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CALIFORNIA STATE SENATE

COMMITTEE ON BUDGET AND FISCAL REVIEW

LEGISLATIVE OFFICE BUILDING – ROOM 502
SACRAMENTO, CA 95814

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ASSISTANT CONSULTANT
SANDY PEREZ

COMMITTEE ASSISTANT
SAMUEL LANCHESTER

(916) 651-4103
FAX (916) 668-7004

Agenda

February 22, 2023

9:30 a.m. – 1021 O Street, Room 1200

California Advancing and Innovating Medi-Cal (CalAIM): Implementation, Evaluation, and Future Challenges

I. Overview of CalAIM Implementation

- Melora Simon, Associate Director, People Centered Care, California Health Care Foundation
- Michelle Baass, Director, Department of Health Care Services *(Introductory Remarks)*
- Jacey Cooper, Chief Deputy Director and California Medicaid Director, Department of Health Care Services

II. Enhanced Care Management and Community Supports

- Linnea Koopmans, Chief Executive Officer, Local Health Plans of California
- Greg Garrett, Chief Operating Officer, Native American Health Center, Oakland, CA
- Linda Nguy, Senior Policy Advocate, Western Center on Law and Poverty
- Kiran Savage-Sangwan, Executive Director, California Pan-Ethnic Health Network

III. Behavioral Health Reforms and the California Behavioral Health Community-Based Continuum Demonstration (CalBH-CBC)

- Michelle Cabrera, Executive Director, County Behavioral Health Directors Association
- Dr. Le Ondra Clark-Harvey, Chief Executive Officer, California Council of Community Behavioral Health Agencies
- Kim Lewis, Managing Attorney, National Health Law Program

IV. Public Comment

Informational Hearing

California Advancing and Innovating Medi-Cal (CalAIM) Implementation

BACKGROUND

CalAIM – A Whole Person-Centered Transformation of the Medi-Cal Program. The California Advancing and Innovating Medi-Cal (CalAIM) initiative is an ambitious effort to incorporate evidence-based investments in prevention, case management, and non-traditional services into the Medi-Cal program. Many of these investments were piloted during the state's most recent 1115 Waiver, Medi-Cal 2020, and CalAIM incorporates many of these programs into existing Medi-Cal delivery systems on a more consistent, statewide basis. CalAIM also seeks to reform payment structures for Medi-Cal managed care plans and county behavioral health programs to streamline rate-setting and to reduce documentation and auditing workload for plans and their network providers. Other components of CalAIM include changes to populations and services that would be delivered in the fee-for-service or managed care system, continuation of certain dental services piloted in the Dental Transformation Initiative, statewide incorporation of long-term services and supports as a mandatory managed care benefit, seeking a federal waiver to allow Medi-Cal services to be provided in an Institute for Mental Disease (IMD), and testing full integration of physical, behavioral, and oral health service delivery under a single contracted entity.

CalAIM represents a significant transformation of the health care delivery systems that provide physical health, behavioral health, and oral health care services to Medi-Cal beneficiaries. However, CalAIM also represents an opportunity to build into the foundations of the Medi-Cal program an incentive structure that achieves a healthier Medi-Cal population with a comprehensive, whole-person approach that addresses the social determinants of health and avoids cross-cutting impacts and cost shifts to other state or local social service and public safety agencies. While CalAIM contains the broad outlines of building such a foundation, the Legislature will need to carefully evaluate each component of the proposal to ensure the program changes that are ultimately implemented are consistent with the values of a publicly-supported health care program.

Recent Budget Investments and Trailer Bill to Support CalAIM Implementation. During the fall of 2019, the Newsom Administration released its comprehensive proposal to transform the delivery system of physical, behavioral, and oral health care services in the Medi-Cal program, which would ultimately become known as CalAIM. Due to the pandemic, the Administration delayed implementation of CalAIM in the 2020-21 fiscal year. The Administration returned to its implementation planning for CalAIM in the 2021 Budget Act, which included 69 positions and expenditure authority of $1.6 billion ($675.7 million General Fund and $954.7 million federal funds). The Legislature also approved trailer bill language to authorize implementation of CalAIM in the health omnibus, AB 133 (Committee on Budget), Chapter 143, Statutes of 2021. (*Codified in Article 5.51, commencing with Section 14184.100, of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code*)

The 2022 Budget Act included expenditure authority of $1.1 billion ($458.6 million General Fund, $624.9 million federal funds, and $60.4 million special funds and reimbursements) in 2021-22 and $3.1 billion ($1.2 billion General Fund, $1.8 billion federal funds, and $100.2 million special funds and reimbursements) in 2022-23, and the Legislature approved additional trailer bill language, to support implementation of the CalAIM initiative. The 2022 Budget Act also included state operations resources of 97 positions and expenditure authority of $107.8 million ($53.9 million General Fund and $53.9 million federal funds) to support state operations for the implementation of the components of the CalAIM initiative.

