Santa Cruz – Monterey – Merced Managed Medical Care Commission

(800) 700-3874

Meeting Agenda

Wednesday, January 25, 2023

3:00 p.m. – 5:00 p.m.

Teleconference Meeting

(Pursuant to Assembly Bill 361 signed by Governor Newsom, September 16, 2021)

Important notice regarding COVID-19: In the interest of public health and safety due to the state of emergency caused by the spread of COVID-19, this meeting will be conducted via teleconference. Alliance offices will be closed for this meeting. The following alternatives are available to members of the public to view this meeting and to provide comment to the Board.

1. Members of the public wishing to join the meeting may do so as follows:
    a. Computer, tablet or smartphone via Microsoft Teams:
    Click here to join the meeting
    b. Or by telephone at:
    United States: +1 (323) 705-3950
    Phone Conference ID: 295 659 371#

2. Members of the public wishing to provide public comment on items listed on the agenda may do so in one of the following ways.
    a. Email comments by 5:00 p.m. on Tuesday, January 24, 2023 to the Clerk of the Board at clerkoftheboard@ccah-alliance.org.
        1. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        2. Comments will be read during the meeting and are limited to five minutes.
    b. Public comment during the meeting when that item is announced.
        1. State your name and organization prior to providing comment.
        2. Comments are limited to five minutes.

3. Mute your phone during presentations to eliminate background noise.
    a. State your name prior to speaking during comment periods.
    b. Limit background noise when unmuted (i.e., paper shuffling, cell phone calls, etc.).

1. Call to Order by Chairperson Jimenez. 3:00 p.m.

A. Roll call; establish quorum.
B. Supplements and deletions to the agenda.

2. Oral Communications.

A. Members of the public may address the Commission on items not listed on today's agenda that are within the jurisdiction of the Commission. Presentations must not exceed five minutes in length, and any individual may speak only once during Oral Communications.
B. If any member of the public wishes to address the Commission on any item that is listed on today's agenda, they may do so when that item is called. Speakers are limited to five minutes per item.

3. Comments and announcements by Commission members.

A. Board members may provide comments and announcements.

4. Comments and announcements by Chief Executive Officer.

A. The Chief Executive Officer (CEO) may provide comments and announcements.

5. Consider approving findings that the state of emergency continues to impact the ability of members to meet safely in person and/or State or local officials continue to impose or recommend measures to promote social distancing. (3:10 – 3:20 p.m.)

A. Ms. Stephanie Sonnenshine, Chief Executive Officer (CEO), will review and Board will consider approving findings that the state of emergency continues to impact the ability of members to meet safely in person and/or State of local officials continue to impose or recommend measures to promote social distancing.
- Reference materials: Staff report and recommendation on above topic.

Pages 5-01 to 5-02

Regular Agenda Items: (6. – 7.): 3:20 p.m.

6. Discuss Medi-Cal Capacity Grant Program (MCGP) Evolution: Foundation Progress Report. (3:20 – 3:50 p.m.)

A. Ms. Sonnenshine, CEO, will review and Board will discuss MCGP evolution.
- Reference materials: Staff report on above topic; and Medi-Cal Capacity Grant Program Framework.

Pages 6-01 to 6-05

7. Discuss 2023 Proposals and Priorities. (3:50 – 4:15 p.m.)

A. Ms. Sonnenshine, CEO, will review and Board will discuss California FY 2023-24 budgetary proposals and Alliance priorities in 2023.
- Reference materials: LHPC Highlights from Governor's Proposed Budget for 2023-24; CalAIM Initiatives Launch Timeline as of July 2022; California Health Care Foundation Reflections on CalAIM's First Year; and 2023 Alliance Operating Plan.

Pages 7-01 to 7-30

Adjourn to Closed Session:

8. Closed Session pursuant to Government Code Section 54956.9, subdivision (d)(1) – Conference with Legal Counsel – Pending Litigation (Doe. v. Santa Cruz-Monterey-Merced Managed Medical Care Commission, dba Central California Alliance for Health). (4:15 – 4:30 p.m.)

A. Closed session agenda item.

9. Closed session pursuant to Government Code Section 54957.6 regarding the Agency's performance evaluation of the CEO. (4:30 – 4:55 p.m.)

A. Closed session agenda item.

- Reference materials: Evaluation of CEO Performance (Confidential).

<u>Return to Open Session</u>: (4:55 – 5:00 p.m.)

10. Open Session pursuant to Government Code Section 54956.9, subdivision (d)(1) – Conference with Legal Counsel – Pending Litigation (Doe. v. Santa Cruz-Monterey-Merced Managed Medical Care Commission, dba Central California Alliance for Health).

A. Board will report on action taken in closed session.

11. Open session pursuant to Government Code Section 54957.6 regarding the Agency's performance evaluation of the CEO.

A. Board will report on action taken in closed session.

Announcements:

Meetings of Advisory Groups and Committees of the Commission
The next meetings of the Advisory Groups and Committees of the Commission are:

- Finance Committee
  Wednesday, March 22, 2023; 1:30 – 2:45 p.m.

- Member Services Advisory Group
  Thursday, February 9, 2023; 10:00 – 11:30 a.m.

- Physicians Advisory Group
  Thursday, March 2, 2023; 12:00 – 1:30 p.m.

- Whole Child Model Clinical Advisory Committee
  Thursday, March 16, 2023, 12:00 – 1:00 p.m.

- Whole Child Model Family Advisory Committee
  Monday, March 13, 2023; 1:30 – 3:00 p.m.

The above meetings will be held in-person at Alliance offices or via remote teleconference unless otherwise noticed.

The next meetings of the Commission, after this January 25, 2023 meeting will be held via remote teleconference unless otherwise noticed:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  - Monday, February 6, 2023; 7:30 – 8:00 a.m.
  - Wednesday, February 22, 2023; 3:00 – 5:00 p.m.

Members of the public interested in attending should call the Alliance at (831) 430-5523 to verify meeting dates and locations prior to the meetings.

The complete agenda packet is available for review on the Alliance website at www.ccah-alliance.org/boardmeeting.html. The Commission complies with the Americans with Disabilities Act (ADA). Individuals who need special assistance or a disability-related accommodation to participate in this meeting should contact the Clerk of the Board at least 72 hours prior to the meeting at (831) 430-5523. Board meeting locations in Salinas and Merced are directly accessible by bus. As a courtesy to persons affected, please attend the meeting smoke and scent free.

DATE: January 25, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: AB 361 – Brown Act: Teleconferencing Meeting Procedures

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Recommendation. Staff recommend the Board consider making the following findings by majority vote, pursuant to Government Code § 54953 (e) (3), to allow the Board the option to meet remotely through teleconferencing, due to the present state of emergency, under the permissions provided via AB 361:

(A) The Board has considered the circumstances of the current COVID-19 state of emergency; and,

(B) Any of the following exists:

(i) The state of emergency continues to directly impact the ability of the members to meet safely in person.

(ii) State or local officials continue to impose or recommend measures to promote social distancing.

Staff further recommend that the Board consider making these findings on behalf of its Committees and the Advisory Groups of the Board to allow for the conduct of business via teleconferencing compliant with Government Code § 54953.

Summary. AB 361 (Statutes 2021) amended Government Code § 54953 to modify rules related to the remote participation of members of a public agency for the purposes of conducting a public meeting during declared states of emergency and/or when state or local officials have imposed or recommended measures to promote social distancing. To meet while in compliance with the permissions provided by AB 361, the Board must make the above referenced findings by majority vote and must reconsider the circumstances every 30 days.

Background. On September 16, 2021 Governor Newsom signed AB 361 (Rivas) which allows a local agency to use teleconferencing without complying with certain Brown Act requirements as long as notice and accessibility requirements are met, public members are allowed to observe and address the local agency body during the meeting, and the local agency body has a procedure for receiving and swiftly resolving requests for reasonable accommodations.

Under the provisions of AB 361, during a proclaimed state of emergency and/or when state or local officials have imposed or recommended measures to promote social distancing, a public body may meet via the specified teleconferencing procedures when the public body has determined by majority vote that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

Discussion. The federal public health emergency and the Governor's declared State of Emergency related to the COVID-19 pandemic remain in place.

In order to continue utilizing teleconferencing under the procedures outlined by AB 361, following this meeting of the Board, and if the state of emergency remains active or state or local officials continue to impose or recommend measures to promote social distancing, the Board must, no later than 30 days after this meeting and every 30 days thereafter, reconsider the circumstances of the state of emergency. To that end, at the December 7, 2022 meeting the Board approved a meeting schedule for 2023 to meet in compliance with AB 361 to consider the present state of emergency and determine if the above circumstances continue to exist in order to enable continued meeting via teleconferencing and will next consider this at the Board's February 22, 2023 meeting should California's COVID-19 state of emergency continue past February 28, 2023.

Fiscal Impact. There is no fiscal impact associated with this agenda item.

Attachments. N/A

DATE: January 25, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Medi-Cal Capacity Grant Program Evolution: Foundation Progress Report

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Summary. This report provides a status update on efforts to develop the operating model and implementation plan for a new 501(c)(3) non-profit foundation to administer the Alliance's grantmaking function, which is a strategic use of reserves and a component of the Alliance's overall financial plan. The initial donation is relevant to the final design of the operating model and implementation plan. A recommendation regarding the initial donation amount to the Foundation will not be available until later in the year, and thus, staff will not be able to present a recommendation on the operating model and implementation plan in February 2023 as originally planned.

