California Advancing and Innovating Medi-Cal (Cal AIM) Proposal: *An Overview*

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California Primary Care ASSOCIATION

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Agenda

- **Background**
- **Cal AIM Major Components**
- **Cal AIM Proposal Deep Dive**
- **DHCS' Stakeholder Process / CPCA's Engagement**
- **Next Steps**

Background

- **What is Cal AIM?**
  - Cal AIM (California Advancing and Innovating Medi-Cal) is a multi-year initiative proposed by the Administration to transform the current Medi-Cal care program.

- **What does Cal AIM try to do?**
  - The proposal aligns and advances several key priorities of the Administration, focusing on improving the entire continuum of care, behavioral health, high utilizers, children, homeless population, and aging population.

- **Why do we need Cal AIM? How does it relate to California Medi-Cal waiver?**
  - Current 1115 and 1915(b) waivers will expire at the end of 2020 presenting an opportunity to transform care delivery in California.
  - California need federal approval to implement many of the changes proposed in Cal AIM.

- **What impact may it have on the Medi-Cal program? On FQHCs?**
  - Cal AIM will impose more requirements and responsibilities on Medi-Cal managed care plans, which can lead to more requirements and responsibilities for Medi-Cal providers including FQHCs (e.g. NCQA accreditation, Population Health Management).

- **What is the timeline for Cal AIM implementation?**
  - DHCS' public engagement: Nov 2019 – Feb 2020
  - DHCS' submission to CMS: Mid/late 2020
  - Expected implementation date: Jan 1, 2021

Cal AIM Major Components

Managed Care
- Benefit standardization
- Mandatory managed care enrollment
- Annual open enrollment
- NCQA accreditation requirements
- Regional rate setting

Behavioral Health
- Medical necessity criteria
- Payment reform for SMH/SUD
- Administrative integration of SMH and SUD
- SUD Managed Care Program (DMC) Renewal
- Institutions for Mental Disease (IMD) waiver

Dental Care
- New dental benefits
- P4P Initiatives

Long-term Care/Aging Population
- Carve-in long-term services and support
- Dual eligible special needs plans

Social Determinants of Health (SDOH)
- Population health management program
- Enhanced care management
- In-lieu-of services
- Shared risk, shared savings, and incentive payments

Full Integration Plans
- Create new health plan model that fully integrates physical, behavioral, and oral health under one contracted entity.

Benefit Standardization

- DHCS proposes to standardize benefits that are provided through Medi-Cal managed care plans.
- Proposed changes include:
  - **Carved out benefits** – the following benefits will be carved out completely:
    - **All prescription drugs and/or pharmacy services** billed on a pharmacy claim.
    - **Specialty mental health services** that are currently carved in for Medi-Cal members enrolled in Kaiser in Solano and Sacramento counties.
    - The **Multipurpose Senior Services Program** which is currently included in the Medi-Cal managed care plans in the seven Coordinated Care Initiative counties.
    - **Fabrication of optical lenses** statewide through the fee-for-service system.
      - Currently CenCal Health and Health Plan of San Mateo provide these services within their managed care contract.
  - **Carved in benefits** - the following benefits that are currently not within the scope of many plans will be carved into all plans statewide:
    - **All institutional long-term care services**
      - Skilled nursing facilities.
      - Pediatric/adult subacute care.
      - Intermediate care facilities for individuals with developmental disabilities.
      - Disabled/habilitative/nursing services.
      - Specialized rehabilitation in a skilled nursing facility or intermediate care facilities.
    - **All major organ transplants**
- Timeline: the benefit standardization will be effective and included in Medi-Cal managed care plan contracts on January 1, 2021.

