FEBRUARY 2020

Exploring the basics of health policy in California

California is facing the expiration of two federal Medicaid waivers at the end of this year: Medi-Cal 2020, California's current Section 1115 waiver, and the 1915 (b) Specialty Mental Health Services waiver.

The waivers provide authority for major elements of Medi-Cal, California's Medicaid program, including managed care programs for physical and behavioral health services (mental health and substance use disorder (SUD) services) and the financing and performance of the state's public health care safety net.

In the Fall of 2019, the state Department of Health Care Services (DHCS) unveiled a sweeping initiative, *California Advancing and Innovating Medi-Cal (CalAIM)*, to reshape the expiring federal waivers and institute significant structural and policy changes in the Medi-Cal program.

This issue of ITUP **ESSENTIALS** provides an overview of CalAIM, the related proposals in the Governor's 2020-21 budget, and highlights potential issues and questions to inform the analysis and review of CalAIM currently underway.

Overview

According to DHCS, CalAIM provides a framework for the upcoming renewal of federal waivers but also incorporates broader delivery system, program, and payment reforms into Medi-Cal.

The stated program goals for CalAIM are:

▶ Identify and manage member risk and need through whole person care approaches and addressing social determinants of health;

▶ Work toward a more consistent and seamless system by reducing complexity and increasing flexibility; and

▶ Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.

In the 180 page proposal, DHCS states its intent to advance "key priorities of the [Newsom] Administration," and leverage Medicaid as a "tool" to address complex challenges facing many Medi-Cal beneficiaries, including homelessness, insufficient behavioral health access, and

the needs of special populations, such as children with complex medical conditions, justice-involved populations, and seniors and persons with disabilities.

CalAIM is a comprehensive multi-year reform plan that would impact most aspects of Medi-Cal: delivery system, benefits, managed care eligibility, and rates. CalAIM would dramatically expand and reshape the responsibilities of Medi-Cal managed care plans (MCPs) which currently serve approximately 82 percent of Medi-Cal beneficiaries. At the same time, the initiative would make major changes to county programs, particularly behavioral health services, as well as the financing and delivery system of the state's public hospitals and health systems.

As proposed, CalAIM will be implemented over a six-year period, 2020-2026. DHCS is currently conducting a stakeholder process with multiple workgroups to consider and refine the elements of CalAIM.

FAST FACTS

4 out of 5
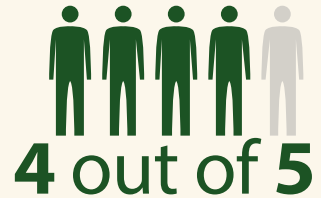
Medi-Cal beneficiaries are enrolled in managed care.

50%

Individuals with serious mental illness have a co-occurring substance use disorder.

4 in 10
Men

6 in 10
Women

Leaving prison report multiple physical health, mental health, and substance abuse conditions.

Federal Framework

Medicaid is a state-federal partnership program funded through a combination of state sources and matching federal funds. States support Medicaid programs financially by providing the "nonfederal share," which can come from a variety of state and local sources and is matched by federal funds. "Federal financial participation" (FFP) is based on federal rules and formulas that determine the federal medical assistance percentage (FMAP) for each state and program. (See Figure 1 below on how California raises the nonfederal share.)

Federal rules effect all aspects of state Medicaid programs including eligibility, benefits, reimbursement, and delivery models. The Medicaid State Plan is based on requirements in Title XIX of the Social Security Act (SSA) and is the comprehensive written document created by each state, and approved by the federal government, that describes the nature and scope of each state Medicaid program.

When a state wants to make significant changes to the Medicaid program, it must take one of two steps: either (1) amend the state Medicaid plan to implement changes permissible under federal law, or (2) apply to the federal Centers for Medicare and Medicaid Services (CMS) for a waiver of specified SSA requirements.

State Framework

California's current Section 1115 demonstration waiver—known as Medi-Cal 2020—which expires December 31, 2020, provides federal funding and authority for major elements of the existing Medi-Cal program.

Building on previous Medi-Cal waivers, Medi-Cal 2020 leverages state and local funds (using county funds to provide the nonfederal share for programs they administer) to draw down additional federal dollars for county and UC hospital systems. Medi-Cal 2020 also secures additional funds for specific pilot programs. The revenues available to the state are determined through a negotiation between the state and CMS, and the amount available is based in large part on estimates of historical savings from California's implementation of managed care.

In addition to financing for California's public health care systems, Medi-Cal 2020 establishes several landmark demonstration programs, such as the Whole Person Care Pilot and the Drug Medi-Cal Organized Delivery System (DMC-ODS) and authorizes California's entire Medi-Cal managed care program for physical health care.

Under the terms of a federal Medicaid 1915 (b) "Freedom of Choice" waiver, California requires that Medi-Cal beneficiaries enroll in the single county-administered mental health plans (MHPs) in each county to receive specialty mental health services. Under the terms of the waiver, and state realignment,[1] counties provide the nonfederal share as certified public expenditures (CPEs) using realignment and other county revenues.

For additional details on California's Medicaid waivers see the 2019 ITUP publication *Medi-Cal Waiver Discussion Guide*.

