County Oversight: DHCS will implement the County Performance Monitoring Dashboard. The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.</p>
July 2022	<p>Behavioral Health Payment Reform</p> <p>Enhanced care management:</p> <ul style="list-style-type: none"> • Implementation of additional enhanced care management Target Populations in HHP/WPC Counties. • Managed care plans in non- WPC and/or HHP counties begin implementing enhanced care management target populations
September 2022	<p>County Oversight: DHCS will begin publishing the County Performance Monitoring Dashboard on the CHHS Open Data Portal.</p>
October 2022	<p>County oversight (CCS, CHDP): Initiate Memorandum of Understanding between State and counties, continuous monitoring and oversight, and continuous updates to standards, policies, and guidelines</p>
December 31, 2022	<p>Cal MediConnect: End of program</p>
2023	
January 2023	<p>Aligned Enrollment:</p>

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL PROPOSAL

Date	Implementation Activity
	<ul style="list-style-type: none"> • Require statewide mandatory enrollment of dual eligibles in Medi-Cal managed care⁵ • All Medi-Cal health plans in CCI counties required to operate Dual Eligible Special Needs plans in all service areas they operate as an Medi-Cal managed care plan, including dual eligible LTC residents • Require statewide mandatory enrollment for eligible LTC residents for both non-dual and dual beneficiaries <p>County Inmate Pre-Release Application Process: Implementation</p> <p>Shared Risk/Shared Savings (at the earliest)</p> <p>Enhanced care management: Implementation of all enhanced care management target populations, including Individuals Transitioning from Incarceration.</p>
December 2023	County Oversight: DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.
2024	
January 2024	Regional Rates, Phase II (at the earliest)
2025	
January 2025	<p>Aligned Enrollment:</p> <ul style="list-style-type: none"> • All Medi-Cal health plans in non-CCI counties required to operate Dual Eligible Special Needs plans in all service areas they operate as a Medi-Cal managed care plan.
2026	
January 2026	NCQA: All Medi-Cal managed care plans required to be NCQA accredited
2027	
January 2027	<p>Behavioral Health Administrative Integration: submit for a single, integrated behavioral health managed care plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder services under the 1915(b) waiver</p> <p>Long-Term Services and Supports, Long-Term Care, Dual Eligible Special Needs Plans: Full implementation</p> <p>Full Integration Plan: Go Live (no sooner than)</p>

⁵ Mandatory Managed Care enrollment: See **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage.**

Appendix B: Targeted Case Management

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Alameda County	X	X	X	X		
Alpine County						X
Amador County						X
Butte County				X		
Calaveras County						X
Colusa County						X
Contra Costa County	X	X	X	X	X	
Del Norte County						X
El Dorado County						X
Fresno County						X
Glenn County						X
Humboldt County	X	X		X	X	
Imperial County						X
Inyo County						X
Kern County				X		
Kings County						X
Lake County						X
Lassen County						X
Los Angeles County	X			X		

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL PROPOSAL

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Madera County				X		
Marin County						X
Mariposa County	X	X	X	X	X	
Mendocino County	X	X	X	X	X	
Merced County						X
Modoc County						X
Mono County						X
Monterey County	X	X		X		
Napa County	X	X		X		
Nevada County						X
Orange County	X	X	X	X	X	
Placer County		X	X	X		
Plumas County						X
Riverside County	X	X	X	X	X	
Sacramento County				X		
San Benito County						X
San Bernardino County						X
San Diego County	X	X	X	X	X	
San Francisco County						X
San Joaquin County						X

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL PROPOSAL

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
San Luis Obispo County	X	X		X		
San Mateo County	X	X		X		
Santa Barbara County						X
Santa Clara County	X	X	X	X	X	
Santa Cruz County	X	X		X		
Shasta County		X		X		
Sierra County						X
Siskiyou County						X
Solano County	X	X		X	X	
Sonoma County	X	X	X	X	X	
Stanislaus County	X	X	X	X	X	
Sutter County	X	X	X	X	X	
Tehama County						X
Trinity County				X		
Tulare County						X
Tuolumne County	X	X	X	X		
Ventura County	X	X	X	X	X	
Yolo County						X
Yuba County						X
City of Berkeley	X	X	X	X	X	
City of Long Beach	X	X	X	X	X	
Total	23	24	16	30	15	30

Appendix C: County Inmate Pre-Release Application Process sample contracting Models

Contracting Model	Counties Currently Using a Similar Process
County Contracts with County Sheriff's Office	Butte Kern San Bernardino San Diego San Francisco Tuolumne Ventura Yolo
County Contracts with County Jail	Glenn Santa Barbara
County Contracts with Multiple Entities (e.g. Community Based Organizations and County Sheriff's Office)	Contra Costa Imperial Placer Sacramento San Luis Obispo San Mateo Solano Sutter

Appendix D: Institutions for Mental Disease/Serious Mental Illness/Severe Emotional Disturbance Demonstration Goals & Milestones

Below is a summary of demonstration goals as outlined in CMS SMD Letter #18-011:

- Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with serious mental illness or serious emotional disturbance while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with serious mental illness or serious emotional disturbance including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Below is a summary of demonstration milestones as outlined in CMS SMD Letter #18-011:

- Ensuring quality of care in psychiatric hospitals and residential settings. Involves facility accreditation, unannounced visits, use of a utilization review entity, facilities meeting federal program integrity requirements, and facilities having the capacity to address co-morbid physical health conditions;
- Improving care coordination and transitions to community-based care. Involves implementation of a process to assess housing situations, requirement that facilities have protocols to contact beneficiaries within 72-hours after discharge, strategies to prevent or decrease lengths of stays in emergency departments, and strategies to develop and enhance interoperability and data sharing;
- Increasing access to continuum of care including crisis stabilization services. Involves annual assessments of availability of mental health services across the state, commitment to an approved finance plan, strategies to improve the state's

capacity to track available beds, and implementation of an evidence-based assessment tool; and

- Earlier identification and engagement in treatment including through increased integration. Involves strategies for identifying and engaging individuals in treatment sooner, increased integration of behavioral health care in non-specialty settings and establishing specialized settings and services.

Federal Application Requirements

States wishing to pursue this demonstration opportunity must first submit an application to CMS. CMS will consider a state's commitment to ongoing maintenance of effort on funding outpatient community-based mental health services as demonstrated in their application when determining whether to approve a state's proposed demonstration project to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. Below is a summary of required elements for the application;

- A comprehensive description of the demonstration, including the state's strategies for addressing the goals and milestones discussed above for this demonstration initiative;
- A comprehensive plan to address the needs of beneficiaries with serious mental illness or serious emotional disturbance, including an assessment of how this demonstration will complement and not supplant state activities called for or supported by other federal authorities and funding streams;
- A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration, to the extent such provisions would vary from the state's current program features and the requirements of the Social Security Act;
- A list of the waivers and expenditure authorities that the state believes to be necessary to authorize the demonstration;
- An estimate of annual aggregate expenditures by population group impacted by the demonstration, including development of baseline cost data for these populations.
- Specifically, CMS requests that states' fiscal analysis demonstrate how the proposed changes will be budget neutral, i.e., will not increase federal Medicaid spending. CMS will work closely with states to determine the feasibility of their budget neutrality models and suggest changes as necessary;

- Enrollment data including historical mental health care coverage and projected coverage over the life of the demonstration, of each category of beneficiary whose health care coverage is impacted by the demonstration;
- Written documentation of the state's compliance with the public notice requirements at 42 CFR 431.408, with a report of the issues raised by the public during the comment period and how the State considered those comments when developing the final demonstration application submitted to CMS;
- The research hypotheses that are related to the demonstration's proposed changes, goals, and objectives, and a general plan for testing the hypotheses including, if feasible, the identification of appropriate evaluation indicators; and
- An implementation plan describing the timelines and activities necessary to achieve the demonstration milestones including a financing plan. The implementation plan can be submitted with the application, or within 90 days of application approval from CMS.

Other Demonstration Requirements

In addition to the required application elements above, states must also develop the following:

- Demonstration monitoring reports including information detailing the state's progress toward meeting the milestones and timeframes outlined in the implementation plan, as well as information and data so that CMS can monitor budget neutrality.
- A Health IT plan (health information technology plan) that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals.
- Monitoring protocols that identify expectations for quarterly and annual monitoring reports including agreed upon performance measures (see SMD #18-011 for a list of potential measures), measure concepts, and qualitative narrative summaries. The monitoring protocol will be developed and finalized after CMS approval.
- Interim and final evaluations that will draw on the data collected for the milestones and performance measures, as well as other data and information needed to support the evaluation that will describe the effectiveness and impact of the demonstration using quantitative and qualitative outcomes and a cost analysis. An evaluation design will be developed by the state, with technical assistance from CMS, to be finalized within 180 days of the demonstration approval.

States that fail to submit an acceptable and timely evaluation design as well as any monitoring, expenditure, or other evaluation reporting are subject to a \$5 million deferral per deliverable.

