WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 7. Basic Health Care [14000 - 14199.87] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 5.51. California Advancing and Innovating Medi-Cal Act [14184.100 - 14184.800] *(Article 5.51 added by Stats. 2021, Ch. 143, Sec. 402.)*

14184.100. (a) This article shall be known, and may be cited, as the California Advancing and Innovating Medi-Cal (CalAIM) Act.

(b) The implementation of CalAIM, as set forth in this article and the CalAIM Terms and Conditions, shall support all of the following goals:

(1) Identify and manage the risk and needs of Medi-Cal beneficiaries through whole-person-care approaches and addressing social determinants of health.

(2) Transition and transform the Medi-Cal program to a more consistent and seamless system by reducing complexity and increasing flexibility.

(3) Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

(Added by Stats. 2021, Ch. 143, Sec. 402. (AB 133) Effective July 27, 2021.)

14184.101. For purposes of this article, and elsewhere in law where specified, the following definitions shall apply:

(a) “CalAIM” or “CalAIM initiative” means the respective components of the California Advancing and Innovating Medi-Cal initiative authorized by this article and approved by the federal Centers for Medicare and Medicaid Services in the CalAIM Terms and Conditions.

(b) “CalAIM term” means the entire period during which an applicable component of the CalAIM initiative is in effect, as approved by the federal Centers for Medicare and Medicaid Services, including any applicable extension period.

(c) “CalAIM Terms and Conditions” means those terms and conditions issued and approved by the federal Centers for Medicare and Medicaid Services, including any attachments, appendices, or similar documents, and subsequent amendments thereto, that govern implementation of the respective components of the CalAIM initiative pursuant to this article. CalAIM Terms and Conditions shall include, at a minimum, any terms and conditions specified in the following:

(1) California Advancing and Innovating Medi-Cal Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 1315 of Title 42 of the United States Code, effective for the period from January 1, 2022, to December 31, 2026, inclusive, and any applicable extension period, or for any period otherwise approved therein.

(2) Any associated Medicaid Waivers as approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 1396n of Title 42 of the United States Code that are necessary to implement a CalAIM component, effective for the period from January 1, 2022, to December 31, 2026, inclusive, and any applicable extension period, or for any period otherwise specified in the CalAIM Terms and Conditions.

(3) Any associated Medi-Cal State Plan amendments approved by the federal Centers for Medicare and Medicaid Services that are necessary to implement a CalAIM component.

(4) Any provision of a comprehensive risk contract, nonrisk contract, or other similar managed care arrangement, including an intergovernmental agreement, approved by the federal Centers for Medicare and Medicaid Services to implement the authorities described in paragraph (1), (2), or (3).

(d) “CalAIM year” or “Initiative Year” means the applicable effective period identified in the CalAIM Terms and Conditions that corresponds to a specific period of time as set forth in paragraphs (1) to (5), inclusive. Individual programs or components under the CalAIM Initiative may be operated on program years that differ from the CalAIM years identified in paragraphs (1) to (5), inclusive, or may be operated without regard to program years, as applicable.

(1) Initiative year 1 corresponds to the period of January 1, 2022, to December 31, 2022, inclusive.

(2) Initiative year 2 corresponds to the period of January 1, 2023, to December 31, 2023, inclusive.

(3) Initiative year 3 corresponds to the period of January 1, 2024, to December 31, 2024, inclusive.

(4) Initiative year 4 corresponds to the period of January 1, 2025, to December 31, 2025, inclusive.

(5) Initiative year 5 corresponds to the period of January 1, 2026, to December 31, 2026, inclusive.

(e) “Comprehensive risk contract” has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(f) “Designated public hospital” means any one of the hospitals identified in subdivision (f) of Section 14184.10, and any successor, including any restructured, reorganized, or differently named hospital, that is operated by a county, a city and county, the University of California, or a special hospital authority described in Chapter 5 (commencing with Section 101850) or Chapter 5.5 (commencing with Section 101852) of Part 4 of Division 101 of the Health and Safety Code, or any additional public hospital to the extent identified as a “designated public hospital” in the CalAIM Terms and Conditions.

(g) “Federal disproportionate share hospital allotment” means the amount specified for California under Section 1396r-4(f) of Title 42 of the United States Code for a federal fiscal year.

(h) “Federal medical assistance percentage” means the federal medical assistance percentage applicable for federal financial participation purposes for medical assistance under the Medi-Cal State Plan pursuant to Section 1396b(a)(1) of Title 42 of the United States Code.

(i) “Medi-Cal behavioral health delivery system” means an entity or local agency that contracts with the department to provide covered behavioral health Medi-Cal benefits pursuant to Article 3.2 (commencing with Section 14124.20), or Section 14184.400 and Chapter 8.9 (commencing with Section 14700), or a county Drug Medi-Cal Organized Delivery System pilot authorized under the CalAIM Terms and Conditions and described in Section 14184.401 or authorized under the Medi-Cal 2020 Demonstration Project Act pursuant to Article 5.5 (commencing with Section 14184).

(j) “Medi-Cal managed care plan” means any individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to any provision of this chapter or Chapter 8 (commencing with Section 14200).

(k) “Nonrisk contract” has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(l) “Nonfederal share percentage” means the difference between 100 percent and the applicable federal medical assistance percentage.

(m) “Total computable disproportionate share hospital allotment” means the federal disproportionate share hospital allotment for a federal fiscal year, divided by the applicable federal medical assistance percentage with respect to that same federal fiscal year.

(Added by Stats. 2021, Ch. 143, Sec. 402. (AB 133) Effective July 27, 2021.)

14184.102. (a) Consistent with federal law, the department shall seek federal approval for, and implement, the CalAIM initiative, including, but not limited to, all of the following components:

(1) Continuation of the Medi-Cal Managed Care program, described in part in Sections 14184.200 to 14184.208, inclusive, and, elsewhere in this chapter and Chapter 8 (commencing with Section 14200), and which includes any comprehensive risk contract between the department and an individual, organization, or entity to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to any provision of this chapter or Chapter 8 (commencing with Section 14200).

(2) Continuation of the Global Payment Program, described in Section 14184.40, as amended by the act that added this section, and Section 14184.300.

(3) Continuation of the Medi-Cal Specialty Mental Health Services Program, as described in part in Section 14184.400.

(4) Continuation of the Drug Medi-Cal organized delivery system program, as described in part in Section 14184.401.

(5) Behavioral Health Medical Necessity Changes, Payment Reform, Administrative Simplification, and Behavioral Health Quality Improvement Program, as described in Sections 14184.402, 14184.403, 14184.404, and 14184.405.

(6) The State Plan Dental Improvement Program, as described in Section 14184.500.

(7) Enhancing County Oversight and Monitoring, as described in Section 14184.600.

(8) Providing Access and Transforming Health (PATH) Supports, as described in Section 14184.700.

(9) Targeted Pre-Release Medi-Cal Benefits for Qualified Inmates, as described in Section 14184.800.

(b) The department shall report to the Legislature any conflicts between this article and the CalAIM Terms and Conditions, including identification of the specific conflicts and recommendations for conforming language.

(c) The department, as appropriate and to the extent practicable, shall consult with interested stakeholders with regard to implementation of applicable components of CalAIM under subdivision (a) in which they will participate, including, but not limited to, the issuance of departmental guidance pursuant to subdivision (d). Interested stakeholders may include, but need not be limited to, designated public hospitals, district and municipal public hospitals, other local governmental agencies, consumer representatives, and Medi-Cal managed care plans.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article or the CalAIM Terms and Conditions, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar instructions, without taking any further regulatory action. The department shall make use of appropriate processes to ensure that affected stakeholders are timely informed of, and have access to, applicable guidance issued pursuant to this authority, and that this guidance remains publicly available until all payments related to the applicable CalAIM component are finalized.

(e) For purposes of implementing this article or the CalAIM Terms and Conditions, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis, and may implement changes to existing information technology systems. Notwithstanding any other law, contracts entered into or amended, or changes to existing information technology systems, pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(f) The department shall seek any federal approvals it deems necessary to implement CalAIM under this article and other provisions of law amended by the act that added this subdivision. This shall include, but need not be limited to, approval of any amendment, addition, or technical correction to the CalAIM Terms and Conditions, as the department deems necessary. This article shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(g) Consistent with subdivision (b), the director shall report to the Legislature on any recommended amendments to any provision, process, or methodology specified in this article, Article 5.4 (commencing with Section 14180), Article 5.5 (commencing with Section 14184), or other sections of law amended by the act that added this subdivision, to the extent necessary to comply with federal law or the CalAIM Terms and Conditions, to obtain or maintain federal approval, or to ensure federal financial participation is available and not otherwise jeopardized, if the amendment is consistent with the goals set forth in this article and its individual components, and does not significantly alter the relative level of support for participating entities. If the director, after consulting with those entities participating in the applicable CalAIM component and that would be affected by that amendment, determines that the potential amendment would be consistent with the goals set forth in this article and would not significantly alter the relative level of support for affected participating entities, the amendment shall be submitted to the Legislature for its consideration.

(h) During the course of the CalAIM term, the department may develop and implement successor payment methodologies or programs to continue to support entities participating in one or more components of CalAIM following the expiration of the CalAIM term and that further the goals set forth in this article. The department shall consult with the entities participating in the payment methodologies or program components under CalAIM, affected stakeholders, and the Legislature in the development of any successor payment methodologies or program components pursuant to this subdivision.