Mandatory Managed Care Enrollment

- DHCS is proposing to **standardize which aid code groups will require mandatory managed care enrollment verses mandatory fee-for-service enrollment**, across all models of care and aid code groups, statewide.
  - Under this proposal, beneficiaries who are currently in FFS would be required to choose a Medi-Cal managed care plan and will not be permitted to remain in fee-for-service.
- **Mandatory managed care enrollment** – the following are populations who are currently receive benefits through FFS that would be transition to managed care:
  - Individuals eligible for long-term care services (includes long-term care share of cost populations)
  - Trafficking and Crime Victims Assistance Program (except share of cost)
  - Individuals participating in accelerated enrollment
  - Child Health and Disability Prevention infant deeming
  - Pregnancy-related Medi-Cal (Pregnant Women only, 138-213% citizen/lawfully present)
  - American Indians
  - Beneficiaries with other health care coverage
  - Beneficiaries living in rural zip codes
  - All dual aid code groups, except share of cost or restricted scope, will be mandatory Medi-Cal managed care, in all models of care starting in 2023
- **Mandatory FFS enrollment** – patient populations include those under the Omnibus Budget Reconciliation Act (previously mandatory managed care in Napa, Solano, and Yolo counties) and Share of cost (i.e. beneficiaries in COHS and Coordinated Care Initiative counties).
  - Restricted scope
  - Share of cost (including Trafficking and Crime Victims Assistance Program share of cost, excluding long-term care share of cost)
  - Presumptive eligibility
  - State medical parole, County compassionate release, and incarcerated individuals
  - Non-citizen pregnancy-related aid codes enrolled in Medi-Cal

Annual Open Enrollment

- DHCS proposes to establish an **annual Medi-Cal managed plan open enrollment process for all enrollees in counties where two or more Medi-Cal managed care plans operate** (not applicable to COHS).
- DHCS proposes **several exceptions** to the annual open enrollment including:
  - First time enrolled beneficiary who was assigned through default enrollment process may change plan during the first year of enrollment
  - A newborn that is automatically assigned to their mother's Medi-Cal managed care plan may change plan during the first year of enrollment
  - A beneficiary moving from one county to another, whose plan in the new county was assigned through the default enrollment process
  - An enrollee for whom their primary care provider and/or specialists, has terminated his/her contract with the Medi-Cal managed care plan that they are enrolled in, but are available in another Medi-Cal managed care plan.
  - An enrollee for whom their current provider has terminated his/her contract with the plan; and the enrollee prefers a different provider who is only available in another plan's network.
  - At any time, for "good cause" as defined in Title 42 C.F.R 438.56(d)(2). For example:
    - Transgender services not available in network;
    - HIV/AIDS services not available in network;
    - Lack of access to services covered under the contract; and
    - Conditions whose management requires coordination of multiple specialties.
- Timeline
  - DHCS proposes implementing the first annual Medi-Cal health plan open enrollment period from November 1, 2021 to December 31, 2021 for enrollment effective January 1, 2022.
  - Each year thereafter, the annual health plan open enrollment period would occur from November 1 through December 15. Medi-Cal managed care plan enrollment would be effective on January 1 of each year.

NCQA Accreditation Requirements

- DHCS proposes to **require all Medi-Cal managed care plans and their subcontractors (delegated entities) to be NCQA accredited by 2025**.
  - DHCS would use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain State and federal Medicaid requirements.
  - DHCS would not accept accreditation from entities other than NCQA (e.g. URAC) except for specific plans for which NCQA does not offer accreditation, due to the limited population (e.g. population-specific plans).
- DHCS would align all applicable processes in its Medi-Cal managed care plan contract and All Plan Letters with the following **seven NCQA health plan accreditation categories**:
  - Quality Improvement;
  - Population Health Management;
  - Network Management;
  - Utilization Management;
  - Credentialing;
  - Member Rights and Responsibilities; and
  - Member Connections.
- DHCS is considering requiring Medi-Cal managed care plan NCQA accreditation to include the Long Term Services and Supports Distinction Survey.
- DHCS is considering discussing the **addition of the Medicaid (MED) module to routine NCQA health plan accreditation**, as this could potentially maximize the opportunity for streamlining state compliance and deeming.
- DHCS is considering requiring Medi-Cal managed care plans to **ensure any subcontractors to whom certain contractual elements are delegated are NCQA accredited for that function**.
  - At a minimum, DHCS is considering **plan-to-plan delegation** would likely require NCQA accreditation.
- Timeline: DHCS would require all Medi-Cal managed care plans to be NCQA accredited by 2025.