Background. The Alliance established the Medi-Cal Capacity Grant Program (MCGP) in 2015 in response to the rapid expansion of the Medi-Cal population as a result of the Affordable Care Act. Since 2015, the Alliance has awarded 588 grants totaling over $129.8M to increase the availability, quality and access of health care and supportive resources for Medi-Cal members in Merced, Monterey and Santa Cruz counties. After seven years of experience operating the MCGP, staff determined that ongoing investment through grantmaking is a stable and reliable long-term strategy within the Alliance financial plan to support capacity in the Medi-Cal delivery system.

Over the course of 2022, the Alliance Board acted to evolve the MCGP to respond to the current health care landscape, address the current and emerging needs of Alliance members, and align with organizational and State priorities. Through this process, the Board approved:

1. A revised Health Care Reserve policy, which includes the process for future allocations to the MCGP, and an additional allocation of $43.6M of reserves to the MCGP in accordance with the revised policy; and
2. A revised and expanded MCGP Framework that clarifies the financial strategy, investment criteria and guiding principles for the MCGP; and
3. New grantmaking focus areas, funding goals and a theory of change for outcome evaluation.

In October 2022, the Board approved the establishment of a 501(c)(3) non-profit public charity foundation for the Alliance's future grantmaking. This would enable the Santa Cruz-Monterey-Merced Managed Medical Care Commission (the Board) to focus on health plan operations, provide for separate governance for grantmaking, and provide transparency in the Alliance's strategic allocation of reserves beyond the reserves target for grantmaking. The Board directed staff to return in February 2023 with recommendations on: 1) the initial donation amount to the Foundation to establish the endowment, grantmaking budget and administrative budget; and 2) the timeline and next steps to establish the public charity, including final details regarding the operating model, transition and phasing plan for existing grants and new funding opportunities.

Discussion. As described above, in October 2022, the Board approved establishing a 501(c)(3) non-profit foundation as the structure for the Alliance's future grantmaking and directed staff to return with a donation recommendation and operating model and implementation plan. During the October meeting and in its decision, the Board considered and accepted that accounting principles and tax related rules require that the proposed foundation and the Alliance be separate entities and not related parties. The operating model to be adopted for the foundation must demonstrate separation between entities to achieve the Board's objective of transparency in strategic use of reserves and fund balance. In the absence of such separation, financial statements must be consolidated and transparency in the funds allocated for grantmaking would not be available. The documents establishing the foundation and its governance must be well-crafted to clearly identify alignment with Medi-Cal purpose and that the funds donated be used to expand access and member benefits while also demonstrating that the Alliance does not have direct or indirect control of the foundation.

To that end, staff engaged with an advisory, tax and accounting services consultant in addition to its health care and foundation legal specialists to support the development of an appropriate operating model and implementation plan. Particular areas of emphasis in developing the operating model include: 1) how the foundation could be established to ensure the foundation operates in accordance with the MCGP Framework without direct or indirect control by the Alliance; 2) how to ensure funds are used for the purposes as required by the Alliance's ordinances; 3) how to properly establish a foundation board; 4) what administrative services (if any) the Alliance may provide to the foundation; 5) what permissible role the Alliance Chief Executive Officer (CEO) or other staff may have in or with the foundation; 6) what role the foundation can or cannot play in the administration of existing MCGP programs and awards; and 7) what aspects of above elements and administrative operations should be addressed in foundation bylaws.

Review against these issues is underway. Staff will finalize a recommendation regarding the operating model (including administrative budget) and implementation plan responsive to the legal and accounting guidance received, as well as to the final recommendation regarding donation amount and transfer schedule.

In the discussions following the October 2022 Board meeting, the Chief Financial Officer determined the recommendation as to foundation donation will not be available by February 2023 and that the donation proposed may differ from the amount assumed in the initial foundation recommendation adopted by the Board. The final operating model and its administrative budget is dependent on the donation amount and thus will not be finalized until after the donation is identified. It is anticipated that a recommendation for the donation amount will be available after the May 2023 independent financial audit and a reforecasting of plan financial performance through 2027. Given the impending CEO transition as of April 17, 2023, staff will hold the development of final recommendations relating to the foundation to enable the incoming CEO to return to the Board with final recommendations regarding the foundation in mid-to-late 2023.

Staff will proceed with making recommendations for new grantmaking opportunities responsive to the new MCGP priorities and goals to be administered through the *existing* MCGP administrative structure to meet member and Medi-Cal capacity needs in 2023. Staff expect to bring those recommendations forward to the Board in March 2023 to enable grants to be awarded by June 2023.

Conclusion. Staff are unable to present a recommendation for the amount to be donated to the foundation, and thus will be unable to make a recommendation with regards to the operating model (including administrative budget and annual spending plan) and implementation plan by February 2023. Staff will proceed with identifying new grantmaking opportunities to be administered in the current MCGP administrative structure and will continue to work with consulting experts on the foundation recommendations. The CEO will ensure the incoming-CEO's understanding of the remaining steps toward the final recommendation to the Board to ensure staff make well informed recommendations regarding final disposition of this matter.

Fiscal Impact. To be determined, dependent on final recommendation of total donation to foundation and implementation plan.

Attachments.

1. Medi-Cal Capacity Grant Program Framework

Medi-Cal Capacity Grant Program (MCGP) Framework

MCGP Investment Strategy. The MCGP is a part of the Alliance's financial plan, which creates prudent health plan reserves and enables the use of surplus funds to expand access and improve Alliance member benefits. The Alliance allocates funding to the MCGP from its earned net income, after meeting regulatory and Board designated reserve requirements and ensuring adequate funding for augmented provider reimbursements and successful implementation of Medi-Cal program requirements. The MCGP's financial strategy is founded on the following elements:

1. Funding Allocations. MCGP funding is allocated by county and funding opportunity. Funding allocations also consider equity in impact of programs, and not just equity in allocation.
2. Annual Spending Plan. The MCGP develops and adheres to an annual spending plan to ensure transparency to potential grantees about the level of funding to be made available in the community for activities within the focus areas.
3. Member Benefit. The MCGP makes strategic use of Alliance reserves to strengthen the delivery system to meet Medi-Cal member needs.
4. Local Innovation. The MCGP ensures strategic use of reserves to enable local innovation rather than supplanting state resources for ongoing program administration. Covered Service benefit expansions, provider payment augmentation and other services managed by the health plan are addressed via the health plan's operating budget, not through the MCGP.
5. Funding Decisions Free from Conflicts of Interest. The MCGP relies on an administrative decision-making structure which avoids conflicts of interest in the approval of programs and specific grants.

MCGP Investment Criteria. These key criteria are used to evaluate funding requests and will be used to guide planning for future MCGP investments:

1. Medi-Cal Purpose: All grants must benefit Medi-Cal beneficiaries.
2. Sustainability: The Alliance makes investments with the goal of creating lasting change in the Medi-Cal delivery system or in member and community health that is sustainable past the grant funding period. Grants are generally one-time investments to build capacity or ensure adequate local infrastructure to meet Alliance member needs.
3. Service Area: Grantees must maintain ongoing operations, including staffing and programs, in the Alliance service area.
4. Alignment with Vision, Mission and Priorities: The Alliance invests in organizations and efforts that advance the Alliance's vision, mission and strategic priorities.
5. Focus Areas: Funding awards must be associated with at least one of the MCGP focus areas and support the identified goals for that focus area.
6. Supplanting: MCGP funding should not be used to supplant or duplicate other funding in order to focus investments on areas where limited funding is available or where other funding sources can be leveraged to have a greater impact.

MCGP Guiding Principles. The following principles guide MCGP grantmaking.

1. Equity in impact.
   - The MCGP will ensure grantmaking is tailored to local needs and prioritizes resources and attention to communities and populations who experience inequities.
   - The MCGP will engage the community to understand the diversity of health-related needs and opportunities to advance the Alliance's vision of *Healthy People. Healthy Communities.*
   - The MCGP will create opportunities for members to play a central role in crafting solutions through grantmaking to improve health and well-being for themselves, their families and their communities.
2. Trusting relationships with partners.
   - The MCGP is committed to building trusting, collaborative relationships with community partners based on mutual respect, collaborative learning and aligned priorities.
3. Transparent, accessible and responsive grantmaking.
   - The MCGP seeks to minimizes administrative burden on grantees and ensure the level of effort is commensurate with the grantee organization's scale and administrative ability.
   - The MCGP ensures accountability for grant funds and transparency about funding decisions and requirements.
   - The scale and impact of MCGP investments on the Medi-Cal system, infrastructure and members is measured and communicated.
4. Grantmaking informed by Medi-Cal delivery system expertise and experience.
   - Grantmaking is responsive to funding gaps and infrastructure needs to meet the challenges of Medi-Cal transformation.
   - Investments support systems change and innovations in the safety net health care delivery system to address root causes that impact health.
   - Grantmaking is developed in close coordination with Alliance staff, Board and community stakeholders.
5. Holistic view of health.
   - Grantmaking promotes a holistic view of health that includes supporting Medi-Cal members in achieving and maintaining optimum physical, mental and social well-being.
   - Investments to address disease prevention and disease management are made upstream from the medical model to address root causes and prevention.