(i) The department may seek to extend the payment methodologies or programs described in this article, or in the CalAIM Terms and Conditions, including modification thereto, through the CalAIM term or to subsequent time periods by way of amendment or extension of the relevant CalAIM Terms and Conditions, amendment to the Medi-Cal State Plan, or any combination thereof, consistent with the applicable federal requirements. This subdivision shall only be implemented after consultation with the entities participating in, or affected by, those methodologies or programs, and only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(j) Notwithstanding any other state or local law, including, but not limited to, Section 5328 of this code, and Sections 11812 and 11845.5 of the Health and Safety Code, the sharing of health, social services, housing, and criminal justice information, records, and

other data with and among the department, other state departments, including the State Department of Public Health and the State Department of Social Services, Medi-Cal managed care plans, Medi-Cal behavioral health delivery systems, counties, health care providers, social services organizations, care coordination and case management teams, and other authorized provider or plan entities, and contractors of all of those entities, shall be permitted to the extent necessary to implement applicable CalAIM components described in this article and the CalAIM Terms and Conditions, and to the extent consistent with federal law. The department shall issue guidance identifying permissible data-sharing arrangements to implement CalAIM.

(k) (1) Notwithstanding any other law, and to the extent authorized by the CalAIM Terms and Conditions, the department may claim federal financial participation for expenditures associated with the designated state health programs identified in the CalAIM Terms and Conditions for use solely by the department as specified in this subdivision.

(2) Any federal financial participation claimed pursuant to paragraph (1) shall be used to offset applicable General Fund expenditures. These amounts are hereby appropriated to the department and shall be available for transfer to the General Fund for this purpose.

(3) An amount of General Fund moneys equal to the federal financial participation that may be claimed pursuant to paragraph (1) is hereby appropriated to the Health Care Deposit Fund for use by the department for purposes of implementing this article.

(4) (A) Notwithstanding any other law, the department shall maintain reimbursement rates in the Medi-Cal program for primary care, obstetric care, and behavioral health services, and shall increase reimbursement rates for those service codes, as necessary to meet federally imposed minimum requirements specified in the CalAIM Terms and Conditions for dates of service on or after January 1, 2024, to the extent required by the federal Centers for Medicare and Medicaid Services as a condition of claiming federal financial participation for designated state health programs as described in this subdivision.

(B) To the extent required by the CalAIM Terms and Conditions, subparagraph (A) shall apply to claims for the identified codes paid by the department in fee-for-service and to claims paid by a Medi-Cal managed care plan.

(Amended by Stats. 2023, Ch. 42, Sec. 156. (AB 118) Effective July 10, 2023.)

14184.200. (a) Notwithstanding any other law, the department may standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with the CalAIM Terms and Conditions and as described in this section.

(1) (A) The department shall ensure the Medi-Cal managed care plan's readiness for network adequacy includes a geographic access review of rural ZIP Codes to ensure time or distance standards are met, or alternative access standard requests are approved, as applicable, and the plan's ability to meet existing federal and state mandatory provider type requirements, where available.

(B) The department shall not require a population to enroll in managed care if Medi-Cal managed care plans fail to meet the Medi-Cal managed care plan readiness requirements detailed in this paragraph for that population.

(2) The Medi-Cal managed care plan shall comply with the continuity of care requirements in Section 1373.96 of the Health and Safety Code and shall be consistent with and no more restrictive than existing or future policy and guidance issued by the department, including All Plan Letter 22-032, any superseding all plan letter, and related guidance.

(3) The disenrollment process for an enrollee in any county shall be consistent with and no more restrictive than existing federal and state statutes and regulations, including Section 53889 and subdivision (c) of Section 53891 of Title 22 of the California Code of Regulations. The beneficiary may request a medical exemption from mandatory enrollment in a Medi-Cal managed care plan in accordance with Section 53887 of Title 22 of the California Code of Regulations and may disenroll or be exempted from mandatory enrollment under the limited circumstances set forth in subdivision (c) of Section 53891 of Title 22 of the California Code of Regulations. That disenrollment or exemption from mandatory enrollment in a Medi-Cal managed care plan shall be consistent with subsection (c) of Section 438.56 of Title 42 of the Code of Federal Regulations and applicable state law.

(b) (1) Notwithstanding any other law, if the department standardizes those populations subject to mandatory enrollment in a Medi-Cal managed care plan pursuant to subdivision (a), commencing January 1, 2022, and subject to subdivision (f) of Section 14184.102, a non-dual-eligible beneficiary, except a beneficiary identified in paragraph (2), shall be required to enroll, or shall continue to be required to enroll, in a Medi-Cal managed care plan for purposes of their receipt of covered Medi-Cal benefits.

(2) Notwithstanding any other law, if the department standardizes those populations subject to mandatory enrollment in a Medi-Cal managed care plan pursuant to subdivision (a), commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, the following dual and non-dual beneficiary groups, as identified by the department, shall be exempt from mandatory enrollment in a Medi-Cal managed care plan:

(A) A beneficiary eligible for only restricted-scope Medi-Cal benefits, as described in subdivision (d) of Section 14007.5 and Sections 14005.65 and 14007.7.

(B) A beneficiary made eligible on the basis of a share of cost, including, but not limited to, a non-dual-eligible beneficiary residing in a county that is authorized to operate a county organized health system (COHS), as described in Article 2.8 (commencing with Section 14087.5), except for a non-dual-eligible beneficiary that is eligible on the basis of their need for long-term care services with a share of cost, as identified by the department.

(C) A beneficiary made eligible on the basis of a federally approved Medi-Cal Presumptive Eligibility program, as determined by the department, but only during the relevant period of presumptive eligibility.

(D) An eligible beneficiary who is an inmate of a public institution, or who is released pursuant to Section 26605.6 or 26605.7 of the Government Code.

(E) A beneficiary with satisfactory immigration status, including a noncitizen that is lawfully present, who is eligible for only pregnancy-related Medi-Cal coverage and who received services through the Medi-Cal fee-for-service delivery system prior to January 1, 2022, as identified by the department, but only through the end of the postpartum period.

(F) A beneficiary without satisfactory immigration status or who is unable to establish satisfactory immigration status as required by Section 14011.2, who is eligible for only pregnancy-related Medi-Cal coverage, excluding a beneficiary enrolled in the Medi-Cal Access Program described in Chapter 2 (commencing Section 15810) of Part 3.3.

(G) A non-dual-eligible beneficiary who is an Indian, as defined in subdivision (a) of Section 438.14 of Title 42 of the Code of Federal Regulations, and who elects to forego voluntary enrollment in a Medi-Cal managed care plan.

(H) A non-dual-eligible beneficiary eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who elects to forego voluntary enrollment in a Medi-Cal managed care plan, except for a non-dual beneficiary described in this subparagraph who resides in a county that is authorized to operate COHS, as described in Article 2.8 (commencing with Section 14087.5), or, effective January 1, 2025, in a county operating a Single Plan model of managed care established under Article 2.7 (commencing with Section 14087.3) and Article 2.8 (commencing with Section 14087.5). For the purpose of this subdivision, the following requirements shall apply to non-dual-eligible beneficiaries eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who are transitioning to mandatory enrollment in a Medi-Cal managed care plan in a county operating a Single Plan model of managed care:

(i) Medi-Cal managed care plans shall comply with the access requirements in Section 14197 and in accordance with All Plan Letter 23-001, any superseding all plan letter, and any related guidance.

(ii) The department shall use the Intercounty Transfer process as outlined in All County Welfare Directors Letter 18-02E to provide for immediate access to care and treatment services in the month of enrollment when a beneficiary moves from one county to another.

(iii) The department shall issue guidance with input from stakeholders, including county child welfare departments.

(I) A non-dual-eligible beneficiary enrolled with an entity with a contract with the department pursuant to the Program of All-Inclusive Care for the Elderly (PACE), as described in Chapter 8.75 (commencing with Section 14591).

(J) Any other non-dual-eligible beneficiary, as identified by the department, for whom federal law prohibits mandatory enrollment in a Medi-Cal managed care plan.

(K) A beneficiary residing in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(c) (1) Notwithstanding any other law, if the department standardizes those populations subject to mandatory enrollment in a Medi-Cal managed care plan pursuant to subdivision (a), commencing January 1, 2023, and subject to subdivision (f) of Section 14184.102, a dual eligible beneficiary, except as provided in paragraph (2) of subdivision (b) or paragraph (2) of this subdivision, shall be required to enroll, or shall continue to be required to enroll, in a Medi-Cal managed care plan for purposes of their receipt of covered Medi-Cal benefits.

(2) The following dual eligible beneficiary groups, as identified by the department, shall be exempt from mandatory enrollment in Medi-Cal managed care as described in paragraph (1):

(A) A dual eligible beneficiary made eligible on the basis of a share of cost, including, but not limited to, a dual eligible beneficiary residing in a county that is authorized to operate COHS, as described in Article 2.8 (commencing with Section

14087.5), except for a dual eligible beneficiary who is eligible on the basis of their need for long-term care services with a share of cost, as determined by the department.

(B) A dual eligible beneficiary enrolled with an entity with a contract with the department pursuant to PACE as described in Chapter 8.75 (commencing with Section 14591).

(C) A dual eligible beneficiary enrolled with an entity with a Senior Care Action Network (SCAN) contract with the department.

(D) A dual eligible beneficiary who is an Indian, as defined in subsection (a) of Section 438.14 of Title 42 of the Code of Federal Regulations, and who elects to forego voluntary enrollment in a Medi-Cal managed care plan.

(E) A dual eligible beneficiary with HIV/AIDS who elects to forego voluntary enrollment in a Medi-Cal managed care plan.