Regional Rate Setting

- DHCS proposes a **regional rate-setting methodology** that will simplify the rate-setting process for the Medi-Cal managed care program.
- Proposed two-phased approach:
  - Phase 1 - Implement regional rates in targeted counties
    - Implement Phase I for calendar years 2021 and 2022 for a number of targeted counties and plans
    - Implement new regional rate-setting approaches and streamline rate processes and methodologies
    - Identify strategies, lessons learned and further improvements that will inform Phase 2 implementation
  - Phase 2 – Fully implement regional rates statewide
    - Fully implement regional rates statewide no sooner than calendar year 2023
    - DHCS will consider health care market dynamics, including but not limited to health care cost and utilization data, across counties when determining regional boundaries
- Timeline
  - Calendar Year 2020: Develop regional rate-setting methodologies and approaches with appropriate stakeholder input
  - January 1, 2021: Implement Phase I for targeted counties and Medi-Cal managed care plans
  - Calendar Year 2022: Evaluate and continue to refine the rate-setting process prior to the implementation of regional rates statewide
  - No sooner than January 1, 2023: Fully Implement regional rates statewide
  - Post-implementation: Continue to evaluate and refine the rate-setting process and regions

Questions/Comments

- What proposed changes do you like? Dislike?
- What are the proposed changes that may negatively impact your current operation? How? What are the solutions? How can we comment on them?
- What changes would you like to see or want CPCA to send to DHCS?
- Reviewing the deep dive slides, what are the immediate red flags for you? What changes do you recommend?

Behavioral Health

Medical Necessity Criteria for SMH/SUD

- DHCS is proposing to **modify the existing medical necessity criteria** for both outpatient and inpatient specialty mental health services.
- **Eligibility criteria** (e.g. level of impairment, diagnosis or a set of factors across the bio-psycho-social continuum) should determine which delivery system is appropriate for the beneficiaries, either Medi-Cal managed care plans for mild to moderate mental health services or through the mental health managed care plans for specialty mental health services.
- Proposed changes to **outpatient Specialty Mental Health services**
  - **Covered Diagnosis**: County can provide and be paid for treatment services to meet a beneficiary's mental health needs prior to determining whether the beneficiary has a covered diagnosis.
  - **Impairment Criteria**: Identification of an existing, or development of a new, statewide, standardized level of care assessment tools, one for beneficiaries 21 and under and one for beneficiaries over 21.
  - **Service Criteria**: Revise the existing intervention criteria to clarify that SMH services should be provided to beneficiaries who meet the eligibility criteria for SMH and that services are reimbursable when they are provided in accordance with the Medi-Cal State Plan.
  - **SMH services** must also meet the following criteria:
    - Allow beneficiaries to sustain their current level of functioning, remain in the community, prevent deterioration in an important area of life functioning, and prevent the need for institutionalization or a higher level of medical care intervention
    - Provided in the least restrictive setting, consistent with the goals of recovery and resiliency, the requirements for learning and development, and/or independent living and enhanced self-sufficiency
    - Provided based on medical necessity criteria, in accordance with an individualized client plan, and approved and authorized according to State requirements.
  - **No Wrong Door approach** for children under the age of 21: Whether the child presents first in the Medi-Cal managed care plan or the mental health managed care plan, each system is responsible for providing services to the child, assessing the child and either providing ongoing treatment, as necessary, or referring the child to the appropriate delivery system.

Medical Necessity Criteria for SMH/SUD (cont.)

- Proposed changes to inpatient Specialty Mental Health Services for Adults and Children/Youth
  - Require **physician's certification/recertification to document a beneficiary's need** for acute psychiatric hospital services and that services are provided at the appropriate level of care.
  - Set a **consistent approach to authorization and reauthorization** of inpatient mental health services.
- Proposed changes to SUD services
  - Provide services to meet a beneficiary's SUD needs prior to determining whether the beneficiary has a covered diagnoses
- Timeline: Changes to the SMH and SUD eligibility and medical necessity criteria will be effective January 1, 2021 with the approval of the 1115 and 1915(b) waivers.

Payment Reform for SMH/SUD

- DHCS proposes **shifting reimbursement for all inpatient and outpatient SMH and SUD services from Certified Public Expenditure-based methodologies to other rate-based/value-based structures** that instead utilized intergovernmental transfers to fund the county non-federal share.
- To achieve this goal, DHCS will:
  - Transition SMH and SUD services from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding
  - Establish reimbursement rates, as well as an ongoing methodology for updating rates, for the updated codes with non-federal and State share being provided by counties via intergovernmental transfer
- Rates will be **set by peer grouping**. Each peer group would be made up of counties with similar costs of doing business to best reflect local needs.
- Intergovernmental transfers and DHCS payments to counties will be on a monthly basis initially, and will be moved to quarterly.