CalAIM Implemented Through New Federal Waiver Authority. CalAIM transitions many of Medi-Cal's existing programs into managed care benefits under a new 1915(b) Waiver, maintains some programs under the previous 1115 Waiver authority, and makes other changes through amendments to the Medicaid State Plan. The federal Centers for Medicare and Medicaid Services (CMS) approved California's 1115 Waiver and 1915(b) Waiver applications implementing CalAIM reforms on December 29, 2021. Both Waivers are approved until December 31, 2026. While the managed care authorities provided by the two Waivers are similar, there are key differences. For example, while 1115 Waivers require budget neutrality (federal expenditures must not be greater under the Waiver than they would have been without the Waiver), 1915(b) Waivers only require the demonstration of cost effectiveness and efficiency (actual expenditures cannot exceed projected expenditures)[1]. This distinction allows for the provision of certain non-traditional community supports services that would previously have been required to undergo a more difficult accounting of savings to the state and federal governments.

Enhanced Care Management. The Governor's January budget includes expenditure authority of $677.6 million ($224.3 million General Fund and $453.2 million federal funds) in 2022-23 and $992.4 million ($374.4 million General Fund and $618 million federal funds) in 2023-24 to support the new enhanced care management benefit, implemented beginning on January 1, 2022. Under its previous 1115 Waiver authority, Medi-Cal 2020, DHCS implemented Whole Person Care pilot programs to coordinate health, behavioral health, and social services in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. The 25 approved WPC pilots targeted services to individuals with chronic conditions, with behavioral health needs, experiencing or at-risk of homelessness, or who are justice-involved. The pilots provided eight categories of service to these individuals, including: 1) outreach, 2) care coordination, 3) housing support, 4) peer support, 5) benefit support, 6) employment assistance, 7) sobering centers, and 8) medical respite.

Beginning January 1, 2022, CalAIM expanded the Whole Person Care delivery concept statewide through implementation of a mandatory enhanced care management (ECM) benefit and voluntary community supports benefits delivered by Medi-Cal managed care plans in each county. ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Medi-Cal beneficiaries with the most complex medical and social needs through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high touch, and person-centered. Medi-Cal beneficiaries are eligible for ECM if they are included in one of the following populations of focus:

[1] MACPAC. "Features of federal Medicaid managed care authorities". January 2016.

Children and Youth Populations of Focus

- Children (up to age 21) experiencing homelessness
- High utilizers
- Children with serious emotional disturbance or identified to be at clinical high risk for psychosis
- California Children's Services (CCS) with additional needs beyond CCS qualifying conditions
- Involved in, or with a history of involvement in, child welfare
- Children transitioning from incarceration

Adult Populations of Focus

- *Individuals and Families Experiencing Homelessness.* Individuals who are experiencing homelessness and have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes or decreased utilization of high-cost services.
- *High Utilizers.* Adult high utilizers including those with five or more avoidable emergency room, or three or more avoidable, unplanned hospital or short-term skilled nursing facility stays in a six month period.
- *SMI/SUD.* Adults with serious mental illness (SMI) or substance use disorders (SUD), with at least one complex social factor influencing their health (e.g. food, housing, or economic insecurity; history of Adverse Childhood Experiences, former foster youth, justice-involvement), and are at high risk for institutionalization, overdose and/or suicide; use crisis services, emergency rooms, urgent care, or inpatient stays as the sole source of care; experienced two or more emergency department or hospital visits due to SMI or SUD in the past 12 months; or are pregnant or post-partum.
- *Individuals Transitioning From Incarceration.* Adults transitioning from incarceration within the past 12 months with at least one of the following conditions: chronic mental illness, SUD, chronic disease, intellectual or developmental disability, traumatic brain injury, human immunodeficiency virus (HIV), or pregnancy.
- *Individuals at Risk for Institutionalization.* Adults at risk of institutionalization eligible for long-term care services who, in the absence of services and supports, would otherwise require care for 90 days or more in an inpatient nursing facility.
- *Nursing Facility Residents Seeking Community Transition.* Adults residing in nursing facilities who desire to transition back to the community and are likely to make a successful transition.

ECM requires Medi-Cal managed care plans and their contracted ECM providers to deliver the following core services:

- *Outreach and Engagement.* Medi-Cal managed care plans are required to develop comprehensive outreach policies and procedures that can include, but are not limited to:
  - Attempting to locate, contact, and engage Medi-Cal beneficiaries who have been identified as good candidates to receive ECM services, promptly after assignment to the plan.
  - Using multiple strategies for engagement including in-person meetings, mail, email, texts, telephone, community and street-level outreach, follow-up if presenting to another partner

