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Joint Informational Hearing

Assembly Health Committee and Budget Subcommittee No. 1

Medi-Cal Managed Care Accreditation, Regional Rates, Dual Eligible Special Needs Plan Provisions and County Oversight Components of California Advancing and Innovating Medi-Cal

Thursday, March 25, 2021 – Upon Adjournment of Session
State Capitol, Room 4202

BACKGROUND

Introduction

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

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

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

To implement CalAIM effective January 1, 2022, the Budget proposes $1.1 billion total funds ($531.9 million General Fund [GF]) for fiscal year (FY) 2021-22, growing to $1.5 billion total

($755.5 million GF) in FY 2022-23. This spending is for enhanced care management (ECM) and funds in lieu of services (ILOS) provided by the Medi-Cal Managed Care (MCMC) plans, promote necessary infrastructure to expand whole person care (WPC) approaches statewide, build upon existing dental initiatives, and promote greater consistency in the delivery systems where beneficiaries receive services. Beginning in FY 2024-25, the Administration proposes to phase out incentive funding to plans, resulting in ongoing costs of $846 million total funds ($423 million GF). DHCS also released a Budget Change Proposal as part of the Governor's Budget requesting 69 permanent positions, limited term resources equivalent to 46 positions, and expenditure authority of $23.9 million ($11 million GF and $12.8 million in federal funds) for FY 2021-22.

Due to the scope, complexity, amount of detail, and number of proposals in CalAIM, this is the third CalAIM Hearing. The first hearing on March 9, 2021 was on the proposed behavioral health components of CalAIM, the second hearing on March 16, 2021 was on the proposed eligibility, benefit and managed care changes, and this third hearing will focus on the following proposals:

1) Requirement for MCMC Plans to be National Committee for Quality Assurance (NCQA) Accredited, and Option for DHCS to "Deem" Plan's Compliance with NCQA Standards as Meeting Applicable State and Federal Medicaid Requirements;

2) Authority for DHCS to Establish MCMC Rates on a Regional Basis;

3) Sunset of Cal MediConnect (CMC) and Requirement for "Aligned" Dual Eligible Special Needs Plans (D-SNPs);

4) Mandatory Medi-Cal Application Process upon Release from Jail and County Juvenile Facilities;

5) Increasing DHCS Oversight and Monitoring of the County Medi-Cal Eligibility Determination Process;

6) Increasing DHCS Oversight and Monitoring of Local California Children's Services (CCS) and Child Health Disability Prevention (CHDP) Programs;

7) Improving Medi-Cal Beneficiary Contact and Demographic Information;

8) New Denti-Cal Dental Benefits and Pay for Performance; and,

9) Extension of Hospital Quality Improvement Program to District Hospitals and Extension of Global Payment Program; and,

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

- Are MCMC plans able to deliver the expanded scope of the proposed benefit changes (such as ECM and ILOS) intended to address social determinants of health (SDOH)?
- Is the CalAIM implementation timeframe for the proposed changes (and the ability of the various Medi-Cal delivery system to implement the proposed changes) realistic given the PHE and competing demands on those systems?
- How does the Administration propose to ensure the CalAIM changes are evaluated to determine if goals and outcomes are being achieved? To what extent should policy issues be delegated to executive branch discussions for yet to be determined Terms and Conditions (T&Cs) of the waiver?
- Should, as the proposed TBL requires, in the event of a conflict between the state law CalAIM-related provisions, the T&C control? Should this requirement be in statute in advance of the Legislature and the public knowing and analyzing what is contained in the T&C?
- Should the TBL focus only on those provisions necessary to avoid the expiration of an existing program or service under a prior waiver (such as WPC), and allow more time to analyze those provisions that change the Medi-Cal program?
- Is the financing of CalAIM, including the additional state GF and the state assumption of county-funded benefits sustainable?
- Several of the proposed CalAIM changes are enacted by adding a new article of law instead of amending existing state law provisions by using the phrase "notwithstanding any other law." This method of drafting makes understanding the changes to existing law difficult. Should existing statutory requirements be amended, rather than notwithstood?

Background on Medi-Cal

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

CalAIM Goals and Guiding Principles

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

CalAIM Goals

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

CalAIM Guiding Principles

- Improve the member experience;
- Deliver person-centered care that meets the behavioral, developmental, physical, Long-Term Services and Supports (LTSS) and oral health needs of all members;
- Work to align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals;
- Build a data-driven Population Health Management (PHM) strategy to achieve full system alignment;
- Identify and mitigate SDOH and reduce disparities and inequities;
- Drive system transformation that focuses on value and outcomes;
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation;
- Support community activation and engagement;
- Improve the plan and provider experience by reducing administrative burden when possible; and,
- Reduce the per-capita cost over time through iterative system transformation.

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

1) Requirement for MCMC Plans to be NCQA Accredited, and Option for DHCS to "Deem" Plan's Compliance with NCQA Standards as Meeting Applicable State and Federal Medicaid Requirements

To oversee and monitor the quality, provision of services and financial solvency of MCMC plans, state and federal law and regulation[2] and state contractual provisions contain various requirements. For example, existing state law requires annual medical audits,[3] to evaluate MCMC plan's compliance with DHCS contractual requirements and applicable laws and regulations. DHCS' Managed Care Quality and Monitoring Division (MCQMD) is responsible for ensuring overall monitoring and oversight of MCMC plans. MCQMD designates the Medical Review Branch of DHCS' Audits and Investigations Division to perform the mandated audits. The audit scope encompasses the following six categories of review:

Category 1 – Utilization Management;
Category 2 – Case Management and Coordination of Care;
Category 3 – Access and Availability;
Category 4 – Member's Rights;
Category 5 – Quality Improvement; and,
Category 6 – Administrative and Organizational Capacity.

