CALIFORNIA LEGISLATURE

STATE CAPITOL
SACRAMENTO, CALIFORNIA
95814

Joint Informational Hearing

Assembly Health Committee and Budget Subcommittee No. 1

Medi-Cal Eligibility, Benefits and Managed Care Components of California Advancing and Innovating Medi-Cal

Tuesday, March 16, 2021 - 1:30 p.m.

State Capitol, Assembly Chambers

BACKGROUND

Introduction

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

First released in October 2019, CalAIM was the multi-year product of DHCS site visits, a DHCS 2018 care coordination advisory committee, and an extensive CalAIM stakeholder workgroup process (November 2019 to February 2020) consisting of over 20 in-person workgroup meetings across five separate workgroups. CalAIM had an original initial implementation date of January 1, 2021, but due to the COVID-19 Public Health Emergency's (PHE) impact in the state's budget and health care delivery system, CalAIM was put on hold for the duration of 2020, as were the five bills[1] introduced to implement the various proposals.

As part of the Governor's January 2021 budget, DHCS released an updated 230 page CalAIM proposal with modifications resulting from the workgroup process, stakeholder input, ongoing policy development, and new implementation dates. In addition, the Administration released 94 pages of CalAIM proposed Trailer Bill language (TBL) with over 20 policy proposals.

To implement CalAIM effective January 1, 2022, the Budget proposes $1.1 billion total funds ($531.9 million General Fund [GF]) for fiscal year (FY) 2021-22, growing to $1.5 billion total ($755.5 million GF) in FY 2022-23. This spending is for enhanced care management (ECM) and funds in lieu of services (ILOS) provided by the Medi-Cal Managed Care (MCMC) plans,

promote necessary infrastructure to expand whole person care (WPC) approaches statewide, build upon existing dental initiatives, and promote greater consistency in the delivery systems where beneficiaries receive services. Beginning in FY 2024-25, the Administration proposes to phase out incentive funding to plans, resulting in ongoing costs of $846 million total funds ($423 million GF). DHCS also released a Budget Change Proposal as part of the Governor's Budget requesting 69 permanent positions, limited term resources equivalent to 46 positions, and expenditure authority of $23.9 million ($11 million GF and $12.8 million in federal funds) for FY 2021-22.

Due to the scope, complexity, amount of detail, and number of proposals in CalAIM, this second hearing will focus on the following major CalAIM MCMC eligibility, rate and benefit change proposals:

1) Medicaid Reimbursable Option for MCMC Plans to Voluntarily Provide "In Lieu of Services" and Sunset of Health Homes Program (HHP);
2) New ECM Benefit Through MCMC Plans;
3) Requirement for Incentive Payments to be Paid to MCMC Plans;
4) Requirement of MCMC Plans to Have a Population Health Management (PHM) Program;
5) Requirement for DHCS to Standardize Benefits Provided by MCMC Plans;
6) Requirement for DHCS to Standardize Mandatory Eligibility for MCMC Plans;

The overall CalAIM proposal raises multiple policy, financing, process and timing issues for legislative consideration, including the following overarching questions:

- Are MCMC plans able to deliver the expanded scope of the proposed benefit changes (such as ECM and ILOS) intended to address social determinants of health (SDOH)?
- Is the CalAIM implementation timeframe for the proposed changes (and the ability of the various Medi-Cal delivery system to implement the proposed changes) realistic given the PHE and competing demands on those systems?
- How does the Administration propose to ensure the CalAIM changes are evaluated to determine if goals and outcomes are being achieved? To what extent should policy issues be delegated to executive branch discussions for yet to be determined Terms and Conditions (T&Cs) of the waiver?
- Should, as the proposed TBL requires, in the event of a conflict between the state law CalAIM-related provisions, the T&C control? Should this requirement be in statute in advance of the Legislature and the public knowing and analyzing what is contained in the T&C?
- Should the TBL focus only on those provisions necessary to avoid the expiration of an existing program or service under a prior waiver (such as WPC), and allow more time to analyze those provisions that change the Medi-Cal program?

- Is the financing of CalAIM, including the additional state GF and the state assumption of county-funded benefits sustainable?
- Several of the proposed CalAIM changes are enacted by adding a new article of law instead of amending existing state law provisions by using the phrase "notwithstanding any other law." This method of drafting makes understanding the changes to existing law difficult. Should existing statutory requirements be amended, rather than notwithstood?

Background on Medi-Cal

The Medi-Cal program is projected to provide services to about 14 million individuals each month at a projected cost of $117.9 billion total funds ($22.5 billion GF) in 2020-21, increasing to 15.6 million individuals each month and a cost of $122.2 billion ($28.4 billion GF) in 2021-22. Over the last decade, Medi-Cal has significantly expanded and changed, most predominantly because of changes enacted and funding provided through the federal Patient Protection and Affordable Care Act (ACA), federal regulations, as well as state-level statutory and policy changes. In addition to the program growth, the Medi-Cal delivery models have changed as the number of beneficiaries receiving the majority of their physical health care through MCMC plans has increased from less than 50% to over 80%. Medi-Cal is a complex program, and services are delivered by multiple different governmental administrative entities and public and private payors and providers and delivery models. Depending on a person's needs, some Medi-Cal beneficiaries may access six or more separate delivery systems (MCMC, fee-for-service [FFS], specialty mental health services [SMHS], substance use disorder [SUD], dental, developmental services, and In-Home Supportive Services [IHSS]) in order to receive services to address health-related needs.

CalAIM Goals and Guiding Principles

In order to address the complexity of the program and the medical needs of the population the program serves, DHCS has proposed the below as CalAIM goals and guiding principles:

CalAIM Goals

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

CalAIM Guiding Principles

- Improve the member experience;
- Deliver person-centered care that meets the behavioral, developmental, physical, Long-Term Services and Supports (LTSS) and oral health needs of all members;

- Work to align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals;
- Build a data-driven PHM strategy to achieve full system alignment;
- Identify and mitigate SDOH and reduce disparities and inequities;
- Drive system transformation that focuses on value and outcomes;
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation;
- Support community activation and engagement;
- Improve the plan and provider experience by reducing administrative burden when possible; and,
- Reduce the per-capita cost over time through iterative system transformation.

DHCS argues the CalAIM proposals offer solutions designed to ensure the stability of the Medi-Cal program and allow the critical successes of waiver demonstrations such as WPC Pilots, the HHP, the Coordinated Care Initiative (CCI), and the public hospital system delivery transformation that advance the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees.

Identifying and Managing Member Risk and Need through WPC Approaches and Addressing SDOH

1) Medicaid Reimbursable Option for MCMC Plans to Voluntarily Provide "In Lieu of Services"

The Medi-Cal program provides coverage for a defined set of health care services for low-income individuals. While MCMC plans provide required services, they also provide some services which are not Medi-Cal covered benefits using their own funds (such as from their reserves) when it is beneficial to the member's health or where the non-covered service would avert the need for a higher cost services. These additional benefits and services are not currently recognized in the DHCS MCMC rate setting process, and are not eligible for federal financial participation (FFP is known as Medicaid "matching funds").