(F) A dual eligible beneficiary eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who elects to forego voluntary enrollment in a Medi-Cal managed care plan, except for a dual beneficiary described in this subparagraph who resides in a county that is authorized to operate COHS, as described in Article 2.8 (commencing with Section 14087.5), or, effective January 1, 2025, in a county operating a Single Plan model of managed care established under Article 2.7 (commencing with Section 14087.3) and Article 2.8 (commencing with Section 14087.5). For the purpose of this subdivision, the following requirements shall apply to non-dual-eligible beneficiaries eligible on the basis of their receipt of services through a state foster care program, or eligible pursuant to Section 14005.28, who are transitioning to mandatory enrollment in a Medi-Cal managed care plan in a county operating a Single Plan model of managed care:

(i) Medi-Cal managed care plans shall comply with the access requirements in Section 14197 and in accordance with All Plan Letter 23-001, any superseding all plan letter, and any related guidance.

(ii) The department shall use the Intercounty Transfer process as outlined in All County Welfare Directors Letter 18-02E to provide for immediate access to care and treatment services in the month of enrollment when a beneficiary moves from one county to another.

(iii) The department shall issue guidance with input from stakeholders, including county child welfare departments.

(G) A dual eligible beneficiary residing in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(H) Any other dual eligible beneficiary, as identified by the department, for whom federal law prohibits mandatory enrollment in a Medi-Cal managed care plan.

(d) (1) This section shall not prohibit a Medi-Cal beneficiary from receiving covered benefits on a temporary basis through the Medi-Cal fee-for-service delivery system pending enrollment into an individual Medi-Cal managed care plan in accordance with this section and the CalAIM Terms and Conditions.

(2) This section shall not prohibit certain Medi-Cal beneficiaries eligible for full-scope benefits under the Medi-Cal State plan, as identified by the department, from voluntarily enrolling in a Medi-Cal managed care plan, in accordance with the CalAIM Terms and Conditions.

(e) (1) No later than January 1, 2023, in all non-County Organized Health System counties, in areas where a PACE plan is available, the PACE plan shall be presented as an enrollment option, included in enrollment materials, and made available to an applicable beneficiary whenever enrollment choices and options are presented. Outreach and enrollment materials shall enable a Medi-Cal beneficiary to understand what PACE provides, that, if eligible, they may be assessed for PACE eligibility and enroll in PACE, and how they can receive additional information and request to be assessed for PACE eligibility. A person meeting the age qualifications for PACE and who chooses PACE shall not be assigned to a Medi-Cal managed care plan for the lesser of 60 days or until they are assessed for eligibility for PACE and determined not to be eligible for PACE. A person enrolled in a PACE plan shall receive all Medicare and Medi-Cal services from the PACE plan pursuant to the three-way agreement between the PACE plan, the department, and the federal Centers for Medicare and Medicaid Services.

(2) In areas of the state where a presentation on Medi-Cal managed care plan enrollment options is unavailable, the department, or its contracted vendor, shall provide informational, outreach, and enrollment materials about the PACE program.

(f) For purposes of this section, the following definitions apply:

(1) "Dual eligible beneficiary" means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or both, and is eligible for medical assistance under the Medi-Cal State Plan. For purposes of this article, "dual eligible beneficiary" shall include both a "full-benefit dual eligible beneficiary" and a "partial-benefit dual eligible beneficiary," as those terms are defined in this subdivision.

(2) “Full-benefit dual eligible beneficiary” means an individual 21 years or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), Medicare Part B (42 U.S.C. Sec. 1395j et seq.), and Medicare Part D (42 U.S.C. Sec. 1395w-101), and is eligible for medical assistance under the Medi-Cal State Plan.

(3) “Non-dual-eligible beneficiary” means an individual eligible for medical assistance under the Medi-Cal State plan, as determined by the department, that is not eligible for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.).

(4) “Partial-benefit dual eligible beneficiary” means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), but not Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or who is enrolled for Medicare Part B (42 U.S.C. Sec. 1395j et seq.), but not Medicare Part A (42 U.S.C. Sec. 1395c et seq.), and is eligible for medical assistance under the Medi-Cal State Plan.

(Amended by Stats. 2025, Ch. 21, Sec. 112. (AB 116) Effective June 30, 2025.)

14184.201. (a) Notwithstanding any other law, the department shall standardize those applicable covered Medi-Cal benefits provided by Medi-Cal managed care plans under comprehensive risk contracts with the department on a statewide basis and across all models of Medi-Cal managed care in accordance with this section and the CalAIM Terms and Conditions.

(b) (1) Notwithstanding any other law, commencing January 1, 2023, subject to subdivision (f) of Section 14184.102, the department shall include, or continue to include, skilled nursing facility services as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan.

(2) For contract periods from January 1, 2023, to December 31, 2025, inclusive, during which paragraph (1) is implemented, each Medi-Cal managed care plan shall reimburse a network provider furnishing skilled nursing facility services to a Medi-Cal beneficiary enrolled in that plan, and each network provider of skilled nursing facility services shall accept the payment amount the network provider of skilled nursing facility services would be paid for those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State Plan and guidance issued pursuant to subdivision (d) of Section 14184.102. For contract periods commencing on or after January 1, 2026, during which paragraph (1) is implemented, the department may elect to continue the payment requirement described in this paragraph, subject to subdivision (f) of Section 14184.102.

(3) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (2) as applicable. The department may require Medi-Cal managed care plans and network providers of skilled nursing facility services to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(c) (1) Notwithstanding any other law, commencing January 1, 2024, subject to subdivision (f) of Section 14184.102, the department shall include, or continue to include, institutional long-term care services not described in subdivision (b) as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan.

(2) For contract periods from January 1, 2024, to December 31, 2025, inclusive, during which paragraph (1) is implemented, each Medi-Cal managed care plan shall reimburse a network provider furnishing institutional long-term care services not described in subdivision (b) to a Medi-Cal beneficiary enrolled in that plan, and each network provider of institutional long-term care services not described in subdivision (b) shall accept the payment amount the network provider of institutional long-term care services would be paid for those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State Plan and guidance issued pursuant to subdivision (d) of Section 14184.102. For contract periods commencing on or after January 1, 2026, during which paragraph (1) is implemented, the department may elect to continue the payment requirement described in this paragraph, subject to subdivision (f) of Section 14184.102.

(3) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (2), as applicable. The department may require Medi-Cal managed care plans and network providers of institutional long-term care services to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(4) The department shall convene, in collaboration with the State Department of Developmental Services (DDS), a workgroup to address transition of intermediate care facility/developmentally disabled (ICF/DD) facilities, and Intermediate Care Facility for the Developmentally Disabled-Nursing (ICF/DD-N) and Intermediate Care Facility for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes from the Medi-Cal fee-for-service delivery system to the Medi-Cal managed care delivery system to ensure a smooth transition to CalAIM.

(d) (1) Notwithstanding any other law, commencing January 1, 2022, the department shall include donor and recipient organ transplant surgeries, as described in Section 14132.69 and in the CalAIM Terms and Conditions, and donor and recipient bone marrow transplants, as described in Section 14133.8 and in the CalAIM Terms and Conditions, as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan.

(2) For contract periods from January 1, 2022, to December 31, 2024, inclusive, during which paragraph (1) is implemented, each applicable Medi-Cal managed care plan shall reimburse a provider furnishing organ or bone marrow transplant surgeries to a Medi-Cal beneficiary enrolled in that plan, and each provider of organ or bone marrow transplant surgeries shall accept the payment amount the provider of organ or bone marrow transplant surgeries would be paid for those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State Plan and guidance issued pursuant to subdivision (d) of Section 14184.102. For contract periods commencing on or after January 1, 2025, during which paragraph (1) is implemented, the department may elect to continue the payment requirement described in this paragraph, subject to subdivision (f) of Section 14184.102.

(3) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (2) as applicable. The department may require Medi-Cal managed care plans and providers of organ or bone marrow transplant surgeries to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(e) (1) Notwithstanding any other law, commencing January 1, 2022, Community-Based Adult Services (CBAS), as described in Section 14186.3, shall continue to be available as a capitated benefit for a qualified Medi-Cal beneficiary under a comprehensive risk contract with an applicable Medi-Cal managed care plan, in accordance with the CalAIM Terms and Conditions.

(2) CBAS shall only be available as a covered Medi-Cal benefit for a qualified Medi-Cal beneficiary under a comprehensive risk contract with an applicable Medi-Cal managed care plan. Medi-Cal beneficiaries who are eligible for CBAS shall enroll in an applicable Medi-Cal managed care plan in order to receive those services, except for beneficiaries exempt from mandatory enrollment in a Medi-Cal managed care plan pursuant to the CalAIM Terms and Conditions and Section 14184.200.

(3) CBAS shall be delivered in accordance with applicable state and federal law, including, but not limited to, the federal home and community-based settings regulations set forth in Sections 441.301(c)(4), 441.530(a)(1), and 441.710(a)(1) of Title 42 of the Code of Federal Regulations, and related subregulatory guidance and any amendment issued thereto.

(4) For contract periods during which paragraph (1) is implemented, each applicable Medi-Cal managed care plan shall reimburse a network provider furnishing CBAS to a Medi-Cal beneficiary enrolled in that plan, and each network provider of CBAS shall accept the payment amount the network provider of CBAS would be paid for the service in the Medi-Cal fee-for-service delivery system, as defined by the department in guidance issued pursuant to subdivision (d) of Section 14184.102, unless the Medi-Cal managed plan and network provider mutually agree to reimbursement in a different amount.