Under the terms of its boilerplate model contracts with plans, if a MCMC plan has received a rating of "Excellent," Commendable" or "Accredited" from NCQA, the plan is "deemed" to meet the DHCS requirements for credentialing and is exempt from the DHCS medical review audit of credentialing.[4] In addition, MCMC plans and their subcontractors (e.g. a medical group or independent physician organization) may obtain credentialing provider organization certification (POC) from the NCQA. The DHCS contract permits the MCMC plan to accept evidence of NCQA POC certification in lieu of a monitoring visit at delegated physician organizations. DHCS indicates it does not currently "deem," or use information obtained from a national accreditation review, to satisfy mandatory external quality review activities, with the exception of the credentialing requirement of the annual medical audit. Federal Medicaid managed care regulations permit the state to deem this information for credentialing purposes.[5]

The NCQA is a private, not-for-profit organization that offers accreditation to health plans and other health care-related entities (e.g., accountable care organizations) in the areas of quality improvement, PHP, network management, utilization management, credentialing and re-credentialing, and member experience. NCQA also develops quality performance measures known as the Healthcare Effectiveness Data and Information Set (HEDIS) measures, which provide a standardized method for comparing health plan performance. DHCS indicates that 26 states currently require NCQA accreditation for their contracted Medicaid managed care plans.

DHCS does not currently require MCMC plans to be accredited by NCQA. DHCS

indicates that, out of 24 full scope MCMC plans in the state, 17 currently have NCQA accreditation. DHCS indicates MCMC plans that provide private coverage as qualified health plans through Covered California are required to be accredited by either NCQA, the Utilization Review Accreditation Commission (URAC), or the Accreditation Association for Ambulatory Health Care.

DHCS recommends, to streamline MCMC oversight and to increase standardization across plans, requiring all MCMC plans and their health plan subcontractors to be NCQA accredited by 2026. DHCS indicates it may use NCQA findings to certify or deem that MCMC plans meet particular state and federal Medicaid requirements. However, DHCS acknowledges that numerous stakeholders have shared with DHCS their concerns around DHCS deeming any elements of its current oversight of the MCMC plans. Before DHCS recommends deeming of elements of its annual medical audits of the plans, DHCS indicates it will solicit feedback on the proposed deemable elements. DHCS states that, if deeming does occur, it will post information on the deeming elements and the corrective action plan (CAP) for NCQA oversight findings on its website. DHCS will not accept accreditation from entities other than NCQA (e.g. URAC).

DHCS indicates it will also require MCMC plan NCQA accreditation to include the LTSS Distinction Survey subsequent to all health plans operating a D-SNP by 2027. DHCS indicates the exact effective date for the LTSS Distinction Survey will be determined at a later date. DHCS argues requiring the LTSS Survey will align with the state's effort to carve-in long-term care (LTC) services and expand ILOS to make managed long term services and supports (MLTSS) a statewide benefit. While DHCS is interested in the potential future addition of the NCQA Medicaid module to routine NCQA health plan accreditation, as it could potentially maximize the opportunity for streamlining state compliance and deeming, DHCS has determined that it is premature to require the Medicaid module at this point, given how new it is for NCQA.

Finally, DHCS had considered requiring MCMC plans to ensure any non-health plan subcontractors to whom certain contractual elements are delegated are NCQA accredited for that function. DHCS indicates it will not require this in its contracts with the MCMC plans at this time; MCMC plans will need to determine if they will require any accreditation of their non-health plan subcontractors. If DHCS decides to deem particular elements of NCQA health plan accreditation standards, and any MCMC plans elect to require NCQA accreditation of their subcontractors, the MCMC plans will have the option to offer deeming on those same elements, if applicable, with their subcontractors.

DHCS argues requiring NCQA accreditation of MCMC plans and following the NCQA framework would:

- Increase standardization throughout the state and reduce redundancies in various processes and assessments, in areas such as care coordination;

- Assist in streamlining DHCS monitoring and oversight of MCMC plans, particularly with regard to the annual medical audits, by increasing the number of elements in which DHCS may consider deeming MCMC plans; and,
- Allow the annual medical audits to focus on other DHCS priority areas not reviewed by NCQA.

Proposed Timeline

DHCS will require all MCMC plans and their health plan subcontractors to be NCQA accredited by 2026.

- DHCS will review and consider elements of NCQA health plan accreditation standards for deeming in relation to the annual Audits and Investigations compliance audits.
    - DHCS will ensure that a complete crosswalk of federal and state Medicaid requirements and NCQA health plan accreditation standards is available online for comment prior to finalizing any deeming decisions.
    - DHCS will ensure that any NCQA health plan accreditation elements selected for potential deeming are vetted with stakeholders prior to finalizing any deeming decisions.
- DHCS may consider implementing deeming of the select elements sooner than 2026 for MCMC plans that already have NCQA accreditation. DHCS will align all applicable processes in its MCMC plan contract and All Plan Letters with the following six NCQA health plan accreditation categories to correspond with the requirement for accreditation by 2026:
    - Quality Improvement;
    - PHM;
    - Network Management;
    - Utilization Management;
    - Credentialing; and,
    - Member Experience.

Proposed TBL:

1) Requires DHCS, for contract periods commencing on or after January 1, 2026, to require each MCMC plan and each health plan subcontractor of a MCMC plan to be accredited by the NCQA, or an alternative entity pursuant (authorized below) in accordance with CalAIM T&C.

2) Defines a "health plan subcontractor" by reference to federal regulation to mean an individual or entity that has a contract with a Medicaid managed care organization (MCO is the federal term for a MCMC plan) or prepaid inpatient health plan (in California, county mental health plans and Drug Medi-Cal Organized Delivery Systems are considered PIHPS under federal Medicaid regulation) that relates directly or

indirectly to the performance of the MCO's or PIHP's obligations under its contract with the State. Excludes a network provider from the "subcontractor" definition by virtue of the network provider agreement with the MCO or PIHP.

3) Requires DHCS to use findings from the accreditation to certify or "deem" a MCMC plan's compliance with applicable state and federal Medicaid requirements, to the extent DHCS determines appropriate and upon consultation with affected stakeholders, to the extent practicable.

4) Permits DHCS, in the event DHCS determines that a MCMC or an applicable health plan subcontractor is not able to receive accreditation from the NCQA due to population size, to authorize alternate accreditation so long as the requirements applied are substantially similar to the NCQA requirements, as determined by DHCS.

5) Permits DHCS, after consultation with affected MCMC plans, to elect to require that a MCMC plan or applicable health plan subcontractor thereof include in its required accreditation one or more of the following:
   a) The LTSS Distinction Survey;
   b) The Medicaid module; or,
   c) Other similar surveys or modules identified by DHCS as appropriate for this purpose.