Key Resources

- State Medicaid Director Letter #18-011: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>
- Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity Technical Assistance Questions & Answers: <https://www.medicaid.gov/federal-policy-guidance/downloads/faq051719.pdf>

Appendix E: CalAIM Benefit Changes Chart

Benefit Changes Effective April 1, 2021	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Pharmacy	All pharmacy benefits or services billed by a pharmacy on a pharmacy claim, which includes covered outpatient drugs (including Physician Administered Drugs), medical supplies, and enteral nutrition products. This also includes drugs currently “carved-out” of the managed care delivery system, (e.g., blood factor, HIV/AIDS, antipsychotics, and drugs used to treat substance use disorder), which are currently carved-in to some county operated health systems and AIDS Healthcare Foundation. This does not include any pharmacy benefits or services billed on medical and/or institutional claims.
Benefit Changes Effective January 1, 2022	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Specialty Mental Health Services	Currently full benefit in Partnership Solano (Kaiser members only) and Kaiser Sacramento
Multipurpose Senior Services Program	Currently full benefit in CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside)
Benefits to be Carved-In to Managed Care Statewide	
Major Organ Transplant	Currently full benefit in county operated health systems counties; non-county operated health systems counties currently only cover kidney transplants
Benefit Changes Effective January 1, 2023	
Benefits to be Carved-In to Managed Care Statewide	
Long Term Care	<p>Long Term Care Umbrella</p> <ul style="list-style-type: none"> • ICF-DD Disabled (excluding beneficiaries in an ICF-DD Waiver center), Disabled Habilitative, and Disabled Nursing • Pediatric Subacute Care Services • Skilled nursing facility • Specialized Rehabilitative Services in skilled nursing facility and ICF • Subacute Care Services <p>Currently full benefit in county operated health systems and CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside); in non-county operated health systems/non-CCI counties, Medi-Cal managed care plans are responsible for the month of admission and the month following</p>

Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage

Managed Care Enrollment											
Aid Code Group Coverage											
			Current			2022			2023		
Aid Code Group	Aid Codes⁶	Non-Dual/Dual⁷	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
Adult Expansion	7U, L1, M1	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Non-Disabled Adults (19 & Over)	01, 02 ⁸ , 08, 30, 34, 35, 37, 39, 38, 54, 59, 81 ⁸ , 82, 83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A

⁶ Members residing in a LTC facility in a non-LTC aid code subject to the LTC benefit carve-in will be transitioned into managed care based on the Non-Dual/Dual Mandatory and Voluntary timeline.

⁷ Non-Dual/Dual Definitions: (1) Non-Dual – A Medi-Cal only beneficiary or a Medi-Cal only beneficiary with Medicare Part A or Part B only; (2) Dual – Medi-Cal only beneficiary with Medicare Part A and Part B or Medicare Part A, B, and D.

⁸ Aid code can have a SOC or no SOC

Managed Care Enrollment

Aid Code Group Coverage

Aid Code Group	Aid Codes ⁶	Non-Dual/ Dual ⁷	Current			2022			2023		
			Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
Aged	10 ⁹ , 14, 16, 1E, 1H, 1X, 1Y	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Disabled	20 ² , 23, 24, 26, 27, 36, 60 ² , 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, K4, K8, L6	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Long Term Care (includes LTC SOC)	13, 23, 53, 63	Non-Dual	COHS, CCI	N/A	All Other Models	COHS, CCI	N/A	All Other Models	All Models	N/A	N/A
Foster Children	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 2P, 2R, 2S, 2T, 2U,	Non-Dual	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A

⁹ Aid codes 10, 20, 60 are Supplemental Security Income (SSI)/State Supplemental Payment (SSP). Medi-Cal beneficiaries in these three aid codes have mandatory and voluntary enrollments based on different managed care models. These beneficiaries are mandatory in COHS, voluntary in San Benito, voluntary in GMC/Regional/Two-Plan for duals, and mandatory in GMC/Regional/Two-Plan for non-duals.

Managed Care Enrollment

Aid Code Group Coverage

		Current				2022			2023		
Aid Code Group	Aid Codes ⁶	Non-Dual/ Dual ⁷	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
	4A, 4C, 4F, 4G, 4H, 4K, 4L, 4M, 4S, 4T, 4W, 5K, 5L										
Omnibus Budget Reconciliation Act (OBRA) Restricted Scope Only	58	Non-Dual	Napa, Solano, and Yolo counties	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81 ⁸ , 83, 85, 87, 89, 02 ⁸ , 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Non-Dual	COHS & CCI	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Non-Disabled Adults (19 & Over)	01, 02 ⁸ , 08, 30, 34, 35, 37, 39, 38, 54, 59, 81 ⁸ , 82, 83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Non-Disabled Children (Under 19)	30, 32, 33, 34, 35, 37, 38, 39, 47, 54, 59, 72, 82, 83, 2C, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4N, 4U, 5C, 5D, 5E, 6P,	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A

Managed Care Enrollment

Aid Code Group Coverage

Aid Code Group	Aid Codes ⁶	Non-Dual/ Dual ⁷	Current			2022			2023		
			Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
	7A, 7J, 7T, 7W, 7X, 8P, 8R, 9H, E6, E7, H1, H2, H3, H4, H5, M5, P5, P7, P9, T1, T2, T3, T4, T5										
Aged	10 ² , 14, 16, 1E, 1H, 1X, 1Y	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Disabled	20 ² , 23, 24, 26, 27, 36, 60 ² , 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, L6, K4, K8	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Long Term Care (includes LTC SOC)	13, 23, 53, 63	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81 ⁸ , 83, 85, 87, 89, 02 ⁸ , 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Dual	COHS, CCI	N/A	Non-COHS & Non-CCI	N/A	N/A	All Models	N/A	N/A	All Models

Managed Care Enrollment

Aid Code Group Coverage

Aid Code Group	Aid Codes ⁶	Non-Dual/ Dual ⁷	Current			2022			2023		
			Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
Presumptive Eligibility (Hospital and CHDP PE)	2A, 4E, 8L, 8W, 8X, H0, H6, H7, H8, H9, P1, P2, P3	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Trafficking and Crime Victims Assistance Program (TCVAP)	2V, 4V, 5V, 7V, R1	Both	N/A	N/A	All Models	All Models	N/A	TCVAP SOC	All Models	N/A	TCVAP SOC
Accelerated Enrollment (AE)	8E	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
Child Health and Disability Prevention (CHDP) Infant Deeming	8U, 8V	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
State Medical Parole/County Compassionate Release/Incarcerated Individuals	F1, F2, F3, F4, G0, G1, G2, G3, G4, G5, G6, G7, G8, G9, J1, J2, J3, J4, J5, J6, J7, J8, K2, K3, K4, K5, K6, K7, K8, K9, N0, N5, N6, N7, N8, N9	N/A	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Limited/Restricted Scope Eligible	48, 50, 53, 55, 58, 69, 71, 73, 74, 76, 77, 80, 0L, 0R, 0T, 0U, 0V, 0X, 0Y, 1U, 3T, 3V, 5J, 5R, 5T, 5W, 6U, 7C, 7F, 7G,	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models

Managed Care Enrollment

Aid Code Group Coverage

Aid Code Group	Aid Codes ⁶	Non-Dual/ Dual ⁷	Current			2022			2023		
			Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
	7H, 7K, 7M, 7N, 7P, 7R, 8N, 8T, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, E1, L7, M0, M2, M4, M6, M8, P0, P4, P6, P8, T0, T6, T7, T8, T9, F1, F2, F3, F4, G1, G2, G3, G4, G5, G6, G7, G8, G9, J3, J4, J6, J8, K3, K5, K7, K9, N0, N5, N6, N7, N8, N9										

Pregnancy Related Aid Codes							
	Citizen/Lawfully Present				Non-Citizen		
	Aid Codes	Current	Proposed (2021)		Aid Codes	Current	Proposed (2021)
Title XXI (SCHIP) 213-322%	86, 87, 0E	Full Scope/MC	Full Scope/MC	Title XXI (SCHIP) 213-322%	0E	Full Scope/MC	Full Scope/MC
Title XIX (PRS/ES) 138-213%	44, M9	Limited Scope/FFS	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 138-213%	48, M0	Limited Scope/FFS	Limited Scope/FFS
Title XIX (PRS/ES) 0-138%	M7	Full Scope/MC	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 0-138%	D8, D9, M8	Limited Scope/FFS	Limited Scope/FFS

Population Exclusions									
Populations	Current			2022			2023		
	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
American Indian¹⁰	COHS	Non-COHS	N/A	All Models ¹¹	N/A	N/A	All Models ¹¹	N/A	N/A
Beneficiaries with Other Healthcare Coverage (OHC)	COHS	N/A	Non-COHS	All Models ¹¹	N/A	N/A	All Models ¹¹	N/A	N/A
Beneficiaries in Rural Zip Codes¹²	COHS	Non-COHS	Non-COHS	All Models ¹¹	N/A	N/A	All Models ¹¹	N/A	N/A
Beneficiaries in Home and Community Based Services Waivers	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	All Models ¹¹	N/A	N/A

¹⁰ American Indian Beneficiaries will be enrolled into a managed care plan, but they will have the option to opt out of enrollment if they choose to remain in FFS

¹¹ Would align with Mandatory/Voluntary/Excluded MC Enrollment by aid code, no special exclusions from enrollment solely based on zip code, OHC, American Indian or 1915c Waiver Enrollment

¹² The following zip codes are currently excluded from enrollment or are voluntary for enrollment: 93558, 90704, 92225, 92226, 92239, 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 9359293555, 93556, 93560, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304, 92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92358, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, 92398

Appendix G: Global Payment Program Extension Timeline

Program Year	Calendar Year	Federal Fiscal Year	Service Period Dates
6 ¹³	2021	2021	January 1, 2021-December 31, 2021
7	2022	2022	January 1, 2022 – December 31, 2022
8	2023	2023	January 1, 2023 – December 31, 2023
9	2024	2024	January 1, 2024 – December 31, 2024
10	2025	2025	January 1, 2025 – December 31, 2025
11	2026	2026	January 1, 2026 – December 31, 2026

¹³ PY 6 is part of Medi-Cal 2020 demonstration extension through 12/31/21

Appendix H: Dental in Proposition 56 vs. CalAIM

Dental Procedure Code	Description	Proposition 56 Supplemental Payment	CalAIM Performance Payment
D0120	Periodic oral evaluation – established patient	No	Yes
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No	Yes
D0150	Comprehensive oral evaluation – new or established patient	No	Yes
D0601	Caries risk assessment and documentation, with a finding of low risk (children ages 0-6)	No	Yes
D0602	Caries risk assessment and documentation, with a finding of moderate risk (children ages 0-6)	No	Yes
D0603	Caries risk assessment and documentation, with a finding of high-risk (children ages 0-6)	No	Yes
D1110	Prophylaxis – adult	Yes	No
D1120	Prophylaxis - child	No	Yes
D1206	Topical application of fluoride varnish (child)	No	Yes
	Topical application of fluoride varnish (adult)	Yes	No
D1208	Topical application of fluoride – excluding varnish (child)	No	Yes
	Topical application of fluoride – excluding varnish (adult)	Yes	No
D1310	Nutritional counseling for the control of dental disease (child)	No	Yes