in the ECM network, or using claims data to contact other providers the beneficiary is known to use.
  - Using an active and progressive approach to outreach and engagement until the beneficiary is engaged.
  - Documenting outreach and engagement attempts and modalities.
  - Utilizing educational materials and scripts developed for outreach and engagement.
  - Sharing information between the managed care plan and ECM providers to assess beneficiaries for other programs if they cannot be reached or decline ECM.
  - Providing culturally and linguistically appropriate communications and information to engage members.
- *Comprehensive Assessment and Care Management Plan.* Medi-Cal managed care plans must conduct a comprehensive assessment and develop a comprehensive, individualized, person-centered care plan with beneficiaries, family members, other support persons, and clinical input. The plan must incorporate identified needs and strategies to address those needs, such as physical and developmental health care, mental health care, dementia care, SUD services, long-term services and supports (LTSS), oral health services, palliative care, necessary community-based and social services, and housing.
- *Enhanced Coordination of Care.* Enhanced coordination of care includes coordination of the services necessary to implement the care plan. This coordination could include:
  - Organizing patient care activities in the care management plan
  - Sharing information with the care team and family members or support persons.
  - Maintaining regular contact with providers, including case conferences
  - Ensuring continuous and integrated care, with follow-up with primary care, physical and developmental health care, mental health care, SUD treatment, LTSS, oral health care, palliative care, necessary community-based and social services, and housing.
- *Health Promotion.* Medi-Cal managed care plans must provide services to encourage and support lifestyle choices based on healthy behavior, such as: identifying and building on successes and support networks, coaching, strengthening skills to enable identification and access to resources to assist in managing or preventing chronic conditions, smoking cessation or other self-help recovery resources, and other evidence-based practices to help beneficiaries with management of care.
- *Comprehensive Transitional Care.* Medi-Cal managed care plans must provide services to facilitate transitions from and among treatment facilities, including developing strategies to avoid admissions and readmissions, planning timely scheduling of follow-up appointments, arranging transportation for transitional care, and addressing understanding of rehabilitation and self-management activities and medication management.
- *Member and Family Supports.* Medi-Cal managed care plans must ensure the beneficiary and family or support persons are knowledgeable about the beneficiary's conditions, including documentation and authorization for communications, providing a primary point of contact for the beneficiary and family or support persons, providing for appropriate education of the beneficiary and family or support persons, and ensuring the beneficiary has a copy of the care plan and how to request updates.
- *Coordination of and Referral to Community and Social Support Services.* Medi-Cal managed care plans must ensure any present or emerging social factors can be identified and properly addressed, including determining appropriate services to meet needs such as housing or other

community supports services, and coordinating and referring beneficiaries to available community resources and following up to ensure services were provided.

The ECM phase-in schedule is based on which counties implemented Home Health Programs and Whole Person Care pilots under the 1115 Waiver, and for certain populations of focus, as follows:

Previous Implementation Dates

- January 1, 2022 – Counties with Home Health Programs (HHP) or Whole Person Care (WPC) pilots implemented ECM services for the following populations of focus:
  - Individuals and Families Experiencing Homelessness
  - High Utilizer Adults
  - Adults with SMI/SUD
- July 1, 2022 – Counties without HHP or WPC pilots implemented ECM services to the following populations of focus:
  - Individuals and Families Experiencing Homelessness
  - High Utilizer Adults
  - Adults with SMI/SUD
- January 1, 2023 – All counties implemented ECM services to the following populations of focus:
  - Individuals Transitioning from Incarceration (Children and Adults)
  - Individuals at Risk for Institutionalization
  - Nursing Facility Residents Seeking Community Transition

Future Implementation Date

- July 1, 2023 – All counties must provide ECM services to all other Children and Youth

Community Supports. The Governor's January budget includes expenditure authority of $198.3 million ($57.6 million General Fund and $140.7 million federal funds) in 2022-23 and $237 million ($74.4 million General Fund and $162.6 million federal funds) in 2023-24 to support implementation of community supports services. Previously known as In-Lieu of Services, community supports are services or service settings that Medi-Cal managed care plans may offer as a medically appropriate, cost-effective alternative to Medi-Cal eligible services or settings. Provision of community supports is voluntary for Medi-Cal managed care plans to provide and voluntary for Medi-Cal beneficiaries to receive. Plans may change their election of which community supports they provide every six months. The community supports plans may provide include the following:

- Housing Transition Navigation Services – These services assist beneficiaries with obtaining housing and include assessing a beneficiary's housing needs, developing a housing support plan, navigating housing options and applications, assisting with advocacy and securing available income and housing subsidy resources, assisting with reasonable accommodation and move-in readiness, and coordinating necessary environmental modifications.
- Housing Deposits – These services assist beneficiaries with securing or funding one-time housing services that do not constitute room and board including security deposits, setup fees

or deposits for utilities or other services, first month coverage of utilities, first and last month's rent if required for occupancy, health and safety services such as pest eradication or cleaning upon moving in, and medically necessary adaptive aids and services such as air conditioners or air filters.