Policy Questions:
1) What is the goal of requiring MCMC plans and their subcontractors to be NCQA accredited (or accreditation by an alternate entity)?
2) Should MCMC plans and applicable subcontractors that are NCQA accredited be deemed to meet applicable state and federal Medicaid requirement, to the extent DHCS determines appropriate?
3) What state MCMC oversight requirements would be replaced by NCQA accreditation?
4) Are there areas should of state oversight of MCMC plans that should continue to be performed directly via state staff?
5) In lieu of NCQA accreditation, should the Department of Managed Health Care (DMHC) perform the managed care monitoring function, either directly for Knox-Keene plans, or through an interagency agreement with the DMHC?
6) Because NCQA accreditation and deeming proposal has a 2026 effective date, can this proposal be deferred to a later date?

Witnesses:
Jacey Cooper, Chief Deputy Director for Health Care Programs and State Medicaid Director, Department of Health Care Services
Ben Johnson, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Katherine Barresi, RN, BSN, PHN, CCM Director Care Coordination, Partnership Health Plan of California
Cary Sanders, Senior Policy Director, California Pan-Ethnic Health Network
Mary June G. Diaz, Government Relations Advocate, California State Council of the Service Employees International Union (SEIU California)

2) Authority for DHCS to Establish MCMC Rates on a Regional Basis

MCMC rate requirements are contained in state and federal law and regulation and DHCS policy. Existing state law requires DHCS, for rates established on or after August 1, 2007, to pay capitation rates to health plans participating in the MCMC program using actuarial methods, but permits DHCS to establish health-plan- and county-specific rates.[6] A capitation payment is a payment DHCS makes periodically to a plan on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of Medi-Cal services, regardless of whether the particular beneficiary receives services during the period covered by the payment.[7] Federal Medicaid regulations require actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the plan for the time period and the population covered under the terms of the contract, and capitation rates must be reviewed and approved by CMS as actuarially sound.[8] Existing state law further requires DHCS to utilize a county- and model-specific rate methodology to develop MCMC capitation rates for contracts entered into between DHCS and any entity pursuant to the primary care case management model, certain county organized health system and two plan model counties, and the geographic managed care model. Plans submit utilization and cost experience for each category of aid and (for example, for children versus persons who are aged/disabled) and over 10 categories of service (for example, inpatient hospital, physician primary care, transportation) example, there is different monthly payment rate for children as compared to individuals who are aged/disabled). DHCS applies efficiency adjustments, supplement payments for certain services (such as maternity) to account for higher costs, adjusts the rates using a pharmacy-based risk adjustment and a risk-adjusted county average and includes an administration and underwriting profit/risk/contingency load. DHCS uses rate ranges (for example, a category of aid rate would have lower bound amount, a middle amount and higher bound amount), and DHCS typically pays at the lower bound of the rate range.

DHCS indicates it currently develops, certifies, and implements MCMC capitation rates on an annual basis for contracted MCMC plans. DHCS develops distinct rates for each contracted plan by county/region and population group. Due to the complexities of the MCMC program, which includes varied and intricate financing mechanisms, DHCS states it calculates multiple rating components for each capitation rate for a total of more than 4,000 rating components on an annual basis as of state FY 2018-19.

DHCS proposes to shift the development of MCMC plan rates from a county-based model to a regional rate model. DHCS proposes a regional rate-setting methodology as a means toward simplification of the rate-setting process for the MCMC program. The proposal does not identify the proposed regions for rates or the number of regions that will be used.

DHCS argues the proposed simplification will afford DHCS the flexibility to continue to pursue strategies that support advancements and innovations within the program. DHCS argues regional rate setting will:

- Reduce the excessively large number of rating components DHCS must develop on an annual basis, which DHCS argues is administratively burdensome and contributes to lengthy annual federal review and approval timeframes.
- Decrease the number of distinct actuarial rating cells that are required to be submitted to the Centers for Medicare and Medicaid Services (CMS) for review and approval, as the reduction in rating cells will simplify the presentation of rates to CMS and allow DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model.
- Incentivize plan cost efficiencies as cost averaging across all MCMC plans as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging beyond the experience of plans operating within a single county.
- Advance DHCS' ability to implement value-based and outcomes-focused rate setting methodologies.
- Help, through a simplified methodologies with a reduced number of components, achieve DHCS' broader goals of improving care delivery, access, quality and outcomes for Medi-Cal beneficiaries.

DHCS argues this proposed change is fundamental to the ability of DHCS to implement and sustain the other changes proposed in CalAIM.

Proposed Timeframe
DHCS proposes a two-phased approach:

Implement Regional Rates in Targeted Counties (Phase I)

- DHCS would implement Phase I for calendar years 2022 and 2023 (at a minimum) for targeted counties and MCMC plans;
- DHCS would advance new regional rate-setting approaches and streamline rate processes and methodologies;
- DHCS would utilize Phase I as a means of identifying strategies and further improvements that will support a seamless transition to regional rate setting statewide; and,
- DHCS would engage and collaborate with contracted MCMC plans and industry associations as part of this process.

Fully Implement Regional Rates Statewide

- DHCS proposes to fully implement regional rates statewide no sooner than calendar year 2024, to align with the end of Phase I; and
- DHCS will consider health care market dynamics, including but not limited to health care cost and utilization data, across counties when determining regional boundaries.

Proposed TBL:

1) Permits DHCS, notwithstanding any other law, as a component of the CalAIM Initiative, and any successor waiver, demonstration, or state plan amendment authorizing the MCMC program, to establish capitation rates to contracted health plans on a regional basis in lieu of health-plan and county-specific rates.

2) Prohibits the regional-based rate methodology authorized above from being effective no sooner than the contract rating period commencing on January 1, 2022.

3) Permits DHCS, subject to FFP being available, to elect to implement capitation rates on a regional basis in multiple phases with respect to designated regions of the state or MCMC models.

4) Requires DHCS, in consultation with affected contracted health plans, to develop the regional groupings and rate methodologies to be used, consistent with applicable federal requirements, actuarial methods, and the CalAIM T&C. Requires DHCS, in developing and implementing any methodology, to seek to incentivize improved quality and outcomes for MCMC enrollees.