Figure 1. How California Raises the Nonfederal Share For Medi-Cal

Because Medicaid is a state-federal partnership program, states draw down federal funds by providing state matching revenues, often referred to as the nonfederal share of Medicaid. The nonfederal share typically comes from a variety of sources but at least 40 percent must be financed by the state and up to 60 percent may come from local governments. In addition to **state general fund** resources, California raises the nonfederal share from the sources listed below.

Certified Public Expenditures (CPEs)	Intergovernmental Transfers (IGTs)
State and local government entities certify that they have spent CPE funds on items or services eligible for federal Medicaid matching funds. For example, California counties providing Medicaid reimbursable, specialty mental health services incur the total cost of the services, and certify the total amount of reimbursable expenditures, to secure a federal match.	Transfers of public funds between or within levels of government (e.g., county to state). For example, under California's current §1115 waiver, public health care systems and district hospitals receive federal Medicaid match for meeting quality outcomes under the Public Hospital Redesign and Incentives in the Medi-Cal (PRIME) program, financed by their own IGTs.

Provider Taxes/Fees	Special Funds
State-imposed taxes or fees on health care providers. To use provider taxes/fees as the nonfederal share, federal rules require the fee or tax to be broad-based and uniformly imposed. Federal rules also prohibit the state from holding similar providers harmless from the tax/fee burden. For example, the Hospital Quality Assurance Fee (HQAF) Program collects fees from private hospitals in California and uses these funds, matched with federal funds, to enhance Medi-Cal reimbursement for hospital services.	Funds created by statute, including through ballot initiatives, restricted by law for specific government activities. For example, by taxing cigarettes and tobacco products, Proposition 56, passed in 2016, created a special fund to help finance health care expenditures, including the nonfederal share of Medi-Cal expenditures.

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Figure 2 highlights the existing elements of the Medi-Cal 2020 waiver and the related CalAIM proposals.

Figure 2. Medi-Cal 2020 Section 1115 Waiver CalAIM Proposals by Program Element		
PROGRAM	**DESCRIPTION**	**CALAIM PROPOSAL**
Medi-Cal Managed Care	Waives freedom of choice and statewideness, so that beneficiaries receive care through managed care plans and the state operates different managed care models depending on the county or region.	DHCS proposes to combine this program with county mental health and substance use managed care services, and other related programs, into one §1915 (b) managed care waiver.
Global Payment Program (GPP)	Streamlines funding sources for county-owned and operated hospitals to serve the remaining uninsured, including Disproportionate Share Hospital (DSH) payments. The GPP merges the Safety Net Care Pool waiver funds from prior waivers with DSH using an incentive payment to improve access and quality of primary and preventive care for uninsured patients.	▪ Participating county hospitals provide the nonfederal share through intergovernmental transfers (IGT). ▪ DSH funding component would continue in a new §1115 waiver, but Safety Net Care Pool funding available in Medi-Cal 2020 and previous §1115 waivers will not be available.
Public Hospital Redesign and Incentives in Medi-Cal (PRIME)	Reimburses public and district hospitals using a pay-for-performance program to improve access, health outcomes, and integration of physical and behavioral health. Participating public hospitals must gradually increase the portion of patients in alternative payment arrangements through contracts with Medi-Cal managed care plans (MCPs).	▪ Participating public hospitals provide the nonfederal share as IGTs. ▪ Beginning January 2021 participating public hospitals will have the opportunity to receive expanded Quality Improvement Program directed payments through managed care plans based on quality improvement performance measures.
Whole Person Care (WPC) Pilot Program	Coordinates health, behavioral health, and social services administered by counties, cities, or health facilities. Program helps meet beneficiary needs with non-traditional Medi-Cal benefits like housing supports. Participating counties provide the nonfederal share as IGTs.	DHCS proposes new benefits provided by MCPs, the enhanced care management (ECM) benefit and "In Lieu of Services" (ILOS), in both WPC counties and non-WPC counties. Governor's Budget proposes new state General Funds to support the new benefits.
Health Homes Program (HHP)	Waives freedom of choice so that beneficiaries must get HHP services through MCPs. Coordinates the full range of physical health, behavioral health and community-based services for individuals meeting specific criteria. Nonfederal share supported with external grant funds	As with WPC, proposes to transition the HHP to the new ECM and ILOS benefits in managed care. Governor's Budget proposes new state General Funds to support the new benefits.
Drug Medi-Cal Organized Delivery System (DMC-ODS)	A program to expand county substance use disorder treatment program offering a full continuum of care through a managed care system. Participating counties currently provide CPEs as the nonfederal share	Proposes transition to 1915(b) managed care waiver starting in January 2021.
Dental Transformation Initiative (DTI)	Provides direct incentive payments to Medi-Cal dental providers to increase use of preventative dental services for children, prevent and treat more childhood caries, and increase continuity of care	Transition to new state plan benefits and pay for performance incentives through dental homes.
Designated State Health Programs (DSHP)	Authorizes the state to claim FFP for selected state programs up to specific annual dollar limits	CMS has signaled that the state will no longer be able to claim FFP for these state programs.