Behavioral Health

Administrative Integration of SMH and SUD

- DHCS is proposing administrative integration of SMH and SUD services into one behavioral health managed care program that provides those services for all Medi-Cal beneficiaries in that county or region.
- Clinical Integration
  - **Access Line**: Counties will have an integrated, 24-hour access line for beneficiaries seeking either specialty mental health and/or substance use disorder services.
  - **Intake/Screening/Referrals**: Counties will have standardized and streamlined processes to intake, screen and refer patients.
  - **Assessment**: Counties will establish uniform, standardized assessment for use across the behavioral health delivery system. Currently, ASAM placement tool is required in substance use disorder managed care but not in FFS counties; and Child and Adolescent Needs and Strengths tool is required for children and youth, but no equivalent tool for adults.
  - **Treatment Planning**: Counties will implement a standardized and streamlined treatment plan for both SMH and SUD services, as well as documentation requirements that are less burdensome on the counties, providers and beneficiaries.
  - **Beneficiary Informing Materials:** Counties will consolidate beneficiary information materials in order to streamline them into one user-friendly handbook, reduce confusion, increase access, and achieve administrative efficiencies.
- Integration of Prepaid Inpatient Health Plans/FFS Functions
  - **Contracts**: Under an integrated system, the goal would be to have only one contract in every county that would cover both SMH and SUD services.
  - **Data Sharing/Privacy Concerns**: Counties will assess existing data structure to identify barriers and solutions to enhance data sharing while ensure protection for patient privacy.
  - **Electronic Health Record Integration and Re-Design**: Counties will establish timelines for integrating different EHR components and/or making modifications to integrate existing EHRs.
  - **Cultural Competence Plans**: Counties will need to have only one integrated cultural competence plan instead of two separate plans currently.

Administrative Integration of SMH and SUD (cont)

Behavioral Health

- Administrative Integration
  - **Quality Improvement**: Counties will develop and operationalize a consolidated quality improvement plan, have a single quality improvement committee, and develop a comprehensive list of performance measures for specialty mental health services and substance use disorder services.
  - **External Quality Review Organizations**: Under this proposal, counties will implement a combined external quality review process that results in one EQRO report and performance improvement plans.
  - **Compliance Reviews**: Counties will consolidate compliance reviews into a single protocol, which will reduce duplicative documentation requirements and mitigate audit/compliance risk.
  - **Network Adequacy**: DHCS would certify one network for SMH and SUD managed care services for each county, instead of certifying two networks as currently required.
  - **Licensing & Certification**: Existing requirements and processes for licensing and certification are different and separate for SMH and SUD providers. This proposal will streamline licensing and certification requirements, processes, and timeframes across the behavioral health managed care system.

Behavioral Health Regional Contracting

- DHCS encourages counties to develop regional approaches to administer and deliver SMH and SUD services to Medi-Cal beneficiaries.
  - Examples include Joint Powers Authority or County Medical Services Program leading the efforts. Regional partnership is also another example.

Behavioral Health

SUD Managed Care Program (DMC) Renewal

- DHCS proposes to incorporate DMC into the 1915(b) waiver and to encourage participation across the states in currently non participating counties.
- DHCS proposes several changes to the current DMC program
  - **Residential Treatment Length of Stay Requirements**: DHCS proposes to remove the current LOS requirement, which restrict to two non-continuous stays for up to 90 days for each stay with one 30 day extension within a 365-day period.
  - **Residential Treatment Definition**: The definition of residential treatment will be updated to remove the adolescent length-of-stay limitations, and to add mandatory provisions for referral to medication assisted treatment. DHCS also proposes to remove the distinction between adults and adolescents except in the case of EPSDT.
  - **Recovery Services**: DHCS proposes to clarify the following policies related to recovery services:
    - Specify the services included in the benefit (e.g., group, education sessions, and assessment);
    - Establish when and how beneficiaries may access these services, including language to encourage the use of recovery services for justice-involved individuals: and
    - Define the term "after completing their course of treatment," to not inadvertently prohibit beneficiaries receiving long-term medication assisted treatment from having access to recovery services.
  - **Additional Medication Assisted Treatment**: Currently, while counties are required to cover NTP services, other MAT services including ordering, prescribing, administering and monitoring all medication are optional. DHCS proposes that all substance use disorder managed care providers must demonstrate that they either directly offer, or have referral mechanisms to, medication assisted treatment.
  - **Physician Consultation Services**: DHCS proposes to make this benefit optional, and to clarify the terms of physician consultation, particularly with regard to how and who can claim this activity. Physician consultation services include SUD managed care physicians consulting with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists.