To: Board of Directors & Plan Staff

From: LHPC Staff

Subject: Highlights from Governor's Proposed Budget for 2023-24

Date: January 10, 2023

This memo includes highlights from Governor Newsom's Proposed Budget for FY 2023-24, specifically health and human services proposals of relevance to local plans. See the Governor's Budget Summary, DHCS Budget Highlights, and the DHCS Medi-Cal Estimate for additional details (references and page numbers are provided throughout the memo). LHPC will continue to review and analyze Budget proposals impacting local plans and provide additional information as it becomes available. Please contact Rebecca Sullivan at rsullivan@lhpc.org with any questions.

State Budget Overview

The following highlights provide a snapshot of California's overall State Budget:

- ***Total Budget***: $296.97 billion total fund ($223.6 billion General Fund) in 2023-24 (Summary Chart, p. 13).
- ***Reduced Revenues and Budget Shortfall****:* Forecasted revenues are $29.5 billion lower than the 2022 Budget Act projections, resulting in a FY 2023-24 budget shortfall of $22.5 billion. The Governor presented a balanced budget by proposing the following solutions to fulfill the shortfall:
    - $7.4 million in Funding Delays – Delays funding for certain initiatives to later fiscal years without reducing the total value of initial investments.
    - $5.7 billion in Reductions/Pullbacks – Significant items include a $3 billion reduction to the prior 2022 Budget Act inflationary adjustment and the pullback of a $750 million unemployment trust fund payment.
    - $4.3 billion in Funding Shifts – For a subset of expenditures other funding source will be utilized to fund these investments in place of the previously allocated General Fund.
    - $3.9 billion in Trigger Reductions – Reduces certain expenditures tied to FY 2020-21 through 2023-24, these reductions would be restored (through a trigger) in the 2024 budget subject to resource availability in the following categories:
        - $3.1 billion in Climate and Transportation
        - $600 million in Housing
        - $106 million in Parks

        - $55 million in Workforce Training
    - $1.2 billion Limited Revenue Generation and Borrowing – Additional revenue generation includes renewal of the MCO tax beginning in calendar year (CY) 2024 and special fund loans to the General Fund.
- ***Budget Reserves****:* $35.6 billion in budgetary reserves, the reserves include:
    - $22.4 billion in the Rainy Day Fund (Budget Stabilization Account)
    - $900 million in the Safety Net Reserve
    - 8.5 billion in the Public School System Stabilization Account, and
    - $3.8 billion in the state's operating reserve (Special Fund for Operating Uncertainties)

The Rainy Day fund continues to remain at the constitutional maximum which requires $951 million to be dedicated for infrastructure investments. In order to access the Rainy Day fund, the Governor would need to declare a fiscal emergency, any withdrawal is limited to no more than 50 per cent of the fund balance for any given fiscal year. While the Governor's budget does not project a recession, the administration has highlighted general fiscal uncertainty and will update the budget forecast in Spring.

As required by Proposition 2, the budget accelerates the paydown of payments for state's retirement liabilities and includes an additional $1.9 billion in 2023-24 and approximately $5.3 billion over the next three years.

Based on the current revenue forecast, the Governor's budget focused on sustaining prior key investments such as:047

- Transitional Kindergarten, Child Care Availability and Affordability, and Universal School Meals
- Maintaining Higher Education Commitments
- Advancing Climate Agenda
- Expanding Health Care Access and Delivery Transformation
- Increased Cash Assistance to Individuals with Disabilities and Older Adults
- Expanding the Behavioral Health Continuum
- Developmentally Disabled Services Rate Reform Implementation
- Investments in Infrastructure, Housing, Homelessness, and continued Workforce Development

Reference: Budget Summary, pp. 1-7

Significant Medi-Cal Budget Items
Overall Medi-Cal Budget

- *2023-24 Budget estimate*: $138.9 billion ($38.7 billion General Fund) (DHCS Budget Highlights, p.17).
    - The 2023-24 budget estimates are $1.2 billion higher than the revised 2022-23 projections of $137.7 billion ($32.3 billion General Fund)

- *Total projected enrollment*: The 2023-24 projected average monthly caseload is 14.4 million, a decrease of 5.22% from FY 2022-23. (DHCS Budget Highlights, p. 13)

The state's budget will need to be updated to reflect the federal budget that was released in December 2022 and policies such as the decoupling of the COVID public health emergency (PHE) and the pause on Medi-Cal redetermination.

- The state's current budget assumes the PHE ends in mid-April 2023, assumed enhanced federal funding of 6.2% would be available through June 30, 2023, and disenrollment of members would begin in August 2023 through August 2024.
- The federal budget requires Medicaid redetermination activities to begin in April 2023 (regardless as to when the PHE is lifted) and provides states 14 months to complete the needed activities. Based on the California's PHE unwinding plan and factoring in the new federal requirements, it is assumed members will begin to lose coverage beginning in July 2023 through July 2024.
    - Lastly, the federal budget provides a step down of federal participation that was not factored into the state budget as follows:
        - 6.2% enhanced match through March 31, 2023
        - 5.0% enhanced match April 1, 2023 through June 30, 2023
        - 2.5% enhanced match July 1, 2023 through September 30, 2023
        - 1.5% enhanced match October 1, 2023, through December 31, 2023

Reference: DHCS Budget Highlights, pp. 10, 130.

MCO Tax

The Governor's Budget proposes renewal of the MCO tax for a three-year period, effective January 1, 2024 through December 31, 2026, and assumes $1.3 billion of revenue in 2023-24 for the partial fiscal year and $6.5 billion over three years (assuming just over $2 billion annual revenue from the tax). Note that the Budget proposal indicates the Administration will be exploring opportunities to increase the size of the MCO tax. The Budget proposal also suggests that revenue from the MCO tax ensures preservation of Medi-Cal expansion and protects recent investments in what will be a difficult budget year. LHPC will work closely local plans on our positioning with respect to the MCO tax, including Medi-Cal stakeholder partnerships and engagement, modeling, and other technical issues. Below are highlights both from the Governor's Budget and recent discussion with DHCS:

- The current estimate assumes continuation of the same MCO tax model that expired at the end of 2022 (authorized via AB 115, Chapter 348, Statutes of 2019).
- Base year enrollment assumptions will be updated to use CY 2021 enrollment, and DHCS will begin working with plans in the coming weeks to discuss these assumptions.
- DHCS will be proposing trailer bill language related to the MCO tax, which should be available by February.
- DHCS has shared they are working with CMS and receiving technical assistance regarding California's MCO tax model to ensure they are constructing a tax that will be federally approvable. DHCS is note yet able to share their timing for providing any current or updated modeling with LHPC.

Reference: Budget Summary, p. 60; DHCS Budget Highlights, p. 4

Medi-Cal Eligibility Expansion
The Budget maintains the expansion of full-scope Medi-Cal coverage to all income-eligibility adults aged 26 through 49 regardless of immigration status, beginning January 1, 2024. The Budget allocates $844.5 million ($653.3 million General Fund) in FY 2023-24 and $2.1 billion ($1.6 billion General Fund) in FY 2024-25, and approximately $2.5 billion ($2 billion General Fund) ongoing to fund this expansion.

Reference: DHCS Budget Highlights, p. 4

CalAIM
The state continues to honor its prior commitments and investments in CalAIM and focus on delivery system transformation. Additional investments in CalAIM include:

- *Transitional Rent* – DHCS will seek an amendment to the CalAIM 1115 waiver to authorize a new Community Support by CY 2024 that would allow for up to six months of rent or temporary housing to eligible individuals to be funded by managed care plans. The Budget allocates $17.9 million ($6.3 million General Fund) in FY 2025-26 and increases at full implementation to $116.6 million ($40.8 million General Fund).
- *Justice Involved* – The Budget includes $109.7 million total fund ($39.1 million General Fund) in FY 2023-24 for the CalAIM inmate pre-release program. (DHCS Budget Highlights, p. 7)
- *ICF/DD and Adult/Pediatric Subacute Facility Carve-In* – Members currently served in the FFS delivery system are expected to transition to managed care on July 1, 2023, the budget reflects these assumptions. However, there are stakeholder requests and external pressure to delay the implementation to January 1, 2024. To date, DHCS has advised they are evaluating the requested delay.
- *Forthcoming Trailer Bill Language* – DHCS will seek statutory changes to align with waiver approvals.

References: Budget Summary, pp. 61, DHCS Budget Highlights, p. 6

Designated State Health Program (DSHP) and Provider Rate Increases
The Budget proposes the continuation of the DSHP program under CalAIM for the period of CY 2023 through CY 2026 to support the Providing Access and Transforming Health (PATH) Supports program. The continuation of DSHP provides $646.4 million in federal funding over a 4-year period. As a condition of DSHP approvals, CMS requires states to provide provider rate increase for certain services if the Medicaid to Medicare provider rate ratio is less than 80 percent.

- As a result, primary care codes/rates beneath the 80 percent threshold will receive a 10 percent increase. The net impact of provider rate increase and DSHP funding is $22 million total fund ($152.9 million General Fund savings).
    - This includes primary care codes such as obstetrics and doulas services that do not have a Medicare rate.

- DHCS will continue to evaluate the need for additional targeted rate increase and make updates in the May Revision.
- Our understanding is the above referenced rate increase are over and beyond the 2022 Budget Act rate increase tied to the elimination of the AB97 provider rate reductions.