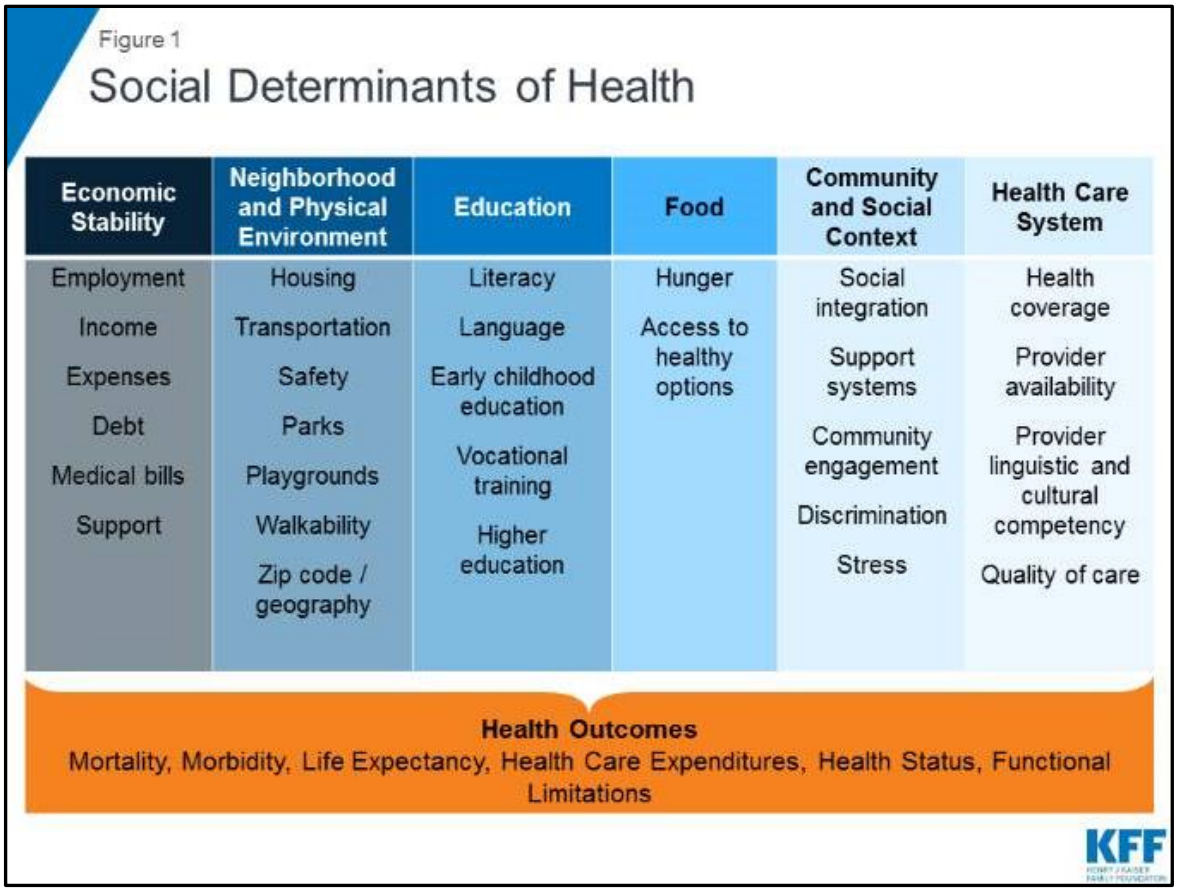
As part of the state's 2015 Section 1115 Medicaid waiver[2] known as "Medi-Cal 2020," the state has been able to obtain federal Medicaid matching funds for WPC programs operated outside of MCMC plans by 24 counties and one city in California. WPC programs vary in population focus but are aimed at the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. Local governments put up state matching funds to draw down federal Medicaid funds. Over 202,000 individuals have received services through WPC programs, with a point in time

enrollment of approximately 86,000 (data through September 2020).

In addition to WPC, the federal ACA authorized 90% federal Medicaid funding for up to two years for a HHP for Medi-Cal beneficiaries. The HHP gives states the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. As of March 2020, approximately 27,000 individuals were enrolled at a point in time in the HHP. Federal law defines the individuals eligible for health home services as individuals meeting one of the following:

1) Having at least two chronic conditions;
2) Having one chronic condition and are at risk of having a second chronic condition; or,
3) Having one serious and persistent mental health condition.

The provision of non-covered benefit by MCMC plans, the provision of a variety of benefits in the HHP and WPC programs are intended to address medically complex and high cost Medi-Cal beneficiaries in part by addressing SDOH. SDOH are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.



Source: Kaiser Family Foundation

Because of a change in federal policy on waiver funding that will make federal funding for the county and federally funded WPC unavailable, the time-limited nature of the HHP 90% enhanced federal funding, and the availability of a new "in lieu of services" option authorized under federal Medicaid managed care regulations, DHCS has proposed to instead establish two new categories of state-funded Medi-Cal benefits (ILOS and ECM) as part of the CalAIM proposal, with incentive funding to build infrastructure.

ILOS

In 2016, federal Medicaid managed care regulations were changed to permit federal Medicaid matching funds to be provided to plans that provide services or settings that are "in lieu of" services or settings covered under the state's Medicaid program.[3] These ILOS are provided as a substitute, or to avoid, other services such as a hospital or skilled nursing facility (SNF) admission, discharge delays or emergency department (ED) use. Under federal Medicaid regulation, ILOS are subject to the following:

- The State determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State plan;
- The enrollee is not required by the plan to use the alternative service or setting;
- The approved ILOS are authorized and identified in the plan contract, and will be offered to enrollees at the option of the plan; and,
- The utilization and actual cost of ILOS is taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.

As described in the proposed TBL below, DHCS is proposing to sunset the existing HHP and to authorize plans to provide ILOS. DHCS has proposed 14 benefits that MCMC plans could offer as ILOS (see table from Legislative Analyst's Office on following page). Examples of the ILOS that DHCS proposes to cover include many of the services currently provided in the WPC pilot program that are not covered as Medi-Cal State Plan benefits. Some of these include, but are not limited to, respite, recuperative care, medically tailored meals, supplemental personal care services, housing tenancy navigation and sustaining services, and sobering centers.

DHCS states MCMC plans will develop a network of providers of allowable ILOS with consideration for which community providers have expertise and capacity regarding specific types of services. DHCS is proposing the initial use of ILOS to serve as a transition of the work done through existing pilots (e.g. WPC, HHP, the CCI, etc.), as well as inform the development of future potential statewide benefits that may be instituted.

In support of his ILOS CalAIM proposal, DHCS argues ILOS are flexible wrap-around services that:

- MCMC plans will integrate into its PHP programs;

- Are provided as a substitute or to avoid utilization of other services such as hospital or SNF admissions, discharge delays, or ED use; and,
- Fill gaps in Medi-Cal State Plan benefits to address medical or other needs that may arise due to SDOH.