Dental Procedure Code	Description	Proposition 56 Supplemental Payment	CalAIM Performance Payment
D1320	Tobacco counseling for the control and prevention of oral disease (adult)	No	Yes
D1351	Sealant – per tooth (child)	No	Yes
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth (child)	No	Yes
D1354	Interim caries arresting medicament application – per tooth (children ages 0-6 and restricted adult populations)	No	Yes
D1510	Space maintainer – fixed, unilateral – per quadrant (child)	No	Yes
D1516	Space maintainer – fixed, bilateral, maxillary (child)	No	Yes
D1517	Space maintainer – fixed, bilateral, mandibular (child)	No	Yes
D1526	Space maintainer – removable, bilateral, maxillary (child)	No	Yes
D1527	Space maintainer – removable, bilateral, mandibular (child)	No	Yes
D1551	Re-cement or re-bond space maintainer – bilateral space maintainer, maxillary (child)	No	Yes
D1552	Re-cement or re-bond space maintainer – bilateral space maintainer, mandibular (child)	No	Yes
D1553	Re-cement or re-bond space maintainer – unilateral space maintainer – per quadrant (child)	No	Yes
D1556	Removal of fixed unilateral space maintainer – per quadrant (child)	No	Yes
D1557	Removal of fixed bilateral space maintainer – maxillary (child)	No	Yes
D1558	Removal of fixed bilateral space maintainer – mandibular (child)	No	Yes
D1575	Distal shoe space maintainer – fixed unilateral – per quadrant (child)	No	Yes
D1999	Unspecified preventive procedure, by report (adult)	No	Yes

Appendix I: Enhanced Care Management Target Population Descriptions

Enhanced care management is designed for populations who have the highest levels of complex health care needs as well as social factors influencing their health. To be eligible for enhanced care management, members must meet criteria below in addition to any criteria specific to the respective enhanced care management population:

1. Have complex physical or behavioral health condition with inability to successfully self-manage AND
2. Limited activity or participation in social functioning as defined by at least one of the following:
 - a. Establishing and managing relationships;
 - b. Major life areas, including education, employment, finances, engaging in the community

Candidates for enhanced care management have an opportunity for improved health outcomes if they receive high-touch, in-person care management and are connected to a multidisciplinary team that manages physical health, behavioral health (substance use and/or mental health), oral health, developmental disabilities, and health-related non-clinical needs as well as any needed long-term services and supports.

Enhanced care management will be implemented in phases:

- January 1, 2022: All Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will begin implementation of the enhanced care management benefit, for those target populations currently receiving Health Homes Program and/or Whole Person Care services.
- July 1, 2022:
 - Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will implement additional mandatory enhanced care management target populations.
 - All Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs must begin implementation of select enhanced care management target populations.
- January 1, 2023: All Medi-Cal managed care plans in all counties must implement enhanced care management for all target populations.

Characteristics of ECM target populations are set forth below and detailed further in this document. Risk stratification is the responsibility of the Medi-Cal managed care plans,

which will determine member needs and apply criteria to determine eligibility and facilitate ECM services. Medi-Cal managed care plans may propose additional populations to receive ECM or propose expansions of criteria within populations. ECM target populations are subject to further refinement by DHCS.

Medi-Cal managed care plans may propose additional populations to receive enhanced care management, for example to allow the transition for members receiving services under a Whole Person Care pilot. At a minimum, Medi-Cal managed care plans must provide enhanced care management to the below list of mandatory target populations:¹⁴

- Children and youth with complex physical, behavioral, and/or developmental health needs (i.e. 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, eligible for long-term care.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children and youth with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD).
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

These target population descriptions are intended as guidance for Medi-Cal managed care plans. Managed care plans will determine criteria for population identification and stratification in accordance with this guidance.

Settings

For all populations, the role of enhanced care management is to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the

¹⁴ Individuals transitioning from incarceration must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2022.

member, including participating in the care planning process, regardless of setting. This benefit is intended to provide primarily face-to-face services whenever possible.

Services should be offered where the members live, seek care or prefer to access services, essentially meeting the member (and, for children and youth, their family, caretaker or circle of support) where they are within the community. This may include different settings based on the target population. For example, for individuals experiencing homelessness, enhanced care management care managers may conduct street outreach or coordinate with shelters, hotels or motels including those participating in Project Homekey, homeless services providers, recuperative care providers, community partners (e.g., homeless coordinated entry systems) and other service providers to connect with target individuals in these settings. For individuals with SMI and/or SUDs, initial contact may be in settings such as psychiatric inpatient units, Institutions for Mental Disease (IMDs) or residential settings. Children and youth may receive services in a variety of community settings, including homes and schools, where appropriate. These are examples of how enhanced care management settings will reflect individualized needs of the target populations.

Risk Stratification

Enhanced care management is the highest tier of case management and is intended for members at the highest risk level who need long-term coordination for multiple chronic conditions, social determinants of health issues, and utilization of multiple service types and delivery systems. As part of their plan submitted to DHCS, Medi-Cal managed care plans will detail the algorithms, processes, and partnerships they will use to identify those individuals who have the highest levels of complex health care needs and social factors influencing their health, and who present the best opportunity for improved health outcomes through enhanced care management services.

Algorithms and data sources may vary by population. For example, some individuals may be identified using claims data and/or other health assessment information to identify multiple complex conditions or a history of utilization of high-cost services.

However, for a variety of reasons, claims data may be insufficient to identify other good candidates for enhanced care management. For some members, access to care issues and multiple social factors may limit the utility of claims data in identifying health risks. Therefore, managed care plans must also use data sources that capture social determinants of health as well as referrals. For individuals experiencing homelessness, data systems such as the Homeless Management Information System (HMIS) may be used. For individuals transitioning from incarceration, data sharing agreements with city and county jail systems to identify those at highest risk may be considered

For many populations, referrals and partnerships will be a critical method to identify enhanced care management candidates. Entities such as health care providers, community-based organizations, social services agencies, tribal partners, and local governments are important partners in identifying individuals who are at high risk of significant health care utilization and who would benefit from enhanced care management. Medi-Cal managed care plans are encouraged to partner with these entities to ensure enhanced care management benefits are highly coordinated with other service types. Medi-Cal managed care plans should also plan to establish clear protocols to receive and consider enhanced care management referrals from external entities.

Core Components of Enhanced Care Management Services

The types of supports and services provided through enhanced care management may vary based on the needs of the target populations. In the individual target population descriptions, this document describes examples of interventions that enhanced care management may support for each unique target population. However, core components of enhanced care management that are universal for all target populations include:

- Comprehensive Assessment and Care Management Plan:
 - Engage with Members authorized to receive the enhanced care management Benefit primarily through in person contact;
 - *When in-person communication is unavailable or does not meet the needs of the Member, use alternative methods to provide culturally appropriate and accessible communication.*
 - Develop a comprehensive, individualized, person-centered care plan by working with the Member, and as appropriate their chosen family/support persons, to assess strengths, risks, needs, goals, and preferences
 - Incorporate into the Member’s care plan needs in the areas including, but not limited to physical and developmental health, mental health, SUD, community-based Long-Term Services and Supports (LTSS), oral health, palliative care, trauma-informed care, necessary community-based and social services, and housing;
 - Ensure the care plan is reassessed at a frequency appropriate for the Member’s individual progress or changes in need.
- Enhanced Coordination of Care:
 - Organize patient care activities as laid out in the care plan, share information with the Member’s key care team, and implement the Member’s care plan;

- Be continuous and integrated among all service providers and refer to primary care/physical and developmental health, mental health, SUD treatment, community-based LTSS, oral health, palliative care, trauma-informed care, necessary community-based and social services, and, housing, as needed;
- Provide support for Member treatment adherence including coordination for medication review/reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, identifying barriers to adherence, ensuring continuous enrollment in Medi-Cal, and maintaining social services benefits, and accompaniment to key appointments;
- Communicate Members' needs and preferences timely to all members of the Members' care team in a manner that ensures safe, appropriate, and effective person-centered care;
- Be in regular contact with the Member, consistent with the care plan;
- Health Promotion:
 - Work with Members to identify and build on resiliencies and potential family or community supports;
 - Provide services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health;
 - Support the Member in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.
- Comprehensive Transitional Care
 - Perform engagement activities that seek to reduce avoidable Member admissions and readmissions;
 - For Members that are experiencing or are likely to experience a care transition:
 - Develop and regularly update a transition plan for the Member, and incorporate it into the Member's care plan;
 - Evaluate a Member's medical care needs and coordination of any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;

- Track each Member’s admission or discharge to/from an emergency department, hospital inpatient facility, skilled nursing facility, residential/treatment facility, incarceration facility, or other treatment center and communicate with the appropriate care team members;
 - Coordinate medication review/reconciliation; and
 - Provide adherence support and referral to appropriate services.
- Member and Family Supports:
 - Document a Member’s chosen caregiver or family/support person;
 - Include activities that ensure that the Member and chosen family/support persons, including as guardians and caregivers, are knowledgeable about the Member’s condition(s) and care plan with the overall goal of improving the Member’s care planning and follow-up, adherence to treatment, and medication management;
 - Serve as the primary point of contact for the Member and their chosen family/support persons;
 - Identify supports needed for the Member and chosen family/support persons to manage the Member’s condition and direct them to access needed support services, including peer supports when applicable and available; and,
 - Provide for appropriate education of the Member, family members, guardians, and caregivers on care instructions for the Member.
- Coordination of and Referral to Community and Social Support Services:
 - Determine appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services that are offered by managed care plan as an ILOS;
 - Coordinate and referring Members to available community resources and following up with Members to ensure services were rendered (i.e. “Closed loop referrals”).