Reference: Budget Summary, p. 60, DHCS Budget Highlights, p. 4

Behavioral Health

The Budget includes significant new investments in behavioral health over the next several years while also maintaining existing investments that were approved in the 2022-23 enacted budget.

- *California's Behavioral Health Community-Based Continuum Demonstration* – With total funding of $6.1 billion over five years, the CalBH-CBC demonstration is a comprehensive waiver proposal to build out California's community-based continuum of behavioral health services. The demonstration primarily focuses on services that are or will be covered by county behavioral health. One component of the demonstration includes enhancing coordination between managed care, county behavioral health, and social services for foster youth, however, the Budget does not include details regarding the proposed incentive pool that which was outlined in the DHCS concept paper published last year.
    - Over the five-year demonstration, the $6.1 billion total funding includes $314 million GF, $175 million Mental Health Services Fund, $2.1 billion Medi-Cal County Behavioral Health Fund, and $3.5 billion federal funds.
- *Opioid and Fentanyl Response Package* – The Budget proposes an additional $93 million in Opioid Settlement Funds over four years through programs administered by DHCS and CDPH, including:
    - $79 million to expand the Naloxone Distribution Program
    - $10 million for fentanyl program grants for education, testing, recovery and support services
    - $4 million to make fentanyl test strips and naloxone more widely available
- *Recent Behavioral Health Investments Maintained with Some Delays* – In addition to the new investments in behavioral health outlined above, the following programs or services were maintained in the proposed Budget, but some were delayed as noted below:
    - $16.5 million GF in 2023-24 for CARE Act implementation, with growing costs in the outyears as additional counties implement CARE Court. Note there is no delay in CARE Court implementation.
    - $480.7 million GF for the last round of Behavioral Health Continuum Infrastructure Program funding is being delayed from the current budget year to be equally distributed across two future Budget years, 2024-25 and 2025-26.
    - $250 million GF of the total $1.5 billion GF for Behavioral Health Bridge Housing Program is being delayed to 2024-25. Note that the current budget year includes $1 billion for this program, and the Administration continues to include $250 million for 2023-24.

- Funding for the Children and Youth Behavioral Health Initiative (CYBHI) is being maintained as previously approved, with appropriations over several budget years.

Reference: Budget Summary, pp. 59, 61; DHCS Budget Highlights, pp. 8-10

Equity and Practice Transformation Payments

The 2022-23 Budget Act committed $700 million ($140 million per year) over 5 years to support practice transformation and COVID-19 recovery payments. The proposed FY 2023-24 budget maintains the initial $700 million dollar investment as outlined below.

- $140 million in FY 2022-23
- $215 million in FY 2023-24
- $115 million FY 2024-25 through FY 2026-27

These payments are intended to advance equity; address gaps in preventative, maternity and behavioral health care measures; reduce COVID-19 driven care disparities; support upstream interventions to address SDOD and improve early childhood outcomes.

Reference: DHCS Medi-Cal Estimate, p. 731

Managed Care - Other

- *Year over Year Growth in Managed Care Costs* – General fund costs tied to managed care are expected to increase from FY 2023-24 to 2024-25 by $664 million related to forecasted changes in managed care rates and enrollment.
- *Retroactive Managed Care Payment* – The budget includes $490.7 million total funds ($251.6 million General Fund) for retroactive managed care payments tied to the 10 percent PHE add-on for long-term care facilities.

Reference: DHCS Budget Highlights, p. 12

Health Care Workforce

The 2022 Budget Act allocated $1.5 billion General Fund to HCAI for workforce development. The 2023-24 Budget has delayed the funding over multiple years: $68 million in FY 2022-23, $329.4 million in 2023-24, 198.7 million in FY 2024-25 and 2025-26.

- *Community Health Workers* – Delays $130 million General Fund to $65 million in FY 2024-25 and 2025-26, respectively. Funding was originally intended to recruit, train, and certify 25,000 new community health workers by 2025, with specialty certifications in areas that include climate health, homelessness, and dementia.
- *Nursing and social work* – During the CalHHS press conference it was noted these categories tied to workforce training are expected to be delayed. More details will be shared as they become available.

Reference: Budget Summary, p. 97

Reproductive Health
DHCS will develop an 1115 demonstration waiver to support access to reproductive and family planning services. The Budget proposes $200 million total fund ($15 million General Fund) in FY 2024-25 for a grant program through this Reproductive Services 1115 waiver. The program intends to support access to family planning and related services, system transformation, capacity, and sustainability of the safety net.

References: Budget Summary, pp. 60-1; DHCS Budget Highlights, p. 7

Data Exchange Framework Implementation
Although the Governor's Budget Summary does not reference forthcoming trailer bill language regarding the establishment of governance for the Data Exchange Framework and statewide data sharing agreement, we understand that it is the Administration's intent to introduce language that will authorize a formal governance structure that will be housed within California Health and Human Services Agency and the Center for Data Insights and Innovation (CDII).

Public Health and COVID-19 Response
Funding for COVID-19 response is ongoing, including $176.6 million GF in 2023-24 to support implementation of the State's SMARTER plan primarily for IT systems for lab data management and case and outbreak investigation. However, given the reduced COVID-19 response activities over the past six months, the Governor's Budget assumes a reduction of $614 million in 2022-23 for COVID-19 response compared to what was assumed in the 2022-23 enacted budget.

Reference: Budget Summary, p. 66-7

Human Services
- *In-Home Supportive Services (IHSS)* – The budget includes $20.5 billion ($7.8 billion General Fund) for the IHSS program in FY 2023-24. The average monthly case is estimated to be 642,000 recipients in FY 2023-24.
- *Supplemental Security Income/State Supplementary Payment (SSI/SSP)* – The budget includes $3.5 billion General Fund in FY 2023-24 and the average monthly caseload is 1.1 million recipients. This includes an 8.7 percent federal SSI cost of living adjustment and 10.3 percent SSP increase that took effect on January 1, 2023. Increasing the maximum SSI/SSP grant level to $1,134 per individual and $1,928 per couple.

Reference: Budget Summary, p. 63

TBL Section
The following list outlines trailer bill language of interest to local plans. LHPC will be monitoring for trailer bill language in the coming weeks and will share more information once available:
- Managed Care Organization Provider Tax
- CalAIM: Designated State Health Programs
- Conform Statutory Estimate Requirements to Recent Program Changes
- Data Exchange Framework Governance

CalAIM Initiatives Launch Timeline as of July 2022

This is a dynamic document that reflects the CalAIM team's expected timing of launches. In some instances, program launch dates are contingent upon timely CMS approval. Because these dates may shift, the document will be updated regularly to reflect any changes.

CONTEXT:

California Advancing and Innovating Medi-Cal, or CalAIM, is a transformational plan to modernize the State's Medicaid program. It will improve the quality of life and health outcomes of Medi-Cal beneficiaries, including those with the most complex health and social needs. CalAIM includes a series of far-reaching initiatives that together represent broad reforms of Medi-Cal's programs and systems. The Department of Health Care Services (DHCS) is implementing CalAIM in partnership with Medi-Cal providers, Managed Care Plans (MCPs), Counties, Community-Based Organizations and other stakeholders. These changes will span a multi-year period, with the first reforms already underway effective January 1, 2022 and subsequent reforms to be phased in through 2027.[1]

This CalAIM Initiatives Launch Timeline is a dynamic document that reflects DHCS' expected timing of initiative launches across the implementation period for CalAIM and key related initiatives. In some instances, program launch dates are contingent upon timely Centers for Medicare and Medicaid Services (CMS) approval. Because these dates may shift as policies are finalized, the document will be updated regularly to reflect any changes. Stakeholders are encouraged to check the DHCS CalAIM website for updates to ensure access to the most up-to-date information.

ORIENTATION:

This document is divided into three sections:

1. A summary timeline of initiative go-live dates
2. A detailed matrix of initiative go-live dates
3. Brief descriptions of each initiative organized by broader categories of impact

[1] See the DHCS CalAIM Webpage for additional details.

CalAIM Initiatives Launch Timeline as of July 2022

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CalAIM Initiatives Launch Timeline – Summary of Go-Live Dates[2]

DHCS Major CalAIM Program Initiatives -- Go-Live Dates (pending readiness and federal approvals)														*Updated: July 2022*
Activity	**1/22**	**7/22**	**8/22**	**9/22**	**10/22**	**11/22**	**12/22**	**1/23**	**7/23**	**11/23**	**1/24**	**1/25**	**1/26**	**2027**
Administrative Integration of SMH and SUD	Starts													Fully Integrated
Benefits Standardization	Transplant In/ MSSP Out							SNF	ICF/DD & Subacute Care Facilities					
Dental (new benefits and P4P)	X													
Enhanced Care Management (ECM) / Community Supports (ILOS)	X	X						X	X					
Incentive Payments	X							X			X			
Mandatory Managed Care Enrollment	Non-Duals							Duals						
PATH Funds (ECM, Community Supports, Justice-Involved)	X		Justice-Involved	Collaborative Planning	WPC Services		CITED	TA Marketplace						
Regional Capitation Rates and Shared Savings/Risk	X							X			X	X		X
Specialty Mental Health Services - Criteria for Services	X													
Behavioral Health No Wrong Door		X												
Contingency Management						Fall 2022								
SMI/SED IMD Waiver					Earliest to CMS				X					
Transition to Statewide MLTSS and D-SNP (CCI ends)		Feasibility Study						CCI Counties					Non-CCI Counties	Statewide MLTSS
Behavioral Health CPT Code Transition									X					
Behavioral Health Standard Screening and Transition Tools								X						
Justice-Involved Package								No Sooner Than						
Population Health Management (including Service)								PHM Program	PHM Service					
Behavioral Health Payment Reform									X					
County CCS Oversight											X			
NCQA Accreditation													X	
Full Integration Plans														X
County Eligibility and Oversight										X				
Foster Care Model of Care (TBD)														
DMC-ODS Traditional Healers and Natural Helpers (TBD)														
Improving Beneficiary Contact and Demographic Information (TBD)														

[2] Detailed launch timeline tables that follow include additional CalAIM-specific initiatives.