SUD Managed Care Program (DMC) Renewal

- **Evidence-based practice requirements**: DHCS proposes to retain five current evidence-based practices: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho Education. DHCS proposes to add Contingency Management to the waiver renewal proposal.
- **Treatment after Incarceration**: DHCS proposes exploring solutions to clarify access language for individuals leaving incarceration who have a known substance use disorder.
- **Billing for Services Prior to Diagnosis**: DHCS proposes clarifying the waiver Special Terms and Conditions to allow reimbursement for substance use disorder assessments (even if it takes multiple visits) before a final diagnosis is determined.

IMD Exclusion Waiver

- DHCS seeks input from stakeholders regarding whether California should pursue this serious mental illness/serious emotional disturbance Section 1115 demonstration to receive federal financial participation for services provided to Medi-Cal beneficiaries in an institution for mental disease.
  - If California decides to pursue this waiver opportunity, DHCS must submit an application to CMS using the usual process for submitting an 1115 application.
  - Similar to the State's existing 1115 demonstration to provide residential and other substance use disorder treatment services under Medi-Cal, county participation would be voluntary.
- In considering applying for this Section 1115 demonstration opportunity, DHCS would need to consult with CMS to ensure that the "costs not otherwise matchable" under the mental illness waiver would be considered a pass-through of State and federal funds in the same manner as the substance use disorder treatment waiver.
  - Because DHCS will not have budget neutrality savings to apply to an 1115 waiver moving forward, this determination is critical to the feasibility of pursuing this demonstration opportunity.

Questions/Comments

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New Dental Benefits and P4P Initiatives

- DHCS proposes the following reforms for Medi-Cal dental be made statewide:
  - Add new dental benefits based on the successes of the Dental Transformation Initiative that will provide better care and align with national dental care standards.
  - Continue and expand pay for performance Initiatives that reward increasing the use of preventive services and establishing/maintaining continuity of care through a Dental Home, available to children and adult enrollees.
- **New Dental Benefits**
  - Adding coverage of a **Caries Risk Assessment Bundle for children ages 0 to 6 years** including associated codes to educate and influence behavior change, including nutritional counselling.
  - Modify the **frequency of preventive services based on risk level** associated with each individual Medi-Cal dental member ages 0 to 6. For example:
    - Low – comprehensive preventive services 2x/year
    - Moderate – comprehensive preventive services 3x/year
    - High – comprehensive preventive services 4x/year
  - Add **coverage of Silver Diamine Fluoride for children ages 0 to 6 years and adults living in a skilled nursing facility/intermediate care facility** or part of the Department of Developmental Services population.
    - Two visits per member per year, four to ten teeth per visit, at a per tooth rate
- **P4P Initiatives**
  - Provide a flat rate performance incentive payment for
    - Each paid preventive service rendered by a service office location
    - Each paid claim for Current Dental Terminology exam codes D0120, D0150, or D0145 for the same Medi-Cal member for two or more years in a row.
- Timeline: Implementation of both new benefits and P4P initiatives will begin on Jan 1, 2021

Questions/Comments

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Carved-in LTSS and Dual Eligible Special Needs Plan