Proposed "In Lieu of Services" Benefits	
Benefit	**Description**
Services to Address Homelessness and Housing	
Housing deposits[a]	Funding for one-time services necessary to establish a household, including security deposits to obtain a lease, first month's coverage of utilities, or first and last month's rent required prior to occupancy.
Housing transition navigation services[a]	Assistance with obtaining housing. This may include assistance with searching for housing or completing housing applications, as well as developing an individual housing support plan.
Housing tenancy and sustaining services[a]	Assistance with maintaining stable tenancy once housing is secured. This may include interventions for behaviors that may jeopardize housing, such as late rental payment and services, to develop financial literacy.
Services for Long-Term Well-Being in Home-Like Settings	
Asthma remediation[b]	Physical modifications to a beneficiary's home to mitigate environmental asthma triggers.
Day habilitation programs	Programs provided to assist beneficiaries with developing skills necessary to reside in home- like settings, often provided by peer mentor-type caregivers. These programs can include training on use of public transportation or preparing meals.
Environmental accessibility adaptions	Physical adaptations to a home to ensure the health and safety of the beneficiary. These may include adaptations ramps and grab bars
Meals/medically tailored meals	Meals delivered to the home that are tailored to meet beneficiaries' unique dietary needs, including following discharge from a hospital.
Nursing facility transition/diversion to assisted living facilities[c]	Services provided to assist beneficiaries transitioning from nursing facility care to community settings, or prevent beneficiaries from being admitted to nursing facilities.
Nursing facility transition to a home	Services provided to assist beneficiaries transitioning from nursing facility care to home settings in which they are responsible for living expenses.
Personal care and homemaker services[d]	Services provided to assist beneficiaries with daily living activities, such as bathing, dressing, housecleaning, and grocery shopping.
Recuperative Services	
Recuperative care (medical respite)	Short-term residential care for beneficiaries who no longer require hospitalization, but still need to recover from injury or illness.
Respite	Short-term relief provided to caregivers of beneficiaries who require intermittent temporary supervision.
Short-term post-hospitalization housing[a]	Setting in which beneficiaries can continue receiving care for medical, psychiatric, or substance use disorder needs immediately after exiting a hospital.
Sobering centers	Alternative destinations for beneficiaries who are found to be intoxicated and would otherwise be transported to an emergency department or jail.

[a] Restricted to use once in a lifetime, unless managed care plan can demonstrate cost-effectiveness of providing a second time.
[b] New benefit introduced this year. Restricted to lifetime maximum amount of $5000, unless beneficiary's condition changes dramatically.
[c] Includes residential facilities for the elderly and adult residential facilities.
[d] Does not include services already provided in the In-Home Supportive Services program.

Proposed Timeline: DHCS is proposing statewide implementation and inclusion of ILOS in MCMC plans contracts on January 1, 2022.

Proposed TBL (ILOS):

1) Requires DHCS, commencing January 1, 2022, subject to federal approval, to allow MCMC plans to elect to cover those services or settings approved by DHCS as cost effective and medically appropriate in the comprehensive risk contract that are in lieu of applicable Medi-Cal State Plan services covered by the MCMC plan, in accordance with the CalAIM T&C.
2) Requires approved ILOS or settings to only be available to Medi-Cal beneficiaries enrolled in a MCMC plan under a comprehensive risk contract.
3) Prohibits approved ILOS or settings from supplanting other covered Medi-Cal benefits that are not the responsibility of the MCMC plan under the comprehensive risk contract, including, but not limited to, IHSS.
4) Prohibits an enrolled Medi-Cal beneficiary from being required by their MCMC plan to use the ILOS or setting.
5) Permits ILOS or settings to include, but need not be limited to, the following when authorized by DHCS in the comprehensive risk contract with each MCMC plan and to the extent DHCS determines that the ILOS or setting is a cost-effective and medically appropriate substitute for the applicable covered Medi-Cal benefit under the MCMC plan's comprehensive risk contract:
    a) Housing transition navigation services;
    b) Housing deposits;
    c) Housing tenancy and sustaining services;
    d) Short-term post-hospitalization housing;
    e) Recuperative care (medical respite);
    f) Respite;
    g) Day habilitation programs;
    h) Nursing facility transition/diversion to assisted living facilities, such as residential care facilities for the elderly or adult residential facilities;
    i) Nursing facility transition to a home;
    j) Personal care and homemaker services;
    k) Environmental accessibility adaptations (home modifications);
    l) Medically tailored meals;
    m) Sobering centers; and,
    n) Asthma remediation.

Proposed Health Homes Program TBL:

1) Requires, notwithstanding any other law, for the 2021–22 state fiscal year and thereafter as applicable, the HHP to be implemented using General Fund moneys upon appropriation by the Legislature.

2) Requires DHCS, notwithstanding any law, to cease to implement the HHP on January 1, 2022, or the effective date reflected in any necessary federal approvals obtained by DHCS to implement the ECM benefit under CalAIM, whichever is later.

3) Requires DHCS to conduct any necessary close-out activities associated with the HHP including, but not limited to, the required evaluation.

4) Sunsets the HHP on January 1, 2023, and as of that date is repealed.

Policy Questions:

1) Given that federal regulations require ILOS to be at plan option, what will be DHCS' process for assessing the effectiveness of ILOS and disseminating best practices?

2) As part of DHCS' CalAIM proposal, a number of ILOS benefits have utilization limits (such as once a lifetime unless a determination is made). Please explain the purpose of these limits and whether the proposed utilization limits restrict the ability of plans to connect people to non-medical services to address SDOH?

3) How will DHCS oversee the federal regulation requirement for cost effectiveness? How much discretion will MCMC plans have to make that determination?

4) How will ILOS costs be shown on the MCMC plan Rate Development Template (RDT)? Will they be trackable as an expenditure or embedded in another service or benefit category?

5) How will the availability of ILOS be disclosed to Medi-Cal beneficiaries?

6) Can MCMC plans provide additional ILOS beyond the 14 listed in the CalAIM proposal?

Witnesses:

Will Lightbourne, Director and Jacey Cooper, Chief Deputy Director of Health Care Programs and State Medicaid Director, Department of Health Care Services
Ned Resnikoff, Fiscal and Policy Analyst, Legislative Analyst's Office
Karen Hansberger, MD, Chief Medical Officer, Inland Empire Health Plan
Linda Nguy, Policy Advocate, Western Center on Law & Poverty
Mary June G. Diaz, Government Affairs Advocate, SEIU California State Council

2) New ECM Benefit Required Through MCMC Plans

Case management services actively assist at-risk members in navigating health delivery systems and acquiring self-care skills to improve functioning and health outcomes, slow the progression of disease or disability or prepare for the progression of a serious illness. Case management services are intended for members who are medium- or high-risk or may have rising risks that would benefit from case management services.