Source: DHCS proposal crosswalk of Medi-Cal 2020 to CalAIM. Chart prepared by ITUP.

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The California Story

The Medi-Cal 2020 waiver builds on previous waivers the state secured dating back to a federal §1115 waiver in the mid-1990s aimed at increasing federal funding to stabilize the Los Angeles County public hospital system. (For an historical overview of California's Medicaid waivers see the 2019 ITUP publication *Medi-Cal Waiver Discussion Guide*, Appendix A.)

The LA waiver set the stage for future Medi-Cal waivers by expanding the expenditures that qualify for federal matching funds, such as outpatient care for the uninsured, and requiring the County to reshape the delivery system for uninsured and Medi-Cal recipients. The federal waiver required the County to focus on improving access to outpatient primary and preventive care and reducing the use of higher cost inpatient and emergency room care.

Over time, California added and refined the programs in the state's §1115 waivers to reflect state priorities and program needs. California's waivers grew in scope, funding, and impact on Medi-Cal and the state's health care safety net.

California negotiated waiver provisions that allowed it to draw down federal matching funds not normally permitted under traditional Medicaid rules (not otherwise matchable) based on savings to the federal and state government from the adoption, and the growth over time, of managed care in the Medi-Cal program.

In the most recent waivers, including Medi-Cal 2020, California leveraged state and local funds (using county funds to provide the nonfederal share for programs counties administer) to increase FFP for UC and county hospitals and create financial incentives for public systems to improve performance and expand access for the remaining uninsured.

California Section 1115 Federal Medicaid Waivers Prior to Medi-Cal 2020

Medi-Cal Hospital Care Waiver. California secured its first statewide, five-year §1115 waiver, starting in 2005 through 2010, the "Medi-Cal Hospital Care Waiver." California proposed the waiver in response to CMS concerns about California's reliance on IGTs as the mechanism for financing the nonfederal share of Medi-Cal payments to hospitals. The Hospital Care Waiver moved instead to use CPEs for hospital financing. The 2005 waiver also created the Safety Net Care Pool, a fixed amount of federal matching funds to support public hospitals in caring for the uninsured.

Bridge to Reform Waiver. California sought a five-year renewal and expanded scope in the Bridge to Reform Waiver 2010-2015. The Bridge to Reform Waiver helped California prepare for the implementation of the federal Affordable Care Act (ACA) Medicaid expansion for low-income adults before the 2014 federal timeline.

The 2010 waiver: (1) Phased-in coverage for low-income adults 19 to 64 with incomes up to 200 percent of the Federal Poverty Level, (2) Maintained the Safety Net Care Pool and other 2005 waiver initiatives, (3) Expanded managed care to seniors, persons with disabilities, and children with special health care needs, and (4) Created the Delivery System Reform Incentive Pool (DSRIP) program to enhance the quality of care in California's public hospitals and health systems. Public health care systems continued to self-finance their waiver payments through a mix of CPE and IGT mechanisms.

Governor's CalAIM Budget Proposal

The 2020-21 budget proposes funding for the first stages of CalAIM starting January 1, 2021. The budget proposes $695 million ($348 million General Fund), increasing to $1.4 billion ($695 million General Fund) in 2021-22 and 2022-23.[2] The proposed funding would support the following program elements for the first six months of 2021:

▶ ***Enhanced Care Management (ECM).*** Implement a new statewide Medi-Cal benefit through Medi-Cal MCPs that will replace the existing Whole Person Care (WPC) pilots and the Health Homes Program (HHP). According to DHCS, the intent of the new benefit is to provide multiple opportunities to engage high-cost or "high-need" Medi-Cal beneficiaries and provide a set of services that extend beyond

standard care coordination and chronic disease management ($225 million, $112.5 million General Fund). DHCS recently estimated that approximately one percent of MCP enrollees will receive ECM.[3]

▶ ***In-Lieu of Services (ILOS)***. Allow MCPs to provide ILOS as a new benefit, defined as payment for services or settings that substitute to avoid other services, such as inpatient hospitalization or a nursing facility stay, focusing primarily on medium-to-high risk beneficiaries. ILOS services are subject to federal Medicaid criteria and standards as outlined in Figure 1 ($357.5 million, $178.8 million General Fund). The funds in this category would be allocated as follows:

▪ Continue existing ILOS through MCPs in regions where they exist, such as housing transition services, sobering centers and recuperative/medical respite care ($57.5 million)

▪ Provide incentives to MCPs to develop and offer ECM and ILOS in regions where they do not exist today. DHCS proposes to eliminate the incentive funding in 2023-24 ($300 million)

Dental Transformation Initiative. Build on and expand successful elements of the existing DTI that will end in December 2020 ($112.5 million, $56.3 million General Fund).

If fully adopted, CalAIM would revise and restructure major elements of the Medi-Cal program, with the most significant changes being proposed in the roles of MCPs and counties. Since November 2019, DHCS has been leading a series of workgroups on the major CalAIM components with the goal of refining the proposals based on stakeholder input.

Figure 3 provides an overview of CalAIM, as proposed by program category, background on the related existing programs, and discussion questions to inform CalAIM deliberations in the months to come.