(5) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to an applicable Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (4) as applicable. The department may require applicable Medi-Cal managed care plans and network providers of CBAS to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(f) Notwithstanding any other law, including, but not limited to, subdivision (a), the department may not transfer responsibility for specialty mental health services in the Counties of Sacramento and Solano from the Medi-Cal managed care plan responsible for those services on July 1, 2022, in those counties until no sooner than all of the following requirements have been met:

(1) The requirements of Section 14184.403 have been implemented.

(2) Each county and Medi-Cal managed care plan has submitted to the department a transition plan that contains provisions for continuity of care or the transfer of care.

(3) Notice has been provided to affected beneficiaries, including the ability of beneficiaries to request continuity of care pursuant to mental health and substance use disorder information notices issued by the department.

(g) For purposes of this section, the following definitions apply:

(1) “Comprehensive risk contract” has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(2) “Institutional long-term care services” has the same meaning as set forth in the CalAIM Terms and Conditions and, subject to subdivision (f) of Section 14184.102, includes at a minimum all of the following:

(A) Skilled nursing facility services.

(B) Subacute facility services.

(C) Pediatric subacute facility services.

(D) Intermediate care facility services.

(3) “Network provider” has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(Amended by Stats. 2023, Ch. 42, Sec. 158. (AB 118) Effective July 10, 2023.)

14184.203. (a) For contract periods commencing on or after January 1, 2026, the department may require each Medi-Cal managed care plan and each health plan subcontractor of a Medi-Cal managed care plan to be accredited by the National Committee for Quality Assurance, or an alternative entity pursuant to subdivision (c), in accordance with this section and the CalAIM Terms and Conditions.

(b) The department shall not use findings from the accreditation pursuant to subdivision (a) to certify or deem a Medi-Cal managed care plan’s compliance with applicable state and federal Medicaid requirements, except in the area of credentialing.

(c) If the department determines that a Medi-Cal managed care plan or an applicable health plan subcontractor thereof is unable to receive accreditation from the National Committee for Quality Assurance due to population size, the department may authorize alternate accreditation if the requirements applied are substantially similar to those applied pursuant to subdivision (a), as determined by the department.

(d) For purposes of this section, “subcontractor” has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(Added by Stats. 2021, Ch. 143, Sec. 402. (AB 133) Effective July 27, 2021.)

14184.204. (a) Commencing January 1, 2023, subject to subdivision (f) of Section 14184.102, the department shall implement the Population Health Management Program under the Medi-Cal managed care delivery system to improve health outcomes, care coordination, and efficiency through application of standardized health management requirements, in accordance with the CalAIM Terms and Conditions.

(b) The department shall require each Medi-Cal managed care plan, after consultation with counties and other affected stakeholders, to develop and maintain a beneficiary-centered population health management program, which is a model of care and plan of action designed to address member health needs at all points along the continuum of care, as described in the CalAIM Terms and Conditions.

(c) Each Medi-Cal managed care plan in the population health management program shall, at a minimum, do all of the following:

(1) Prioritize preventive and wellness services.

(2) Identify and assess beneficiary member risks and needs on an ongoing basis.

(3) Manage beneficiary member safety and outcomes during care transitions, across all applicable delivery systems and settings, through effective care coordination.

(4) Identify and mitigate social determinants of health and reduce health disparities or inequities.

(d) To support implementation of this section, the department shall develop and implement a Medi-Cal Population Health Management service that expands access to available medical, behavioral, and social service data and provides authorized entities access to necessary administrative and clinical data and information with respect to Medi-Cal beneficiaries across Medi-Cal delivery systems and other applicable public programs, as identified by the department. Data will be available at the individual member level and include the ability for bulk downloads for the purposes of population health analytics and clinical management by Medi-Cal managed care plans in support of the population health management activities described in subdivision (f).

(e) Population health management program components shall be developed in consultation with appropriate stakeholders, including, but not limited to, the State Department of Public Health, Medi-Cal managed care plans, Medi-Cal behavioral health delivery systems, county public health and social services, providers, community-based organizations, and consumer advocates.

(f) The Population Health Management Program shall include, but is not limited to, all of the following:

(1) Appropriate use of preventive services for children and adults, and other interventions, including chronic disease management, referrals for behavioral and oral health care services, housing, nutrition, and other health-related social needs.

(2) Risk assessment is comparable and consistent between Medi-Cal managed care plans.

(3) Any algorithm used to conduct member risk assessment is comparable, standardized, and mitigated for racial and other biases through consideration of disease burden relative to utilization and other patient risk factors beyond cost and historical utilization. The department shall report the underlying measures it uses in its algorithm.

(4) Any screening tool used to assess beneficiaries is age appropriate and comparable across Medi-Cal managed care plans.

(5) Each Medi-Cal managed care plan incorporates the findings of its Population Needs Assessment in its population health management program.

(6) Each Medi-Cal managed care plan describes how it will incorporate preventive and wellness services in partnership with Medi-Cal behavioral health delivery systems, county public health and social services, providers, community-based organizations, and consumer advocates.

(g) Beginning no later than January 1, 2024, the department shall annually post an analysis of the Population Health Management Program on its internet website.

(Added by Stats. 2021, Ch. 143, Sec. 402. (AB 133) Effective July 27, 2021.)

14184.205. (a) Subject to subdivision (f) of Section 14184.102, the department shall implement an enhanced care management (ECM) benefit designed to address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans, in accordance with this section and the CalAIM Terms and Conditions.

(b) (1) Subject to the effective dates listed in subdivision (c), the ECM benefit shall be available on a statewide basis to an eligible Medi-Cal beneficiary who is enrolled in an applicable Medi-Cal managed care plan and who meets the criteria in the CalAIM Terms and Conditions for one or more target populations, as determined by the department. A Medi-Cal beneficiary is excluded from ECM while enrolled in a 1915(c) waiver or the Family Mosaic Project, or while receiving California Community Transitions (CCT) Money Follows the Person (MFTP) services. ECM shall be available to a qualifying dual eligible beneficiary, as described under Section 14184.200, except for a dual eligible beneficiary enrolled in a fully integrated program for members who are dually eligible for Medicare and Medicaid, including Cal MediConnect during the duration of the demonstration authorized in Section 14132.275, Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), and the Programs of All-Inclusive Care for the Elderly (PACE).

(2) ECM only shall be available as a covered Medi-Cal benefit under a comprehensive risk contract with a Medi-Cal managed care plan. A Medi-Cal beneficiary who is eligible for ECM shall enroll in a Medi-Cal managed care plan in order to receive those services.

(c) (1) A Medi-Cal managed care plan operating in counties in which either the Whole Person Care pilot program, pursuant to Section 14184.60, or the Health Home Program, pursuant to Article 3.9 (commencing with Section 14127), or both, were implemented, as determined by the department, shall be required to cover ECM under its comprehensive risk contract as follows:

(A) Commencing January 1, 2022, a Medi-Cal managed care plan described in this paragraph shall be required to cover ECM for existing target populations under either the Whole Person Care pilot program or the Health Home Program, or both, as identified by the department.

(B) (i) Commencing January 1, 2023, a Medi-Cal managed care plan described in this paragraph shall be required to cover ECM for other select target populations described in subdivision (d), as identified by the department and in accordance with the CalAIM Terms and Conditions.

(ii) Commencing July 1, 2023, a Medi-Cal managed care plan described in this paragraph shall be required to cover ECM for all target populations described in subdivision (d) and in accordance with the CalAIM Terms and Conditions.

(2) A Medi-Cal managed care plan operating in counties in which neither the Whole Person Care pilot program, pursuant to Section 14184.60, or the Health Home Program, pursuant to Article 3.9 (commencing with Section 14127), was implemented, as determined by the department, shall be required to cover select ECM target populations, as identified by the department, under its comprehensive risk contract, commencing July 1, 2022. All other target populations, including the target population described in paragraph (7) of subdivision (d), shall be covered commencing January 1, 2023, or July 1, 2023, in accordance with the CalAIM Terms and Conditions.

(d) Target populations shall include the following, consistent with the department's eligibility criteria, and to the extent approved in the CalAIM Terms and Conditions:

(1) Children or youth with complex physical, behavioral, developmental, or oral health needs, including, but not limited to, those eligible for California Children's Services, those involved or with a history of involvement in child welfare or the juvenile justice system, or youth with clinical high-risk syndrome or a first episode of psychosis.

(2) Individuals experiencing homelessness.

(3) High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.

(4) Individuals at risk for institutionalization and eligible for long-term care services.

(5) Nursing facility residents who want to transition to the community.

(6) Individuals with serious mental illness (SMI), and children with serious emotional disturbance (SED) or substance use disorder (SUD).

(7) Individuals transitioning from incarceration requiring immediate transition of services to the community.

(e) Notwithstanding any other law, for any time period in which a Medi-Cal beneficiary is eligible to receive ECM services through enrollment in their Medi-Cal managed care plan, the beneficiary shall not receive duplicative targeted case management services as described in Section 14132.44 or otherwise authorized in the Medi-Cal State Plan, as determined by the department.

(f) Medi-Cal managed plans shall consult and collaborate with Medi-Cal behavioral health delivery systems for the delivery of ECM for beneficiaries with an SMI, SED, or SUD.

(g) If a Medi-Cal managed care plan proposes to keep some level of ECM in house instead of contracting with direct providers, the Medi-Cal managed care plan shall demonstrate to the state that its ECM benefit is appropriately community based and shall provide a rationale for not contracting with existing providers.

(h) The department shall develop, in consultation with Medi-Cal managed care plans and other appropriate stakeholders, a monitoring plan and reporting template for the implementation of ECM pursuant to this section. The department shall annually publish a public report on reported ECM utilization data, populations served, and demographic data, stratified by age, sex, race, ethnicity, and languages spoken, to the extent statistically reliant data is available.