DHCS' model contracts with MCMC plans require plans to ensure the provision of Comprehensive Medical Case Management to each enrolled beneficiary.[4] MCMC plans are required to maintain procedures for monitoring the coordination of care provided to

beneficiary members, including but not limited to all medically necessary services delivered both within and outside the plan's provider network. These services are provided through either Basic Case Management (BCM), or Complex Case Management (CCM) activities based on the medical needs of the member, as described below:

BCM services are provided by the primary care provider (PCP), in collaboration with the plan, and are required to include:

1) Initial Health Assessment;
2) Individual Health Education Behavioral Assessment;
3) Identification of appropriate provider and facilities (such as medical, rehabilitation, and support services) to meet the beneficiary's care needs;
4) Direct communication between the provider and beneficiary/family;
5) Beneficiary and family education, including healthy lifestyle changes when warranted; and,
6) Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.

CCM services are provided by the MCMC plan in collaboration with the PCP, and are required to include, at a minimum:

1) BCM services;
2) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team;
3) Intense coordination of resources to ensure member regains optimal health or improved functionality; and,
4) With input from the beneficiary and their PCP, development of care plans specific to individual needs, and updating of these plans at least annually.

In addition to the contractual requirement, MCMC plans in the Coordinated Care Initiative are required to develop care management and care coordination for the beneficiary across the medical and long-term services and supports care system.[5]

As part of CalAIM, DHCS is proposing a new ECM benefit designed for populations that have the highest levels of complex health care needs as well as social factors influencing their health. To be eligible for ECM, Medi-Cal beneficiaries must meet criteria below in addition to any criteria specific to the respective ECM population:

1) Have complex physical or behavioral health condition with an inability to successfully self-manage; and,
2) Limited activity or participation in social functioning, as defined by at least one of the following:

a) Establishing and managing relationships; or,

b) Major life areas, including education, employment, finances, engaging in the community.

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

DHCS CalAIM proposal lists mandatory ECM target populations (described in 6) of the proposed TBL as an "includes but is not limited to" list that plans are authorized to provide).

DHCS states that, for all populations, the role of ECM is to coordinate all primary, acute, behavioral, developmental, oral, and LTSS for the member, including participating in the care planning process, regardless of setting, and the ECM benefit is intended to provide primarily face-to-face services whenever possible

Enhanced Care Management Implementation Dates by County

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

List is subject to changed based on WPC pilots decisions to continue operating through 2021.
Source: Department of Health Care Services

Proposed Timeline:

- All MCMC plans in counties with WPC pilots and/or HHP will begin implementation of the ECM benefit, for those target populations currently receiving HHP and/or WPC services on January 1, 2022.
- All MCMC plans in counties with WPC pilots and/or HHP will implement additional mandatory ECM target populations on July 1, 2022.
- All MCMC plans in counties without WPC pilots and/or HHP must begin implementation of select ECM target populations on July 1, 2022.
- All MCMC plans in all counties must implement ECM for all target populations January 1, 2023.

Proposed ECM TBL:

1) Requires DHCS, subject to federal approval, to implement an 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 MCMC plans, in accordance with the requirements below and the CalAIM T&C.
2) Requires the ECM benefit to be available on a statewide basis (subject to phased in implementation dates) to eligible Medi-Cal beneficiaries who are enrolled in an applicable MCMC plan and who meet the criteria in the CalAIM T&C for one or more target populations, as determined by DHCS.
3) Requires ECM to be available to qualifying dual eligible beneficiaries, except for those dual eligible beneficiaries enrolled in a Cal MediConnect (CMC) plan.
4) Requires ECM to only be available as a covered Medi-Cal benefit under a comprehensive risk contract with a MCMC plan, and requires Medi-Cal beneficiaries who are eligible for ECM to enroll in a MCMC plan in order to receive those services.
5) Phases in the ECM benefit by requiring MCMC plans care plans operating in counties in which either the WPC program, or the HHP or both, were implemented, as determined by DHCS, as follows:
    a) Requires MCMC plans, commencing January 1, 2022, to cover ECM for existing target populations under either the WPC pilot program or the HHP, or both, as identified by DHCS;
    b) Requires MCMC plans, commencing July 1, 2022, to cover ECM for other select target populations below, as identified by DHCS;
    c) Requires MCMC plans, commencing January 1, 2023, to cover ECM for all target populations described below; and,
    d) Requires MCMC plans operating in counties in which neither the WPC pilot program nor the HHP, was implemented, as determined by DHCS, to cover select ECM target populations, as identified by DHCS commencing July 1, 2022.

Requires other target populations, including individual transitioning from incarceration, to be covered commencing January 1, 2023.

6) Permits target populations of Medi-Cal beneficiaries to include, but need not be limited to, the following, to the extent approved in the CalAIM T&C:
   a) Children or youth with complex physical, behavioral, developmental, or oral health needs, including, but not limited to, those eligible for California Children Services (CCS), foster care children or youth, or youth with clinical high-risk syndrome or first episode of psychosis;
   b) Individuals experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless;
   c) High utilizers with frequent hospital admissions, short-term SNF stays, or emergency room visits;
   d) Individuals at risk for institutionalization and eligible for Long-Term Care (LTC) services;
   e) Nursing facility residents who want to transition to the community;
   f) Individuals at risk for institutionalization with serious mental illness, children with serious emotional disturbance or SUD with co-occurring chronic health conditions; and,
   g) Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.
7) Prohibits a Medi-Cal beneficiary, notwithstanding any other law, for any time period in which a Medi-Cal beneficiary who is eligible to receive ECM services through enrollment in their MCMC plan, from receiving duplicative targeted case management services or otherwise authorized in the Medi-Cal State plan, as determined by DHCS.

Policy Questions:

1) What percentage of a MCMC plan's enrollment is projected to use ECM? How does this compare to Whole Person Care and Health Homes enrollment in the applicable areas, if known?
2) Are the ECM target population mandatory populations? Will the target populations be consistent across plans, or will the target populations vary by plan?
3) How do the services and benefits provided and the populations served by the proposed ECM benefit compare to existing contractually required case management program benefits, services and populations?
4) Will the ECM benefit be a designed benefit category (similar to physician services) in the RDT?

5) How does DHCS intend to monitor the provision of this benefit and provide data on its outcomes?
6) How does ECM improve upon or build from lessons learned from other case management services provided today, such as for seniors and persons with disabilities?
7) Has DHCS come up with best practices that will be integrated in how ECM will operate?

Witnesses:
Jacey Cooper, Chief Deputy Director of Health Care Programs and State Medicaid Director, Department of Health Care Services
Ned Resnikoff, Fiscal and Policy Analyst, Legislative Analyst's Office
Mary Zavala, Director of Health Homes Program, LA Care
Linda Nguy, Policy Advocate, Western Center on Law & Poverty
Julie Wallace, Community Health Worker, Los Angeles County, Department of Mental Health, SEIU Local 721 Member
Farrah McDaid Ting, Senior Legislative Representative, California State Association of Counties
Paula Wilhelm, Director of Policy, County Behavioral Health Directors Association of California
Behavioral Health, President, County Behavioral Health Directors Association

3) Requirement for Incentive Payments to be Paid to MCMC Plans

Federal Medicaid managed care regulations permit incentive arrangements to be paid to plans, at an amount not to exceed 105% of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement.[6]

DHCS is proposing to implement incentive payments to drive MCMC plans and providers to invest in the necessary infrastructure to build appropriate ECM and ILOS capacity statewide.