- Housing Tenancy and Sustaining Services – These services assist beneficiaries in maintaining safe and stable tenancy after housing is secured including early identification and intervention for behaviors that may jeopardize housing, education and training on rights and responsibilities of tenants and landlords, coordination and assistance to maintain relationships with landlords and resolve disputes, advocacy and linkage to community resources to prevent eviction, health and safety visits, unit habitability inspections, and training for independent living and life skills.
- Short-Term Post-Hospitalization Housing – These services may include supported housing in an individual or shared interim housing setting and are designed to assist beneficiaries who are homeless and who have high medical or behavioral health needs with the opportunity to continue their recovery immediately after exiting an inpatient hospital, substance abuse or mental health treatment facility, custody facility, or recuperative care.
- Recuperative Care (Medical Respite) – These services provide short-term residential care for beneficiaries who no longer require hospitalization, but still need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment. At a minimum, the service would include interim housing with a bed and meals with ongoing monitoring of the beneficiary's condition. The service may also include limited or short-term assistance with activities of daily living, coordination of transportation to post-discharge appointments, connection to other necessary health and human services benefits or housing, or stabilizing case management relationships and programs.
- Caregiver Respite – These services provide relief to caregivers of beneficiaries who require intermittent temporary supervision and may be provided by the hour on an episodic basis, by the day or overnight, or include services that attend to the beneficiary's basic self-help needs or other activities of daily living.
- Day Habilitation Programs – These services assist beneficiaries in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the beneficiary's natural environment. These services may include training or assistance with the use of public transportation, personal skills development in conflict resolution, community participation, developing and maintaining interpersonal relationships, daily living skills, community resource awareness (e.g. police, fire, other local services), selecting and moving into a home, locating and choosing suitable housemates, locating household furnishings, settling disputes with landlords, managing personal financial affairs, managing needs for personal attendants, dealing with and responding to governmental agencies and personnel, asserting rights through self-advocacy, and coordinating health and human services benefits.
- Nursing Facility Transition/Diversion to Assisted Living Facilities – These services assist beneficiaries to live in the community or avoid institutionalization by transitioning to a Residential Care Facility for Elderly and Adult (RCFE) or Adult Residential Facility (ARF). These services, which do not include room and board, may include assessing housing needs and presenting options, assessing onsite service needs at the RCFE or ARF, assisting in securing a residence, communicating with facility administration and coordinating the move, establishing procedures and contacts to maintain housing placement, and coordinating with enhanced care management or other in-lieu-of services necessary for stable housing.

- Nursing Facility Transition to a Home – These services assist beneficiaries to live in the community and avoid institutionalization by transitioning to a private residence. These services, which do not include room and board, may include assessing housing needs and presenting options, assisting in securing housing, communicating with landlords and coordinating the move, establishing procedures and contacts to maintain housing placement, and coordinating with enhanced care management or other ILOS necessary for stable housing.
- Personal Care and Homemaker Services – These services assist beneficiaries with activities of daily living such as bathing, dressing, toileting, ambulation, or feeding. These services also assist beneficiaries with instrumental activities of daily living such as meal preparation, grocery shopping and money management. These services are provided in addition to any approved In-Home Supportive Services (IHSS) benefits approved by the county or during any IHSS waiting period.
- Environmental Accessibility Adaptations (Home Modifications) – These services provide physical adaptations to a home that are necessary to ensure the health, welfare, and safety of a beneficiary, or enable the beneficiary to function with greater independence in the home. Adaptations may include installation of ramps and grab-bars, doorway widening for beneficiaries who require a wheelchair, installation of stair lifts, bathroom or shower accessibility, installation of specialized electric or plumbing systems to accommodate medical equipment or supplies, installation and testing of a Personal Emergency Response System for beneficiaries who are alone for significant parts of the day without a caregiver and otherwise require routine supervision.
- Medically-Supportive Food/Meals/Medically Tailored Meals – These services help beneficiaries achieve nutrition goals at critical times to help them regain and maintain their health and may include meals delivered to the home immediately following discharge from a hospital or nursing facility, or medically-tailored meals provided to the beneficiary at home to meet the unique dietary needs of a chronic condition.
- Sobering Centers – These services provide a safe, supportive environment to become sober for individuals found to be publicly intoxicated and who would otherwise be transported to an emergency department or jail. These services also include medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, homeless care support services, and screening and linkage to ongoing supportive services.
- Asthma Remediation – These services are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home without acute asthma episodes that could result in emergency utilization or hospitalization. These services would include allergen-impermeable mattress and pillow dustcovers, high-efficiency particulate air filtered vacuums, integrated pest management, de-humidifiers, air filters, other moisture-controlling interventions, minor mold removal and remediation, ventilation improvements, asthma-friendly cleaning products and supplies, and other interventions identified to be medically appropriate and cost-effective.

As of January 2023, the availability of community supports in each county, or future date of implementation are as follows:

- Housing Transition Navigation Services
  - **Currently Available – All 58 Counties**: As of January 2023, all 58 counties have a Medi-Cal managed care plan that offers housing transition navigation services.
- Housing Deposits
  - **Currently Available – All 58 Counties**: As of January 2023, all 58 counties have a Medi-Cal managed care plan that offers housing deposits.
- Housing Tenancy and Sustaining Services
  - **Currently Available – All 58 Counties**: As of January 2023, all 58 counties have a Medi-Cal managed care plan that offers housing tenancy and sustaining services.
- Short-Term Post-Hospitalization Housing
  - **Currently Available – 37 Counties**: Amador, Contra Costa, Del Norte, Fresno, Humboldt, Imperial, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Trinity, Tulare, Ventura, Yolo, Yuba
  - **July 1, 2023**: Alameda, Alpine, Butte, El Dorado, Inyo, Mono, Nevada, San Francisco, Santa Clara,
  - **January 1, 2024**: Calaveras, Colusa, Glenn, Mariposa, Plumas, San Benito, Sierra, Tehama, Tuolumne
- Recuperative Care (Medical Respite)
  - **Currently Available – 42 Counties**: Alameda, Amador, Contra Costa, Del Norte, Humboldt, Imperial, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Trinity, Tulare, Ventura, Yolo, Yuba
  - **July 1, 2023**: Alpine, Butte, Calaveras, Fresno, Inyo, Mariposa, Mono
  - **January 1, 2024**: Colusa, El Dorado, Glenn, Plumas, San Benito, Sierra, Tehama, Tuolumne
- Caregiver Respite
  - **Currently Available – 53 Counties**: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mariposa, Mendocino, Modoc Mono, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo, Yuba
- Day Habilitation Programs
  - **Currently Available – 23 Counties**: Alameda, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Kern, Kings, Los Angeles, Madera, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare

  - **July 1, 2023**: Alpine, Amador, Butte, Calaveras, Inyo, Mariposa, Mono, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba
  - **January 1, 2024**: San Benito, Ventura
- Nursing Facility Transition/Diversion to Assisted Living Facilities
  - **Currently Available – 39 Counties**: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Mariposa, Mono, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, Ventura, Yuba
- Nursing Facility Transition to a Home
  - **Currently Available – 39 Counties**: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Mariposa, Mono, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, Ventura, Yuba
- Personal Care and Homemaker Services
  - **Currently Available – 53 Counties**: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo, Yuba
- Environmental Accessibility Adaptations (Home Modifications)
  - **Currently Available – 42 Counties**: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Mariposa, Merced, Mono, Monterey, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, Ventura, Yuba
- Medically-Supportive Food/Meals/Medically Tailored Meals
  - **Currently Available – All 58 Counties**: As of January 2023, all 58 counties have a Medi-Cal managed care plan that offers medically-supportive food, meals, and medically tailored meals.
  - Sobering Centers
  - **Currently Available – 19 Counties**: Imperial, Kern, Kings, Los Angeles, Merced, Monterey, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Barbara, Santa Clara, Stanislaus, Tulare
  - **July 1, 2023**: Butte, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Inyo, Madera, Mono
  - **January 1, 2024**: Alameda, Alpine, Amador, Calaveras, Mariposa, Nevada, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, Ventura, Yuba
- Asthma Remediation
  - **Currently Available – 37 Counties**: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Mariposa, Mono, Nevada, Orange, Placer, Plumas, Riverside,

Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, Yuba
- **July 1, 2023**: Ventura

Managed Care Plan Incentives. The Governor's January budget includes expenditure authority of $300 million ($150 million General Fund and $150 million federal funds) in 2022-23 and $600 million ($300 million General Fund and $300 million federal funds) in 2023-24 for managed care plan incentives. Beginning January 1, 2022, Medi-Cal managed care plans were eligible for incentive payments for investing in expanding and improving delivery of ECM and community supports. Federal regulations allow a percentage above a Medi-Cal managed care plans capitation payment to be allocated for quality improvement programs. To receive incentive payments, Medi-Cal managed care plans must improve delivery system infrastructure, build provider capacity for ECM and community supports services, and achieve certain quality benchmarks.

Medi-Cal Providing Access and Transforming Health (PATH). The Governor's January budget includes expenditure authority of $711.9 million ($271.2 million General Fund, $356 million federal funds, and $84.7 million special funds and reimbursements) in 2022-23 and $599.9 million ($272 million General Fund, $300 million federal funds, and $28 million special funds and reimbursements) in 2023-24 for the Medi-Cal Providing Access and Transforming Health (PATH) initiative. The Medi-Cal PATH initiative is intended to provide a smooth transition between current 1115 Waiver pilots and statewide services and capacity building, including for effective pre-release care and coordination with justice agencies. PATH funding will support the transition from Whole Person Care pilots to ECM and community supports, including funding for counties, community-based organizations, and other providers to build the capacity and infrastructure necessary for these new statewide services. In addition, PATH funding will help ensure jails and prisons are ready for service delivery for the justice-involved, including mandatory Medi-Cal applications; behavioral health referrals, linkages, and warm hand-offs from county jails to Medi-Cal managed care plans and county behavioral health departments; "in reach" services up to 90 days prior to release, and the re-entry ECM benefit available in January 2023. PATH funding will also support workforce development for the homeless and home- and community-based services systems of care, including outreach, training in evidence-based practices, information technology for data sharing, and training stipends.

Dental Initiatives. The Governor's January budget includes expenditure authority of $258.5 million ($124.2 million General Fund and $134.2 million federal funds) in 2022-23 and $259.3 million ($123.5 million General Fund and $134.8 million federal funds) in 2023-24 to support incentive payments to improve dental care for Medi-Cal beneficiaries, available through the Medicaid State Plan. During the previous 1115 Waiver, DHCS implemented the Dental Transformation Initiative, which included four dental "domains", including: 1) incentive payments for increasing preventive services utilization in children; 2) incentive payments for caries risk assessment and disease management; 3) incentive payments to encourage continuity of care; and 4) local dental pilot projects. Beginning January 1, 2022, DHCS transitioned the three incentive payments programs of the Dental Transformation Initiative into the State Plan and included coverage of silver diamine fluoride as a dental benefit for certain populations. The department reports it has set an initial goal of achieving a 60 percent dental utilization rate for eligible Medi-Cal children and adults.