(Added by Stats. 2021, Ch. 143, Sec. 402. (AB 133) Effective July 27, 2021.)

14184.206. (a) Commencing January 1, 2022, and subject to subdivision (f) of Section 14184.102, a Medi-Cal managed care plan may elect to cover those community supports approved by the department as cost effective and medically appropriate in the comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services, in accordance with the CalAIM Terms and Conditions.

(b) (1) Approved community supports pursuant to this section shall be available only to beneficiaries enrolled in a Medi-Cal managed care plan under a comprehensive risk contract, subject to paragraph (2).

(2) Approved community supports shall not supplant other covered Medi-Cal benefits that are not the responsibility of the Medi-Cal managed care plan under the comprehensive risk contract, including, but not limited to, in-home supportive services provided pursuant to Article 7 (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.

(3) An enrolled Medi-Cal beneficiary shall not be required by their Medi-Cal managed care plan to use the community support.

(c) Subject to subdivision (f) of Section 14184.102, community supports that the department may approve include, but need not be limited to, all of the following when authorized by the department in the comprehensive risk contract with each Medi-Cal managed care plan and to the extent the department determines that the community support is a cost-effective and medically appropriate substitute for the applicable covered Medi-Cal benefit under the comprehensive risk contract:

(1) Housing transition navigation services.

(2) Housing deposits.

(3) Housing tenancy and sustaining services.

(4) Short-term post-hospitalization housing.

(5) Recuperative care or medical respite.

(6) Respite.

(7) Day habilitation programs.

(8) Nursing facility transition or diversion to assisted living facilities, including, but not limited to, residential care facilities for the elderly or adult residential facilities.

(9) Nursing facility transition to a home.

(10) Personal care and homemaker services.

(11) Environmental accessibility adaptations or home modifications.

(12) Medically supportive food and nutrition services, including medically tailored meals.

(13) Sobering centers.

(14) Asthma remediation.

(d) The department shall publicly post on its internet website a list of which community supports are offered to enrollees by each Medi-Cal managed care plan.

(e) A Medi-Cal managed care plan shall provide information on the available community supports in its member handbook and plan website, including any limitations on community supports on the plan website.

(f) The department shall develop, in consultation with Medi-Cal managed care plans and other appropriate stakeholders, a monitoring plan and reporting template for the implementation of community supports pursuant to this section. The department shall annually publish a public report on reported community supports utilization data, populations served, and demographic data, stratified by age, sex, race, ethnicity, and languages spoken, to the extent statistically reliant data are available.

(g) The department shall conduct an independent evaluation of the effectiveness of community supports in accordance with the parameters and timeframes specified in the CalAIM Terms and Conditions.

(h) The department shall take into account the utilization and actual cost of community supports in developing capitation rates.

(i) For purposes of this section, the following definitions apply:

(1) “Community supports” means those alternative services and settings approved in the CalAIM Terms and Conditions and administered according to paragraph (2) of subsection (e) of Section 438.3 of Title 42 of the Code of Federal Regulations.

(2) “Comprehensive risk contract” has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(Amended by Stats. 2022, Ch. 47, Sec. 127. (SB 184) Effective June 30, 2022.)

14184.207. (a) Commencing January 1, 2022, subject to appropriation by the Legislature in an applicable fiscal year and subdivision (f) of section 14184.102, the department shall make incentive payments available to qualifying Medi-Cal managed care plans that meet predefined milestones and metrics associated with implementation of applicable components of CalAIM, including, but not limited to, Sections 14184.205 and 14184.206, as determined by the department and in accordance with the CalAIM Terms and Conditions.

(b) The department, in consultation with Medi-Cal managed care plans, consumer advocates, the Medi-Cal behavioral health delivery system, and other stakeholder representatives, shall establish the methodology, parameters, and eligibility criteria for incentive payments pursuant to this section. This shall include, but is not limited to, the milestones and metrics that Medi-Cal managed care plans must meet in order to receive an incentive payment pursuant to this section and the CalAIM Terms and Conditions.

(c) The department, in accordance with the CalAIM Terms and Conditions, shall determine if a Medi-Cal managed care plan has earned an incentive payment, and the amount of that payment, for any relevant time period in which this section is implemented.

(d) Incentive payments pursuant to this section shall be made in accordance with the requirements for incentive arrangements described in Section 438.6(b)(2) of Title 42 of the Code of Federal Regulations and any associated federal guidance.

(e) (1) Notwithstanding subdivision (a), the department may make additional or augmented incentive payments available to Medi-Cal managed care plans, subject to subdivision (f) of Section 14184.102 and to the extent sufficient nonfederal share funds are available for this purpose in each applicable CalAIM year.

(2) The nonfederal share of additional or augmented incentive payments pursuant to this subdivision may consist of voluntary intergovernmental transfers of funds provided by eligible governmental agencies or other public entities, pursuant to Section 14164. Upon providing any intergovernmental transfer of funds, a transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations and any other applicable Medicaid laws, and in the form and manner specified by the department. An intergovernmental transfer of funds made

pursuant to this subdivision shall be considered voluntary for purposes of all state and federal laws. Notwithstanding any other law, the department shall not assess the fee described in subdivision (d) of Section 14301.4 or any other similar fee on the intergovernmental transfers made pursuant to this subdivision.

(Added by Stats. 2021, Ch. 143, Sec. 402. (AB 133) Effective July 27, 2021.)

14184.208. (a) To promote more integrated care for dual eligible beneficiaries, the department shall seek to align the enrollment of dual eligible beneficiaries in affiliated Medi-Cal managed care plans and Medicare plans, including Medicare Advantage Dual Special Needs Plans (D-SNP), as described in this section and in accordance with the CalAIM Terms and Conditions. A dual eligible beneficiary shall not be required to enroll in a D-SNP for purposes of receiving their Medi-Cal benefits.

(b) (1) Commencing January 1, 2023, subject to subdivision (f) of Section 14184.102, the department shall require each Medi-Cal managed care plan operating in Coordinated Care Initiative counties to operate, or continue to operate, a D-SNP in accordance with the CalAIM Terms and Conditions, and in accordance with federal requirements for each D-SNP, to have an executed contract with the department, referred to as a State Medicaid Agency Contract (SMAC). The requirements described in this paragraph shall not be applicable to a subcontracted delegate health plan.

(2) In Coordinated Care Initiative counties, beginning in contract year 2023, the department may only contract with a proposed D-SNP that is affiliated with a Medi-Cal managed care plan or a subcontracted delegate health plan, or was contracted with the department for a D-SNP in contract year 2022 in the proposed D-SNP service area.

(3) In Coordinated Care Initiative counties, beginning with contract year 2023, dual eligible beneficiaries that are not already enrolled in a D-SNP for contract year 2022 may only enroll in a D-SNP that is affiliated with a Medi-Cal managed care plan or a subcontracted delegate health plan in the beneficiary's service area.

(4) In Coordinated Care Initiative counties, beginning with contract year 2023, a dual eligible beneficiary shall be assigned to a Medi-Cal managed care plan, or subcontracted delegate health plan, that is affiliated with the Medicare Advantage plan, including a D-SNP, in which the dual eligible beneficiary is enrolled. The department may approve exceptions to this policy, to support beneficiary enrollment choice.

(c) (1) Commencing January 1, 2026, subject to subdivision (f) of Section 14184.102 and paragraph (5) of this subdivision, the department may require each Medi-Cal managed care plan to operate, or continue to operate, a D-SNP in accordance with the CalAIM Terms and Conditions, and in accordance with federal requirements for each D-SNP to have an executed contract with the department, referred to as an SMAC. The requirements described in this paragraph shall not be applicable to a subcontracted delegate health plan.

(2) In non-Coordinated Care Initiative counties, beginning no later than contract year 2025, the department shall only contract with a proposed D-SNP that is affiliated with a Medi-Cal managed care plan or subcontracted delegate health plan, or was contracted with the department for a D-SNP in the proposed D-SNP service area in the contract year that immediately precedes the contract year in which this paragraph is implemented with respect to an individual county.

(3) In non-Coordinated Care Initiative counties, beginning no later than contract year 2026, a dual eligible beneficiary shall be assigned to a Medi-Cal managed care plan or a subcontracted delegate health plan that is affiliated with the Medicare Advantage plan, including a D-SNP, in which the dual eligible beneficiary is enrolled. The department may approve exceptions to the requirement described in this subparagraph when it determines necessary to support beneficiary enrollment choice.

(4) In non-Coordinated Care Initiative counties, beginning no later than contract year 2025, dual eligible beneficiaries not already enrolled in a D-SNP, in the contract year that immediately precedes the contract year in which this paragraph is implemented with respect to an individual county, may only enroll in a D-SNP that is affiliated with a Medi-Cal managed care plan, or a subcontracted delegate health plan, in the beneficiary's service area. Beginning no later than contract year 2025, D-SNPs that are not affiliated with a Medi-Cal managed care plan or a subcontracted delegate health plan shall not accept new enrollment of dual eligible beneficiaries.

(5) The department shall conduct a feasibility study of D-SNPs, in specific non-Coordinated Care Initiative counties as determined by the department, to be completed no later than July 1, 2022. As a result of the study findings, or evidence provided by a Medi-Cal managed care plan of the potential for significant financial losses that may be incurred by a Medi-Cal managed care plan as a result of operating a D-SNP, and evidence provided by a Medi-Cal managed care plan that the plan has made a good faith effort but is not able to develop a partnership with a D-SNP for coordinated care across Medicare and Medi-Cal, the department may provide, in its sole discretion, an exemption from the requirements in paragraph (1) of this subdivision on an individual plan basis for a period of three years. The department may renew this exemption for successive three-year periods based on study findings or evidence of potential losses, and evidence of a good faith effort, as specified in this paragraph.