Target Populations

A description of each population is outlined below. Beneficiaries must be enrolled in Medi-Cal managed care to receive enhanced care management. In general, for all target populations, individuals who, after multiple outreach attempts, using different modalities, opt not to participate in enhanced care management services or whose assessment

(completed or confirmed by the managed care plan) indicates they would not benefit from the services, would not be good candidates for enhanced care management. The number of outreach attempts and approaches will vary based on the populations and individualized needs.

Enhanced care management is designed to provide support to individuals who require high levels of intensive interventions. Individuals who are receiving or who would benefit from other existing types of interventions (e.g., end of life care, standard case management, disease management or other care coordination efforts) would not be appropriate candidates for enhanced care management unless those interventions are not successful. Medi-Cal managed care plans and/or their subcontractors or contracted providers will evaluate individuals for enhanced care management and not all individuals will be good candidates. For example, individuals with the following circumstances may not be good candidates for enhanced care management:

- Individuals who have a well-treated chronic disease and are compliant with their care plan and have unavoidable or expected admissions due to the condition.
- Individuals who refuse to engage in any telephonic or face to face case management after multiple outreach attempts using different modalities.
- Individuals receiving services that the managed care plan determines to be duplicative of enhanced care management, such as 1915(c) Home and Community Based Services (HCBS) Waiver programs.

All Medi-Cal beneficiaries currently receiving care management through the Health Homes Program and Whole Person Care shall be transitioned to enhanced care management through one of the target populations listed and will be reassessed.

The populations eligible for enhanced care management are those with the highest needs who use multiple delivery systems and services, who need ongoing coordination across medical, behavioral and social needs, and who are part of the mandatory target populations described below. Note that some enhanced care management candidates will meet criteria for multiple target populations. Medi-Cal managed care plans will assign these individuals authorized to receive enhanced care management services to an enhanced care management provider that has appropriate competencies and experience for the needs of the beneficiary. For example, individuals with SMI or SUDs may also be homeless or high utilizers. These members may be assigned to an enhanced care management provider that has the necessary skills and experience to work with individuals with SMI and SUDs.

Children and Youth

Target Population:

Children and youth (up to age 21, or foster youth to age 26) with complex physical, behavioral, and/or developmental health needs, with significant functional limitations and social factors influencing their health outcomes (e.g., California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).

For example:

- Children/Youth with complex health needs who are medically fragile or have multiple chronic conditions. This may include children with a history of trauma and children who are engaged or have history with the child welfare system. These children often access care across multiple service delivery systems and require significant coordination to ensure their needs are being met.
- Children/Youth with significant functional limitations and multiple social factors influencing their health outcomes.

Enhanced Care Management Services:

Enhanced care management can be used to assess gaps in both health care and social support needs and develop a care plan that addresses the whole health needs of the child. While Medi-Cal managed care plans may use claims data to identify good candidates, referrals will be an important mechanism to identify children and youth who would benefit from enhanced care management. Health care providers, the child welfare system, schools, community-based organizations, California Children's Services (CCS), county behavioral health, and social services agencies are examples of other important potential referral partners for children/youth. Medi-Cal managed care plans should establish a process for providers to refer for enhanced care management based on a needs assessment, behavioral health screens, other EPSDT screening, and/or ACE score which includes consideration of the community supports available for the children and their families and caretakers, as well as social factors impacting their health.

Services should be offered where the members live, seek care or where the family, caretaker, or circle of support prefers to access services, essentially meeting the member and family/caretaker/support where they are within the community. Activities may include coordination in school-based settings if permitted by the schools. Services should be offered by culturally and linguistically aligned trauma-informed providers.

For this population, enhanced care management services include (but are not limited to):

- Helping families, caretakers, and circles of support access resources such as information, coordination, and education about the child's conditions.
- Identifying coordinating, and providing (when appropriate) services that will help families, caretakers, and circles of support with the health needs of their children, which may include referrals for services those individuals need to enable them to support their children's health (e.g., referral to behavioral health, including SUD services, for a parent, or housing-related services for households experiencing homelessness, either of which could be critical to ensure the parent can support the health needs of the child).
- Referral to housing related services for youth experiencing homelessness.
- Coordination of services across various health, behavioral health, developmental disability, housing and social services providers, including facilitating cross-provider data- and information-sharing and member advocacy to ensure the child's whole person needs are met and needed services are accessible.
- Assistance with accessing respite care as needed.
- Referral to community and social services to address food insecurity and other social factors that may impact the child's health.
- Coordination of other services as required by EPSDT.
- Referral to community and social services to address food insecurity and other social factors that may impact the child's health

Homeless

Target Population:

Individuals experiencing homelessness or chronic homelessness, or who are at risk of experiencing homelessness (as defined below), with complex health and/or behavioral health needs, for whom coordination of services would likely result in improved health outcomes and decreased utilization of high-cost services.

For example:

- Individuals with complex health care needs as a result of medical, psychiatric or SUD-related conditions, who may also experience access to care issues (resulting in unmet needs or barriers to care) and multiple social factors influencing their health outcomes.
- Individuals with repeated incidents of avoidable justice involvement, emergency department use, psychiatric emergency services or hospitalizations.

Homeless: Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution). For the purpose of enhanced care management, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals.

Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

- A. In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
- B. By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

1. A “homeless individual with a disability,” as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
 - i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
 - ii. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;
2. An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

- (1) An individual or family who:
 - (i) Has an annual income below 30 percent of median family income for the area, as determined by HUD;
 - (ii) Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
 - (iii) Meets one of the following conditions:

(A) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

(B) Is living in the home of another because of economic hardship;

(C) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

(D) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

(E) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

(F) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

(G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

(2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

(3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who meet the State’s No Place Like Home definition for a person with SMI and/or SED “at risk of chronic homelessness,” which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with

significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Enhanced Care Management Services:

Individuals experiencing or at risk of homelessness are among the highest-need individuals in Medi-Cal. They often lack access to necessities such as food and shelter that are critical to attaining health. Individuals often have high medical needs that are difficult to manage due to the social factors that influence the individual's health. This often results in high utilization of costly services such as emergency departments and inpatient settings.

Engagement for this population may include street outreach or coordinating with shelters, homeless services providers, recuperative care providers, community partners (e.g., homeless coordinated entry systems) and other service providers to connect with target individuals.¹⁵ As individuals are connected to resources, the enhanced care management care coordinator will meet the member in the community or at provider locations.

Enhanced care management can be used to link individuals with a variety of services to meet their complex needs. This includes (but is not limited to):

- Utilizing housing-related in-lieu-of services (ILOS) to identify housing and prepare individuals to for securing and/or maintaining stable housing.
- Coordinating short-term post-hospitalization housing and recuperative care services as appropriate.
- Regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to ensure progress towards regaining health and function continues.
- Coordinating and collaborating with various health and social services providers, including Regional Centers, including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to

¹⁵ These same entities will be important referral partners to identify potential enhanced care management candidates

public benefits, identifying barriers to adherence, and accompanying members to appointments as needed.

- Addressing barriers to housing stability by connecting member to housing, health, and social support resources.
- Utilize best practices for Member who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care

High Utilizers

Target Population:

High utilizers are Members with multiple hospital admissions, OR multiple short-term skilled nursing facility stays, OR multiple emergency room visits that could be avoided with appropriate outpatient care or improved treatment adherence.

For example:

- Individuals that have impactable conditions or opportunities for interventions that have the potential to decrease inappropriate utilization or can be performed at an alternative location.
- Individuals with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement. Individuals with multiple chronic or poorly managed conditions requiring intensive coordination, beyond telephonic intervention.
- Significant functional limitations and/or adverse social determinant of health that impede the ability of the individual to navigate their healthcare and other services.

Enhanced Care Management Services:

Enhanced care management will provide multiple opportunities to engage individuals by stratifying risk and need and developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Medi-Cal managed care plans will identify the algorithms they will use to identify individuals who are high utilizers of medical services. DHCS expects Medi-Cal managed care plans will rely on available healthcare research related to appropriate identification of high utilizers and will leverage the managed care plan utilization data to identify members that meet the respective criteria established by the managed care plans.

For this population enhanced care management may include, but is not limited to:

- Frequent follow up visits, culturally and linguistically appropriate education and care coordination activities to ensure the member's needs are being met where they are.
- Connection to culturally and linguistically appropriate community-based organizations, programs and resources that will meet the member's needs.
- Improving member engagement to improve adherence to the member's treatment plan, including through more culturally and linguistically aligned approaches toward member and provider education and tools on how to increase adherence.

- Medication review, reconciliation, assistance obtaining medications, and culturally and linguistically appropriate reinforcement with medication adherence.

Risk for Institutionalization – Long Term Care

Target Population:

Individuals at risk for institutionalization, eligible for long-term care services. Medi-Cal beneficiaries who, in the absence of services and supports would otherwise require care for 90 consecutive days or more in an inpatient nursing facility (NF) would qualify.

Individuals must meet NF level of care criteria AND be able continue to live safely in the community with wrap around supports. \

Examples include, but are not limited to:

- Seniors and persons with disabilities who reside in the community but are at risk of being institutionalized.
- Individuals in need of increasing assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
- Possibly, individuals with changes to family or caregiver status.
- Possibly, individuals with medical or surgical setbacks resulting in a decrease in functional, cognitive, or psychological status.
- Possibly, individuals showing early signs of dementia with few or no natural supports.
- Possibly, individuals who are noncompliant with their prescribed medical regime.
- Possibly, individuals who are not appropriately engaged to take advantage of necessary health care services.
- Possibly, individuals who lack a family or community support system to assist in appropriate follow-up care at home.

Would not include:

- Individuals with complex needs but who are not at risk of institutionalization.