Figure 3. California Advancing and Innovating Medi-Cal Proposal by Program Category		
PROPOSAL BY CATEGORY	**EXISTING PROGRAM BACKGROUND**	**DISCUSSION QUESTIONS**
FULL INTEGRATION PILOTS		
Population Health Management in Managed Care – Require MCPs to develop patient-centered population health management strategies that include standardized risk assessment processes, risk stratification to identify high-risk, potentially high-cost enrollees, consideration of social determinants of health, assurance of smooth care transitions, and a focus on data collection and reporting.	MCPs are required to conduct various health assessments and screenings that evaluate enrollee risk (health status and risk of future health issues), including initial health assessments for new enrollees and risk assessments for newly enrolled Seniors and Persons with Disabilities (SPDs). MCPs are required to coordinate care transitions for enrollees, but current state contract requirements are general with some exceptions (e.g., more specific for SPDs and enrollees receiving managed long-term services and supports).	▪ How will DHCS align risk stratification and assessment requirements across multiple systems of care (MCPs, county Mental Health Plans (MHPs), Drug Medi-Cal Organized Delivery System (DMC-ODS), Regional Centers, etc.)? ▪ MCP case management has historically been clinically based. How will MCPs transition to addressing social and nonmedical needs? ▪ How will DHCS monitor an MCP population health management program? What types of data and reporting will be required? ▪ How can DHCS, MCPs and providers avoid duplication?
Medi-Cal MCP Annual Open Enrollment – Implement an annual open enrollment period for Medi-Cal MCPs limiting enrollee choice of health plan to once per year.	Medi-Cal enrollees may switch MCPs monthly. Federal managed care regulations require states to provide a 90- day period for a member to switch health plans after initial selection.	**DHCS has withdrawn this proposal.**
NEW MANAGED CARE BENEFITS		
Enhanced Care Management (ECM) Establish a new, statewide ECM benefit to provide a whole-person approach to care that would encompass both medical and nonmedical needs of high-risk/high-need Medi-Cal beneficiaries enrolled in managed care. The new ECM benefit is intended to reflect a collaborative, interdisciplinary approach to providing intensive and comprehensive care management services to enrollees. DHCS recently estimated that approximately 1 percent of MCP enrollees will receive ECM, but MCPs may need to reach out to assess 2-3 percent in determining who will be eligible for ECM.[4]	The WPC pilots seek to coordinate health, behavioral health, and social services for targeted populations to improve outcomes. In total, 25 pilots have been approved under the Medi-Cal 2020 Waiver, which expires on December 31, 2020. HHP is designed to serve eligible beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. As of July 1, 2019, MCPs in 11 counties have implemented HHP. Both WPC and HHP would be eliminated and components transitioned to ECM.	▪ How would the WPC pilots and HHP be transitioned to the new ECM benefit? Which components of WPC and/or HHP will continue? Which components will end? ▪ The HHP structure is complex and has been challenging for MCPs and providers (e.g., some MCPs have declined to proceed with HHP implementation). How can an ECM benefit be designed so it is not cumbersome to implement? ▪ How will the ECM be financed? Will funding levels differ (ECM vs. WPC/HHP)? ▪ What will be the role of counties and other local entities that currently administer and provide the nonfederal match for WPC?

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Figure 3. California Advancing and Innovating Medi-Cal Proposal by Program Category

PROPOSAL BY CATEGORY	EXISTING PROGRAM BACKGROUND	DISCUSSION QUESTIONS
In-Lieu of Services (ILOS) – Allow MCPs to provide ILOS, defined as flexible wrap-around services or settings that substitute for other potentially more costly services, such as inpatient hospitalization or nursing facility placement. DHCS notes that ILOS will not be "separately accounted" for in MCP rates. Proposed ILOS include: housing transition navigation services, housing deposits, housing transition and sustaining services, short-term post-hospitalization housing, recuperative care, respite, day habilitation programs, nursing facility transition/diversion to assisted living facilities, nursing facility transition to home, personal care and homemaker services, environmental accessibility adaptation (home modifications), meals/medically tailored meals, and sobering centers. DHCS would incorporate ILOS into ECM provided to medium-to-high risk enrollees, potentially filling gaps to address medical or social needs.	DHCS does not currently recognize ILOS for MCP rate-setting purposes, although some MCPs report providing these types of services to enrollees. Federal law identifies four criteria in order for ILOS to be covered as substitutes of covered benefits under the Medicaid State Plan: 1. State determines the alternative service or setting is medically appropriate and a cost-effective substitute; 2. Enrollee is not required to use the alternative service or setting; 3. Approved ILOS is authorized and identified in the MCP contract and offered at the option of the MCP; and, 4. The state must take utilization and actual cost of ILOS into account in developing the component of the MCP capitation rates.[5] Managed care plans choosing to offer ILOS would develop a network of providers.	▪ How can DHCS monitor and oversee MCP provision of ILOS? ▪ Are there additional ILOS that should be considered? ▪ What incentives will there be for MCPs to voluntarily provide ILOS? ▪ Given the types of services that qualify as ILOS, there is the potential for significant demand for the services. Will the funding and capacity of MCPs, their providers, and community organizations match demand? ▪ What requirements will DHCS impose to ensure that MCPs meet federal standards, such as the requirement that the services be both medically appropriate and cost-effective compared to another Medi-Cal benefit for which the ILOS is being substituted.
BEHAVIORAL HEALTH (BH)		
DHCS is considering several changes to Medi-Cal BH, including: 1. Changes to the county MH and SUD reimbursement structure, 2. Revisions to medical necessity criteria for BH services, 3. §1115 waiver authority for counties to receive federal Medicaid match for residential MH and SUD treatment for eligible adults in Institutions for Mental Disease (IMD), facilities with more than 16 beds, 4. Development of regional approaches to administer and provide MH and SUD services, 5. One single contract with counties for county-administered MH and SUD programs.	Specialty MH and SUD services are both provided by the counties but under separate waiver authorities and DHCS contracts. Both also are carved out of MCPs in most counties. In late 2018, CMS released guidance that allows states to use §1115 Medicaid waivers to obtain federal match for short-term stays in an IMD, in return for expanding access to community-based mental health services. DMC-ODS participating counties currently receive federal match for medically necessary IMD residential treatment for SUDs under the terms of the Medi-Cal 2020 waiver.	▪ What would be the programmatic impacts on the counties from consolidating specialty mental health and SUD services under a single contract? Fiscal impacts? ▪ What would be the role of county MHPs in an integrated model? DMC-ODS pilots? ▪ What impact would consolidation of MH and SUD services have on care coordination with MCPs? ▪ What are the barriers, concerns, and impacts from continuing the use of IMDs in DMC-ODS and extending the use to mental health treatment?