5) Requires the above-requirements to be implemented only to the extent that DHCS obtains any necessary federal approvals, and that FFP is available and not otherwise jeopardized.

6) States legislative intent that both affected contracted health plans and the state have appropriate actuarial protections against the risk of either significant overpayments or significant underpayments in capitation rates developed and paid under the above provisions that are associated with the changes to the MCMC program described in CalAIM, as identified by DHCS.

7) Permits DHCS, notwithstanding any other law, as a component of the CalAIM initiative, and any successor waiver, demonstration, or State Plan Amendments authorizing the MCMC program, to develop and implement appropriate actuarial methods to prevent significant overpayments or significant underpayments. Permits this to include, but need not be limited to, one or more of the following:

    a) A medical or profit/loss risk corridor;
    b) Blended capitation rates based on projected member risk; or,
    c) Other prospective or retrospective shared savings or risk models.

8) Requires the methods or models described above to seek to encourage quality improvement and promote appropriate utilization incentives, including, but not limited to, reduced rehospitalization and shorter lengths of institutional stay.

9) Requires DHCS to consult with affected contracted health plans in implementing the above requirements.

10) Implements the above provision only to the extent that DHCS obtains any necessary federal approvals, and that FFP is available and not otherwise jeopardized.

Policy Questions:

1) Are MCMC rates currently set exclusively by county under current law/practice?

2) What is the policy and fiscal goal of having rates set by region?

3) Should the proposed regions be codified in law?

4) Are MCMC plans going to see a dramatic change in their rates as a result of this proposal?

5) Are there plan characteristics that make a plan more likely to be "winners" or "losers" under a regional rate setting model? Can adjustments be built into the rates to meet local cost variations or the enrollment of higher cost populations?

6) Existing law authorizes DHCS to implement pay for performance for MCMC. Should the MCMC rate setting process be required to take into account quality and access to reward better performing plans?

Witnesses:

Jacey Cooper, Chief Deputy Director for Health Care Programs and State Medicaid Director, Department of Health Care Services
Ben Johnson, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
Maya Altman, Chief Executive Officer, Health Plan of San Mateo
Larry deGhetaldi, MD, Sutter Palo Alto Medical Foundation Santa Cruz CEO

3) Sunset of CMC and Requirement for "Aligned" D-SNPs

Medicare is a federal program, while Medi-Cal is a federally funded and regulated program administered and jointly funded and regulated by states. Medicare consists of various "parts" to describe the benefits it provides. For example, Part A provides hospital services, Part B provides physician services, Part C is enrollment in a managed care plan, and Part D is prescription drug coverage.

Medicare and Medi-Cal provide overlapping medical services, and Medicare is the primary payer for the services that it covers (such as hospitalization and physician services). However, Medi-Cal coverage is more expansive and covers services that Medicare does not, such as an extended stay in a skilled nursing facility, non-emergency non-medical transportation to medical appointments, personal care services (such as IHSS), dental, and vision services (glasses). In addition, Medi-Cal pays for Medicare cost-sharing (co-insurance and deductibles) and premiums for dual eligible individuals.

Individual eligible for both Medicare and Medi-Cal are known as "dual eligible." California has nearly 1.4 million individuals or 20% of the United States older adult

population with low incomes and persons with disabilities who receive health care coverage from both Medicare and Medicaid.[9] In California, seven in 10 dual eligible enrollees are age 65 and over, nearly six in 10 are female. Populations of color in California are disproportionately more likely to be dually eligible in comparison with the state's total Medicare population, as are people of limited English proficiency.

The LAO's March 2021 "CalAIM: New Directions for Services for Seniors and Persons with Disabilities" indicates the senior population is expected to grow faster than California's population as a whole. The LAO publication cites Department of Finance estimates that the state's aged 65 and older population will increase from 6 million in 2019 to 11 million in 2060 (83%). The estimated growth rate of the senior population is higher than the estimated growth rate of the state's total population (13%) over the same period.

In addition, the LAO indicates, in its 2016 report, "A Long-Term Outlook: Disability Among California's Seniors" the LAO projected that the number of seniors in California with disabilities (SPDs are defined by limitations in routine activities of daily living, such as dressing or bathing) will increase by 135%, from 1.2 million in 2019 to 2.7 million in 2060, which is greater than the projected growth of the overall senior population (83%) over the same period. The faster growth of the SPDs is partially driven by long-term increases in average life expectancy, as seniors over the age of 85 are more likely to have developed disabilities late in life.

On average, dual eligible enrollees constitute the highest-need, highest-cost segment of both the Medicare and Medi-Cal enrollee populations, with wide variation in need and cost within the population. Because these enrollees receive health care services through Medi-Cal and Medicare, each with its own complex rules, accessing services and integrating care present unique challenges. For example (as described by the LAO), within the Medi-Cal, beneficiaries can receive long-term services and supports from several programs—with different access points, delivery systems, and eligibility assessment processes—that may serve the same or similar beneficiaries while operating independently. For example, a SPD Medi-Cal beneficiary may simultaneously may receive case management through the Multipurpose Senior Services Program (MSSP), personal and home care services through In-Home Supportive Services (IHSS), and care in a congregate setting through Community-Based Adult Services (CBAS). This individual likely would receive these services through three different providers, after establishing eligibility separately for each program. Many LTSS programs—such as MSSP, Programs of All-Inclusive Care for the Elderly (described further below), Assisted Living Waiver, and CBAS—also have a limited number of slots or limited capacity, such that many individuals who are eligible for these programs may not be able to receive services from them due to supply constraints.

Medicare beneficiaries (including dual eligible) can receive services through Medicare FFS (often referred to as "traditional Medicare') or enroll in a Medicare Advantage (MA) plan (aka a "Medicare HMO").[10] One type of MA Plan is a D-SNP. D-SNPs are a type of MA plan that enrolls individuals who are eligible for both Medicare and Medi-Cal. There are several different types of D-SNPs. D-SNPS must coordinate the delivery of Medi-Cal and Medicare benefits, contract with the state's Medicaid agency, and have a Model of Care describing how the plan will meet the needs of dually eligible individuals.