Enhanced Care Management Services:

Services include preventing skilled nursing admissions for individuals with an imminent need for nursing facility placement. For this population enhanced care management may include, but is not limited to:

- Assessment to determine natural supports available, risk factors, social determinants of health, and other factors to determine safety and feasibility of continued stay in the community. Assessments should be conducted face-to-face whenever possible.
- Connection to needed supportive services, including ILOS such as meals, environmental accessibility adaptations (home modifications), and personal care.
- Frequent follow up visits (including regular home visits), culturally and linguistically appropriate education and care coordination activities to ensure the member and family/caregiver needs are being met where they are.
- Connection to appropriate culturally and linguistically aligned community-based organizations, programs and resources that will meet the member's needs.
- Placement of wrap-around services to maintain the member in their current, community setting.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, ensuring connection to public benefits, coordinating transportation, identifying barriers to adherence, and accompanying members to appointments as needed.

Nursing Facility Transition to Community

Target Population:

Individuals who are currently residing in a Nursing Facility (NF) but desire to return to living in the community. Transition from the NF to community is strictly voluntary. Individuals have the option to transition to the community when that can be done in a cost-effective manner. Individuals must be able to transition safely to the community.

Individuals must have an identified support network system and housing available to them. The support network system may consist of care providers, community-based organizations, family members, primary care physicians, home health agencies, members of the individual's medical team, licensed foster parent, or any other individual who is part of

the individual's circle of support. The individual's circle of support may consist of family members, legal representative/legally responsible adult, and any other person named by the individual.

Would not include:

- Individuals not interested in moving out of the institution.
- Individuals who are not medically appropriate to live in the community (high acuity).
- Individuals whose total projected costs outside the institution are greater than the cost of institutionalization.
- Individuals who do not have the supports to reside safely in the community.
- Individuals who would be at a high risk of re-institutionalization or experiencing homelessness.

Enhanced Care Management Services:

The care team will help individuals move safely between different care settings, such as entering or leaving a hospital or nursing facility and returning to their own home.

Services include facilitating nursing facility transition back into a homelike and community setting with the necessary wrap-around services, community supports, and natural supports when available.

Enhanced Care Manager care manager visits will occur face to face at the facility throughout the transition process. An in-person home visit will occur prior to the

individual's move to ensure the health and safety of the new residence. Post-transition individuals will then be visited in person at a determined schedule at their home or community placement.

SMI, SED and SUD Individuals at Risk for Institutionalization

Target Population:

Individuals who are at risk for institutionalization who have co-occurring chronic health conditions and:

- Serious Mental Illness (SMI, adults);
- Serious Emotional Disturbance (SED, children, and youth); or
- Substance Use Disorder (SUD).

Potential candidates include:

- Individuals who have the highest levels of complex health care needs as a result of psychiatric or SUD-related conditions with co-occurring chronic health conditions, who may also experience access to care issues and have multiple social factors influencing their health outcomes and as a result of these factors are at risk for institutionalization.
- Individuals with repeated incidents of emergency department use, psychiatric emergency services, psychiatric inpatient hospitalizations, including stays at psychiatric health facilities, or short-term skilled nursing facility stays who could be served in community-based settings with supports.

Enhanced Care Manager Services:

For individuals with SMI or SUD, or children and youth with SED, enhanced care management will coordinate across the delivery systems through which members access care. For these individuals, Medi-Cal managed care plans may pursue contracts with county behavioral health systems to perform enhanced care management activities, but this must include coordination of all available services including medical care, behavioral health and long-term services and supports. When managed care plans do not contract with county behavioral health, enhanced care management service providers for this population should have experience and competency in working with individuals with SMI and SUDs as well as a plan to adequately coordinate enhanced care management and behavioral health services and supports across the managed care plan and county behavioral health. Initial engagement may be in treatment settings such as psychiatric inpatient units, IMDs or residential settings.

For children and youth with SED, activities may include coordination in school-based settings if permitted by the schools.

Enhanced care management can be used to link individuals with a variety of services to meet their complex needs. Medi-Cal managed care plans should closely coordinate these

enhanced care management services and supports with county behavioral health to avoid duplication and ensure adequate communication and care coordination. This includes (but is not limited to):

- Provide post-hospitalization or post-residential medical treatment care planning to connect individuals with the supports they need to avoid rehospitalization including identifying appropriate culturally and linguistically appropriate community placements. These services should be provided in close coordination with county behavioral health plans when the hospitalization or residential treatment occurs due to mental illness or substance use disorder.
- Regular culturally and linguistically appropriate contact with members to ensure there are not gaps in the activities designed to avoid institutionalization or hospitalization and swiftly addressing those gaps to ensure the individual can remain in the community placement.
- Utilizing housing related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing, if needed, and connecting to other social services to address social factors that influence the individual's health outcomes.
- Supporting the members' behavioral health recovery goals with related improvements in physical and oral health and long-term services and supports.
- Connecting families, caretakers, and circles of support to resources regarding the member's conditions to assist them with providing support for the member's health/behavioral health.
- Coordinating and collaborating with various health, behavioral health, developmental disability, and social services providers including sharing data (as appropriate).
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence, and accompanying members to appointments as needed

Individuals Transitioning from Incarceration¹⁶

Target Population:

Individuals transitioning from incarceration, including justice-involved juveniles who have significant complex physical or behavioral health needs requiring immediate transition of services to the community. A Medi-Cal managed care plan may stratify eligibility based on populations that have multiple incarcerations, other institutionalizations and/or high utilization. Individuals must have been released from incarceration with the last 12 months.

In addition, this population includes individuals who are involved in pre- or post-booking diversion behavioral health and criminogenic treatment programs and therefore are at risk for incarceration and who could, through care coordination and service placement, have a treatment plan designed to avoid incarceration through the use of community-based care and services.

Enhanced Care Management Services:

Some individuals transitioning from incarceration have significant health and behavioral health care needs that require ongoing treatment in the community post-release. Individuals often also experience significant social factors that impact their ability to successfully manage their health/behavioral health conditions, such as lack of safe and stable housing and unemployment. Upon transition back to the community, individuals are required to coordinate a significant number of basic life needs and as a result often experience care disruptions, which result in deterioration of their conditions and increased use of emergency departments and inpatient settings. For some individuals, unmet health care needs can increase their likelihood of returning to incarceration; diversion programs are designed to address these needs and avoid incarceration.

For this target population, enhanced care management requires coordination with the state prison system and local corrections departments, including probation, courts and the local county jail system to both to identify/refer members and also to ensure connections to care once individuals are released from incarceration. Upon release, all individuals receiving ongoing behavioral health treatment (including treatment for SUD) should be referred to county behavioral health programs and managed care plans on an as needed basis. Medi-Cal managed care plans and county behavioral health programs should coordinate closely to better serve clients that receive services from both entities. Therefore, the enhanced care management care managers will need to coordinate and

¹⁶ This target population must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2022.

collaborate closely with county behavioral health departments, and potentially also with Medi-Cal managed care plans, for those individuals.

The initial enhanced care management engagement locations will depend on the collaborations that Medi-Cal managed care plans are able to build with local justice partners. At first, enhanced care management staff will begin work with individuals expected to transition from incarceration in the setting where they are incarcerated (or just outside that setting), or in criminogenic treatment programs.¹⁷ Post-transition, enhanced care management care managers will engage individuals in the most easily accessible setting for the member. In addition to community-based engagement such as a member's home or regular provider office, this may also include parole or probation offices if the managed care plan builds partnerships that allow for engagement in those offices.

Enhanced care management can be used to link individuals transitioning from incarceration (or in diversion programs) with a variety of services to meet their complex needs. This includes (but is not limited to):

- Coordination of an initial risk assessment to evaluate medical, psychiatric, substance use and social needs for which the individual requires assistance.
- Direct connections with community providers to ensure continuity of care for their conditions (especially for medications) and to address any health care needs not treated while they were incarcerated. This will also include peer mentorship to help provide positive social support.
- Utilizing housing related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing.
- Regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to prevent reincarceration and ensure progress towards regaining health and function continues.
- Screening and providing referrals for various health, developmental disabilities, mental health, substance use disorder and social service needs.

¹⁷ DHCS is looking to leverage H.R. 6 SUPPORT Act to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release. enhanced care management dollars will not be able to be used to provide services directly to justice involved members prior to release

- Coordinating and collaborating with various health, behavioral health, and social services providers as well as parole/probation including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence, and accompanying members to appointments as needed.
- Helping members set and monitor health goals to maintain or improve their health.
- Providing culturally and linguistically appropriate education to families, caretakers, and circles of support regarding the member's health care needs and available supports.
- Navigating members to other reentry support providers to address unmet needs.
- Facilitating benefits reinstatement.¹⁸

¹⁸ To complement these efforts, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023. The enhanced care management care manager would also help facilitate accessing other benefits as needed by the member.

Enhanced Care Management Implementation Dates by County

Counties with Whole Person Care and/or Health Homes¹⁹ (Begin implementation on 1/1/22)	Counties without Whole Person Care or Health Homes (Begin implementation on 7/1/22*)
Alameda HHP, WPC Contra Costa WPC Imperial HHP Kern HHP, WPC Kings WPC Los Angeles HHP, WPC Marin WPC Mendocino WPC Monterey WPC Napa WPC Orange HHP, WPC Placer WPC Riverside HHP, WPC Sacramento HHP, WPC San Bernardino HHP, WPC San Diego HHP, WPC San Francisco HHP, WPC San Joaquin WPC San Mateo WPC Santa Clara HHP, WPC Santa Cruz WPC Shasta WPC Sonoma WPC Tulare HHP Ventura WPC	Alpine Amador Butte Calaveras Colusa Del Norte El Dorado Fresno Glenn Humboldt Inyo Lake Lassen Madera Mariposa Merced Modoc Mono Nevada Plumas San Luis Obispo Santa Barbara Sierra Siskiyou Solano Stanislaus Sutter Tehama Trinity Tuolumne Yolo Yuba

¹⁹ List is subject to changed based on WPC pilots decisions to continue operating through 2021.