Figure 3. California Advancing and Innovating Medi-Cal Proposal by Program Category

PROPOSAL BY CATEGORY	EXISTING PROGRAM BACKGROUND	DISCUSSION QUESTIONS
FULL INTEGRATION PILOTS		
DHCS proposes to test the effectiveness of integrating physical health, behavioral health, and oral health under a single entity at the local level.	MCPs are currently responsible for providing services for enrollees with mild- to-moderate mental health conditions, while county MHPs provide specialty mental health services to Medi-Cal beneficiaries with serious mental illness. Some MCPs and counties have started to explore integrating physical and behavioral health. Oral health services are provided statewide through the fee-for-service Denti-Cal program and managed care in two counties. DHCS proposes to eliminate dental managed care.	▪ How will the pilot be structured? How many pilots will be implemented? ▪ Will all MCPs and MHPs be required to participate in a geographic area? ▪ What will be the impact on county finances if specialty mental health is integrated into the MCPs? ▪ Will DHCS assume any savings from the pilots and how would the associated funding reductions impact the services and programs in the pilots? ▪ How will pilot counties be selected?
MANAGED CARE BENEFITS AND ENROLLMENT		
DHCS proposes to standardize the benefits provided by MCPs across the state. This will eliminate county-level variations in how Medi-Cal beneficiaries receive their benefits (MCP or FFS). Some benefits will be carved-out of all MCP contracts (e.g., prescription drugs, Multipurpose Senior Services Program), while others will be carved-in (e.g., major organ transplants, institutional long-term care services). DHCS proposes to standardize the beneficiaries required to enroll in MCPs, in two phases: all Med-Cal (non-dual) populations would be mandatorily enrolled in 2021, Medicare/Medi-Cal dually eligible beneficiaries in 2023.	Nearly 85 percent of Medi-Cal beneficiaries are currently enrolled in managed care. Across the six models of Medi-Cal managed care, the benefits provided in managed care v. FFS differ based on model type and, in some cases, by county or MCP. Individuals currently not required to enroll in managed care include those who are dually eligible and those who are eligible for long-term care services, pregnancy-only services, and infants deemed to be eligible through the Child Health and Disability Prevention program.	▪ Is mandatory managed care enrollment appropriate for all populations included in the DHCS proposal? Should some remain in FFS or voluntary managed care status? ▪ How can MCPs and DHCS ensure integrated care for services carved out of the MCPs? ▪ What factors should be taken into consideration to ensure a smooth transition for dual eligibles to managed care?
NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION		
DHCS is considering requiring all MCPs and their subcontractors (delegated entities) to obtain NCQA accreditation as is the case in 26 states.[6] NCQA assesses MCPs on the following standards: quality management and improvement, population health management, network management, utilization management, credentialing and recredentialing, enrollee rights and responsibilities, member connections, and Medicaid benefits and services.[7] DHCS is considering whether NCQA accreditation would streamline the annual MCP medical audit process allowing DHCS to "deem" accredited MCPs in compliance in some categories.	MCPs are not currently required to obtain accreditation to participate in Medi-Cal. DHCS currently deems MCPs with NCQA accreditation as in compliance with provider credentialing requirements as part of the annual DHCS medical compliance audit. Of the 24 Medi-Cal MCPs, 14 are NCQA accredited, six are not accredited, one (Partnership HealthPlan of California) is in the process of obtaining NCQA accreditation, and two (Aetna Better Health of California and United Healthcare) are scheduled to begin the accreditation process.[8]	▪ What value would NCQA accreditation bring to the Medi-Cal MCP program? How would it affect the enrollee experience of care or patient outcomes? ▪ How do NCQA standards align with current DHCS standards (e.g., care coordination)? ▪ How would "deeming" impact oversight of MCPs? What additional categories could DHCS deem MCPs in compliance with state standards? ▪ What would be the impact of requiring NCQA accreditation for provider groups that contract with MCPs? ▪ MCPs can be accredited by other entities. Should DHCS include a broader set of organizations or solely require NCQA accreditation?