CalAIM Initiatives Launch Timeline as of July 2022

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CalAIM Initiatives Launch Timeline – Details of Go-Live Dates

Go-Live Date	Initiative[3]	Go-Live
January 2022	**Enhanced Care Management (ECM)**	Enhanced care management (ECM) services are available for select Populations of Focus in Whole Person Care (WPC) Pilot and Health Home Program (HHP) counties, including for Individuals & Families Experiencing Homelessness; High Utilizer Adults; Adults with Severe Mental Illness or Substance Use Disorder (SMI/SUD); and Adults & Children/Youth Transitioning from Incarceration in WPC Pilot counties only, where the services provided in the Pilot are consistent with those described in the ECM Contract.
	Community Supports	MCPs offer preapproved Community Supports to beneficiaries.
	Incentive Payments	Program Year 1 began on January 1, 2022, and the first round of performance incentive payments were issued to MCPs in April 2022.
	Benefits Standardization	Benefits are standardized for major organ transplants and the Multipurpose Senior Services Program (MSSP). All major organ transplants are carved in and covered by MCPs statewide, and MSSP is no longer covered by MCPs in certain counties.[4,5]
	Mandatory Managed Care Enrollment (MMCE)	Certain beneficiaries are required to enroll into managed care. Other beneficiaries are required to move from managed care into fee-for service.[4]

[3] Includes CalAIM Proposal initiatives and key related initiatives.
[4] Only in Coordinated Care Initiative (CCI) counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, Santa Clara.
[5] See All Plan Letter (APL) 21-015 for more information on MMCE Phase I populations.

CalAIM Initiatives Launch Timeline as of July 2022

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Go-Live Date	Initiative[3]	Go-Live
	Regional Capitation Rates and Shared Savings/Risk	Regional Capitation Rates (Phase 1): County-based rates transitioned to regional rates in targeted groups of counties ("Phase 1 counties").
	Specialty Mental Health Services – Criteria for Services	Specialty Mental Health Services (SMHS) criteria for both adults and children updated and clarified.
	Dental (new benefits and P4P)	New dental benefits are available (including a caries risk assessment bundle for young children and Silver Diamine Fluoride for children and certain high-risk and/or institutional populations) and pay-for-performance initiatives to reward preventive services and continuity of care implemented statewide.
	Drug Medi-Cal Organized Delivery System (DMC-ODS) Renewal and Policy Improvements	DMC-ODS added to the state plan, delivery system authorized by the Section 1915(b) waiver, and certain DMC-ODS policies clarified or changed. These include: updates to DMC-ODS services (i.e., revisions to the definition of residential treatment; expansion of types of clinicians who can provide and claim for Clinician Consultation Services (formerly Physician Consultation Services); new DMC-ODS criteria (per AB 133); and information and clarification regarding requirements for DMC-ODS services.
July 2022	**Enhanced Care Management (ECM)**	ECM services become available for select Populations of Focus in counties with neither WPC Pilot nor HHPs, including for: Individuals & Families Experiencing Homelessness; High Utilizer Adults; and Adults with SMI/SUD.
	Behavioral Health No Wrong Door	Updated documentation requirement guidance for SMHS and SUD services published, no wrong door policy and co-occurring treatment policy go live.
	Behavioral Health Documentation Redesign	Revised, simplified, and streamlined mental health documentation requirements implemented to align with medical provider requirements, improve efficiency and decrease provider burnout.

CalAIM Initiatives Launch Timeline as of July 2022

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Go-Live Date	Initiative[3]	Go-Live
	Transition to Statewide MLTSS and D-SNP (CCI ends)	Release findings from Feasibility Study of Exclusively Aligned Enrollment (EAE) D-SNPs in non-CCI counties.
August 2022	**Providing Access and Transforming Health (PATH) Funds (ECM, Community Supports, Justice-Involved)**	First round of funding disbursed for Justice Involved Capacity Building initiative.
September 2022	**Providing Access and Transforming Health (PATH) Funds (ECM, Community Supports, Justice-Involved)**	First round of funding disbursed for Collaborative Planning Initiative.
October 2022	**Providing Access and Transforming Health (PATH) Funds (ECM, Community Supports, Justice-Involved)**	First round of funding disbursed for WPC Services and Transition to Managed Care Mitigation Initiative.
Fall 2022	**Recovery Incentives: California's Contingency Management Program**	Earliest launch of contingency management pilot in select DMC-ODS counties that will run until March 2024.
December 2022	**Providing Access and Transforming Health (PATH) Funds (ECM, Community Supports, Justice-Involved)**	First round of funding disbursed for Capacity and Infrastructure Transition, Expansion, and Development (CITED) Initiative.

CalAIM Initiatives Launch Timeline as of July 2022

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Go-Live Date	Initiative[3]	Go-Live
January 2023	**Population Health Management (PHM)**	Launch of Population Health Management (PHM) Program, which is a cohesive approach for keeping beneficiaries healthy, improving outcomes, and reducing disparities across the continuum of care.
	PHM Service	Test launch of the PHM Service with multiple partners from January 1 to June 30, 2023.
	Enhanced Care Management (ECM)	ECM services available for select Populations of Focus in all counties, including for Beneficiaries Eligible for Long-Term Care (LTC) and at Risk of Institutionalization, and Nursing Home Residents Transitioning to the Community.
	Incentive Payments	Program Year 2 begins on January 1, 2023.
	Benefits Standardization	LTC services provided by all MCPs statewide.
	Mandatory Managed Care Enrollment	All full dual individuals, except share of cost or restricted scope, and all dual and non-dual individuals receiving LTC services (including those with a share of cost) move into Medicaid managed care.[6]
	Regional Managed Care Capitation Rates and Shared Savings/Risk	Shared Savings/Risk: Earliest implementation of shared savings/risk via a Seniors and Persons with Disabilities (SPD)/LTC blended rate and retrospective financial savings/risk calculation.
	Transition to Statewide MLTSS and D-SNP (CCI ends)	Medi-Cal MCPs operating in Coordinated Care Initiative (CCI) counties required to operate Medicare Dual Eligible Special Needs Plans (D-SNPs). Cal MediConnect (CMC) demonstration program transitions to exclusively aligned enrollment D-SNPs.

[6] See APL 21-015 for more information on MMCE Phase II populations.

CalAIM Initiatives Launch Timeline as of July 2022

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Go-Live Date	Initiative[3]	Go-Live
	Behavioral Health Standard Screening and Transition Tools	Standardized screening and transition of care tools implemented.
	Providing Access and Transforming Health (PATH) Funds (ECM, Community Supports, Justice-Involved)	In Q1 2023, launch of Technical Assistance Marketplace initiative.
	Justice-Involved Package: Pre-Release Medi-Cal Application Process in County Jails	County jails and youth correctional facilities implement pre-release Medi-Cal application process to ensure that incarcerated individuals who are eligible for Medi-Cal and need ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. This process is already implemented in state prisons.
	Justice-Involved Package: Behavioral Health Referrals for County Facilities	County jails and youth correctional facilities implement process for facilitated referral and linkage from county jail release to health plans (MCPs, County mental health plans, DMC-ODS counties) and providers (non-specialty mental health, SHMS, and SUD), in cases where the incarcerated individual was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community. Initiative to launch no sooner than January 2023.

CalAIM Initiatives Launch Timeline as of July 2022

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Go-Live Date	Initiative[3]	Go-Live
	Justice-Involved Package: Medi-Cal Coverage in State Prisons, County Jails and Youth Correctional Facilities in the Facilities 90 Days Prior to Release	Select Medi-Cal-eligible individuals eligible for Medi-Cal coverage 90-days prior to their release from county jails, state prisons and youth correctional facilities, and eligible to receive limited Medi-Cal services during the 90-day pre-release period. Individuals will have a re-entry plan including referrals to ECM, Community Supports, clinical supports and behavioral health linkages. Initiative to launch no sooner than January 2023.
July 2023	**PHM Service**	Statewide launch of the PHM Service.
	Enhanced Care Management (ECM)	ECM services available for all children and youth Populations of Focus.
	Benefits Standardization	SMHS fully carved out to County mental health plans (MHPs) in Sacramento and Solano Counties. Intermediate Care Facility/Developmentally Disabled (ICF/DD) facilities and Subacute Care facilities transition to managed care.
	SMI/SED IMD Waiver	DHCS receives authority for federal matching funds for services provided to Medi-Cal beneficiaries in institutions for mental disease (IMDs) in county mental health plans that opt-in; additional federal funding will provide opportunities to improve service delivery and outcomes across the behavioral health continuum of care.
	Behavioral Health CPT Code Transition	Specialty mental health and SUD services transitioned from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, Current Procedural Terminology (CPT).