(d) To ensure dual eligible beneficiaries are fully informed regarding aligned enrollment, the department or the Med-Cal managed care plan, as applicable, shall provide informing notices to affected beneficiaries regarding Medi-Cal plan enrollment changes related to aligned enrollment. The notices shall be developed in consultation with consumer advocates.

(e) Beginning in contract year 2023, the department shall include requirements for network adequacy, aligned networks, and continuity of care in the SMAC. The requirements shall be developed in consultation with affected stakeholders.

(f) The department shall contract with public or private entities in assisting dual eligible beneficiaries in understanding their health care coverage options, overcoming access to care barriers, and addressing eligibility and enrollment barriers.

(g) The department shall convene a workgroup including plans, providers, and consumer stakeholders to discuss transition to a statewide Managed Long-Term Services and Supports and D-SNP structure.

(h) For purposes of this section, the following definitions apply:

(1) “Coordinated Care Initiative counties” means the Counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

(2) “Dual eligible beneficiary” means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or both, and is eligible for medical assistance under the Medi-Cal State Plan. For purposes of this section, “dual eligible beneficiary” shall include both “full-benefit dual eligible beneficiaries” and “partial-benefit dual eligible beneficiaries,” as those terms are defined in this subdivision.

(3) “Full-benefit dual eligible beneficiary” means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), Medicare Part B (42 U.S.C. Sec. 1395j et seq.), and Medicare Part D (42 U.S.C. Sec. 1395w-101), and is eligible for medical assistance under the Medi-Cal State Plan.

(4) “Medicare Advantage Dual Special Needs Plan” or “D-SNP” shall have the same meaning as set forth in Section 1395w-28(b)(6) of Title 42 of the United States Code.

(5) “Partial-benefit dual eligible beneficiary” means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), but not Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or who is enrolled for Medicare Part B (42 U.S.C. Sec. 1395j et seq.), but not Medicare Part A (42 U.S.C. Sec. 1395c et seq.), and is eligible medical assistance under the Medi-Cal State Plan.

(6) “Subcontracted delegate health plan” means a health care service plan that is a subcontractor of a Medi-Cal managed care plan that the department determines to have assumed the entire financial risk for all Medi-Cal services provided to a dual eligible beneficiary that are covered under the applicable comprehensive risk contract of the Medi-Cal managed care plan.

(7) “Subcontractor” shall have the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(i) For purposes of this section, “Medi-Cal managed care plan” shall not include a managed care plan contract with the AIDS Healthcare Foundation.

(Added by Stats. 2021, Ch. 143, Sec. 402. (AB 133) Effective July 27, 2021.)

14184.300. (a) (1) To the extent federal financial participation is available, the department shall continue to implement the Global Payment Program (GPP) as described in Section 14184.40 during the CalAIM term. The department shall continue to administer the GPP in accordance with Section 14184.40, except to the extent changes are approved in the CalAIM Terms and Conditions and except as provided in subdivision (b).

(b) (1) Commencing January 1, 2021, the GPP program year shall be aligned with the calendar year. The department shall provide to the GPP systems a revised schedule for the reporting, notification, intergovernmental transfer, and payment set forth in paragraphs (3) and (4) of subdivision (d) of Section 14184.40, which shall maintain the same conditions and timeline, adjusted by six months to align with the calendar year, and consistent with the CalAIM Terms and Conditions.

(2) Commencing January 1, 2021, the GPP system-specific IGT factors identified in paragraph (3) of subdivision (g) of Section 14184.40 shall be inapplicable and the initial transfer amount calculated for each GPP system shall be identified by the department and communicated in writing to each GPP system for each applicable GPP program year.

(3) Commencing January 1, 2021, for purposes of determining the applicable GPP’s aggregate annual limit, applicable portions of the federal disproportionate share allotment for the federal fiscal year that ends in the GPP program year, and for the federal fiscal year that commences in the applicable GPP program year, shall be appropriately aligned with the GPP program year.

(4) Subject to subdivision (f) of Section 14184.102, a hospital that is operated by the University of California, and its affiliated and contracted providers, may elect to participate as a GPP system during the CalAIM terms by providing written notice to the department no later than June 1 of the calendar year immediately preceding the subject GPP program year.

(A) A University of California hospital that is approved to participate as a GPP system shall continue to participate as a GPP system for all remaining GPP program years during the CalAIM term, and shall be subject to all other provisions, requirements, and restrictions applicable to GPP systems in accordance with the CalAIM Terms and Conditions.

(B) A University of California hospital that is approved to participate as a GPP system shall be ineligible to receive disproportionate share hospital payments through the termination of GPP.

(C) If a University of California hospital is approved to participate as a GPP system, the department shall make all appropriate funding and program adjustments necessary to account for the additional participating GPP system in the subject GPP program years, including, but not limited to, the determinations of the federal disproportionate share hospital allotment funding available to nonparticipating University of California hospitals and the resulting GPP aggregate annual limits.

(5) Subject to the availability of sufficient nonfederal share funds for this purpose, the department may seek federal approval for, and implement, additional funding and program components for GPP systems that support and further the objectives of CalAIM and GPP.

(c) Before implementing any of the modifications described in subdivision (b), the department shall consult with the GPP systems.

(d) Except as otherwise provided in the CalAIM Terms and Conditions or in this section, and without limiting the authority in subdivision (g) of Section 14184.102, the rights, obligations, and limitations set forth in Section 14184.40 shall apply to the GPP as continued pursuant to this section.

(Added by Stats. 2021, Ch. 143, Sec. 402. (AB 133) Effective July 27, 2021.)

14184.301. The payment methodologies and requirements described in Section 14184.30, as amended by the act that added this section, shall continue to apply during the entirety of the CalAIM term and any extension periods in which the Global Payment Program pursuant to Section 14184.300 is authorized.

(Added by Stats. 2021, Ch. 143, Sec. 402. (AB 133) Effective July 27, 2021.)

14184.400. (a) Commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, the department shall continue to implement the Specialty Mental Health Services Program described in part in Chapter 8.9 (commencing with Section 14700), as a component of CalAIM and in accordance with this article and the CalAIM Terms and Conditions.

(b) Each mental health plan contracting with the department to provide specialty mental health services pursuant to Chapter 8.9 (commencing with Section 14700) shall comply with all applicable CalAIM Terms and Conditions and any guidance issued by the department pursuant to subdivision (d) of Section 14184.102.

(c) (1) As a component of the Specialty Mental Health Services Program described in this section, the department, in consultation with counties and other affected stakeholders, may seek federal approval for a demonstration project under Section 1315(a) of Title 42 of the United States Code, which may include receipt of federal financial participation for services furnished to Medi-Cal beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as institutions for mental diseases. The department may elect to seek approval for this demonstration project to operate on a statewide basis or on a county-by-county basis.

(2) Notwithstanding any other law, to the extent that the department receives the necessary federal approvals to implement the demonstration project described in paragraph (1), and subject to approval by the Department of Finance, the department shall implement the demonstration in accordance with the terms of the federal approval and only to the extent that federal financial participation is available and is not otherwise jeopardized.

(3) For purposes of this subdivision, “institution for mental diseases” has the same meaning as set forth in Section 1396d(i) of Title 42 of the United States Code.

(Amended by Stats. 2022, Ch. 47, Sec. 128. (SB 184) Effective June 30, 2022.)

14184.401. (a) Commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, the department shall continue to implement the Drug Medi-Cal organized delivery system (DMC-ODS) program, previously authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184), as a component of CalAIM and in accordance with this article and the CalAIM Terms and Conditions.

(b) A county, or consortium of counties in a regional model, that elects to administer, or elects to continue to administer, a DMC-ODS pilot shall enter into and maintain an intergovernmental agreement with the department. Those counties shall comply with all applicable CalAIM Terms and Conditions and any guidance issued by the department pursuant to subdivision (d) of Section 14184.102 as a condition of participation.

(c) An election by a county, or consortium of counties in a regional model, to participate as a DMC-ODS pilot shall be considered voluntary for purposes of all state and federal laws.

(Added by Stats. 2021, Ch. 143, Sec. 402. (AB 133) Effective July 27, 2021.)

14184.402. (a) Notwithstanding any other law, including, but not limited to, the applicable provisions of Chapter 11 (commencing with Section 1810.100) of Division 1 of Title 9, and Chapter 3 (commencing with Section 51000) of Subdivision 1 of Division 3 of Title 22, of the California Code of Regulations, commencing no sooner than January 1, 2022, all medically necessary determinations for covered specialty mental health services and substance use disorder services provided by a Medi-Cal behavioral health delivery system shall be made in accordance with Section 14059.5, except as provided in this section and any written instructions issued by the department pursuant to subdivision (j) until such time that regulations are promulgated or amended.

(b) (1) Subject to subdivision (f) of Section 14184.102, the following nonspecialty mental health services shall be covered by a Medi-Cal managed care plan, or available through the Medi-Cal fee-for-service delivery system for beneficiaries not enrolled in a Medi-Cal managed care plan or for services that are carved out from a Medi-Cal managed care plan's comprehensive risk contract:

(A) Individual and group mental health evaluation and treatment, including psychotherapy, family therapy, and dyadic services.

(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.

(E) Outpatient laboratory, drugs, supplies, and supplements.