Appendix J: In Lieu of Services Options

Following is the proposed menu of in lieu of services that would be covered under the CalAIM initiative. ILOS are optional for both the plan to offer and the beneficiary to accept. Individuals do not have to be enrolled in Enhanced Care Management to be eligible for in lieu of services. ECM target populations/ILOS Service definitions are subject to further refinement by DHCS.

Each set of services is described in detail below:

- 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

Housing Transition Navigation Services

Description/Overview

Housing transition services assist beneficiaries with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the participant's housing needs, potential housing transition barriers, and identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
3. Searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
6. Identifying and securing available resources to assist with subsidizing rent (such as Section 8, state and local assistance programs etc.) and matching available rental subsidy resources to members.
7. If included in the housing support plan, identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.²⁰
8. Assisting with requests for reasonable accommodation, if necessary.
9. Landlord education and engagement
10. Ensuring that the living environment is safe and ready for move-in.
11. Communicating and advocating on behalf of the client with landlords.

²⁰ Actual payment of these housing deposits and move-in expenses is a separate in-lieu service under Housing Deposits.

12. Assisting in arranging for and supporting the details of the move.
13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.²¹
14. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
15. Identifying, coordinating, environmental modifications to install necessary accommodations for accessibility.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For clients who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership clients) is also funded by county behavioral health agencies, and Medi-Cal managed care plans and their contracted ILOS providers should expect to coordinate access to these housing resources through county behavioral health when appropriate.

Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

Eligibility (Population Subset)

²¹ The services associated with the crisis plan are a separate in-lieu service under Housing Tenancy and Sustaining Services.

- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
 - In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
 - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
 - A “homeless individual with a disability,” as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
 - a. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
 - b. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months

or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
 - A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or
- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
 - (1) An individual or family who:
 - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
 - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
 - Meets one of the following conditions:
 - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
 - Is living in the home of another because of economic hardship;
 - Has been notified in writing that their right to occupy their current housing or living situation will be

terminated within 21 days after the date of application for assistance;

- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
 - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
 - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
 - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
 - (2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
 - (3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
 - Have one or more serious chronic conditions;
 - Have a Serious Mental Illness;
 - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
 - Have a Serious Emotional Disturbance (children and adolescents);
 - Are receiving Enhanced Care Management; or
 - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State’s No Place Like Home definition of “at risk of chronic homelessness”, which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions and Limitations

In lieu of services are alternative services covered under the Medi-Cal State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State Plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services are authorized and identified in the managed care plan contracts.

Housing Transition/Navigation services must be identified as reasonable and necessary in the individual’s individualized housing support plan.

Individuals may not be receiving duplicative support from other State, local tax or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Vocational services agencies;
- Providers of services for individuals experiencing homelessness;
- Life skills training and education providers;
- County agencies;
- Public hospital systems;
- Mental health or substance use disorder treatment providers, including county behavioral health agencies;
- Social services agencies;

- Affordable housing providers;
- Supportive housing providers; and
- Federally qualified health centers and rural health clinics.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program ([See Credentialing/Recredentialing and Screening/Enrollment APL 19-004](#)) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, Medi-Cal managed care plans must credential the providers as required by DHCS.

Clients who meet the eligibility requirements for Housing Transition/Navigation services should also be assessed for enhanced care management and Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.²²

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experience working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient Hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

²² One exception to this is for benefits advocacy, which may require providers with a specialized skill set.

Housing Deposits

Description/Overview

Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

1. Security deposits required to obtain a lease on an apartment or home.
2. Set-up fees/deposits for utilities or service access and utility arrearages.
3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
4. First month's and last month's rent as required by landlord for occupancy.
5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with

disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
 - In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
 - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
 - A “homeless individual with a disability,” as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
 - c. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
 - d. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions

included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
 - A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or
- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
 - (1) An individual or family who:
 - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
 - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
 - Meets one of the following conditions:
 - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
 - Is living in the home of another because of economic hardship;
 - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
 - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
 - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
 - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
 - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
 - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
 - Have one or more serious chronic conditions;
 - Have a Serious Mental Illness;
 - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
 - Have a Serious Emotional Disturbance (children and adolescents);
 - Are receiving Enhanced Care Management; or
 - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State’s No Place Like Home definition of “at risk of chronic homelessness”, which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions and Limitations

In lieu of services are alternative services covered under the State plan but are delivered by a different provider or in a different setting than is described in the State plan. In lieu of service can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

Housing Deposits are available once in an individual’s lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual’s individualized housing support plan and are available only when the enrollee is unable to meet such expense.

Individuals must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing and Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

The entity that is coordinating an individual’s Housing Transition Navigation Services, or the Medi-Cal managed care plan case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

Providers must have demonstrated or verifiable experience and expertise with providing these unique services.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Housing Tenancy and Sustaining Services

Description/Overview

This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
2. Education and training on the role, rights and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit.
6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
7. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
8. Assistance with the annual housing recertification process.
9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.
11. Health and safety visits, including unit habitability inspections.
12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy.

Services do not include the provision of room and board or payment of rental costs. Please see housing deposits ILOS.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

- In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
- By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
 - A “homeless individual with a disability,” as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
 - e. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
 - f. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or
 - An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
 - A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose

composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
 - (1) An individual or family who:
 - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
 - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
 - Meets one of the following conditions:
 - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
 - Is living in the home of another because of economic hardship;
 - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
 - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
 - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
 - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
 - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
 - (2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C.

- 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
 - (3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
 - Have one or more serious chronic conditions;
 - Have a Serious Mental Illness;
 - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
 - Have a Serious Emotional Disturbance (children and adolescents);
 - Are receiving Enhanced Care Management; or
 - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or
- Individuals who meet the State’s No Place Like Home definition of “at risk of chronic homelessness”, which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically appropriate and cost-effective substitutes or settings for the State Plan service 2) beneficiaries are not required to use the in lieu of services, and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

These services are available from the initiation of services through the time when the individual’s housing support plan determines they are no longer needed. They are only available for a single duration in the individual’s lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what

conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

Many individuals will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a requirement.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports and may include providers such as:

- Vocational services agencies
- Providers of services for individuals experiencing homelessness
- Life skills training and education providers
- County agencies
- Public hospital systems
- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Supportive housing providers
- Federally qualified health centers and rural health clinics

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established

enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. Medi-Cal managed care plans should coordinate with county homelessness entities to provide these services.

Clients who meet the eligibility requirements for Housing and Tenancy Support Services should also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Short-term Post-Hospitalization Housing

Description/Overview

Short-Term Post-Hospitalization housing provides beneficiaries who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.²³

This setting provides individuals with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management and beginning to access other housing supports such as Housing Transition Navigation.²⁴

This setting may include an individual or shared interim housing setting, where residents receive the services described above.

Beneficiaries must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These services should include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization housing.²⁵

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals exiting recuperative care.
- Individuals exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder

²³ Up to 90 days of recuperative care is available under specified circumstances as a separate in-lieu service.

²⁴ Housing Transition/Navigation is a separate in-lieu service.

²⁵ The development of a housing assessment and individualized support plan are covered as a separate in-lieu service under Housing Transition/Navigation Services.

treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria:

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
 - In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
 - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
 - A “homeless individual with a disability,” as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
 - g. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
 - h. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as

described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
 - A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or
- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
 - (1) An individual or family who:
 - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
 - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
 - Meets one of the following conditions:
 - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
 - Is living in the home of another because of economic hardship;
 - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
 - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
 - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
 - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
 - (2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
 - (3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
 - Have one or more serious chronic conditions;
 - Have a Serious Mental Illness;
 - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
 - Have a Serious Emotional Disturbance (children and adolescents);
 - Are receiving Enhanced Care Management; or
 - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or
- Individuals who meet the State’s No Place Like Home definition of “at risk of chronic homelessness”, which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant

barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

In addition to meeting one of these criteria at a minimum, individuals must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re-hospitalization, or institutional readmission.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Short-Term Post-Hospitalization services are available once in an individual's lifetime and are limited and are not to exceed a duration of six (6) months per episode (but may be authorized for a shorter period based on individual needs). Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

The service is only available if enrollee is unable to meet such an expense.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities
- Supportive Housing providers
- County agencies
- Public Hospital Systems

- Social service agencies
- Providers of services for individuals experiencing homelessness

Facilities may be unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for short-term post-hospitalization housing. Medi-Cal managed care plans shall monitor the provision of all the services included above.

Managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Recuperative Care (Medical Respite)

Description/Overview

Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

1. Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs
2. Coordination of transportation to post-discharge appointments
3. Connection to any other on-going services an individual may require including mental health and substance use disorder services
4. Support in accessing benefits and housing
5. Gaining stability with case management relationships and programs

Recuperative care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing in lieu of services. Whenever possible, other housing in lieu of services should be provided to members onsite in the recuperative care facility. When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health

conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals who are at risk of hospitalization or are post-hospitalization, and
- Individuals who live alone with no formal supports; or
- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification.²⁶

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Recuperative care/medical respite is an allowable in lieu of services service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support

²⁶ For this population, the service could be coordinated with home modifications (which are covered as a separate in lieu service) and serve as a temporary placement until the individual can safely return home

- County directly operated or contracted recuperative care facilities

Facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for recuperative care or interim housing. Managed care plans shall monitor the provision of all the services included above.

Managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plan must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, skilled nursing facility, and emergency department services.

Respite Services

Description/Overview

Respite services are provided to caregivers of participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Respite services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
3. Services that attend to the participant's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

The Home Respite services are provided to the participant in his or her own home or another location being used as the home.

The Facility Respite services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

Eligibility (Population Subset)

Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, beneficiaries enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Clients with Complex Care Needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of service can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

In the home setting, these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care.