Population Health Management. The Governor's January budget includes expenditure authority of $49.6 million ($5 million General Fund and $44.6 million federal funds) in 2022-23 and $52.7 million ($5.3 million General Fund and $47.4 million federal funds) in 2023-24 to support implementation of a Population Health Management (PHM) service. The PHM service would utilize Medi-Cal administrative and clinical data and information for the department, Medi-Cal managed care plans, counties, providers, beneficiaries, and other partners to use in support of the delivery of care for Medi-Cal beneficiaries. According to DHCS, this service would also allow for identification of potential gaps in care, provider or care manager information, information on social determinants of health, as well as allow for population health analytics, health education, and tips for beneficiaries. The PHM system would also provide Medi-Cal beneficiaries with access to their administrative and clinical information.

Transitions of Populations Between Fee-for-Service and Managed Care. The Governor's January budget includes expenditure authority of $211.7 million ($84.7 million General Fund and $127 million federal funds) in 2022-23 and $26 million ($10.4 million General Fund and $15.6 million federal funds) in 2023-24 for transitions of populations between the fee-for-service and managed care delivery systems. CalAIM includes several changes to how certain populations of Medi-Cal beneficiaries would access certain benefits. CalAIM seeks to standardize which benefits are available through the managed care delivery system and which are available through the fee-for-service delivery system. Similarly, CalAIM seeks to standardize the populations of Medi-Cal beneficiaries that would receive services through managed care or through fee-for-service.

Benefit Standardization. CalAIM standardizes which Medi-Cal benefits are provided in the managed care delivery system and which benefits are provided in another delivery system. The proposed changes are as follows:

- **Managed Care Benefits ("Carved In")**
    - Long-term care – Effective January 1, 2023, all institutional long-term care services have become the responsibility of a beneficiary's managed care plan including skilled nursing facilities, pediatric and adult subacute care facilities, intermediate care facilities for individuals with developmental disabilities, disabled/habilitative/nursing services, and specialized rehabilitation in a skilled nursing facility or intermediate care facility.
    - Organ transplants – Effective January 1, 2022, all major organ transplants are the responsibility of a beneficiary's managed care plan.

- **Fee-for-Service Benefits ("Carved Out")**
    - Pharmacy – Under the department's Medi-Cal Rx initiative, all prescription drugs and/or pharmacy services billed on a pharmacy claim are provided in the fee-for-service delivery system as of January 1, 2022. This carve-out does not apply to SCAN Health Plan, Programs for All-Inclusive Care for the Elderly (PACE), Cal MediConnect plans, and the Major Risk Medical Insurance Program (MRMIP).

- <u>Specialty mental health services (Solano and Sacramento)</u> – Effective July 1, 2023, specialty mental health services currently the responsibility of Kaiser health plans in Solano and Sacramento counties, would be provided by the county mental health plans.
- <u>Multipurpose Senior Services Program</u> – Effective January 1, 2022, the Multipurpose Senior Services Program, which had previously been scheduled to become the responsibility of Medi-Cal managed care plans in Coordinated Care Initiative counties, will instead remain a benefit under the existing 1915(c) Home- and Community-Based Services Waiver.

Standardization of Mandatory Managed Care and Fee-for-Service Populations. CalAIM will also standardize which categories of Medi-Cal beneficiaries would be required to enroll in a managed care plan to receive benefits and which beneficiaries would be required to receive benefits in the fee-for-service delivery system. According to DHCS, standardization will enhance coordination of care and reduce complexity across the Medi-Cal program. The populations transitioning from each system are as follows:

- **<u>Transitions from Fee-for-Service to Mandatory Managed Care.</u>** Populations currently receiving benefits in the fee-for-service delivery system that would be required to enroll in a Medi-Cal managed care plan are as follows:

  - Trafficking and Crime Victims Assistance Program beneficiaries, except those with a share of cost
  - Individuals participating in accelerated enrollment
  - Breast and Cervical Cancer Treatment Program (BCCTP) – non-dual beneficiaries
  - Beneficiaries with other health care coverage
  - Beneficiaries living in rural ZIP codes
  - Individuals eligible for long-term care services, including those with a share of cost, beginning January 1, 2023
  - All dual-eligible beneficiaries, not including those with a share of cost or with restricted-scope benefits, beginning January 1, 2023

- **<u>Transitions from Managed Care to Mandatory Fee-for-Service.</u>** Populations currently receiving benefits in the managed care delivery system that would be required to receive benefits in the fee-for-service delivery system:

  - Individuals receiving restricted-scope benefits
  - Individuals with a share of cost, including in county organized health systems, Coordinated Care Initiative counties, Trafficking and Crime Victims Assistance Program, but excluding long-term care
  - Presumptive eligibility
  - State medical parole, county compassionate release, and incarcerated individuals
  - Non-citizen pregnancy-related aid codes enrolled in Medi-Cal, not including Medi-Cal Access Infant Program enrollees
  - Omnibus Budget Reconciliation Act (OBRA) beneficiaries currently in managed care in Napa, Solano, and Yolo counties

According to DHCS, enrollment requirements for foster care children and youth will remain unchanged pending discussions and recommendations of its Foster Care Workgroup on future delivery system reforms for this population.