(2) Covered nonspecialty mental health services for 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 edition of the Diagnostic and Statistical Manual of Mental Disorders, shall be provided by a Medi-Cal managed care plan or through the Medi-Cal fee-for-service delivery system. A Medi-Cal managed care plan shall provide medically necessary nonspecialty mental health services to enrolled beneficiaries under 21 years of age as required pursuant to Section 1396d(r) of Title 42 of the United States Code. A Medi-Cal managed care plan shall also be responsible for providing covered nonspecialty mental health services to enrolled beneficiaries with potential mental health disorders not yet diagnosed.

(c) For enrolled beneficiaries 21 years of age or older, a county mental health plan shall provide covered specialty mental health services for beneficiaries who meet both of the following criteria:

(1) The beneficiary has one or both of the following:

(A) Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

(B) A reasonable probability of significant deterioration in an important area of life functioning.

(2) The beneficiary's condition as described in paragraph (1) is due to either of the following:

(A) A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

(B) A suspected mental disorder that has not yet been diagnosed.

(d) For enrolled beneficiaries under 21 years of age, a county mental health plan shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria:

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experiencing trauma evidenced by scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

(2) The beneficiary meets both of the following requirements:

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

(i) A significant impairment.

(ii) A reasonable probability of significant deterioration in an important area of life functioning.

(iii) A reasonable probability of not progressing developmentally as appropriate.

(iv) A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

(B) The beneficiary's condition as described in subparagraph (A) is due to one of the following:

(i) A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

(ii) A suspected mental health disorder that has not yet been diagnosed.

(iii) Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

(e) (1) Covered services provided under a county Drug Medi-Cal Treatment Program or a Drug Medi-Cal organized delivery system shall use criteria adopted by the American Society of Addiction Medicine to determine the appropriate level of care for substance use disorder treatment services.

(2) Covered services provided under a county Drug Medi-Cal Treatment Program or a Drug Medi-Cal organized delivery system shall include all medically necessary substance use disorder services for an individual under 21 years of age as required pursuant to Section 1396d(r) of Title 42 of the United States Code.

(3) A full assessment utilizing the criteria adopted by the American Society of Addiction Medicine shall not be required for a beneficiary to begin receiving services through a Drug Medi-Cal Treatment Program or a Drug Medi-Cal organized delivery system.

(f) (1) This section and Section 14059.5 shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health or substance use disorder prevention, screening, assessment, treatment, or recovery service under any of the following circumstances:

(A) Services were provided prior to determining a diagnosis.

(B) The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.

(C) The treated Medi-Cal beneficiary has a co-occurring mental health condition and substance use disorder.

(D) For a provider who provides specialty mental health services to a Medi-Cal beneficiary under a contract between the department and a county mental health plan when that beneficiary concurrently receives nonspecialty mental health services from a Medi-Cal managed care plan or under the Medi-Cal fee-for-service delivery system, if those services are coordinated between the specialty and nonspecialty delivery systems and those services are not duplicative.

(E) For a provider who provides nonspecialty mental health services to a Medi-Cal beneficiary pursuant to a comprehensive risk contract with a Medi-Cal managed care plan or under the Medi-Cal fee-for-service delivery system when that beneficiary concurrently receives specialty mental health services from a county mental health plan, if those services are coordinated between the nonspecialty and specialty delivery systems and those services are not duplicative.

(2) This section and Section 14059.5 shall not be construed to exclude clinically appropriate and covered mental health or substance use disorder services during the assessment process.

(g) A dispute between a county mental health plan and a Medi-Cal managed care plan shall not delay the provision of medically necessary services by the county mental health plan or the Medi-Cal managed care plan.

(h) (1) The department shall develop, in consultation with county behavioral health directors, consumer advocates, labor organizations representing county behavioral health workers, mental health and substance use disorder treatment providers, and Medi-Cal managed care plans, standardized screening tools to guide a referral to a Medi-Cal behavioral health delivery system. The department shall develop a standardized screening tool for Medi-Cal beneficiaries who are under 21 years of age and a separate standardized screening tool for those who are 21 years of age or older. The department may require the use of these standardized screening tools by Medi-Cal behavioral health delivery systems and Medi-Cal managed care plans.

(2) The department shall develop, in consultation with county behavioral health directors, consumer advocates, labor organizations representing county behavioral health workers, mental health and substance use disorder treatment providers, and Medi-Cal managed care plans, standardized statewide transition tools to ensure that Medi-Cal beneficiaries requiring transition

between delivery systems receive timely coordinated care. The department shall develop a standardized statewide transition tool for Medi-Cal beneficiaries who are under 21 years of age and a separate standardized statewide transition tool for those who are 21 years of age or older. The department may require the use of these standardized statewide transition tools.

(3) The department shall develop, in consultation with county behavioral health directors, consumer advocates, labor organizations representing county behavioral health workers, and mental health and substance use disorders treatment providers, documentation standards and changes to the department's clinical auditing standards. The department may require the use of these documentation standards by Medi-Cal behavioral health delivery systems, including, but not limited to, restrictions developed in consultation with representatives of Medi-Cal behavioral health delivery systems on what Medi-Cal behavioral health delivery systems impose on their contract providers, consistent with Medi-Cal managed care plans and taking into account the need to ensure quality and program integrity and to address equity and disparities.

(i) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, and make specific this section and the associated CalAIM terms and conditions by means of all-county letters, plan letters, information notices, or similar instructions, until regulations are promulgated or amended in accordance with paragraph (2).

(2) Notwithstanding subdivision (d) of Section 14184.102, the department shall promulgate or amend regulations, as necessary, to implement, interpret, and make specific this section and the associated CalAIM terms and conditions in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code by July 1, 2024.

(Added by Stats. 2021, Ch. 143, Sec. 402. (AB 133) Effective July 27, 2021.)

14184.403. (a) Notwithstanding any other law, commencing no sooner than July 1, 2022, subject to subdivision (f) of Section 14184.102, each Medi-Cal behavioral health delivery system shall comply with the behavioral health payment reform provisions approved in the CalAIM Terms and Conditions and any associated instruction issued by the department pursuant to subdivision (d) of Section 14184.102.

(b) As a component of Behavioral Health Payment Reform under CalAIM, the department shall, at a minimum, design and implement an intergovernmental transfer-based reimbursement methodology to replace the use of certified public expenditures for claims associated with covered Specialty Mental Health and Drug Medi-Cal services provided through Medi-Cal behavioral health delivery systems.

(c) Notwithstanding any other law, commencing no sooner than July 1, 2022, the nonfederal share of any payments associated with each Medi-Cal behavioral health delivery system shall consist of voluntary intergovernmental transfers of funds provided by eligible governmental agencies or public entities associated with a respective Medi-Cal behavioral health delivery system. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations, any other applicable federal Medicaid laws, and the CalAIM Terms and Conditions, and in the form and manner specified by the department. Any intergovernmental transfer of funds made pursuant to this section shall be considered voluntary for purposes of all state and federal laws. Notwithstanding any other law, the department shall not assess the fee described in subdivision (d) of Section 14301.4 or any other similar fee on the intergovernmental transfers made pursuant to this section. The total intergovernmental transfer-funded payment amount, which includes the federal and nonfederal share, paid to a Medi-Cal behavioral health delivery system shall be for the support of behavioral health-related services and activities that benefit patients served by the Medi-Cal behavioral health delivery system, consistent with federal law.

(d) (1) The department shall establish and implement prospective reimbursement rate methodologies utilizing past county cost experience for covered Specialty Mental Health and Drug Medi-Cal services provided by Medi-Cal behavioral health delivery systems. Those methodologies shall make use of peer groups whereby counties are grouped according to past cost experience, where the department determines appropriate. The department shall determine the frequency of payments and intergovernmental transfers made pursuant to this section. The department shall consult with the representatives of Medi-Cal behavioral health delivery systems in the development of the rate methodologies, peer groups, and the payment schedule.

(2) The department, in consultation with the representatives of Medi-Cal behavioral health delivery systems, shall review and may modify the methodologies annually, including, but not limited to, adjustments to the peer groups or to rates.

(e) (1) The Medi-Cal County Behavioral Health Fund is hereby created in the State Treasury.

(2) The nonfederal moneys collected by the department pursuant to this section shall be deposited in the Medi-Cal County Behavioral Health Fund.

(3) Notwithstanding Section 13340 of the Government Code, the moneys deposited in the Medi-Cal County Behavioral Health Fund are continuously appropriated, without regard to fiscal year, to the department for purposes of implementing this section.

(4) (A) Notwithstanding any other law, for counties that elect to participate in the offset and transfer of funds pursuant to this paragraph, moneys from the following sources shall be offset and transferred by the Controller into the Medi-Cal County Behavioral Health Fund pursuant to schedules, in accordance with subparagraph (C), provided by the department and created in consultation with the Department of Finance and applicable counties:

(i) The Behavioral Health Subaccount in the Support Services Account in the Local Revenue Fund 2011 established pursuant to subparagraph (B) of paragraph (2) of subdivision (b) of Section 30025 of the Government Code.

(ii) The Mental Health Subaccount in the Sales Tax Account in the Local Revenue Fund established pursuant to paragraph (1) of subdivision (b) of Section 17600.

(iii) The Mental Health Services Fund established pursuant to Section 5890.

(B) To the extent that funds are offset and transferred from the subaccounts or fund listed in subparagraph (A), the use of the funds shall be consistent with, and in furtherance of, the purposes for which they were previously deposited to the subaccounts or fund, as applicable.