- DHCS is proposing to **discontinue the Cal Medi Connect component** of the Coordinated Care Initiative and begin a transition to a statewide managed long-term services and supports and Dual Eligible Special Needs Plan structure.
- Proposed changes:
  - Discontinue Cal Medi Connect on December 31, 2022
  - Require **statewide integration of long-term care into managed care** for all Medi-Cal populations by 2021
  - Require **statewide mandatory enrollment of dual eligibles** in a Medi-Cal managed care plan by 2023
  - Require all **Medi-Cal health plans to operate Dual Eligible Special Needs plans** in all service areas as of January 1, 2023.
    - Dual Eligible Special Needs plans would have to be operational before Cal Medi Connect ends in order to ensure a seamless transition of beneficiaries from Cal Medi Connect to the new system.
    - Cal Medi Connect plans may either continue their existing Dual Eligible Special Needs Plan or apply for the operation of a new Dual Eligible Special Needs Plan.
    - DHCS may provide some flexibility in the timeline for the continuation and/or development of a new Dual Eligible Special Needs Plan for plans not currently participating in Cal Medi Connect.
- Timeline
  - January 2021:
    - Coordinated Care Initiative and Cal Medi Connect proceed as today
    - Multipurpose Senior Services Program will be carved out
    - Long-term care services will be carved into managed care for all populations enrolled in plans
  - December 31, 2022:
    - Coordinated Care Initiative and Cal Medi Connect end.
  - January 1, 2023:
    - Discontinuation of Cal Medi Connect and CCI
    - Full implementation of mandatory managed care enrollment of dual eligibles into managed care
    - Implementation of D-SNPs

Questions/Comments

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Population Health Management Program

- Medi-Cal managed care plans shall develop and maintain a patient-centered population health strategy that includes:
  - Strategy for focusing on preventive and wellness services.
  - Identify and assess members risks and needs on an ongoing basis.
  - Managed member safety and outcomes during transitions across delivery systems or settings.
  - Identify and mitigate social determinants of health and reduce health disparities and inequities.
- Initial **risk assessment** focusing on behavioral, developmental, physical and oral health status and SDOH.
  - Risk assessment **conduct for every member within 90 days.**
  - Initial assessment must use all available data sources and analytics, as well as member-contact and evidence-based screening.
    - Plans shall conduct a **data and analytics assessment** that considers assessment data, claims and encounter data, pharmacy data, lab data, EHR, etc.
    - **Member-contact screening** must include physical, behavioral, developmental and oral health; adherence to medication, health literacy, cultural and linguistic needs, access to basic needs (e.g. education, food, clothing), LTSS needs, housing, need for community based services and support.
  - Initial assessment of member's risk and need shall be required for all aid codes, and replace existing current assessment including SHA/IHEBA, HIF/MET, and others.
- Medi-Cal managed care plans will **risk stratify** the population to determine the level of intervention that members require based on all available data sources, as well as the results of the member-contact screening.
  - The Medi-Cal managed care plan will link the member with the appropriate services, including, but not limited to wellness and prevention, general case management, complex case management, enhanced care management, external entity coordination, and transition coordination.
- Medi-Cal managed care plan shall **reassess risk and need, including emerging risk, of all members annually** through an approved data-driven risk stratification process.
  - Members newly identified as requiring case management or other services through the annual risk stratification **must be contacted within 30 calendar days** to assess their needs.

Social Determinants of Health

Population Health Management Program (cont)

- Other requirements:
  - Plans shall **integrate required activities with the PHM program** as appropriate such as member services, utilization management, referrals, transportation, benefit education, etc.
  - Plans shall **provide a toll-free line for primary care providers and specialists** who seek technical and referral assistance.
  - Plans must **provide a 24 hours a day, seven (7) days a week, toll-free nurse advice line for members** who seek technical, clinical, and referral assistance for physical, oral, and behavioral health services to address urgent needs.
  - The PHM program shall **integrate wellness and prevention services** for all members.
  - The PHM must **ensure that providers are able to refer members** to other plan services including follow up care.
  - The PHM must **refer members identified as needing care coordination to the member's case manager** for follow-up care and needed services **within thirty (30) calendar days**
  - Plans must **provide appropriate level of case management**, including basic and complex case management
  - Plans will **develop a network of providers of allowable in lieu of services**
  - Plans must **coordinate with culturally and linguistically competent external entities** to provide all necessary services and resources to the beneficiary.
  - Plans shall **ensure transitional services are provided to all members** who are transferring from one setting, or level of care, to another.
  - Plan shall **coordinate with hospital or other acute care facility discharge planners and nursing facility case managers or social workers** to ensure a smooth transition to or from a skilled nursing facility or nursing facility.
- The population health management program would be implemented as part of the new Medi-Cal managed care plan contracts, with an **effective date of January 1, 2021**.