Service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health or respite agencies to provide services in:
 - Private residence
 - Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs)
 - Providers contracted by county behavioral health

Other community settings that are not a private residence, such as:

- Adult Family Home/Family Teaching Home
- Certified Family Homes for Children

- Residential Care Facility for the Elderly (RCFE)
- Child Day Care Facility; Child Day Care Center; Family Child Care Home
- Respite Facility; Residential Facility: Small Family Homes (Children Only)
- Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
- Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
- Respite Facility; Residential Facility: Group Homes (Children Only)
- Respite Facility; Residential Facility: Family Home Agency (FHA): Adult Family Home (AFH)/Family Teaching Home (FTH)
- Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs
- Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, and skilled nursing or other institutional care.

Day Habilitation Programs

Description/Overview

Day Habilitation Programs are provided in a participant's home or an out-of-home, non-facility setting. The programs are designed to assist the participant in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For individuals experiencing homelessness who are receiving enhanced care management or other in lieu of services, the day habilitation program can provide a physical location for participants to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

Day habilitation program services include, but are not limited to, training on:

1. The use of public transportation;
2. Personal skills development in conflict resolution;
3. Community participation;
4. Developing and maintaining interpersonal relationships;
5. Daily living skills (cooking, cleaning, shopping, money management); and,
6. Community resource awareness such as police, fire, or local services to support independence in the community.

Programs may include assistance with, but not limited to:

1. Selecting and moving into a home; ²⁷
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords; ²⁸
5. Managing personal financial affairs;

²⁷ Refer to the Housing Transition/Navigation Services In Lieu of Services

²⁸ Refer to the Housing- Tenancy and Sustaining Services In Lieu of Services

6. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;
7. Dealing with and responding appropriately to governmental agencies and personnel;
8. Asserting civil and statutory rights through self-advocacy;
9. Building and maintaining interpersonal relationships, including a circle of support;
10. Coordination with Medi-Cal managed care plan to link participant to any in lieu of services and/or enhanced care management services for which the client may be eligible;
11. Referral to non-in lieu of services housing resources if participant does not meet Housing Transition/Navigation Services in lieu of services eligibility criteria;
12. Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if client is not receiving these services through in lieu of services or enhanced care management; and
13. Coordination with Medi-Cal managed care plan to link participant to health care, mental health services, and substance use disorder services based on the individual needs of the participant for participants who are not receiving this linkage through in lieu of services or enhanced care management.

The services provided should utilize best practices for clients who are experiencing homelessness or formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals who are experiencing homelessness, individuals who exited homelessness and entered housing in the last 24 months, and individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Licensed Psychologists
- Licensed Certified Social Workers
- Registered Nurses
- Home Health Agencies
- Professional Fiduciary
- Vocational Skills Agencies

Medi-Cal managed care network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and outpatient hospital services, skilled nursing facility, emergency department services.

Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities

DESCRIPTION/OVERVIEW

Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible.

The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

The assisted living provider is responsible for meeting the needs of the participant, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF); includes non-room and board costs (medical, assistance w/ ADLs.). Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board and includes:

1. Assessing the participant's housing needs and presenting options.²⁹
2. Assessing the service needs of the participant to determine if the participant needs enhanced onsite services at the RCFE/ARF so the client can be safely and stably housed in an RCFE/ARF.
3. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
4. Communicating with facility administration and coordinating the move.
5. Establishing procedures and contacts to retain facility housing.
6. Coordinating with the Medi-Cal managed care plan to ensure that the needs of participants who need enhanced services to be safely and stably housed in RCFE/ARF settings have in lieu of services and/or enhanced care management services that provide the necessary enhanced services or fund RCFE/ARF operator directly to provide enhanced services.

²⁹ Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.

Eligibility (Population Subset)

A. For Nursing Facility Transition:

1. Has resided 60+ days in a nursing facility;
2. Willing to live in an assisted living setting as an alternative to a Nursing Facility; and
3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:

1. Interested in remaining in the community;
2. Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
3. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive NF LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals are directly responsible for paying their own living expenses.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Case management agencies

- Home Health agencies
- Medi-Cal managed care plans
- ARF/RCFE Operators

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

The RCFE/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Community Transition Services/Nursing Facility Transition to a Home

Description/Overview

Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization.

Community Transition Services/Nursing Facility Transition to a Home are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

1. Assessing the participant's housing needs and presenting options.³⁰
2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
3. Communicating with landlord, if applicable and coordinating the move.
4. Establishing procedures and contacts to retain housing.
5. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.³¹
7. Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations.³²

Eligibility (Population Subset)

³⁰ Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.

³¹ Refer to Home Modification In Lieu of Services for additional details.

³² Refer to Housing Deposits In Lieu of Services for additional details.

1. Currently receiving medically necessary nursing facility LOC services and in lieu of remaining in, the nursing facility setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services;
2. Has lived 60+ days in a nursing home;
3. Interested in moving back to the community; and
4. Able to reside safely in the community with appropriate and cost-effective supports and services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
- Community Transition Services are payable up to a total lifetime maximum amount of \$5,000.00. The only exception to the \$5,000.00 total maximum is if the participant is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.
- Community Transition Services must be necessary to ensure the health, welfare, and safety of the participant, and without which the participant would be unable to move to the private residence and would then require continued or re-institutionalization.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Case management agencies
- Home Health agencies
- Medi-Cal managed care plans
- County mental health providers
- 1915c HCBA/ALW providers
- CCT/Money Follows the Person providers

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Personal Care and Homemaker Services

Description/Overview

Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management.

Services provided through the In-Home Support Services (In-Home Supportive Services) program include housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments and protective supervision for the mentally impaired.

Homemaker/Chore services include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care, Homemaker and Chore programs aids individuals who otherwise could not remain in their homes.

In lieu of services can be utilized:

- Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and
- As authorized during any In-Home Supportive Services waiting period (member must be already referred to In-Home Supportive Services); this approval time period includes services prior to and up through the In-Home Supportive Services application date.
- For members not eligible to receive In-Home Supportive Services, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through In-Home Supportive Services should always be utilized first. These Personal Care and Homemaker in lieu of services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services.

Eligibility (Population Subset)

- Individuals at risk for hospitalization, or institutionalization in a nursing facility; or
- Individuals with functional deficits and no other adequate support system; or

- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: <http://www.cdss.ca.gov/In-Home-Supportive-Services>.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive Personal Care and Homemaker in lieu of services during this reassessment waiting period.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health agencies
- County agencies
- Personal care agencies
- AAA (Area Agency on Aging)

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another

managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, skilled nursing facility.

Environmental Accessibility Adaptations (Home Modifications)

Description/Overview

Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization.

Examples of environmental accessibility adaptations include:

- Ramps and grab-bars to assist beneficiaries in accessing the home;
- Doorway widening for beneficiaries who require a wheelchair;
- Stair lifts;
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the beneficiary; and
- Installation and testing of a Personal Emergency Response System (PERS) for persons who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

The services are available in a home that is owned, rented, leased, or occupied by the individual. For a home that is not owned by the individual, the individual must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

When authorizing environmental accessibility adaptations as an in lieu of service, the managed care plan must receive and document an order from the participant's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the participant, including any supporting documentation describing the efficacy of the equipment where appropriate. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the participant describing how and why the equipment or service meets the needs of the individual will still be necessary.

For environmental accessibility adaptations, the managed care plan must also receive and document:

1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the managed care plan determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:
 - A. An evaluation of the participant and the current equipment needs specific to the participant, describing how/why the current equipment does not meet the needs of the participant;
 - B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the participant *and reduces the risk of institutionalization*. This should also include information on the ability of the participant and/or the primary caregiver to learn about and appropriately use any requested item, and
 - C. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the participant and a description of the inadequacy.
3. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and
4. That a home visit has been conducted to determine the suitability of any requested equipment or service.

The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

Eligibility (Population Subset)

Individuals at risk for institutionalization in a nursing facility.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.
- EAAs must be conducted in accordance with applicable State and local building codes.
- EAAs are payable up to a total lifetime maximum of \$5,000. The only exceptions to the \$5,000 total maximum are if the beneficiary's place of residence changes or if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare and safety of the beneficiary, or are necessary to enable the beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.
- EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), the managed care plan must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may manage these services directly or may coordinate with a provider to manage the service.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another

managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Area Agencies on Aging (AAA)
- Local health departments
- Community-based providers and organizations

All EAAs that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License with the exception of a PERS installation, which may be performed in accordance with the system's installation requirements.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to nursing facility services, inpatient and outpatient hospital services, emergency department services and emergency transport services.

Meals/Medically Tailored Meals

Description/Overview

Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among members with chronic conditions. Meals help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status and increased member satisfaction.

1. Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.
2. Medically-Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.
3. Medically-Tailored meals are tailored to the medical needs of the member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes.
4. Medically-supportive food and nutrition services, including medically tailored groceries and healthy food vouchers.

Eligibility (Population Subset)

1. Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.
2. Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or
3. Individuals with extensive care coordination needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate

and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Up to three medically-tailored meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.
- Meals that are eligible for or reimbursed by alternate programs are not eligible.
- Meals are not covered to respond solely to food insecurities.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home delivered meal providers
- Area Agencies on Aging
- Nutritional Education Services to help sustain healthy cooking and eating habits
- Meals on Wheels providers

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services.

Sobering Centers

Description/Overview

Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

- When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.
- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
- This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering centers must be prepared to identify clients with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
- The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals age 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu

of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service is covered for a duration of less than 24 hours.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Sobering Centers, or other appropriate and allowable substance use disorder facilities. Medi-Cal managed care plans should consult with county behavioral health agencies to ensure these facilities can offer an appropriate standard of care and properly coordinate follow up access to substance use disorder services and other behavioral health services.
- These facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards, subject to review and approval by DHCS, to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transportation services.

Asthma Remediation³³

Description/Overview

Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) filtered vacuums;
- Integrated Pest Management (IPM) services;
- De-humidifiers;
- Air filters;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;
- Other interventions identified to be medically appropriate and cost effective.

The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver.

When authorizing asthma remediation as an in lieu of service, the managed care plan must receive and document:

1. The participant's current licensed health care provider's order specifying the requested remediation(s);
2. Depending on the type of remediation(s) requested, documentation from the provider describing how the remediation(s) meets the medical needs of the participant. A brief written evaluation specific to the participant describing how and why the remediation(s) meets the needs of the individual will still be necessary;
3. That a home visit has been conducted to determine the suitability of any requested remediation(s).