In addition, to MA and MCMC plans, individuals meeting age and medical criteria can enroll in a Program for All-Inclusive Care for Elderly (PACE) plan in areas of the state where a PACE plan is available. PACE is a capitated benefit provided primarily to certain Medi-Cal and Medicare beneficiaries that offers a comprehensive service delivery system and integrates Medicare and Medicaid financing. The program was modeled after the acute and LTC services of On Lok Senior Health Services in San Francisco. Participants must be at least 55 years old, live in the PACE service area, and be certified as eligible for nursing home care. Enrollment in PACE is voluntary. An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participants' needs, develops care plans, and delivers all services (including acute care services and when necessary, nursing facility services). The PACE service package must include all Medicare and Medicaid covered services and other services determined necessary by the interdisciplinary team for the care of the PACE participant. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

CCI

In 2014, California implemented the CCI to better integrate and coordinate health benefits and LTSS to dual-eligible enrollees and other seniors and persons with disabilities living in seven California counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara). The CCI is comprised of three components:

a) **Mandatory enrollment in MCMC**. When California began mandatory enrollment of many Medi-Cal enrollees into MCMC plans in 2011, certain populations were excluded from mandatory enrollment, including enrollees living in nursing facilities, those responsible for paying a portion of their Medi-Cal costs, and individuals eligible for both Medicare and Medi-Cal. The CCI expanded mandatory enrollment into MCMC plans by requiring those previously excluded groups living in the seven CCI counties to enroll in a MCMC plan to receive Medi-Cal benefits.

b) **LTSS integration**. LTSS historically have not been included in the MCMC benefit package, with the exception of Community-Based Adult Services (CBAS) and the nursing facility benefit in County Organized Health System counties. Under the CCI, MCMC plans in CCI counties became responsible or partly responsible for financing or coordinating nursing facility care. As a practical matter, however, LTSS integration has largely remained the same as it was prior to the CCI. IHSS integration was ended in 2017, and to date only one health plan (Health Plan of San Mateo) has fully integrated MSSP. Only institutional LTC has become a newly integrated LTSS benefit in all CCI counties.

c) **CMC**. The CCI created a new type of managed care program in the seven CCI counties, known as CMC, which combines a dual-eligible enrollee's Medi-Cal and Medicare benefits into one integrated MCMC plan that combined acute, primary, institutional, and home and community-based services into a single benefit package provided by one health plan. CMC was initially a three-year demonstration program

begin in 2014, which the state subsequently opted to extend through December 2022. Dual-eligible enrollees in the seven CCI counties have the option to enroll in a CMC plan. As of June 2020, approximately 109,000 individuals were enrolled in a CMC plan.

Under CalAIM, DHCS is proposing to end CMC and the CCI and transition to a statewide MLTSS and aligned enrollment[11] D-SNP structure, a policy shift away from the original CCI proposal. This CalAIM proposal consists of several components, phased in over time.

Aligned Enrollment

Aligned enrollment means a dually eligible beneficiary could enroll in a D-SNP for Medicare services and a MCMC plan for Medi-Cal services that are provided by the same plan (for example, a Health Net D-SNP and a Health MCMC plan). DHCS indicates it will use its selective contracting to move toward aligned enrollment in D-SNPs. This proposal is phased in as not all MCMC plans have D-SNP products, and not all areas of the state have a D-SNP available. DHCS states the purpose of having Medi-Cal beneficiaries enroll in a MCMC plan and D-SNP operated by the same parent company is to allow for greater integration and coordination of care, phased in as follows:

- In the seven CCI counties, aligned enrollment is proposed to begin in 2023. DHCS is proposing to transition CMC members to an aligned D-SNPs and MCMC operated by the same organization as their CMC product (for example, a Health Net D-SNP and a Health Net MCMC plan in the example above).
- Aligned enrollment will phase-in in the non-CCI counties as plans are ready. DHCS will require MCMC to apply for aligned D-SNPs to be effective no later than contract year 2025.
- Dual eligible beneficiaries already enrolled in a non-aligned D-SNP (a D-SNP that is not affiliated with their MCMC plan) when aligned enrollment takes effect in their county will be in that D-SNP (allowing the beneficiary to stay in the non-aligned D-SNP). DHCS is proposing that new enrollment in those "non-aligned" D-SNPs will be closed.

In conjunction with the aligned enrollment approach, starting in 2022 CMS will limit enrollment into MA plans that are D-SNP "look-alikes." These are MA plans that offer the same cost sharing as D-SNPs, but do not offer integration and coordination with Medi-Cal or other benefits targeted to the dual eligible population, such as risk assessments or care plans.

DHCS is also proposing to also allow plans in the seven CCI counties with MCMC plan contracts, existing D-SNPs, and existing MA D-SNP "look-alike" plans to transition their dual eligible populations enrolled in the look-alike into an existing D-SNP in 2022, prior to the end of CCI. DHCS argues this will provide better coordination of care, without reducing enrollment in CMC plans, and is in alignment and preparation for the CMC transition to D-SNP aligned enrollment in 2023.

D- SNP Integration Requirements
DHCS is proposing to require that all D-SNPs use a model of care addressing both Medicare and Medi-Cal services to support coordinated care, high-quality care transitions, and information sharing. DHCS indicates it will work with CMS to incorporate new CalAIM model of care requirements into the D-SNP model of care, as appropriate. As DHCS implements aligned enrollment, DHCS indicates it will require D- SNPs to:

- Develop and use integrated member materials;
- Include consumers in their existing advisory boards;
- Work with CMS to establish quarterly joint contract management team meetings for aligned D-SNP and MCMC plans;
- Include dementia specialists in their care coordination efforts; and,
- Coordinate carved-out LTSS benefits including IHSS, MSSP, and other Home and Community-Based Services waiver programs.

Additionally, DHCS indicates it will work with CMS to coordinate audit timing, to avoid a D-SNP/MCMC plan being audited by both agencies at the same time.

LTC Carve In
In conjunction with mandatory MCMC enrollment, DHCS will require statewide integration of LTC into MCMC plans for Medi-Cal populations by 2023 (the benefit carve of institutional LTC was discussed in part in the second CalAIM informational hearing). This means that full- and partial-benefit duals in LTC facilities in counties or plans that do not already include LTC will be enrolled in MCMC by 2023.