Social Determinants of Health

Enhanced Care Management (ECM)

- The proposed ECM benefit will replace the current Health Homes Program and elements of the Whole Person Care pilots. It will also usurp the Targeted Case Management program.
- **Required programmatic elements** to be implemented include:
  - Care coordination, health promotion, comprehensive transitional care, member and family supports and referral to community and social services.
- **Target population** may include:
  - High utilizers with frequent hospital or emergency room visits/admissions;
  - Individuals at risk for institutionalization with SMI, children with Serious Emotional Disturbance or SUD with co-occurring chronic health conditions;
  - Individuals at risk for institutionalization, eligible for long-term care;
  - Nursing facility residents who want to transition to the community;
  - Children or youth with complex physical, behavioral, developmental and oral health needs
  - Individuals transitioning from incarceration; and
  - Individuals experiencing chronic homelessness or at risk of becoming homeless.
- The ECM program will coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the member, including participating in the care planning process, regardless of setting.
  - **Care managers are the members' primary point of contact** and are responsible for ensuring that all physical, behavioral, long term care, developmental, oral, social, and psychosocial needs are met in the safest, least restrictive way possible while considering the most cost-effective way to address those needs.
  - **Care managers meet members where they are**, both literally, and from a medical management and plan of care perspective.
  - **Community health workers can also be used to improve outreach and provide care coordination services** to beneficiaries.
- Timeline
  - By Jan 1, 2021: plan will submit an ECM model of care proposal as part of their PHM
  - By Jan 1, 2023: plan will submit an ECM proposal for reentry individuals

Social Determinants of Health

In-lieu-of Services (ILS)

- Medi-Cal managed care plans will integrate ILS into their PHM plans in combination with the new ECM benefits to address gaps in State Plan benefit services.
  - ILS will **focus on addressing combined medical and SDOH needs** and avoid higher levels of care.
- Program Administration
  - The **use of ILS is voluntary to both beneficiaries and plans**.
  - Each service will have defined eligible populations, code sets, providers, restrictions, and limitations.
- **Proposed ILS eligible services**
  - Housing Transition/Navigation Services
  - Housing Deposits
  - Housing Tenancy and Sustaining Services
  - Short-Term Post-Hospitalization Housing
  - Recuperative Care (Medical Respite)
  - Respite
  - Day Habilitation Programs
  - Nursing Facility Transition/Diversion to Assisted Living Facilities
  - Nursing Facility Transition to a Home
  - Personal Care (beyond In-Home Supportive Services) and Homemaker Services
  - Environmental Accessibility Adaptations (Home Modifications)
  - Meals/Medically Tailored Meals
  - Sobering Centers
- Timeline: **Statewide implementation of ILS is Jan 1, 2021**

Social Determinants of Health

Shared risk/savings and incentive payments

- DHCS proposes to **create financial incentive payment program** to drive plans and providers to participate in various SDOH programs, as well as investing in the necessary delivery and systems infrastructure, building appropriate care management and ILS services capacity, and achieving improvements in quality performance.
- DHCS is considering the following models:
  - **A blended capitation rate** for seniors and persons with disabilities and long-term care beneficiaries.
    - The rate would be subject to a rate blend update to align with actual plan membership, which will provide financial protections in case of significant differences between actual long-term care beneficiary enrollment and assumptions used during capitation rate development.
  - **A time-limited, tiered, and retrospective shared savings/risk financial calculation**, which will be available for three calendar years --2021, 2022 and 2023.
  - **A prospective model of shared savings/risk incorporated via capitation rate** development.
    - Potential implementation dates are calendar years 2024 and 2025.
    - DHCS would utilize historical cost and utilization from the implementation providing ILS, managed long-term care services, and ECM benefits statewide.
  - **Establish plan incentives linked to delivery system reform** through an investment in ECM and ILS infrastructure.
    - Payments would also be based on quality and performance improvements and reporting.
- Timeline
  - January – December 2020: Develop shared savings/risk and plan incentive methodologies and approaches with appropriate stakeholder input.
  - January 1, 2021: Implement a seniors and persons with disabilities/long-term care blended rate and plan incentives.

Social Determinants of Health

Questions/Comments

- What proposed changes do you like? Dislike?
- What are the proposed changes that may negatively impact your current operation? How? What are the solutions? How can we comment on them?
- What changes would you like to see or want CPCA to send to DHCS?
- Reviewing the deep dive slides, what are the immediate red flags for you? What changes do you recommend?