DHCS states the combination of carving in LTC statewide, ECM and ILOS provides a number of opportunities, including an incentive for building an integrated, managed long term services and supports (MLTSS) program by 2027 and building the necessary clinically-linked housing continuum for the state's homeless population. In order for the state to be equipped with the needed MLTSS and clinically linked housing continuum infrastructure, DHCS argues it is important to consider potential incentives and shared savings/risk models that could be established to encourage MCMC plans and providers to fully engage. DHCS argues incentive funding will be focused on building a pathway for MCMC plans to invest in the necessary delivery and systems infrastructure, build appropriate and sustainable ECM and ILOS capacity, and achieve improvements in quality performance that can inform future policy. DHCS' CalAIM proposal outlines three prospective models for shared savings/risk.

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

DHCS' proposed risk approaches are intended to strengthen financial incentives for MCMC plans to:

- Divert or transition beneficiaries from long-term institutional care to appropriate home and community-based alternatives, supported by the availability of ILOS and ECM;
- Make the necessary infrastructure investments to support the goal of transitioning to an integrated LTSS program; and,
- Improve quality, performance measurement, and data reporting as a pathway toward realizing better health outcomes for Medi-Cal beneficiaries.

Proposed Timeline:
DHCS states that MCMC rate setting, including associated risk strategies, is a dynamic process. Therefore, DHCS will engage and collaborate with MCMC plans and make future refinements as determined appropriate.

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

Proposed TBL (incentive payments):
1) Requires DHCS, commencing January 1, 2022, subject to appropriation by the Legislature in an applicable fiscal year and federal approval, to make incentive payments available to qualifying MCMC plans that meet predefined milestones and metrics associated with implementation of applicable components of CalAIM, including, but not limited to, ECM and ILOS, as determined by DHCS and in accordance with the CalAIM T&C.
2) Requires DHCS, in consultation with MCMC plans, to establish the methodology, parameters, and eligibility criteria for incentive payments, including, but not limited to, the milestones and metrics that MCMC plans must meet in order to receive an incentive payment.

3) Requires DHCS, in accordance with the CalAIM T&C, to determine if a MCMC plan has earned an incentive payment, and the amount of that payment, for any relevant time period in which this section is implemented.

4) Requires incentive payments to be made in accordance with the requirements for incentive arrangements described in federal regulation and any associated federal guidance.

Policy Questions:

1) Does DHCS currently reimburse MCMC plans for incentive payments? If so, for what activities?

2) What activities can MCMC plans undertake that will result in incentive payments?

3) Has DHCS determined a payment methodology that will determine how incentive payments that will go to MCMC plans?

4) Does DHCS envision a shared savings or risk policy as part of ILOS so MCMC plans will share in any savings so that "premium slide" will not occur and plans will continue have an incentive to continue providing the ILOS?

Witnesses:

Jacey Cooper, Chief Deputy Director of Health Care Programs and State Medicaid Director, Department of Health Care Services
Ben Johnson, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
Karen Hansberger, MD, Chief Medical Officer, Inland Empire Health Plan
Linda Nguy, Policy Advocate, Western Center on Law & Poverty

4) Requirement of MCMC Plans to Have a Population Health Management Program

DHCS currently does not have a specific requirement for MCMC plans to maintain a PHP program. DHCS describes the PHP Program as a model of care and a plan of action designed to address member health needs at all points along the continuum of care. DHCS states that many MCMC plans have a PHP program – often in the context of meeting NCQA requirements – but some do not. In the absence of a PHP program, beneficiary engagement is often driven by a patchwork of requirements that can lead to gaps in care and a lack of coordination.

Under the PHP Program proposal, each MCMC plan would have to include a description of how it would meet specified core objectives, the PHP program would have to meet specified requirements, including utilizing initial and ongoing assessments of data to analyze individual members' needs and identify groups and individuals within groups for targeted interventions. Plans will be required to risk stratify and segment members into group that the plan will use to develop and implement case management, wellness, and

health improvement programs and strategies. DHCS is proposing requiring the risk stratification and segmentation occur within 44 days of the effective of the person's enrollment in the plan. Plans will be required to use DHCS-defined criteria to assign each member into one of four risk tiers: (1) low risk; (2) medium and rising risk; (3) high risk; and (4) unknown risk. DHCS is requiring plans to reassess risk and need of all plan beneficiaries at least annually.

DHCS' goal for the PHM program proposal is to improve health outcomes and efficiency through standardized core PHP requirements for MCMC plans, including NCQA requirements and additional DHCS requirements. The PHP program will be comprehensive and address the full spectrum of care management – including assessing population level and individual member health risks and health-related social needs, creating wellness, prevention, case management, care transitions programs to address identified risks and needs, and using stratification to identify and connect adult and pediatric members to the appropriate programs.

Proposed TBL:

1) Requires DHCS, commencing January 1, 2023, subject to federal approval, to implement the Population Health Management Program under MCMC to improve health outcomes, care coordination, and efficiency through application of standardized health management requirements, in accordance with the CalAIM T&C.

2) Requires DHCS to require each MCMC plan to develop and maintain a beneficiary-centered PHP 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 T&C.

3) Requires each PHP program, at a minimum, to do all of the following:
    a) Prioritize preventive and wellness services;
    b) Identify and assess beneficiary member risks and needs on an ongoing basis;
    c) Manage beneficiary member safety and outcomes during care transitions, across all applicable delivery systems and settings, through effective care coordination; and,
    d) Identify and mitigate SDOH and reduce health disparities or inequities.

Policy Questions:

1) How does DHCS envision plans performing PHM (for example, use of claims data, member surveys)?

2) Will DHCS provide guidance to MCMC plans for identifying and rectifying bias in the algorithms used as part of performing risk tiering and stratification using algorithms?

Witnesses:

Jacey Cooper, Chief Deputy Director of Health Care Programs and State Medicaid

Director, Department of Health Care Services
Ben Johnson, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
Katherine Barresi, RN, BSN, PHN, CCM *Director Care Coordination,* Partnership Health Plan of California
Mike Odeh, Children Now
Cary Sanders, Senior Policy Director, California Pan-Ethnic Health Network

5) Requirement for DHCS to Standardize Benefits Provided by MCMC Plans

While MCMC exists statewide, it is operated under six different model types that currently differ based on whether certain benefits are part of the MCMC plan's responsibility or provided through a different delivery system (such as FFS). Generally, the 22 counties providing Medi-Cal services through County Organized Health System (COHS) model have the most benefits "carved in" to the plan (provided directly by the plan), as compared to the other three major MCMC models (two-plan model, geographic managed care and the regional model).