CalAIM Initiatives Launch Timeline as of July 2022

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Go-Live Date	Initiative[3]	Go-Live
	Behavioral Health Payment Reform	Counties transitioned from cost-based reimbursement funded via Certified Public Expenditure (CPE) methodologies to fee-for-service reimbursement funded via Intergovernmental Transfers (IGTs).
November 2023	**County Eligibility and Oversight**	DHCS begins monitoring counties' performance against eligibility performance standards.
January 2024	**Incentive Payments**	Program Year 3 begins on January 1, 2024 and ends on June 30, 2024.
	Regional Managed Care Capitation Rates and Shared Savings/Risk	Earliest transition from county-based rates to regional rates statewide ("Phase 2 counties"). Continued implementation of shared savings/risk via SPD/LTC blended rate and retrospective financial savings/risk calculation.
	County CCS Oversight	New monitoring and oversight approach implemented following the execution of DHCS/county Memorandum of Understanding to ensure consistent standards for quality and access to care for beneficiaries enrolled in the CCS program throughout the state of California.
January 2025	**Regional Managed Care Capitation Rates and Shared Savings/Risk**	Shared Savings/Risk: Continued implementation of regional rates statewide and shared savings/risk via SPD/LTC blended rate and retrospective financial savings/risk calculation.
January 2026	**Transition to Statewide MLTSS and D-SNP (CCI ends)**	All Medi-Cal MCPs required to operate Medicare Dual Eligible Special Needs Plans (D-SNPs), unless determined otherwise by 2022 D-SNP Feasibility Study. Exclusively aligned enrollment (EAE) required in all counties.
	NCQA Accreditation	All MCPs and their health plan subcontractors must have National Committee for Quality Assurance (NCQA) Health Plan Accreditation and NCQA Health Equity Accreditation.

CalAIM Initiatives Launch Timeline as of July 2022

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Go-Live Date	Initiative[3]	Go-Live
January 2027 or Beyond	**Regional Managed Care Capitation Rates and Shared Savings/Risk**	Shared Savings/Risk: Earliest implementation of shared savings/risk through a prospective rate methodology.
	Full Integration Plans	Full integration of physical health, behavioral health, and oral health in one MCP, meaning beneficiaries obtain services from one plan and DHCS consolidates all services under a single contract.
	Transition to Statewide MLTSS and D-SNP (CCI ends)	Managed long-term services and supports (MLTSS) implemented statewide in Medi-Cal managed care.
	Administrative Integration of SMH and SUD	Administration of specialty mental health and SUD services fully integrated into one behavioral health managed care program. This initiative is a multi-year effort that begins with the implementation of other CalAIM behavioral health policies, starting in 2022, including Criteria for SMHS, the DMC-ODS Policy Improvements and Behavioral Health Payment Reform initiatives.
TBD	**Foster Care Model of Care**	DHCS and California Department of Social Services develop a long-term plan of action for children and youth in foster care, which may involve budget recommendations, waiver amendments, state plan changes, or other activities.
	Behavioral Health Regional Contracting	New counties participate in DMC-ODS leveraging regional contracting approaches where possible. County MHPs leverage other forms of regional contracting (e.g., Joint Powers Authority, Administrative Services Organization/ Third-Party Administrative Services).
	DMC-ODS Traditional Healers and Natural Helpers	Traditional healers and natural helpers can deliver DMC-ODS services.

CalAIM Initiatives Launch Timeline as of July 2022

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Go-Live Date	Initiative[3]	Go-Live
	Improving Beneficiary Contact and Demographic Information	DHCS develops a recommended plan of action to improve the accuracy and flexibility of updating beneficiary contact and demographic information in eligibility and enrollment systems/databases.

CalAIM Initiatives Launch Timeline as of July 2022

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CalAIM Initiatives Descriptions

Population Health Initiatives
Population Health Management (including Service): Implement new PHM Program, which will be a cohesive approach for keeping all beneficiaries healthy, improving health outcomes, and reducing disparities in access and care. MCPs will be required to implement a whole-system person-centered PHM strategy that includes assessments of each beneficiary's health risks and health-related social needs, focuses on wellness and prevention, and provides processes for case management and care transitions across delivery systems and settings. The PHM Service will provide a data-driven service that supports whole-person care through integrating Medi-Cal beneficiary administrative, medical, behavioral, dental, social service and program information from disparate sources, performing population health functions, and allowing for multi-party data access and use.
Enhanced Care Management (ECM): Implement ECM benefit within Medi-Cal managed care, which will address both the clinical and non-clinical needs of the highest-need, highest-cost Medi-Cal beneficiaries through intensive coordination of health and health-related services, performed largely in person and in the community. Through ECM, beneficiaries will have a single care manager with responsibility for coordinating all clinical and non-clinical services, including Community Supports (described below).
Community Supports: Adopt Community Supports, new statewide services that MCPs may elect to offer to beneficiaries as medically appropriate, cost-effective alternatives to traditional medical services or settings. Community Supports are services addressing social drivers of health, which build on and scale existing work in the Whole Person Care Pilots and Health Home Program. California is rolling out 14 Community Supports, including housing-related services, services that support transition from institutional settings to the community, medically tailored meals/food, and recuperative care.
Incentive Payments: Develop a pathway for MCPs to invest in necessary delivery system infrastructure, build appropriate and sustainable ECM and Community Supports capacity, and achieve improvements in cross-delivery system quality performance.
NCQA Accreditation: Require all MCPs and their health plan subcontractors to have NCQA Health Plan Accreditation and NCQA Health Equity Accreditation by 2026. As part of the preparation for this requirement, DHCS must consider elements for deeming in relation to annual Audits and Investigations Division compliance audits and align all applicable processes with NCQA. Components of NCQA accreditation, such as for PHM, are required in advance of 2023.

CalAIM Initiatives Launch Timeline as of July 2022

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Managed Care Initiatives
Benefits Standardization: Standardize the benefits that are provided through Medi-Cal MCPs statewide, so that regardless of a beneficiary's county of residence or 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.
Mandatory Managed Care Enrollment: Enhance coordination of care, increase standardization, and reduce complexity across the Medi-Cal program by standardizing which groups will require mandatory managed care enrollment versus mandatory fee-for-service enrollment, across all models of care and aid code groups, statewide. This will happen in two phases. For Phase I, the following beneficiaries who only have Medi-Cal (non-dual) and a subset of beneficiaries who have both Medi-Cal and Medicare (dual) transitioned from FFS to managed care: Trafficking and Crime Victims Assistance Program (dual and non-dual), individuals granted accelerated enrollment (dual and non-dual), Breast and Cervical Cancer Treatment Program (non-dual), beneficiaries with other health care coverage (non-dual), and beneficiaries living in rural zip codes (non-dual). Also, as part of Phase I of mandatory managed care enrollment, the following populations will transition from a managed care plan to the FFS delivery system: beneficiaries covered under the Omnibus Budget Reconciliation Act in Napa, Solano, and Yolo counties, and share of cost (SOC) (dual and non-dual) beneficiaries in County Organized Health Systems and Coordinated Care Initiative counties. Phase 2 moves all dual aid code groups, except SOC and OBRA, from FFS to Mandatory Managed Care and includes the following populations: individuals in Long Term Care (LTC), including LTC SOC, dual and non-dual, Non-Disabled Adults (with no SOC), Aged, Breast and Cervical Cancer Treatment Program (BCCTP), Disabled, beneficiaries with Other Health Care (OHC) coverage, beneficiaries living in rural zip codes and all beneficiaries in Home and Community Based Services Waivers, including Cal MediConnect. *While implementing the Mandatory Managed Care Phase I transition, DHCS identified additional individuals subject to transition to mandatory managed care that were initially assumed to already be subject to mandatory managed care. DHCS continues work to carefully identify which additional individuals will need to transition.
Regional Capitation Rates and Shared Savings/Risk: Transition from county-based rates to regional rates in targeted groups of counties (Phase 1; 1/1/2022) and then regional rates statewide (Phase 2; no sooner than 1/1/2024). Implementation of retrospective (no sooner than 1/1/2023), and ultimately prospective (no sooner than 1/1/2027), sharing of savings and risk to create mutual incentives for commitment to and investments in ECM, Community Supports, and MLTSS.
Full Integration Plans: Test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity through a Pilot program to address the current fragmented delivery system. DHCS will be engaging with stakeholders to assess the various components necessary for fully integrating health care services.