Full Integration Plans

- DHCS proposes pilots to **test the effectiveness of full integration of physical health, behavioral health, and oral health** under one contracted entity.
  - Multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, substance use disorder managed care, and dental) would be consolidated under one contract with DHCS.
- DHCS is interested in seeking feedback regarding
  - What delivery systems should be a part of the Full Integration Plan?
  - What criteria would an entity need to meet in order to participate in a Full Integration Plan?
  - What are the challenges in implementing a plan that provides medical, dental, specialty mental health and substance use disorder services?
  - What are the opportunities for implementing a program that provides medical, dental, specialty mental health and substance use disorder services?
  - What policy discussions/decisions need to occur before moving forward with a fully integrated delivery system?
  - How much time is needed to build a fully integrated delivery system?
  - What impact would a fully integrated Medi-Cal delivery system have on non-Medi-Cal program mandates (e.g., Mental Health Services Act, SAMHSA block grants)?
  - What challenges and opportunities are there of blending existing separate and complex funding streams (e.g. realignment and Prop 30)?
  - What other considerations should be accounted for when looking to implement a fully integrated delivery system?
  - What are the best ways to utilize and hold accountable the various delivery systems that have expertise and will act as providers of the services in this type of plan?
- Timeline
  - January – December 2021: Build full integration plan contract and request for proposal
  - January – July 2022: Request for proposal posted; DHCS evaluates responses
  - July 2022: Full Integration Plan contracts awarded
  - July 2022 – December 2023: Readiness activities and implementation planning

Questions/Comments

- What proposed changes do you like? Dislike?
- What are the proposed changes that may negatively impact your current operation? How? What are the solutions? How can we comment on them?
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Cal AIM Engagement

DHCS' Stakeholder Process	CPCA's Activities
Public Comment on Cal AIM Proposal ❑ DHCS is soliciting public comment ❑ Comments should be submitted by December 16, 2019 in order to be incorporated into future Cal AIM workgroup meetings and stakeholder discussion.	→ *CPCA is soliciting member feedback to inform our letter to DHCS.* → *CPCA is engaging our partners and other stakeholder groups to exchange our concerns and advocate for commonly identified issues.*
Cal AIM Workgroups ❑ DHCS established five topic-specific stakeholder workgroups to further explore specific sections of the CalAIM proposal ❑ Workgroups will meet between November 2019 and February 2020	→ *CPCA engaged members to encourage them apply to Cal AIM workgroups.* → *At least one CHC representative was appointed to each workgroup.* → *CPCA staff participate in each workgroup and provide support to members as needed.*

Cal AIM Engagement (cont.)

CPCA Cal AIM Task Force

- → *CPCA is creating a Cal AIM Task Force to consult and strategize for the best approaches to waiver engagement and to analyze the CalAIM proposal as outlined by DHCS.*
- → *The Task Force will serve as an advising body as the state implements Cal AIM in the next few years.*
- → *Staff is soliciting membership for the Task Force.*
  - → *If you are interested in joining, please email Allie or Trong.*
- → *The first Task Force meeting will be on Dec 5, 3:30 – 4:30 pm. Registration link can be found here.*

CPCA's Discussion with Other Stakeholder Groups

- → *CPCA staff has begun and will continue to engage with our partners and other stakeholder groups to exchange our positions and concerns regarding Cal AIM proposal.*

Monitoring new developments that might have potential impact on Cal AIM

- → *CMS' proposed regulation on Medicaid Fiscal Accountability (Nov 2019).*
- → *DHCS' proposed Comprehensive Quality Strategy Report (Nov 2019).*
- → *Governor's 2020 Budget (Jan 2020).*

Next Steps

- Sign up for CPCA Cal AIM Task Force.
  - Email Allie at (abudenz@cpca.org) or Trong at tle@cpca.org.
- Join the first Task Force meeting.
  - Date and time: December 5, 3:30 – 4:30 pm.
  - Registration link: https://attendee.gotowebinar.com/register/5772440074666645249.
- Send your comments to Allie and Trong **by Dec 3.**
  - Click here for CPCA's high-level summary and preliminary analysis of Cal AIM proposal.
- Check our CPCA and CaliforniaHealth+ Advocates weekly updates for new information.