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Figure 3. California Advancing and Innovating Medi-Cal Proposal by Program Category		
PROPOSAL BY CATEGORY	**EXISTING PROGRAM BACKGROUND**	**DISCUSSION QUESTIONS**
DUAL ELIGIBLES (Eligible for Medicare and Medi-Cal)		
DHCS proposes to end the Coordinated Care Initiative and the dual eligible pilot known as Cal MediConnect (CMC) on December 31, 2022, coinciding with mandatory enrollment of all dually eligible Medi-Cal beneficiaries in MCPs, and the inclusion of long-term services and supports in MCP contracts. All MCPs will be required to operate a Medicare Dual Eligible Special Needs Plan (D-SNP) to improve the alignment of care for the dually eligible population. DHCS is considering several enrollment options related to the dually eligible, including whether to transition all CMC members into the D-SNP operated by their MCP or to automatically enroll MCP members into the D-SNP operated by their MCP when they are eligible for Medicare.	CMC operates in seven counties: Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino, and Santa Clara. In these counties, dually eligible individuals can choose to receive their Medicare and Medi-Cal benefits through a single MCP. Many MCPs operate D-SNPs, but some would need to develop a new D-SNP and seek approval from CMS. SNPs are federally designated Medicare Advantage plans that provide care for individuals with specific conditions, such as end-stage renal disease, or for dually eligible individuals as in D-SNPs. Under federal law, Medicare beneficiaries can choose whether to enroll in a Medicare Advantage plan or remain in Medicare fee-for-service.	▪ Will MCPs that develop new D-SNPs gain enough enrollment to justify the start-up costs? ▪ How will CMC members be transitioned to the new care model? ▪ How does the proposal address historic concerns about mandatory enrollment of the dually eligible population in managed care? ▪ How can integration of Medicare/Medi-Cal be improved for MCP members who do not enroll in the D-SNP offered by their MCP? ▪ How will DHCS provide oversight and monitor the MCPs?

Source: DHCS CalAIM proposal. Chart prepared by ITUP.

The existing Medi-Cal managed care program has multiple carve outs and inconsistencies among counties and health plan models. CalAIM proposes changes that would make the benefits and populations in MCPs more consistent as outlined in Figure 4 below.

Figure 4. Proposed CalAIM Managed Care Benefit and Enrollment Changes	
"CARVED IN" TO MANAGED CARE	**"CARVED OUT" OF MANAGED CARE**
Benefits	
▪ Institutional long-term care services ▪ Major organ transplants ▪ Enhanced care management ▪ In-lieu of services (voluntary)	▪ Outpatient prescription drugs* ▪ Multipurpose Senior Services program ▪ All specialty mental health services – for Kaiser enrolled beneficiaries in Sacramento and Solano counties ▪ Fabrication of optical lenses
Mandatory Enrollment	
▪ Individuals eligible for long-term care including those with a share of cost ▪ Beneficiaries dually eligible for Medi-Cal and Medicare ▪ Trafficking and Crime Victims assistance program ▪ Individuals participating in accelerated enrollment ▪ Child Health and Disability Prevention infant deeming ▪ Pregnancy-related Medi-Cal ▪ American Indians ▪ Beneficiaries with other health coverage or living in rural zip codes	▪ Omnibus Budget Reconciliation Act – in Napa, Solano, and Yolo counties ▪ Share of Cost beneficiaries in County Organized Health System and Coordinated Care Initiative Counties

Source: DHCS CalAIM Proposal.
*Governor's Executive Order N-01-19 relating to prescription drugs issued January 7, 2019. Chart prepared by ITUP.

Federal Changes Affecting CalAIM and the Expiring Waivers

Waivers and the Federal Medicaid Managed Care Rule

In 2016, CMS issued a comprehensive and sweeping Medicaid policy change through a State Medicaid Directors Letter (SMDL).[9] The SMDL includes changes to the way CMS will work with states to ensure that a proposed Section 1115 waiver achieves budget neutrality.

As part of the negotiations between an applicant state and CMS, CMS and the state must agree on projected federal expenditures that could have occurred absent the waiver, known as "Without Waiver" or baseline expenditures, as well as federal expenditures with the proposed state §1115 waiver or "With Waiver" expenditures. If the projected without waiver expenditures are higher than expenditures under the waiver, the applicant state can capture some or all the projected federal savings. California and many other states have secured additional federal funds using this approach. In negotiating the most recent Section 1115 waivers, California relied on estimated savings from the adoption of Medi-Cal managed care.

Previously, when a waiver was renewed, the baseline calculations from the original waiver were used allowing for a rollover of projected federal savings from waiver to waiver. The SMDL revised the budget neutrality policy to limit the amount of savings a state could capture in a §1115 waiver. While the waiver calculations are complex, the new guidance essentially limits and ultimately phases out savings that states, including California, can roll over from waiver to waiver.