CalAIM Initiatives Launch Timeline as of July 2022

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Behavioral Health Initiatives
SMI/SED IMD Waiver: Develop and submit to CMS a Section1115 demonstration waiver to receive federal matching funds for short-term residential treatment services provided to Medicaid beneficiaries with an SMI or Serious Emotional Disturbance (SED) in an IMD, as part of a broader continuum of care.
Behavioral Health CPT Code Transition: Transition specialty mental health and SUD services from existing HCPCS Level II coding to Level I CPT coding.
Behavioral Health Payment Reform: Transition counties from cost-based reimbursement funded via CPEs to fee-for-service reimbursement funded via IGTs.
CalAIM Behavioral Health Policies: Update and clarify policies for SMHS, develop standardized screening and transition tools, and implement a "no wrong door" policy to ensure beneficiaries receive treatment regardless of the delivery system in which they seek care. In addition, streamline documentation requirements for SMHS and SUD services.
Administrative Integration of SMH and SUD: Improve outcomes for beneficiaries and reduce administrative and fiscal burdens for counties, providers, and DHCS by integrating the administration of specialty mental health and SUD services into one behavioral health managed care program.
Behavioral Health Regional Contracting: Encourage counties that don't currently participate in DMC-ODS to participate through regional approaches. Encourage County MHPs to leverage other forms of regional contracting (e.g., Joint Powers Authority, ASO/TPA).
Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements: Clarify or change DMC-ODS policies to improve beneficiary experience, increase administrative efficiency, and ensure cost-effectiveness and achieve positive beneficiary health outcomes, and encourage new counties to opt into DMC-ODS.
Contingency Management: Design and implement pilot program for DMC-ODS counties that provides incentives to beneficiaries with stimulant use disorder and supports their path to recovery.

CalAIM Initiatives Launch Timeline as of July 2022

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County Oversight Initiatives
County Eligibility and Oversight: Implement a phased approach to working with counties to increase program integrity with respect to eligibility and enrollment. To accomplish this, DHCS is reinstating county performance standards and developing updated processes for monitoring, reporting, and corrective action measures.
Enhancing County Oversight and Monitoring – CCS: Provide enhanced monitoring and oversight of all 58 counties to ensure continuous, and unwavering optimal care for children and youth. To implement the enhanced monitoring and oversight of the California Children's Services (CCS) program in all counties, DHCS will develop a robust strategic compliance program to ensure consistency is applied across the counties.
Improving Beneficiary Contact & Demographic Data: Accurate contact and demographic information is critical for ongoing Medi-Cal eligibility, enrollment, and care management. To ensure that relevant entities (including MCPs and providers) can more easily share and obtain up-to-date beneficiary information, DHCS intends to reconvene the workgroup of interested stakeholders to develop a set of recommendations for ensuring that updated contact and demographic information can be used across all eligibility and enrollment systems and databases, while maintaining compliance with all applicable state and federal privacy laws, and without creating unintended consequences for other social services programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

LTC/MLTSS/Duals Initiatives
Transition to Statewide MLTSS and D-SNP (CCI ends): Transition the CCI, inclusive of Cal Medi-Connect (CMC), which is currently only available in seven counties, to a statewide MLTSS and exclusively aligned enrollment Medicare D-SNP structure. This will provide better coordination of care, improve care integration and person-centered care. Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary. CMC beneficiaries will be automatically transitioned to the aligned Medicare D-SNP and Medi-Cal plan affiliated with their CMC plan.

CalAIM Initiatives Launch Timeline as of July 2022

This is a dynamic document that reflects the CalAIM team's expected timing of launches. In some instances, program launch dates are contingent upon timely CMS approval. Because these dates may shift, the document will be updated regularly to reflect any changes.

Other Initiatives
Dental (new benefits and P4P): Implement a caries risk assessment bundle for young children, Silver Diamine Fluoride for children and specified high-risk and/or institutional populations and pay-for-performance initiatives to reward preventive services and continuity of care.
Foster Care Model of Care: Explore new ways to improve the model of care for foster youth, specifically to address the complex medical, behavioral, oral and developmental needs of children and youth involved in the child welfare system (children and youth, former foster care youth, and youth transitioning out). DHCS has launched a Foster Care Workgroup to inform long-term recommendations for these Medi-Cal beneficiaries.
Justice-Involved Package: • All counties and youth correctional facilities implement a pre-release Medi-Cal application process to ensure that incarcerated individuals who are eligible for Medi-Cal and need ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. • Pending CMS approval, DHCS would provide Medi-Cal coverage—with limited Medi-Cal services—to select individuals in the 90-days prior to their release from county jails, state prisons and youth correctional facilities. • The justice-involved behavioral health linkages proposal would require all county jails and youth correctional 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 incarcerated individuals was receiving behavioral health services while in a county facility, to allow for continuation of behavioral health treatment in the community. • ECM services for eligible justice-involved populations of focus for coordinated re-entry. • Community Supports (e.g., housing support) for justice-involved populations upon re-entry. • Access to recovery services for individuals, including for justice-involved populations. • Enhancements for facilitating data sharing, including for justice-involved populations.
Providing Access and Transforming Health (PATH) Funds (ECM, Community Supports, Justice-Involved): Support for city, county, and other government agencies, county and community-based providers – including but not limited to public hospitals, CBOs, and Medi-Cal Tribal and the Designees of Indian Health Programs – to support capacity building, including payments for infrastructure, interventions, and services to complement and ensure access to the array of services and benefits that are part of successful implementation of ECM and Community Supports under CalAIM, as well as intersecting CalAIM initiatives designed to ensure continuity of health care coverage and care for individuals leaving prisons and county jails and re-entering the community.

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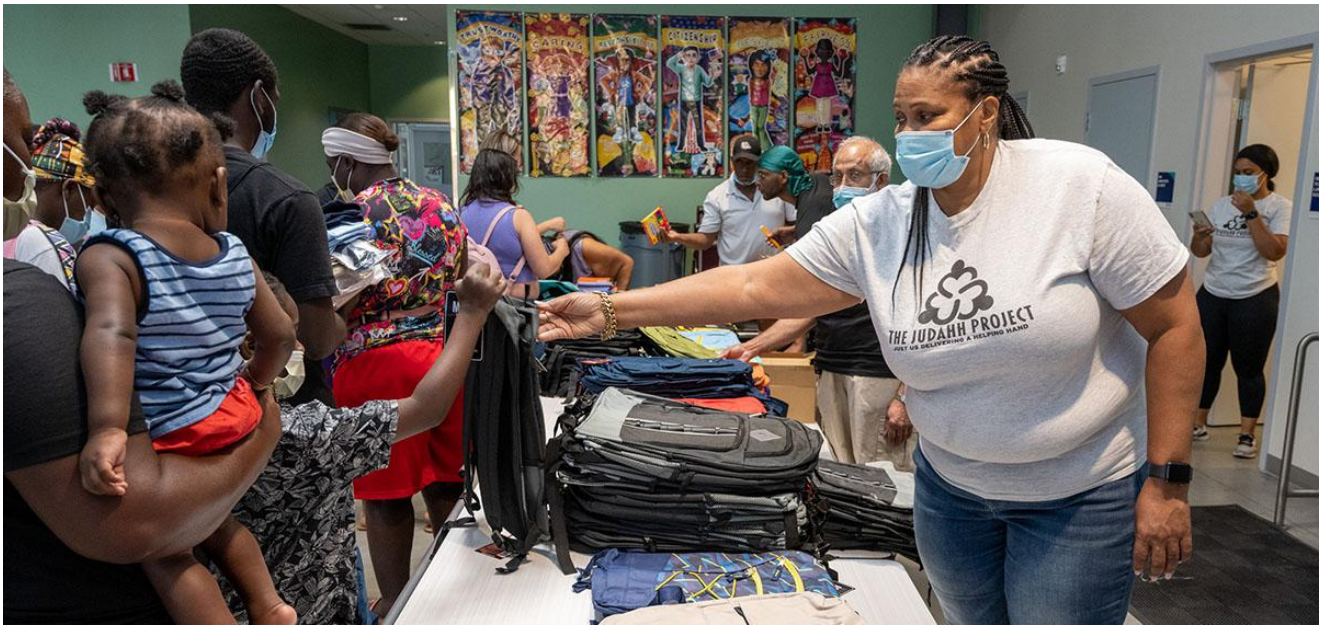
CHCF Blog

Reflections on CalAIM's First Year

January 9, 2023

By Melora Simon



Valerie Andrews, head of the community-based organization The JUDAHH Project (Just Us Delivering a Helping Hand), distributes backpacks at a back-to-school event in South Sacramento. The project makes home visits to address asthma triggers such as mold or dust mites as part of CalAIM's Community Supports program. Photo: José Luis Villegas

As we kick off 2023, it is hard to believe only a year has passed since the federal government approved California's ambitious plan to transform the Medi-Cal program. The initiative, CalAIM (California Advancing and Innovating Medi-Cal), is a multi-year effort to advance person-centered, holistic care for people with complex needs, while also pursuing population health goals to make care more equitable for everyone in Medi-Cal.

CalAIM is so important and far-reaching that it obliges all of us to work together in new ways to realize its promise. So, let's review how much CalAIM has already undertaken and peer over the horizon at what is still to come.

First, the accomplishments. Countless people across California's Department of Health Care Services (DHCS), health systems, provider groups, health plans, community-based organizations, and county health departments came together to ensure a smooth transition for tens of thousands of Medi-Cal enrollees who were supported by CalAIM's precursor programs, known as Whole Person Care and Health Homes. This alone was a huge lift.

In addition, California achieved the following:

- Launched a new benefit — Enhanced Care Management (PDF) — for key populations of focus statewide
- Commenced the novel approach of managed care plans offering up to 14 non-traditional services, such as connecting people to housing or asthma remediation, through Community Supports (PDF)
- Instituted a No Wrong Door (PDF) policy, allowing Medi-Cal patients to receive mental health services regardless of where they initially seek care, and allowing providers to be reimbursed for that care
- Laid the groundwork for contingency management pilot programs in 24 counties, which are set to start in early 2023 under the name "Recovery Incentives." Contingency management is an effective treatment for methamphetamine.