D-SNP Transitions and Enrollment Policies
DHCS states it will encourage aligned enrollment of dual eligibles into matching MCMC plans and D-SNPs to promote more integrated care. DHCS indicates, during the transitions, it will work with CMS to ensure beneficiaries receive continuity of care protections.

Mandatory Enrollment into MCMC Plans
DHCS states it is committed to providing beneficiary and provider education, as well as technical assistance around MCMC plan requirements, for mandatory enrollment of dual eligibles into MCMC. As part of this work, DHCS is proposing to:

- Review and make any needed updates to education and enrollment materials used to assist dual eligibles in enrolling into a MCMC plan or Program of All-Inclusive Care for the Elderly (PACE) for their Medi-Cal benefits; and,
- Help educate providers about necessary billing practices as well as the processes that will not change, building on materials and best practices previously developed under CCI.

In support of its proposed CalAIM changes, DHCS argues that:

- Individuals dually eligible for Medicare and Medi-Cal are among the highest need populations. However, lack of coordination between Medicare and Medi-Cal can make it difficult for individuals enrolled in both programs to navigate these separate systems of care.
- California has made significant progress in building integrated systems through the implementation of CCI and CMC, and while the CCI and CMC the promise of better integrated care for California's dual eligibles, the program is only available in seven out of 58 counties.
- DHCS is leveraging the lessons and success of CCI to develop policies to promote integrated care through D-SNPs and MLTSS across California. This includes mandatory enrollment for dual eligibles into MCMC plans for their Medi-Cal benefit and increasing the availability of aligned D-SNPs. This will allow duals to voluntarily enroll for their Medicare benefits into the D-SNP that is aligned with their MCMC plan.
- CMC has been a complex program to administer, and DHCS is implementing a new approach to take the key lessons learned and innovative strategies from these programs and make them more broadly available across the State.

Proposed timeline:

Year	Program Change
2021	• All existing D-SNPs must meet new regulatory integration standards effective January 1, 2021
2022	• January 1: MSSP carved out of managed care in CCI counties • Voluntary ILOS in all MCMC plans (including CMC plans) on January 1, 2022 • MSSP carved out of managed care in CCI counties on January 1, 2022 • CMS will not enter into contracts with D-SNP "look-alike" MA plans • Plans in CCI counties with existing MCMC plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans may transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP January 1, 2022 • December 31: Discontinue CMC and CCI
2023	• January 1: Statewide mandatory enrollment of full- and partial- benefit dual eligible beneficiaries into MCMC plans for Medi-Cal benefits, and statewide carve-in of LTC into MCMC plans • January 1: CMC enrollees transition to aligned D-SNP/MCMC plans • Aligned enrollment begins in CCI counties and MCMC plans in those counties must stand up D-SNPs • All CMC members crosswalk to matching D-SNP and MCMC plans, subject to CMS and state requirements • CMS will not renew contracts with D-SNP look-alike MA plans, in most cases[1]
2025	• Aligned enrollment begins in non-CCI counties; • All MCMC plans are required to begin operating D-SNPs (voluntary enrollment for dual eligibles' Medicare benefit)
2027	• Implement MLTSS statewide in MCMC plans

[1] See Contract Year 2021 Medicare Advantage and Part D Final Rule 42 CFR 422.514 for more details, available at https://www.federalregister.gov/documents/2020/06/02/2020-11342/medicare-programcontract-year-2021-policy-and-technical-changes-to-the-medicare-advantage-program.

Proposed Sunset of Existing CCI and CMC TBL:

1) Sunsets the CCI demonstration project December 31, 2022, subject to federal approval.

2) Sunsets CCI nursing facility service payment rate provisions under CCI, effective December 31, 2022.

3) Authorizes MCMC plans in CCI counties, for the 2022 contract year and the remainder of the demonstration project, to transition beneficiaries enrolled in their affiliated non-D-SNP MA plans on or before January 1, 2021, into their affiliated D-SNP plan, if the D-SNP plan was approved for that service area as of January 1, 2013.

4) Authorizes DHCS, instead of requires in existing law, for the 2015 calendar year and the remainder of the demonstration project, in non-CCI counties, to offer D-SNP contracts to D-SNP plans, in accordance with existing law. Sunsets this provision December 31, 2022.

5) Sunsets on December 31, 2022 the requirement on DHCS that Medi-Cal beneficiaries who have dual eligibility in Medi-Cal and the Medicare Program be required to be assigned as mandatory enrollees into new or existing MCMC plans for their Medi-Cal benefits in CCI counties.

6) Deletes, effective July 1, 2021, the enrollment cap limitations for a MA Fully-Integrated Dual Eligible Special Needs Plan plans (FI-D-SNP coordinates the delivery of covered Medicare and Medicaid health and LTC services, using aligned care management and specialty care network methods for high-risk beneficiaries), which, after December 31, 2014 have:

    a) Prohibited enrollment in Los Angeles County from exceeding 6,000 additional beneficiaries at any point during the term of the CCI demonstration project; and,
    b) Prohibits enrollment in the combined Counties of Riverside and San Bernardino from exceeding 1,500 additional beneficiaries at any point during the term of the CCI demonstration project.

7) Sunsets on December 31, 2022 the CCI and CMC, including the D-SNP related provisions of the CCI and CMC.

8) Sunsets on December 31, 2022 the risk corridor provisions of CCI for MCMC plans that limit the financial risk with plan provision of LTSS under the CCI on an at-risk basis.

9) Sunsets on December 31, 2022 the CCI notification, transition, risk assessment requirements, network adequacy and provider contracting provisions, appeals, performance measures and enrollment-related provisions.

Proposed Replacement of CCI and CMC with "Aligned" D-SNPs TBL:

1) Require DHCS, commencing January 1, 2023, subject to federal approval, to require each MCMC operating in CCI counties to operate, or continue to operate, a D-SNP in

accordance with the CalAIM T&C, and in accordance with federal requirements for each D-SNP to have an executed contract with DHCS (referred to as a State Medicaid Agency Contract or "SMAC").

2) Defines "CCI counties" as the Counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

3) Requires DHCS, in CCI counties beginning in contract year 2023, to only contract with a proposed D-SNP that is affiliated with a MCMC plan or was contracted with DHCS for a D-SNP in contract year 2022 in the proposed D-SNP service area.