The calculated savings supported the Safety Net Care Pool in Medi-Cal 2020 and prior waivers, as well as funding for programs like Whole Person Care and the Drug Medi-Cal Organized Delivery System pilot.

The changes in the SMDL underly major aspects of the proposed CalAIM, including shifting many elements of Medi-Cal 2020 to managed care (instead of being part of a new Section 1115 waiver) with different financing mechanisms, such as the new ECM and ILOS benefits as an alternative to WPC.

Medicaid Fiscal Accountability Rule

On November 18, 2019, CMS issued a proposed rule on Medicaid fiscal accountability, the Medicaid Fiscal Accountability Rule (MFAR). According to CMS, the rule is intended to strengthen fiscal oversight and enhance overall fiscal integrity of the Medicaid program by imposing new requirements, structural changes, and definitions related to Medicaid financing, including how states finance the nonfederal share of their Medicaid expenditures. For example, the proposed rule would add additional criteria for permissible health care related taxes and changes to how the state can use CPEs and IGTs.

If implemented, MFAR could significantly decrease California's flexibility in providing the nonfederal share of Medi-Cal and could require the state to revisit the current financing arrangements with hospitals, health plans, counties, and other providers that help support the Medi-Cal program. Strategies the state uses to finance the federal share are summarized in Figure 1. Ultimately, MFAR could reduce Medi-Cal funding and have significant budgetary implications for the state.

For more information on the potential impact of MFAR for California, see the DHCS public comments as submitted to CMS.[10]

Key Takeaways

▶ California operates the Medi-Cal program subject to state and federal law, and also administers multiple federal Medicaid waivers. Two waivers, Medi-Cal 2020, a Section 1115 waiver, and the Specialty Mental Health Services 1915(b) waiver, expire this year, necessitating state-level discussion about the future of the waivers and implications for Medi-Cal.

▶ In the Fall of 2019, DHCS proposed CalAIM which outlines potential elements for future waivers but also includes significant proposed Medi-Cal program and policy changes, including substantive changes in county programs and financing, as well as a dramatic expansion in the role and responsibilities of MCPs.

▶ As California considers CalAIM, it must do so under new federal rules and priorities for Section 1115 waivers, and proposed federal policy changes in the MFAR, which could affect state strategies for funding the nonfederal share of Medicaid.

▶ In addition to the challenges and uncertainties of federal policy, there are major policy and operational questions associated with the CalAIM proposal, only some of which are included in this issue of ITUP **ESSENTIALS**. Over the coming months and years, policymakers should scrutinize the financial and programmatic effects and focus on real-world consequences for beneficiaries, counties, health plans, providers, and the state. Given the scope of CalAIM, it is certain that the issues raised in the proposal will frame the debate and discussion on the future of Medi-Cal for the foreseeable future.

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Acknowledgements

Notes

1. Realignment provides counties with dedicated revenues (a portion of state sales taxes and Vehicle Licensing Fees) as part of the 1991 agreement to shift responsibility for specific health and social services programs from the state to the counties. State legislation adjusted the terms of realignment in 2011 and again in 2013.

2. Department of Finance. Governor's 2020-21 Budget Summary: Health and Human Services.

3. Department of Health Care Services, Medi-Cal Healthier California for All, Managed Care Financing Considerations, Presented to the Medi-Cal Stakeholder Advisory Committee, February 2020.

4. Department of Health Care Services, Medi-Cal Healthier California for All, Managed Care Financing Considerations presentation.

5. 42CFR §438.3(e)(2).

6. National Committee on Quality Assurance, Overview of NCQA Accreditation, DHCS Medi-Cal Healthier California for All Accreditation Workgroup, January 21, 2020.

7. National Committee for Quality Assurance, Health Plan Accreditation.

8. For example, Covered California, the state's Affordable Care Act exchange, requires accreditation by one of three national bodies: NCQA, the Utilization Review Accreditation Commission (URAC), and the Accreditation Association for Ambulatory Health Care.

9. CMS, Letter to State Medicaid Directors, SMD # 18-009 RE: Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects, August 22, 2018.

10. DHCS, Comments submitted to CMS, Medicaid Program; Medicaid Fiscal Accountability Regulation, January 29, 2020.

Resources

Insure the Uninsured Project
Medi-Cal Waiver Discussion Guide, October 2019.
Care Coordination Discussion Guide, July 2019.
Mapping the Future of Medi-Cal: What's Next, March 2019.

California Health Care Foundation
Focus on Medi-Cal Healthier for All California: Online Collection

Council on Criminal Justice and Behavioral Health
Behavioral Health Care and The Justice-Involved: Why It Is So Important?

Department of Health Care Services
Medi-Cal Healthier for All California Proposal, October 2019.

Office of Governor Newsom
2020-21 Budget Proposals to Address Homelessness, January 2020.

About ITUP

Insure the Uninsured Project (ITUP) is a Sacramento-based nonprofit health policy institute that for more than two decades has provided expert analysis and facilitated convenings for California policymakers and decisionmakers focused on health reform.