And that is just a partial list.

The main strategy that CalAIM employs to move a fragmented care system to a person-centered system, and to do so with sustainable funding, is managed care. Managed care is not perfect, and it brings with it an additional layer of administrative requirements. But given all the trade-offs, it is probably the best tool we have to ensure that the whole-person care Californians need can be delivered equitably.

It is important to remember that CalAIM has inherently required everyone involved to build the bridge while crossing it. It involves countless new partnerships, myriad new data sharing needs, uncertain referral volume, and cash-flow constraints introduced by retrospective payments — all at the same time. To get this far has been an enormous lift across the entire Medi-Cal system. And all this change has taken place on the heels of a once-in-a century pandemic.

Yet we need to keep our eyes on the mountaintop in the distance. CalAIM offers an unprecedented opportunity to make Medi-Cal and other safety-net programs work better for the Californians who depend on them. It's a chance to make care more equitable and easier to access. Beyond that, it enables transformation of health care delivery to meet the needs of the whole person wherever people go for care. For example, a person who has a stroke needs their immediate health crisis addressed but may also need paid assistance at home to

fully recover. So much of Californians' ultimate well-being hinges on factors outside the health system, and many programs in CalAIM are designed to help address these social needs, particularly for people with complex physical and behavioral health conditions.

And for the millions of people with health needs that are less complex, CalAIM raises the bar on quality, access, satisfaction, and equity (PDF). DHCS is making variation in quality metrics more transparent (PDF) and imposing fines on managed care plans falling short on key measures.

What to Expect in 2023

CalAIM brings a raft of new possibilities and challenges in 2023. Across the state, people will be working on instituting:

- Population Health Management initiatives that will enhance proactive and equitable care for all Medi-Cal members, not just those with complex needs, and add new populations of focus for Enhanced Care Management
- A more seamless system for seniors and people with disabilities that features managed care plans taking responsibility for institutional long-term care
- Standardized screening tools for every behavioral health entry point to minimize provider confusion
- Behavioral health payment reform (PDF) so that billing for these services mirrors the system for physical health billing

Again, this is just a partial list. There's also news to come on additional waiver requests: the California Behavioral Health Community-Based Continuum Demonstration waiver and "pre-release services" for people leaving jails and prisons.

What do all these programmatic changes have in common? They support a deepening of engagement with people who for too long have not been well-served — or not understood by — the system. The goals of these changes are to improve health equity for all Californians. The changes support a more rational and consistent delivery of Medi-Cal services to enrollees in every corner of the state. And they support more reliable funding streams for service providers.

From the patient or consumer perspective, CalAIM should streamline the system to make it easier for people to get the care they need. Initially, it may not feel like an improvement to providers, health plans, county health departments, and other players in the health care system. Indeed, the operational complexities of moving from one established system to a new way of doing business should not be underestimated. And it takes time to cultivate cross-sector collaboration, trust, and relationships.

Building the Infrastructure for People-Centered Care

It would be nearly impossible to implement CalAIM successfully without making other improvements to the system. That's why CalAIM makes key investments around data exchange, health workforce, and the infrastructure to sustain new partnerships. Exchanging data among health care systems and social services agencies is really the only efficient way for different providers to obtain a unified view of the patient as a whole person with complex and interconnected health needs. The state has set a 2024 deadline for most health care providers to be able to share health care information. This year's state budget includes $250 million to support data exchange adoption.

Much of CalAIM relies on managed care organizations, but their key on-the-ground partners — community-based organizations, hospitals, clinics, county agencies, tribes, and other providers — need to hire and train staff and build infrastructure if they are to participate successfully. Of course, that all takes money. DHCS has allocated $1.85 billion in a new program called Providing Access and Transforming Health for these organizations to build up their community-based workforce and systems to be effective partners with managed care organizations in reaching people who too often have been left behind. DHCS announced in late December that it will contract with five commercial health plans in California. This move finalizes which health plans will operate in each county starting in January 2024 so that plans and providers can continue working together to implement CalAIM programs.

CHCF is proud to partner with everyone across the state working to make the CalAIM vision a success. Momentous changes like this take time. It's worth remembering other challenges that California has met. Ten years ago, 22% of Californians were uninsured. Today it is less than 6%, thanks to California's enthusiastic embrace of the Affordable Care Act and additional Medi-Cal coverage expansions. In 10 years' time, we hope to see a statewide health system that responds to all in a person-centered and equitable way. If any place can do this, it is California.

Melora Simon

Melora Simon, MPH, is associate director of complex care at the California Health Care Foundation, where she works in partnership with the senior vice president of strategy and programs and is responsible for being an active participant and thought leader across program areas at the foundation. Previously, she was a senior strategist at CHCF. In this

role, Melora partnered with program teams on the development and delivery of new strategies and opportunities for impact, and managed a portfolio of projects and grants. Read More

More by this Author:

Whole Person Care Pilots Set the Stage for CalAIM
José Luis Villegas

José Luis Villegas is a freelance photojournalist based in Sacramento, California, where he does editorial and commercial work. He has coauthored three books on Latino baseball. His work appears in the Ken Burns documentary *The 10th Inning* and in the upcoming *¡Pleibol!* exhibition at the Smithsonian's National Museum of American History. His work has been exhibited at the Museum of Fine Arts-Houston; the Baseball Hall of Fame in Cooperstown, New York; and at the Oakland Museum of California. Villegas works as a medical photographer at Shriners Hospital in Sacramento.

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2023 Alliance Operating Plan

V1.1 | November 8, 2022 - *Clean*

VISION Healthy People. Healthy Communities.

MISSION Accessible, quality health care guided by local innovation

VALUES Collaboration, Equity, Improvement, Integrity

Ongoing **OBJECTIVE** — Achieve regulatory, contractual and core program requirements

Ongoing **OBJECTIVE** — Adapt health plan operations in an evolving environment

Strategic Priority 1	Strategic Goal 1
Health Equity	Eliminate health disparities and achieve optimal health outcomes for children and youth

Achieve NCQA P50 for all pediatric measures for all counties or 10% of the delta to P50 — Breakthrough **OBJECTIVE 1**

Strategic Priority 1	Strategic Goal 2
Health Equity	Increase member access to culturally and linguistically appropriate health care

Obtain incremental improvement over baseline for the CAHPS cultural competency questions — Breakthrough **OBJECTIVE 2**

Strategic Priority 2	Strategic Goal 3
Person-Centered Delivery System Transformation	Improve behavioral health services and systems to be person-centered and equitable

Assess and design behavioral health system to ensure timely access to BH services — Breakthrough **OBJECTIVE 3**

Strategic Priority 2	Strategic Goal 4
Person-Centered Delivery System Transformation	Improve the system of care for members with complex medical and social needs

Ensure the top 3-5% of the high utilizers are effectively managed — Breakthrough **OBJECTIVE 4**

Primary Priority Projects

Responsive to Objectives and Grouped By Organizational Process

Engage and Support Members (8)

- Optimize Transportation Benefit Administration
- Alliance Service Area Expansion
- Community Health Workers Benefit
- Parity in MH and SUD Benefits for IHSS
- Medi-Cal for All Eligibility Expansion
- Member Texting Program Feasibility
- Claims Payment Outsourcing – Member Reimbursements
- NEMT Optimization

Optimize the Alliance Workforce (1)

- Workplace DEIB Initiative

Manage and Improve Care (7)

- ECM/CS Program Implementation
- Dyadic Care Benefit
- CalAIM Population Health Management Plan
- CalAIM Population Health Management Program
- Doula Benefit
- Person-centered System Transformation
- Manage Member Benefit Process Maturity

Manage Alliance Finances (2)

- Risk-adjusted Provider Payment Methodology
- Value-based Incentive Program

Manage Technology (2)

- Retire AIS (Tech and Process)
- Care Management System Implementation

Manage Data (1)

- CMS Interoperability Rule Requirements

Manage Compliance Commitments (2)

- Revised DHCS Medi-Cal Managed Care Contract
- NCQA Accreditation Gap Analysis and Remediation

Scheduled to close Q1 of 2023

Secondary Priority Projects

Responsive to Objectives and Grouped By Organizational Process

Engage and Support Members (2)

- CMS 9915 Transparency in Coverage
- Children's Savings Accounts Pilot

Pay Providers (1)

- DHCS Alternative Payment Model to FQHCs

Manage and Improve Care (5)

- Behavioral Health System Assessment
- Student Behavioral Health Incentive Program
- Street Medicine Pilot
- Housing and Homelessness Incentive Program
- D-SNP Readiness Assessment

Manage Alliance Finances (2)

- Payment Integrity Implementation
- Regional rate Impact and Analysis

Enhance Operational Effectiveness (2)

- Confidential
- Project Management and Resource Planning Tool

Project Pipeline

Responsive to Objectives and Grouped By Organizational Process

- Healthcare Ecosystem Transformation
- Member Portal Implementation
- Workforce Management Tool

Legend: Status Change; Not Started; Defer/ Hold; Aligns to Breakthrough Objective 1; Aligns to Breakthrough Objective 2; Aligns to Breakthrough Objective 3; Aligns to Breakthrough Objective 4; Organizational tactic to improve or develop an operational capability; Organizational tactic required to achieve a regulatory, contractual or Board requirement; Organizational tactic required to execute or maintain an operational capability

Back to Agenda