Long-Term Services and Supports Integration. Under CalAIM, DHCS will make several changes to the delivery system for long-term services and supports (LTSS) that build upon the state's duals demonstration project, the Coordinated Care Initiative (CCI). DHCS intends to use selective contracting to move toward aligned enrollment in a Medi-Cal managed care plan and a dual-eligible special needs plan (D-SNP) operated by one integrated organization. In the seven CCI demonstration counties, all Medi-Cal beneficiaries in a Cal MediConnect plan would transition to aligned D-SNPs and managed care plans operated by the same organization as their Cal MediConnect product, beginning January 1, 2023. Aligned enrollment would occur in non-CCI counties by 2026. Dual-eligible beneficiaries already in a non-aligned D-SNP (not affiliated with their managed care plan) would be allowed to maintain their enrollment, but new enrollment in non-aligned D-SNPs would be closed.

DHCS will require all D-SNPs to use a model of care addressing both Medicare and Medi-Cal services to support coordinated care, high-quality care transitions, and information sharing. D-SNPs would be required to: 1) develop and use integrated member materials, 2) include consumers in existing advisory boards, 3) establish joint contract management team meetings for aligned D-SNPs and managed care plans, 4) include dementia specialists in care coordination efforts, and 5) coordinate carved-out LTSS benefits including in-home supportive services (IHSS), MSSP, and other home- and community-based services waiver programs.

Beginning January 1, 2023, DHCS implemented mandatory enrollment of full- and partial-benefit dual eligible beneficiaries into managed care plans for Medi-Cal benefits, including dual and non-dual eligible long-term care residents. Long-term care benefits will be integrated into Medi-Cal managed care statewide. Cal MediConnect plans and the Coordinated Care Initiative were also scheduled to be discontinued at this time.

Behavioral Health Quality Improvement Program and Payment Reform. The Governor's January budget includes General Fund expenditure authority of $45.4 million in 2022-23 and $19.5 million in 2023-24 to support the Behavioral Health Quality Improvement Program (BH-QIP). CalAIM seeks to reform behavioral health payment methodologies in a multi-step process from the current cost-based reimbursement process to a rate-based and value-based structure using intergovernmental transfers to fund the non-federal share of services. The first step in the process, supported by the BH-QIP, will transition behavioral health services from the current claims coding system, Healthcare Common Procedure Coding System (HCPCS) Level II, to HCPCS Level I. According to DHCS, this transition would allow for more granular claiming and reporting of services provided, as well as more accurate reimbursements.

DHCS expects that, concurrent with the transition to HCPCS Level I, DHCS will transition to a rate-setting process for behavioral health services by peer groups of counties with similar costs of doing business. The non-federal share of rates would be provided by counties via intergovernmental transfer (IGT), rather than the current, cost-based certified public expenditure (CPE) process. DHCS would make annual updates to established rates to ensure reimbursement

reflects the costs of providing services. DHCS would, at first, make payments to counties on a monthly basis, and would eventually transition to a quarterly payment schedule.

CalAIM also seeks to modify the existing medical necessity criteria for behavioral health services to ensure behavioral health needs are being addressed and guided to the most appropriate delivery system as well as provide appropriate reimbursement to counties. These changes will separate the concept of eligibility for services from that of medical necessity, allow counties to provide services to meet a beneficiary's behavioral health needs prior to diagnosis of a covered condition, clarify that treatment in the presence of a co-occurring substance use disorder is appropriate and reimbursable when medical necessity is met, implement a standardized screening tool to facilitate accurate determinations of which delivery system (specialty mental health, Medi-Cal managed care, or Medi-Cal fee-for-service) is most appropriate for care, implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system in which they seek care, and make other revisions and technical corrections. These changes will ensure that eligibility criteria, largely being driven by level of impairment as well as diagnosis or a set of factors across the bio-psycho-social continuum, will be the driving factor for determining the delivery system in which a beneficiary should receive services.

The budget also includes General Fund expenditure authority of $375 million in 2023-24 to support the non-federal share of behavioral health services provided by counties under payment reform. While behavioral health services are realigned programs, with the non-federal share typically supported by county funding, the budget proposes to use General Fund resources to fund the first year of services under payment reform, with counties reimbursing the state through intergovernmental transfers deposited in a special fund. Because Medi-Cal operates on a cash basis of accounting, this one-time General Fund expenditure will not be recouped unless the state discontinues the intergovernmental transfer arrangement for payment reform.

GOVERNOR'S PROPOSAL

California Advancing and Innovating Medi-Cal (CalAIM). The budget includes expenditure authority of $2.7 billion ($1.1 billion General Fund, $1.6 billion federal funds, and $84.7 million special funds and reimbursements) in 2022-23 and $3.4 billion ($1.5 billion General Fund, $1.9 billion federal funds, and $28 million special funds and reimbursements) in 2023-24 to support implementation of the CalAIM initiative, including the following components:

- Enhanced Care Management and Community Supports – Services and Incentives – $1.2 billion ($431.9 million General Fund and $743.9 million federal funds) in 2022-23 and $1.8 billion ($748.8 million General Fund and $1.1 billion federal funds) in 2023-24.