The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of Californians, through policy-focused research and broad-based stakeholder engagement.

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- California Health Care Foundation
- Kaiser Permanente
- The California Endowment
- The California Wellness Foundation

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Proposed Implementation Timeline for CalAIM

Date	Key Milestone
July 2020	***Medi-Cal Managed Care Plan (MCPs)Transition Proposals.*** Medi-Cal MCPs submit Enhanced Care Management Transition Plan to DHCS focused on transitioning the Whole Person Care (WPC) pilots and Health Homes Programs (HHP) to ECM.
December 2020	***Existing Federal Waivers Expire.*** Medi-Cal 2020 Waiver and Specialty Mental Health Waiver expire.
January 2021	***Medi-Cal Benefits*** ▪ New ECM and ILOS benefits established. ECM will be mandatory in counties with WPC or HHP. ▪ Denti-Cal expanded to include two new benefits (caries risk assessment bundle for young children and silver diamine fluoride for young children and specified high risk and institutional populations). ▪ Outpatient prescription drugs carved out from MCP contracts and transition to FFS managed by DHCS contractor Magellan. ▪ MCP benefits standardized across health plans and regions. (See Figure 4.) ***MCP Changes*** ▪ MCPs eligible for incentive payments and/or shared risk payments related to key areas of CalAIM (managed long-term services and supports, in lieu of services, ECM). ▪ Regional Rate Setting (Phase 1). For targeted counties, MCP capitation rates determined on a regional basis rather than for each MCP by county (or region) and population group covered. ▪ Blended MCP capitation rate for seniors and persons with disabilities and long-term care beneficiaries. ▪ Pay for Performance initiative in dental to target the use of preventive services for both children and adults as well as continuity of care through a Dental Home. ▪ Transition the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program from the Section 1115 waiver to the existing Quality Improvement Program (QIP) in managed care. The QIP is an existing directed payment program that ties MCP payments to California's Designated Public Hospitals to a defined set of performance metrics. The QIP will be expanded to incorporate a portion of the funding available under PRIME and to allow District and Municipal Public Hospitals to participate in the QIP. ***Mandatory MCP Enrollment of Non-Dual Eligibles.*** Most non-dual eligible beneficiaries currently not required to enroll in managed care required to choose an MCP (e.g. individuals eligible for LTC services, beneficiaries with other health coverage, and individuals participating in accelerated enrollment). ***Behavioral Health*** ▪ Revised eligibility and medical necessity criteria for inpatient and outpatient specialty mental health. New criteria separate eligibility for specialty mental health services from medical necessity for behavioral health services. ▪ Specialty mental health and substance use disorder services payment reform (Phase 1). To restructure behavioral health payment rates, specialty mental health and SUD services transition from the existing HCPCS Level II coding system to HCPCS Level 1 (this transition will occur no sooner than January 2021). Change to Level II coding allows for more granular claiming and reporting of services provided, leading to more accurate reimbursement to counties and providers. ▪ Drug Medi-Cal-Organized Delivery System (renamed "Substance Use Disorder Managed Care Program") and renewed through new 1915(b) waiver. ***Enhanced County Eligibility Oversight and Monitoring Activities.*** Counties subject to increased oversight and monitoring by DHCS, including revised Corrective Action Plan approach that includes fiscal penalties.
July 2021	***Medi-Cal Benefits.*** ECM and ILOS benefits established in remaining non-WPC and HHP counties.

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Proposed Implementation Timeline for CalAIM

Date	Key Milestone
January 2022	**County Inmate Pre-Release Application Process.** Counties process applications for county inmates applying for Medi-Cal coverage. **Population Health Management.** MCPs implement strategies to assess, identify, and manage high-risk potentially high-cost beneficiaries.
December 2022	**Coordinated Care Initiative (CCI) and Cal MediConnect (CMC) Sunset**. CCI and CMC replaced by integration of long-term care into managed care statewide and mandatory enrollment of dually eligible beneficiaries.
January 2023	**Mandatory Enrollment for Dual Eligibles.** Statewide mandatory enrollment of dual eligibles into Medi-Cal managed care. Majority of dual eligible beneficiaries required to enroll in an MCP. All MCPs must operate a Dual Eligible Special Needs Plan (D-SNP) in all service areas. MCPs able to coordinate care for their dual eligible members who also enroll in their MCP's D-SNP. **Regional MCP Rates.** Phase II implemented statewide. Phase II will occur no sooner than January 1, 2023.
January 2024	**Full Integration Pilots**. Pilots test effectiveness of integrating physical health, behavioral health, and oral health under one entity.
January 2025	**NCQA Accreditation.** All MCPs and their subcontractors (delegated entities) must be NCQA accredited. NCQA findings used by DHCS to certify or deem MCPs as meeting certain federal and state requirements.
January 2026	**Long-Term Services and Supports (MLTSS) in Managed Care.** Statewide implementation of managed long-term services and supports (MLTSS) in Medi-Cal managed care. **County Behavioral Health Single Contract**. DHCS submits new 1915(b) federal waiver to create a single, integrated behavioral health managed care plan in each county or region to provide specialty mental health and substance use disorder services.