³³ Asthma Remediation should not interfere with EPSDT benefits. All appropriate EPSDT services should be provided and ILOS should be complementary. See https://www.hud.gov/sites/dfiles/HH/documents/HUD%20Asthma%20Guide%20Document_Final_7_18.pdf; Appendix B)

Asthma remediation includes providing information to individuals about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations such as:

1. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.
2. Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters.
3. Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.

Eligibility (Population Subset)

Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.
- Asthma remediations must be conducted in accordance with applicable State and local building codes.
- Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.
- Asthma remediations are payable up to a total lifetime maximum of \$5,000. The only exception to the \$5,000 total maximum is if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the beneficiary, or are necessary to enable the

beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.

- Asthma remediation modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Before commencement of a physical adaptation to the home or installation of equipment in the home, the managed care plan must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may: manage these services directly; coordinate with an existing Medi-Cal provider to manage the services; and/or contract with a county agency, community-based organization or other organization, as needed. The services should be provided in conjunction with culturally appropriate asthma self-management education.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- American Lung Association
- Allergy and Asthma Network
- National Environmental Education Foundation
- Local health departments
- Community-based providers and organizations

Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California Contractor's License.

- Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services and emergency department services.

Glossary

Medicaid Section 1115 Demonstration Waivers: Section 1115 wavers permit States to use federal Medicaid funds in ways that are not otherwise allowed under federal rules, as long as the U.S. Secretary of Health and Human Services determines that the initiative is an “experimental, pilot, or demonstration project” that is “likely to assist in promoting the objectives of the program.” Section 1115 waivers are generally approved for a five-year period.

Section 1915(b) “Freedom of Choice” waivers: States generally use section 1915(b) waivers to require enrollment in managed care delivery systems for certain populations. Many States originally used Section 1115 waiver authority to move enrollees into managed care, but the new federal regulations acknowledge that managed care is now the predominant delivery system in Medicaid and CMS has indicated that Section 1115 waivers may not be the most appropriate authority vehicle for managed care.

Section 1915(c) “Home and Community Based Services” waivers: States generally use 1915(c) waivers to develop programs that meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

Behavioral Health: Mental health and substance use disorder services.

Behavioral Health Managed Care Plan: The county prepaid inpatient health plan (PIHP) that would provide specialty mental health services and SUD treatment services under a single contract with DHCS, after full implementation of the behavioral health integration proposal.

CalAIM: California Advancing and Innovating Medi-Cal: DHCS’ multi-year initiative to implement overarching policy changes across all Medi-Cal delivery systems with the following objectives:

- 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.

Coordinated Care Initiative (CCI): CCI was implemented in 2014 in seven California counties with the goal of coordinating the delivery of medical, behavioral, and long-term services and supports to Medi-Cal beneficiaries also eligible for Medicare (“dual eligibles”). The CCI is composed of Cal MediConnect and Managed Medi-Cal Long-Term

Services and Supports (MLTSS). The Cal MediConnect portion of CCI is currently authorized through December 31, 2022.

County Inmate Pre-Release Application Process: A CalAIM proposal that all counties must implement an inmate pre-release Medi-Cal application process to ensure that county inmates/juveniles who are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. The proposed process would require all county jails and juvenile facilities to implement a process for facilitated referral and linkage from county jail release to specialty mental health, Drug Medi-Cal, DMC-ODS and Medi-Cal managed care providers, in cases where the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Nearly all Medi-Cal beneficiaries in a COHS county receive their care from the COHS health plan.

Cal MediConnect: A program that coordinates medical, behavioral, and long-term services and supports (i.e. both Medicare and Medi-Cal benefits) for dual eligibles in seven California CCI counties.

Dental Transformation Initiative (DTI): The DTI is a component of the Medi-Cal 2020 demonstration that aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.

Designated Public Hospitals: A California hospital operated by a county, a city and a county, or the University of California.

Designated State Health Programs: Designated State Health Programs (DSHPs) are existing State-funded health programs that have not previously qualified for federal funding, including Medicaid. CMS released a State Medicaid Director Letter informing States that they would phase-out federal funding for DSHPs beginning in 2017, meaning that California's DSHPs will not receive federal funding past December 31, 2020 when the Medi-Cal 2020 demonstration expires.

Drug Medi-Cal: Drug Medi-Cal pays for the SUD treatment services a Medi-Cal beneficiary receives through a Drug Medi-Cal certified program.

Drug Medi-Cal Organized Delivery System (DMC-ODS): DMC-ODS is a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services. The program enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. These systems are currently operating in 30 California counties. This program was initially authorized in during the

2010 Bridge to Reform demonstration and was reauthorized in the current Medi-Cal 2020 demonstration.

Enhanced Care Management: A collaborative and interdisciplinary benefit to provide intensive and comprehensive ('whole-person') care management services to high-need Medi-Cal beneficiaries.

Full Integration Plan: A CalAIM proposal to consolidate multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, DMC-ODS, and dental) under one contract with DHCS. This proposal would only be implemented in select areas with managed care plans and corresponding counties who have mutually volunteered to participate.

Global Payment Program (GPP): Established a statewide pool of funding for the remaining uninsured by combining federal disproportional share hospital and uncompensated care funding, where select Designated Public Hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher value, preventive services. GPP is currently set to expire on December 31, 2020 and with approval pending under the Medi-Cal 2020 Demonstration extension to continue for calendar year 2021.

Health Homes Program: Enables participating health plans to provide a range of supports to Medi-Cal beneficiaries with complex medical needs and chronic conditions. The HHP includes coordination of the full range of physical health, behavioral health, and community-based long-term services and supports.

Indian Health Care Providers: Means a health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization per 42 CFR §438.14(a).

In lieu of services: Services offered by a Medi-Cal health plan that are not included in the State Plan, but are medically appropriate, cost-effective substitutes for State Plan services included within the contract. Applicable in lieu of services must be specifically included in a managed care plan's contract. Services are offered at the plan's option and an enrollee cannot be required to use them.

Institution for Mental Diseases (IMD): A hospital, nursing facility, or other institution with more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases (42 U.S.C. §1396d(i)).

Long Term Care: Included skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities.

Long Term Service and Supports: Services that include medical and non-medical care for people with a chronic illness or disability. Long-term care services are those provided

to an individual who requires a level of care equivalent to that received in a nursing facility. Most long-term care services assist people with Activities of Daily Living, such as dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility.

Managed Long Term Services and Supports (MLTSS) Program: The delivery of long-term services and supports through capitated Medi-Cal managed care programs.

Medi-Cal 2020: California's current Section 1115 waiver that expires on December 31, 2020. Medi-Cal 2020 authorized the Whole Person Care program, Global Payment Program, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, Dental Transformation Initiative, and extended several other California waiver programs including the Drug Medi-Cal Organized Delivery System.

Medi-Cal Managed Care Plan: A health plan that has a contract with DHCS to deliver most physical health care and mild-to-moderate mental health care services to Medicaid beneficiaries through a network of providers at a capitated rate. Managed care plans emphasize primary and preventive care.

Mental Health Managed Care Plan: A health plan that has a contract with DHCS to provide specialty mental health services to Medi-Cal beneficiaries. Mental health managed care plans in California are administered by the counties.

National Committee for Quality Assurance (NCQA): A health care accreditation organization with a focus on improving health care quality.

Population Health Management Program: 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 Medi-Cal managed care plan will provide DHCS with a strategy for 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 the social determinants of health and reduce health disparities or inequities.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME): An incentive program for Designated Public Hospitals and District and Municipal Public Hospitals designed to improve their delivery systems through a focus on providing high quality, value-based care. PRIME is the successor program to the first-in-the-nation DSRIP (Delivery System Reform Incentive Payment) program that was authorized in the Bridge to Reform demonstration in 2010. PRIME funding is authorized under the Medi-Cal 2020 demonstration and expired on June 30, 2020.

Quality Incentive Program (QIP): The QIP ties Medi-Cal managed care payments to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to delivery of services under Medi-Cal managed care contracts and increase the amount of funding tied to quality outcomes. California's Designated Public Hospitals receive incentive payments based on achievement of specified improvement targets. Under CalAIM, the District and Municipal Public Hospitals started to participate in the QIP once PRIME expired.

Regional Rates: A CalAIM proposal to develop regional managed care capitation rates, rather than plan- and county-based rates, in order to simplify the rate-setting process for the Medi-Cal program and allow for more capacity to implement outcomes and value based payment structures.

Safety Net Care Pools (SNCPs): Federal Medicaid funding for safety net providers' uncompensated care costs associated with Medicaid eligible and uninsured individuals. California had SNCPs in the Section 1115 demonstrations that began in 2005 and in 2010. This funding transitioned to be a component of the Global Payment Program in the Medi-Cal 2020 demonstration.

Serious Mental Illness/Seriously Emotional Disturbance Demonstration Opportunity: A federal opportunity for States to receive federal Medicaid funding for short-term residential treatment services in settings otherwise subject to the institution for mental disease (IMD) exclusion. (See [SMD #18-011](#))

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks ([Healthy People 2020](#)).

Targeted Case Management: Targeted Case Management (TCM) is a Medi-Cal program that provides specialized case management services to certain Medi-Cal eligible individuals to gain access to needed medical, social, educational, and other services. The TCM Program is an optional Medi-Cal Program operated with federal and local funds. Eligible populations include:

- Children under age 21;
- Medically fragile individuals;
- Individuals at risk of institutionalization;
- Individuals in jeopardy of negative health or psycho-social outcomes; and
- Individuals with a communicable disease.

Whole Person Care: A pilot program that provides approved counties with funding to coordinate health, behavioral health, and social services for Medi-Cal beneficiaries. The program is authorized under the Medi-Cal 2020 demonstration and expires on December 31, 2020, with approval pending to extend through calendar year 2021.