The services carved in or out of MCMC plans are specified in statute, or in contracts between the plan and DHCS. Under CalAIM, DHCS is proposing to standardize the benefits that are provided through MCMC plans statewide across the different models. Regardless of the beneficiary's county of residence or the plan they are enrolled in, DHCS proposed beneficiaries will have the same set of benefits delivered through their MCMC plan as they would in another county or plan. DHCS is proposing the following changes:

Benefit Changes Effective April 1, 2021	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Pharmacy	All pharmacy benefits or services billed by a pharmacy on a pharmacy claim, which includes covered outpatient drugs (including Physician Administered Drugs), medical supplies, and enteral nutrition products. This also includes drugs currently "carved-out" of the managed care delivery system, (e.g., blood factor, HIV/AIDS, antipsychotics, and drugs used to treat substance use disorder), which are currently carved-in to some county operated health systems and AIDS Healthcare Foundation. This does not include any pharmacy benefits or services billed on medical and/or institutional claims.
Benefit Changes Effective January 1, 2022	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Specialty Mental Health Services	Currently full benefit in Partnership Solano (Kaiser members only) and Kaiser Sacramento
Multipurpose Senior Services Program	Currently full benefit in CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside)

Benefits to be Carved-In to Managed Care Statewide	
Major Organ Transplant	Currently full benefit in county operated health systems counties; non-county operated health systems counties currently only cover kidney transplants
Benefit Changes Effective January 1, 2023	
Benefits to be Carved-In to Managed Care Statewide	
Long Term Care	Long Term Care Umbrella • ICF-DD Disabled (excluding beneficiaries in an ICF-DD Waiver center), Disabled Habilitative, and Disabled Nursing • Pediatric Subacute Care Services • Skilled nursing facility • Specialized Rehabilitative Services in skilled nursing facility and ICF • Subacute Care Services Currently full benefit in county operated health systems and CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside); in non-county operated health systems/non-CCI counties, Medi- Cal managed care plans are responsible for the month of admission and the month following

Benefits "Carved Out" into MCMC Plans

- Effective at an unspecified date (previously was scheduled for January 1, 2021, then delayed until April 1, 2021, then postponed with no currently rescheduled implementation date), all pharmacy benefits or services by a pharmacy billed on a pharmacy claim will be carved out from MCMC plans (pursuant to the Governor's Executive Order N-01-19 from January 7, 2019). This applies to all MCMC, including AIDS Healthcare Foundation, but does not apply to SCAN Health Plan, Program of All-Inclusive Care for the Elderly (PACE) organizations, CMC health plans, and Major Risk Medical Insurance Program.
- Effective January 1, 2022, the following benefits that are currently within the scope of some or all the MCMC plans will be carved out:
  - SMHS that are currently carved in for Medi-Cal members enrolled in Kaiser in Solano and Sacramento counties (discussed in May 9, 2016 hearing); and,
  - The Multipurpose Senior Services Program which is currently included in the MCMC plans in the seven CCI counties.

Benefits "Carved In" to MCMC Plans

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

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

- DHCS proposes to require that LTC and transplant providers accept as payment in full and require the MCMC plan to pay the applicable Medi-Cal FFS rate, unless the provider and plan mutually agree upon an alternative payment. DHCS argues this would provide a smooth transition from FFS to MCMC, promote access, maintain affordability, and is consistent with how these transitions to managed care have occurred in the past, such as with the CCI and the CCS Whole Child Model. DHCS argues the standardization of benefits delivered through MCMC plans statewide has two main purposes and benefits:
- Beneficiaries will no longer have to deal with the confusion that may arise when moving counties/plans and to find that different benefits are covered by their new plan or that they need to access another delivery system; and
- DHCS will be able to implement a change to MCMC rate setting. Currently, DHCS states the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the MCMC plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

Proposed Timeline

The benefit standardization will be effective and included in MCMC plan contracts by January 2023.

Proposed CalAIM TBL:

1) Requires, notwithstanding any other law, a MCMC plan, pursuant to its comprehensive risk contract with DHCS, to provide coverage for those health care services or benefits that are both of the following:

    a) Authorized for receipt of FFP in the Medi-Cal State Plan, or waiver thereof, or otherwise required pursuant to federal law, as determined by DHCS.

    b) Included by DHCS as a capitated benefit or otherwise made the financial obligation of the MCMC plan pursuant to its comprehensive risk contract with DHCS.

2) Permits a MCMC plan to also be contractually required by DHCS to provide coverage for a health care service or benefit that does not meet the criteria set forth in 1) to the extent that sufficient state-only funds are appropriated to DHCS for that purpose in an applicable state fiscal year.

3) Requires DHCS, notwithstanding any other law, to standardize those applicable covered Medi-Cal benefits provided by MCMC plans under comprehensive risk

contracts with DHCS on a statewide basis and across all models of MCMC in accordance with the proposed TBL and the CalAIM T&C.

4) Requires DHCS, notwithstanding any other law, commencing January 1, 2023 and subject to federal approval, to include, or continue to include, "institutional LTC services" as capitated benefits in the comprehensive risk contract with each MCMC plan.

5) Requires "institutional LTC services" to have the same meaning as set forth in the CalAIM T&C and, subject to federal approval, to include at a minimum all of the following:
   a) SNF services;
   b) Subacute facility services;
   c) Pediatric subacute facility services; and,
   d) Intermediate care facility services.

6) Requires DHCS, notwithstanding any other law, commencing January 1, 2022, to include as capitated benefits in the comprehensive risk contract with each MCMC plan:
   a) Donor and recipient organ transplant surgeries, as described in existing law and in the CalAIM T&C;
   b) Donor and recipient bone marrow transplants, as described in existing law and in the CalAIM T&C; and,
   c) Community-Based Adult Services (CBAS), in accordance with the CalAIM T&Cs.

7) Requires each MCMC plan, for contract periods during which 4) through 6) above is implemented, to reimburse a network provider furnishing the services in 4) through 6) above to a Medi-Cal beneficiary enrolled in that plan, and requires each network provider of those services to accept as payment in full, the amount the network provider could collect if the applicable Medi-Cal beneficiary accessed those services in the Medi-Cal FFS delivery system, as defined by DHCS in the Medi-Cal State Plan and guidance issued by DHCS, unless the MCMC plan and network provider mutually agree to reimbursement in a different amount, in a form and manner acceptable to DHCS.

8) Requires DHCS, for contract periods during which 4) through 7) is implemented, capitation rates paid to a MCMC plan to be actuarially sound and to account for the payment levels described in 7) as applicable. Permits DHCS to require MCMC plans and network providers of the services in 4) through 7) to submit information DHCS deems necessary to implement this provision, at the times and in the form and manner specified by DHCS.

9) Requires CBAS to only be available as a covered Medi-Cal benefit for a qualified Medi-Cal beneficiary under a comprehensive risk contract with an applicable MCMC plan.