4) Requires, in CCI counties beginning with contract year 2023, dual eligible beneficiaries that are not already enrolled in a D-SNP for contract year 2022 to only enroll in a D-SNP that is affiliated with a MCMC plan in the beneficiary's service area.

5) Requires DHCS, commencing January 1, 2025 and subject to federal approval, to require each MCMC plan to operate, or continue to operate, a D-SNP in accordance with the CalAIM T&C, and in accordance with federal requirements for each D-SNP to have an executed contract with DHCS (referred to as a SMAC).

6) Requires DHCS, in non-CCI counties beginning no later than contract year 2024, to only contract with a proposed D-SNP that is affiliated with a MCMC plan or was contracted with DHCS for a D-SNP in the proposed D-SNP service area in the contract year that immediately precedes the contract year in which this requirement is implemented with respect to an individual county.

7) Requires, in non-CCI counties beginning no later than contract year 2024, dual eligible beneficiaries not already enrolled in a D-SNP, in the contract year that immediately precedes the contract year in which this requirement is implemented with respect to an individual county, to only enroll in a D-SNP that is affiliated with a MCMC in the beneficiary's service area. Prohibits, beginning no later than contract year 2024, D-SNPs that are not affiliated with a MCMC from accepting new enrollment of dual eligible beneficiaries.

8) Requires DHCS, to promote more integrated care for dual eligible beneficiaries, to seek to align the enrollment of dual eligible beneficiaries in affiliated MCMC plans and D-SNPs, in CCI counties commencing January 1, 2023, and in all counties commencing January 1, 2025, and in accordance with the CalAIM T&C.

9) Prohibits a dual eligible beneficiary from being required to enroll in a D-SNP for purposes of receiving their Medi-Cal benefits.

10) Authorizes DHCS to support requests from D-SNP plans to CMS to enroll, unless the beneficiary chooses otherwise, existing MCMC beneficiaries into the affiliated D-SNP when the beneficiary becomes newly eligible for Medicare due to age or disability.

Proposed TBL (sunset of CMC):
Requires, notwithstanding any other law, the CMC demonstration project to remain operative only through December 31, 2022, subject to federal approval. Repeals CMC on January 1, 2025.

Policy Questions:

1) What lessons did the Administration learn from the CCI that informed its policy design and decision making for CalAIM?

2) Will dual eligible individuals be passively enrolled in D-SNPs for their Medicare benefits?

3) Are D-SNPs viable without significant enrollment?

4) Under the aligned D-SNP enrollment proposal, if a Medi-Cal beneficiary is enrolled a sub-delegated plan, will their aligned LTSS plan be the main DHCS contracting plan or the sub-delegated plan?

5) What will be the role of the existing ombudsman for CMC? Is DHCS proposing to continue that contract?

6) Will there be additional funding for the ombudsman and Health Insurance Counseling and Advocacy Programs to deal with increased call volume resulting from the D-SNP transition?

Witnesses:
Jacey Cooper, Chief Deputy Director for Health Care Programs and State Medicaid Director, Department of Health Care Services
Ned Resnikoff, Fiscal and Policy Analyst, Legislative Analyst's Office
Jack Dailey, Director of Policy and Training and Coordinator, the Health Consumer Alliance at Legal Aid Society of San Diego County
Maya Altman, Chief Executive Officer, Health Plan of San Mateo
Eve Gelb, MPH, Senior Vice President, Member and Community Health, SCAN Health Plan®

4) Mandatory Medi-Cal Application Process upon Release from Jail and County Juvenile Facilities

Justice-involved individuals often receive both medical and behavioral health services while incarcerated. Under current law, board of supervisors in each county, in consultation with the county sheriff, is authorized to designate an entity or entities to assist county jail inmates with submitting an application for a health insurance affordability program (Medi-Cal and Covered California are insurance affordability programs) consistent with federal

requirements.[12] The board of supervisors is prohibited from designating the county sheriff as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates unless the county sheriff agrees to perform this function. In addition, if the board of supervisors designates a community-based organization as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates, the designation is required to be subject to approval by the jail administrator their designee.

To ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS proposes to require a county inmate Medi-Cal application process by January 2023. Additionally, DHCS is proposing to require that jails and county juvenile facilities implement a process for facilitated referral and linkage from county institution release to county Specialty Mental Health Services, Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and MCMC plans when the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community. DHCS argues that:

- Proper coordination is needed to ensure the medical and behavioral health needs of an previously incarcerated individual continue to be met;
- Critical non-clinical needs, such as housing, transportation, and overall integration back into the community are met; and,
- Studies have shown that these types of care coordination activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail.

Contracting Model	Counties Currently Using a Similar Process
County Contracts with County Sheriff's Office	Butte Kern San Bernardino San Diego San Francisco Tuolumne Ventura Yolo
County Contracts with County Jail	Glenn Santa Barbara
County Contracts with Multiple Entities (e.g. Community Based Organizations and County Sheriff's Office)	Contra Costa Imperial Placer Sacramento San Luis Obispo San Mateo Solano Sutter

Proposed Timeframe: DHCS is proposing an effective date of January 1, 2023 for counties to implement a county inmate/juvenile pre-release application process.

Proposed TBL:

1) Requires each county board of supervisors, notwithstanding any other law, commencing January 1, 2023, and in consultation with the county sheriff, to designate an entity or entities to assist county jail inmates and juvenile inmates in county juvenile facilities with submitting an application for, or otherwise facilitating their enrollment in, a health insurance affordability program (such as Medi-Cal and Covered California) consistent with federal requirements.

2) Prohibits the board of supervisors from designating the county sheriff as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates and juvenile inmates unless the county sheriff agrees to perform this function.

3) Requires, if the board of supervisors designates a community-based organization as an entity to assist with submitting an application for a health insurance affordability program for county jail inmates and juvenile inmates, the designation to be subject to approval by the jail administrator or their designee.

4) Requires DHCS, no sooner than January 1, 2023, in consultation with counties, MCMC plans, and Medi-Cal Behavioral Health Delivery Systems, to develop and implement a mandatory process by which county jails and county juvenile facilities coordinate with MCMC plans and Medi-Cal Behavioral Health Delivery Systems to facilitate continued behavioral health treatment in the community for county jail inmates and juvenile inmates that were receiving behavioral health services prior to their release.