- Medi-Cal Providing Access and Transforming Health (PATH) – $711.9 million ($271.2 million General Fund, $356 million federal funds, and $84.7 million special funds and reimbursements) in 2022-23 and $599.9 million ($272 million General Fund, $300 million federal funds, and $28 million special funds and reimbursements) in 2023-24.

- Population Health Management Platform – $49.6 million ($5 million General Fund and $44.6 million federal funds) in 2022-23 and $52.7 million ($5.3 million General Fund and $47.4 million federal funds) in 2023-24.

- Dental Initiatives – $258.5 million ($124.2 million General Fund and $134.2 million federal funds) in 2022-23 and $259.3 million ($124.5 million General Fund and $134.8 million federal funds) in 2023-24.

- Populations Transitioning Between Delivery Systems – $211.7 million ($84.7 million General Fund and $127 million federal funds) in 2022-23 and $26 million ($10.4 million General Fund and $15.6 million federal funds) in 2023-24.

- Long-Term Care Benefit Transition – $201 million ($96.9 million General Fund and $104.1 million federal funds) in 2022-23 and $49 million ($23.6 million General Fund and $25.4 million federal funds) in 2023-24.

- Inmate Pre-Release Program – $6.6 million ($4 million General Fund and $2.6 million federal funds) in 2022-23 and $109.7 million ($39.1 million General Fund and $70.7 million federal funds) in 2023-24.

- Behavioral Health Quality Improvement Program – $45.4 million General Fund in 2022-23 and $19.5 million General Fund in 2023-24.

- Behavioral Health Payment Reform – $375 million General Fund in 2023-24.

- Organ Transplant Transition – $9.4 million ($3.5 million General Fund and $5.9 million federal funds) in 2022-23 and $13.7 million ($4.5 million General Fund and $9.1 million federal funds) in 2023-24.

- Designated State Health Programs – General Fund savings of $40.4 million in 2022-23 and $153 million in 2023-24, due to additional federal funds.

ISSUES FOR CONSIDERATION

Adequacy of Provider Networks for New Benefits and Services. The Medi-Cal program has historically experienced challenges ensuring Medi-Cal managed care plans maintain adequate provider networks for the benefits and services that are part of the traditional Medi-Cal program. DHCS monitors Medi-Cal managed care plans for compliance with statutory network adequacy requirements, but frequently allows for alternative access standards that permit plans to maintain networks that do not meet statutory requirements as long as they ensure access to necessary benefits and services in other ways. As plans continue to implement the new enhanced care management benefit and community supports services, the Legislature should monitor how plans are ensuring Medi-Cal beneficiaries are able to access these new benefits and services in a timely manner.

In addition, the new community supports services are voluntary for plans to provide and voluntary for Medi-Cal beneficiaries to receive. These services are voluntary under the CalAIM Waiver because the provider networks for these services are not sufficient to ensure a uniform, statewide benefit for all Medi-Cal beneficiaries, consistent with federal Medicaid law and regulations. However, the state has invested significant resources to provide incentives to plans to build up these provider networks, particularly in the area of housing supports and navigation. Many of the housing supports and navigation benefits, as well as the medically supportive food/meals/medically tailored meals benefit, are available in every county. The Legislature should request DHCS to identify what additional work would be necessary to meet federal requirements to transition these voluntary Waiver services into mandatory benefits under the Medicaid State Plan.

Equitable Identification of Beneficiaries Eligible for New Benefits and Services. Medi-Cal managed care plans are required by DHCS to conduct outreach and engagement to identify members eligible for enhanced care management, conduct comprehensive assessments, develop a care plan, and coordinate access to other services. Commercial methods for identifying eligibility for intensive services like those offered under CalAIM have demonstrated evidence of bias against those for whom access to necessary medical care is already a challenge. The Legislature should monitor how plans are identifying and assessing members' eligibility for enhanced care management and community supports, particularly how they ensure the methodologies they employ to identify eligibility for these services are equitable and reach every population in need. In addition, the Legislature should monitor how successfully plans are integrating existing Medi-Cal services with enhanced care management, community supports, and other non-Medi-Cal social services to support the whole-person approach toward which CalAIM's reforms are oriented.

Improving the Delivery of Behavioral Health Care Through Payment Reform. The implementation of behavioral health payment reform has the potential to significantly simplify how county behavioral health departments pay providers for the services they provide to Medi-Cal beneficiaries. Instead of requiring strict documentation of every unit of service provided, behavioral health providers would be compensated on a fee-for-service basis, reducing the "document burden" on providers. The changes in medical necessity determinations and the "no wrong door" approach likewise should improve the timeliness and appropriateness of care for Medi-Cal beneficiaries. The Legislature should monitor how behavioral health payment reform is implemented and evaluate what further steps may be necessary to ensure Medi-Cal beneficiaries access to, and quality of, behavioral health care improves over time.