(C) (i) If the department prepares monthly schedules, it shall provide the schedules to the Controller by the first day of each month. If the department prepares quarterly schedules, it shall provide the schedules to the Controller detailing offsets for each month in that quarter by the first day of each quarter as agreed upon by the department, the Department of Finance, and the Controller.

(ii) The department shall provide notifications to the Controller to start, stop, or resume offsetting funds by the first day of the month for changes expected to take effect in the current month. Notifications received by the Controller after the first day of the month shall be processed in the subsequent month.

(5) Notwithstanding Section 16305.7 of the Government Code, the Medi-Cal County Behavioral Health Fund shall contain all interest and dividends earned on moneys in the fund and shall be used only for the purpose of implementing this section.

(Amended by Stats. 2023, Ch. 42, Sec. 159. (AB 118) Effective July 10, 2023.)

14184.404. (a) Notwithstanding any other law, commencing January 1, 2027, subject to subdivision (f) of Section 14184.102, an individual county, or counties acting jointly, shall provide and administer covered behavioral health Medi-Cal benefits under a single Medi-Cal behavioral health delivery system contract, in accordance with the CalAIM Terms and Conditions.

(b) During the CalAIM term, the department, in consultation with counties, shall conduct any planning activities it deems necessary and issue related guidance pursuant to subdivision (d) of Section 14184.102 to facilitate implementation of subdivision (a).

(c) The department may authorize a noncounty organization that it contracts with pursuant to Section 14712 or Section 14124.21 to provide and administer covered behavioral health Medi-Cal benefits under a single Medi-Cal behavioral health delivery system contract, in accordance with the CalAIM Terms and Conditions.

(Added by Stats. 2021, Ch. 143, Sec. 402. (AB 133) Effective July 27, 2021.)

14184.405. (a) Subject to appropriation, the department shall establish, implement, and administer the Behavioral Health Quality Improvement Program to provide grants to qualified Medi-Cal behavioral health delivery systems for purposes of preparing those entities and their contracting health care providers for implementation of CalAIM behavioral health components described in this article and for other purposes related to Medi-Cal behavioral health delivery systems as specified in an annual Budget Act or enacted legislation providing appropriations related to those acts.

(b) The department shall, in consultation with representatives of the Medi-Cal behavioral health delivery systems, determine the eligibility criteria, grant application process, and methodology for distribution of the moneys appropriated to the department for the purposes described in this section to Medi-Cal behavioral health delivery systems that the department deems qualified.

(c) This section shall be implemented only if, and to the extent that, the department determines that federal financial participation is not jeopardized.

(Amended by Stats. 2022, Ch. 47, Sec. 129. (SB 184) Effective June 30, 2022.)

14184.500. (a) The department shall implement the State Plan Dental Improvement Program in accordance with the CalAIM Terms and Conditions and as described in this section, with the goal of further improving accessibility of Medi-Cal dental services and oral health outcomes for statewide and targeted populations, as a successor program to the Dental Transformation Initiative described in Section 14184.70.

(b) Commencing no sooner than January 1, 2022, subject to subdivision (f) of Section 14184.102, both of the following shall be covered Medi-Cal benefits for the specified populations, when medically necessary and subject to utilization controls:

(1) Caries Risk Assessment bundle for eligible children 0 to 6 years of age, inclusive.

(2) Silver diamine fluoride for eligible children 0 to 6 years of age, inclusive, and for eligible beneficiaries residing in skilled nursing facilities or intermediate care facilities or that receive services in facilities overseen by the State Department of Developmental Services, as determined by the department.

(c) (1) Commencing no sooner than January 1, 2022, subject to subdivision (f) of Section 14184.102, the department shall make supplemental payments to qualified dental providers for increased utilization of certain preventive dental services, and for the establishment or maintenance of beneficiary continuity of care through a dental home.

(2) The department shall develop the methodology for making supplemental payments pursuant to this subdivision, including, but not limited to, the eligibility criteria for receiving payments, the amount of payments, and the applicable preventive dental services that are eligible for payments.

(A) For payments for increased utilization of certain preventive services, the department shall make a supplemental payment to a qualified dental service office location for each eligible paid claim made for those Current Dental Terminology codes specified by the department and approved in the CalAIM Terms and Conditions. To the extent the department deems practicable, the supplemental payment shall be applied at the same time as the underlying eligible paid claim is made.

(B) For payments for the establishment or maintenance of beneficiary continuity of care through a dental home, the department shall make a supplemental payment to each eligible service office location statewide based on the number of Medi-Cal beneficiaries for which eligible paid claims were submitted using at least one of Current Dental Terminology exam codes, as specified by the department, in two or more consecutive calendar years.

(d) To the extent permissible under federal law and authorized under the CalAIM Terms and Conditions, for purposes of eligibility for payments described in this section, qualified dental providers may include safety net clinics that provide services defined under subdivision (a) or (b) of Section 14132.100. Supplemental payments made pursuant to this section to safety net clinics shall be considered separate and apart from either the Prospective Payment Service reimbursement for federally qualified health centers or rural health clinics, or Memorandum of Agreement reimbursement for Tribal Health Centers.

(e) The department shall seek federal approval of any state plan amendments it deems necessary to implement subdivisions (b) and (c).

(Added by Stats. 2021, Ch. 143, Sec. 402. (AB 133) Effective July 27, 2021.)

14184.600. (a) As a component of the CalAIM initiative, on and after July 1, 2022, the department, in consultation with representatives of county welfare departments and other affected stakeholders, shall develop and make publicly available a dashboard that reflects each county's performance in meeting the measures established pursuant to subdivision (d) of Section 14154 and Section 14154.5.

(b) During the CalAIM term, subject to subdivision (f) of Section 14184.102, the department, in consultation with counties and other affected stakeholders, shall develop and implement all of the following initiatives to enhance oversight and monitoring of county administration of the California Children's Services (CCS) program, pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code:

(1) Establish statewide performance, reporting, and budgetary standards, and accompanying audit tools, used to assess county compliance with federal and state requirements applicable to the CCS program.

(2) Conduct periodic CCS quality assurance reviews and audits to assess compliance with the standards established in paragraph (1).

(3) Assess each CCS program to ensure appropriate allocation of resources necessary for compliance with standards, policies, guidelines, performance, and compliance requirements.

(4) Determine and implement a process to inform each CCS program of, and make available on its internet website, the latest standards, policies, guidelines, and new performance and compliance requirements imposed pursuant to this section.

(5) Establish a statewide, tiered enforcement framework to ensure prompt corrective action for counties that do not meet standards established in paragraph (1), including providing technical assistance to counties on measures where performance is consistently below expectations and on any issues that may be identified to create a continuous quality improvement process prior to the imposition of fiscal penalties.

(6) Require each county to enter into memoranda of understanding with the department to document each county's obligations in administering the CCS program.

(c) During the CalAIM term, the department shall convene a workgroup consisting of counties and other applicable stakeholders to develop and implement one or more initiatives designed to improve the collection and use of beneficiary demographic and contact information in administering the Medi-Cal program and other applicable public assistance programs.

(Added by Stats. 2021, Ch. 143, Sec. 402. (AB 133) Effective July 27, 2021.)

14184.700. (a) Subject to subdivision (f) of section 14184.102 and the availability of sufficient nonfederal share funds for this purpose in each CalAIM year, the department may make incentive payments, grants, or other financial support available to qualified entities or providers under the Providing Access and Transforming Health (PATH) program to support services, infrastructure, and capacity building in advancing and complimenting select goals and components of CalAIM as described in this article.

(b) The department, in consultation with affected entities and providers, shall establish the methodologies, parameters, and eligibility criteria for PATH payments pursuant to this section, in accordance with the CalAIM Terms and Conditions.

(c) For purposes of PATH payments made pursuant to this section, qualified entities or providers may include, but need not be limited to, counties, Medi-Cal managed care plans, designated public hospital systems, community-based organizations, county sheriffs, adult and juvenile correctional facilities, or chief probation officers, to the extent approved in the CalAIM Terms and Conditions.

(d) The nonfederal share of PATH payments may consist of voluntary intergovernmental transfers of funds provided by eligible governmental agencies or other public entities pursuant to Section 14164. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations, any other applicable federal Medicaid laws, and the CalAIM Terms and Conditions, and in the form and manner specified by the department. Any intergovernmental transfer of funds made pursuant to this section shall be considered voluntary for purposes of all state and federal laws. Notwithstanding any other law, the department shall not assess the fee described in subdivision (d) of Section 14301.4 or any other similar fee on the intergovernmental transfers made pursuant to this section.

(Added by Stats. 2021, Ch. 143, Sec. 402. (AB 133) Effective July 27, 2021.)

14184.800. (a) Notwithstanding any other law, commencing no sooner than January 1, 2023, a qualifying inmate of a public institution shall be eligible to receive targeted Medi-Cal services for 90 days, or the number of days approved in the CalAIM Terms and Conditions with respect to an eligible population of qualifying inmates if different than 90 days, prior to the date they are released from a public institution, if otherwise eligible for those services under this chapter and subject to subdivision (f) of Section 14184.102.

(b) Targeted Medi-Cal services made available to qualifying inmates pursuant to subdivision (a) shall be limited to those services approved in the CalAIM Terms and Conditions.

(c) To the extent federal approval is obtained to implement this section, the department shall arrange for an independent, third-party evaluation of the hypotheses and outcomes associated with providing targeted Medi-Cal services to qualifying inmates as described in the CalAIM Terms and Conditions. The department shall post the evaluation report on its internet website following submission to the federal Centers for Medicare and Medicaid Services.

(Amended by Stats. 2022, Ch. 47, Sec. 130. (SB 184) Effective June 30, 2022.)