10) Requires Medi-Cal beneficiaries who are eligible for CBAS to enroll in an applicable MCMC plan in order to receive those services, except for beneficiaries exempt from mandatory enrollment in a MCMC plan pursuant to the CalAIM T&C.

11) Requires CBAS to be delivered in accordance with applicable state and federal law including, but not limited to, the federal Home and Community-Based Settings regulations, and related sub-regulatory guidance and any amendment issued thereto.

Policy Questions:

1) The proposed TBL grants DHCS wide discretion to determine what benefits are provided through MCMC plans. Should DHCS be granted this authority?

2) What is the policy and fiscal rationale for establishing payment requirements for institutional long-term care service providers and organ and bone marrow transplant surgery providers, and requiring the applicable fee-for-service rate to be accepted as payment in full by those providers?

3) Should the MCMC plan access rules (time and distance and appointment availability rules) be updated to take into account folding SNF and other LTC benefits into plans on a statewide basis?

Witnesses:

Jacey Cooper, Chief Deputy Director of Health Care Programs and State Medicaid Director, Department of Health Care Services
Ben Johnson, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
Mark R. Klaus, CEO, Home of Guiding Hands
Abigail (Abbi) Coursolle, Senior Attorney, National Health Law Program

6) Requirement for DHCS to Standardize Mandatory Eligibility for MCMC Plans

The Medi-Cal program provides benefits through both a FFS and managed care delivery system. Enrollment in FFS delivery system or the managed care delivery system is based upon specific geographic areas, the health plan model, and/or the beneficiary's aid code. In some cases, enrolling in MCMC is optional for beneficiaries. More than 80% of Medi-Cal beneficiaries are currently served through the managed care delivery system.

DHCS is proposing to standardize which aid code groups will require mandatory MCMC enrollment versus mandatory FFS enrollment, across all models of care and aid code groups, statewide. Under this proposal, beneficiaries in a voluntary or excluded from

managed care enrollment aid code that are currently accessing the FFS delivery system, would be required to choose a MCMC plan and will not be permitted to remain in FFS. DHCS indicates it completed extensive data analytics to inform this proposal. For example, DHCS states 73% of beneficiaries with other health coverage are already enrolled in managed care today and of non-LTC share of cost (SOC) beneficiaries, on average only 5.4% of beneficiaries meet their monthly SOC (Under SOC, Medi-Cal, beneficiaries must incur a predetermined amount of health care expenses each month (their "share of cost") before Medi-Cal begins to provide health coverage for that month. When the share of cost has been met, Medi-Cal will pay for any additional covered expenses for the month.) DHCS is proposing implementation of this change in two phases, transitioning non-dual eligible populations in 2022 and dual eligible populations in 2023.

Mandatory Managed Care Enrollment
Below are the populations that currently receive benefits through the FFS delivery system that would transition to MCMC upon implementation of this proposal in 2022:

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

Below are the populations that currently receive benefits through the FFS delivery system (except in COHS and CCI counties) that would transition to the MCMC system upon implementation of this proposal in 2023:

- All dual and non-dual individuals eligible for LTC services (includes LTC SOC populations); and,
- All partial and full dual aid code groups, except SOC or restricted scope, will be mandatory MCMC, in all models of care starting in 2023.

Mandatory Fee-for-Service Enrollment
DHCS proposal would also move the following populations from mandatory MCMC enrollment into mandatory FFS enrollment upon implementation of this proposal in 2022:

- Omnibus Budget Reconciliation Act (OBRA): This population was previously mandatory MCMC in Napa, Solano, and Yolo counties; and,
- Share of Cost: beneficiaries in COHS and CCI counties excluding LTC SOC.

Beneficiaries in the following aid code groups will have mandatory FFS enrollment:

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

DHCS recommends keeping enrollment requirements for foster care children and youth in place until the Foster Care Workgroup makes recommendations on the future delivery system for foster care children and youth. DHCS states it firmly believes that MCMC care is a delivery system it should continue to invest in and rely upon, given the ability and directive of MCMC plans to provide case and care management not available in a FFS environment. DHCS plans to increase oversight of the plans and their delegated entities in conjunction with these new and increased responsibilities to ensure that current requirements being met but also that the additional benefits and requirements contained in CalAIM are truly being provided statewide.

DHCS argues its CalAIM proposed managed and FFS are an effort to enhance coordination of care, increase standardization, and reduce complexity across the Medi-Cal program, and that moving to mandatory MCMC will:

- Standardize and reduce the complexity of the varying models of care delivery in California;
- Provide the populations moving between counties with the same experience when it comes to receiving services through a MCMC plan;
- Allow for MCMC plan plans to provide more coordinated and integrated care and provide beneficiaries with a network of primary care providers and specialists;
- Allow DHCS to be able to implement a change to MCMC plan rate setting, as the current capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with MCMC plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

Proposed Timeline

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

Proposed TBL:

1) Requires DHCS, notwithstanding any other law, to standardize those populations that are subject to mandatory enrollment in a MCMC plan across all aid code groups and MCMC models statewide, in accordance with the CalAIM T&C and as described below.
2) Requires all non-dual eligible beneficiaries, except those identified in 3) below, notwithstanding any other law, commencing January 1, 2022 and subject to federal approval, to enroll, or to continue to be required to enroll, in a MCMC plan for purposes of their receipt of covered Medi-Cal benefits.
3) Exempts the following dual and non-dual beneficiary groups, as identified by DHCS from mandatory enrollment in a MCMC plan, notwithstanding any other law, commencing January 1, 2022 and subject to federal approval:
    a) Beneficiaries eligible for only restricted-scope Medi-Cal benefits based on immigration status;
    b) Beneficiaries made eligible on the basis of a SOC, including, but not limited to, non-dual eligible beneficiaries residing in a county that is authorized to operate a COHS, except for non-dual eligible beneficiaries that are eligible on the basis of their need for LTC services with a SOC, as identified by DHCS;
    c) Beneficiaries made eligible on the basis of a federally approved Medi-Cal Presumptive Eligibility (PE) program, as determined by the DHCS, but only during the relevant period of PE;
    d) Eligible beneficiaries who are inmates of a public institution, or who are released based on "compassionate release;"
    e) Eligible, noncitizen beneficiaries eligible for pregnancy-related Medi-Cal coverage, excluding beneficiaries enrolled in the Medi-Cal Access Program;
    f) Non-dual eligible beneficiaries who are Indians as defined in federal regulation who elect to forego voluntary enrollment in a MCMC plan;
    g) Non-dual eligible beneficiaries eligible on the basis of their receipt of services through any state foster care program, or former foster youth up to age 26, who elect to forego voluntary enrollment in a MCMC plan, except for those non-dual beneficiaries who reside in a county that is authorized to operate a COHS; this exemption is until the effective date of any necessary federal approvals obtained by DHCS implement a specialized model of care for foster youth, as described below;
    h) Non-dual eligible beneficiaries enrolled with any entity with a contract with DHCS pursuant to the PACE program.
    i) Any other non-dual eligible beneficiaries, as identified by DHCS, for whom federal law prohibits mandatory enrollment in a MCMC plan; and,
    j) Beneficiaries residing in one of the Veterans' Homes of California.

4) Requires all dual eligible beneficiaries to enroll, or to continue to be required to enroll, in a MCMC plan for purposes of their receipt of covered Medi-Cal benefits except as provided in 3) above or 5) below, notwithstanding any other law, commencing January 1, 2023 and subject to federal approval.

5) Exempts the following dual-eligible beneficiary groups, as identified by the DHCS, from mandatory enrollment in MCMC plan:

    a) Dual eligible beneficiaries made eligible on the basis of a SOC, including, but not limited to, dual eligible beneficiaries residing in a county that is authorized to operate a COHS, except for dual eligible beneficiaries who are eligible on the basis of their need for LTC services with a SOC, as determined by the DHCS.

    b) Dual eligible beneficiaries enrolled with any entity with a contract with DHCS pursuant to the PACE program;

    c) Dual eligible beneficiaries enrolled with any entity with a SCAN contract with DHCS;

    d) Dual eligible beneficiaries who are Indians who elect to forego voluntary enrollment in a MCMC plan;

    e) Dual eligible beneficiaries eligible on the basis of their receipt of services through any state foster care program, or former foster youth up to age 26, who elect to forego voluntary enrollment in a MCMC plan, except for those dual beneficiaries who reside in a county that is authorized to operate a COHS; this exemption is until the effective date of any necessary federal approvals obtained by DHCS to implement a specialized model of care for foster youth;

    f) Dual eligible beneficiaries residing in one of the Veterans' Homes of California; and,

    g) Any other dual eligible beneficiaries, as identified by DHCS, for whom federal law prohibits mandatory enrollment in a MCMC plan.

6) Requires DHCS, in consultation with the Department of Social Services (DSS), to develop a specialized model of care for Medi-Cal beneficiaries eligible on the basis of their receipt of services through any state foster care program or former foster youth up to age 26.

7) Permits DHCS, during the CalAIM term, to seek any necessary federal approvals to authorize and implement the specialized model of care for foster care children and former foster care youth up to age 26.

8) Requires Medi-Cal beneficiaries eligible on the basis of their receipt of services through any state foster care program, or an individual up to age 26 who was in foster care, until the effective date of any necessary federal approvals obtained by DHCS, to continue to receive covered benefits through applicable Medi-Cal delivery systems as they did as of December 31, 2021.

9) Requires, in areas where a PACE plan is available, PACE to be presented as an enrollment option, included in all enrollment materials, enrollment assistance programs, and outreach programs, and made available to applicable beneficiaries whenever enrollment choices and options are presented.

10) Requires persons meeting the age qualifications for PACE and who choose PACE to remain in the FFS Medi-Cal and Medicare programs, and prohibits assignment to a MCMC plan for the lesser of 60 days or until they are assessed for eligibility for PACE and determined not to be eligible for a PACE plan.

11) Requires persons enrolled in a PACE plan to receive all Medicare and Medi-Cal services from the PACE program pursuant to the three-way agreement between the PACE program, DHCS, and Centers for Medicare and Medicaid Services.

12) Prohibits the above-described requirements from being construed to prohibit a Medi-Cal beneficiary from receiving covered benefits on a temporary basis through the Medi-Cal FFS delivery system pending enrollment into an individual MCMC plan in accordance with the above provisions and the CalAIM T&C.

13) Prohibits the above-described requirements from being construed to prohibit certain Medi-Cal beneficiaries eligible for full-scope benefits under the Medi-Cal State plan, as identified by DHCS, from voluntarily enrolling in a MCMC plan, in accordance with the CalAIM T&C.

Policy Questions:

1) The proposed TBL grants DHCS wide discretion to determine what benefits are provided through MCMC plans. Should DHCS be granted this authority?

2) What is the policy and fiscal rationale for establishing payment requirements for institutional long-term care service providers and organ and bone marrow transplant surgery providers, and requiring the applicable fee-for-service rate to be accepted as payment in full by those providers?

3) Should the MCMC plan access rules (time and distance and appointment availability rules) be updated to take into account folding SNF and other LTC benefits into plans on a statewide basis?

Witnesses:

Jacey Cooper, Chief Deputy Director of Health Care Programs and State Medicaid Director, Department of Health Care Services
Ben Johnson, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
Linda Nguy, Policy Advocate, Western Center on Law & Poverty
Lynn Kersey, MA, MPH, CLE, Executive Director, Maternal Child Health Access

Public Comment

Index of Abbreviations

ACA	Federal Patient Protection and Affordable Care Act
BCM	Basic Case Management
CalAIM	California Advancing and Innovating Medi-Cal
CBAS	Community-Based Adult Services
CCI	Coordinate Care Initiative
CCM	Complex Case Management
CMC	Cal MediConnect
COHS	County Organized Health System
DHCS	Department of Health Care Services
ECM	Enhanced Care Management
ED	Emergency Department
FFP	Federal Financial Participation
FFS	Fee-for-Service
FY	Fiscal Year
GF	General Fund
HHP	Health Homes Program
IHSS	In-Home Supportive Services
ILOS	In Lieu of Services
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MLTSS	managed long term services and supports
NCQA	National Committee for Quality Assurance
PACE	Program of All-Inclusive Care for the Elderly
PCP	Primary Care Provider
PHE	Public Health Emergency
PHM	Population Health Management
RDT	Rate Development Template
SDOH	Social Determinants of Health
SMHS	Specialty Mental Health Services
SNF	Skilled Nursing Facility
SUD	Substance Use Disorder
T&Cs	Terms and Conditions
TBL	Trailer Bill Language
WPC	Whole Person Care

[1] AB 2032 (Wood), AB 2042 (Wood), AB 2055 (Wood), SB 910 (Pan), and SB 916 (Pan).
[2] Section 1115 of the Social Security Act gives broad authority to the federal Secretary of the Department of Health and Human Services (DHHS) to authorize "any experimental, pilot or demonstration project likely to assist in promoting the objectives" of the programs. Under Section 1115 research and demonstration authority, the Secretary may waive certain provisions of the Medicaid (statutes related to state program design. Such projects are generally broad in scope, operate statewide, and affect a large portion of the Medicaid population within a state.
[3] Section 438.3(e)(2) of Title 42 of the Code of Federal Regulations.
[4] See (for example) DHCS' Two Plan Non-CCI Boilerplate Contract Exhibit A, Attachment Case Management and Coordination of Care at:
https://www.dhcs.ca.gov/provgovpart/Documents/2-Plan-Non-CCI-Boilerplate-Final-Rule-Amendment.pdf
[5] Welfare and Institutions Code Section 14182.17.
[6] Section 438.6(b)(2) of Title 42 of the Code of Federal Regulations.