5) Requires, notwithstanding any other law, the sharing of health information, records, and other data with and among counties, MCMC plans, Medi-Cal Behavioral Health Delivery Systems, and other authorized providers or plan entities to be permitted to the extent DHCS determines it necessary.

Policy Questions:

1) Is the DHCS proposal modeled on a practice in a particular county?

2) What types of entities does DHCS envision assisting county jail inmates and juvenile inmates with submitting an application for Covered California or Medi-Cal?

3) The proposed TBL has a requirement for what people call a "warm handoff" where DHCS would develop and implement a mandatory process by which jails and juvenile facilities would coordinate the county and MCMC plans to facilitate continued behavioral health treatment in the community for inmates receiving those services prior to release. Who is DHCS thinking would perform this function? For example, would it be county eligibility staff, jail staff or a non-profit entity?

4) The Legislative Analyst's Office has indicated this is a reimbursable mandate. Will there be funding proposed in the DHCS budget for this requirement?

5) Under this proposal, will inmates receive assistance in selecting a MCMC plan while applying for Medi-Cal prior to release?

Witnesses:
Jacey Cooper, Chief Deputy Director for Health Care Programs and State Medicaid Director, Department of Health Care Services
Ned Resnikoff, Fiscal and Policy Analyst, Legislative Analyst's Office
Cathy Senderling-McDonald, Executive Director, County Welfare Directors Association
Assistant Sheriff Dave Putnam, Kings County
Mary June G. Diaz, Government Relations Advocate, California State Council of the Service Employees International Union (SEIU California)
Cathren Cohen, Staff Attorney, National Health Law Program

5) Increasing Oversight and Monitoring of the County Medi-Cal Eligibility Determination Process

Counties determine Medi-Cal eligibility on behalf of the state, and counties are required to determine Medi-Cal eligibility in accordance with state and federal law.[13] Existing law establishes timeframes for eligibility determinations and redeterminations, and reporting requirements on various eligibility-related issues generally referred to as "County Performance Standards." For example, counties are required to:

1) Complete Medi-Cal eligibility determinations as follows:

   a) 90% of the general applications without applicant errors and are complete are required to be completed within 45 days; and,
   b) 90% of the applications for Medi-Cal based on disability are required to be completed within 90 days, excluding delays by the state.

2) Perform timely annual redeterminations (Medi-Cal eligibility must be "renewed" or redetermined annually), as follows:

   a) 90% of the annual redetermination forms are required to be mailed to the recipient by the anniversary date;
   b) 90% of the annual redeterminations are required to be completed within 60 days of the recipient's annual redetermination date for those redeterminations based on forms that are complete and have been returned to the county by the recipient in a timely manner;
   c) 90% of those annual redeterminations where the redetermination form has not been returned to the county by the recipient are required to be completed by sending a notice of action to the recipient within 45 days after the date the form was due to the county.

Existing permits DHCS, if a county does not meet the performance standards for completing eligibility determinations and redeterminations, at its sole discretion, to reduce the allocation of funds to that county in the following year by 2%. Any reduced funds may be restored by DHCS if, in the determination of DHCS, sufficient improvement has been made by the county in meeting the performance standards during the year for which the funds were reduced. If the county continues not to meet the performance standards, DHCS is authorized to reduce the allocation by an additional 2% for each year thereafter in which sufficient improvement has not been made to meet the performance standards. However, the reduction of the allocation of funds to a county is prohibited from being be imposed for failure to meet performance standards during any period of time in which the state funded cost-of-doing-business increase for counties is suspended. The Legislature stated legislative intent to not appropriate funds for the cost-of-doing-business adjustment for FYs 2008–09, 2009–10, 2010–11, 2011–12, 2012–13, 2014–15, 2015–16, 2016–17, and 2017–18.

In addition, existing law requires counties to submit reconciliation files of its Medi-Cal eligible population to DHCS every three months, based upon a schedule and in a format determined by DHCS, to identify any discrepancies between eligibility files in the county records and eligibility as reflected in Medi-Cal Eligibility Data System (MEDS).[14] Existing law requires counties to be notified of any changes to the standard format for submitting reconciliation files sufficiently in advance to allow for budgeting, scheduling, development, testing, and implementation of any required change in county automated eligibility systems. For those records that are on the county's files, but not on MEDS, the county is required to receive worker alerts from DHCS that identify these cases, and the county is required to fix any data discrepancies.

If DHCS finds that a county is not conducting reconciliation, processing 95% of worker alerts within the timeframes and processing 90% of errors alerts that affect eligibility or SOC within timeframes, the county is required to submit a CAP to DHCS for approval. The CAP, at a minimum, must include steps that the county must take to improve its performance on the requirements with which the county is out-of-compliance, and the plan is required to establish interim benchmarks for improvement expected to be met by the county in order to avoid sanctions. If the county does not meet the interim benchmarks for improvement standards, DHCS is authorized to reduce the allocation of funds to that county in the following year by 2%. However, no reduction of the allocation of funds to a county is required to be imposed for failure to meet performance standards during any period of time in which the cost-of-doing-business increase is suspended.

DHCS states the implementation of the ACA marked a monumental overhaul of the Medi-Cal program by financing a coverage expansion to populations that previously did not qualify, in addition to streamlining eligibility requirements for some populations, county social service agencies strived to acclimate to the vast changes in regulations while managing an unprecedented surge in Medi-Cal applications submitted statewide. DHCS writes that, to afford counties the opportunity to modify business processes to effectively administer the Medi-Cal program post-ACA, counties were held harmless by DHCS for performance standards.

DHCS states that federal, state, and DHCS audits of Medi-Cal eligibility determinations

conducted since the implementation of the ACA have identified several issues that DHCS argues must be addressed and resolved. Audit findings include performance issues related to timeliness of application processing and timeliness of annual eligibility renewal processing. Discrepancies between the MEDS, and the county Statewide Automated Welfare System (SAWS) also resulted in audit findings, which in part were caused by system-related issues connected to the implementation of the California Healthcare, Eligibility, Enrollment and Retention System (CalHEERS).

DHCS argues audit findings, recommendations, and CAPs imposed require the DHCS to implement additional oversight activities needed to increase the administrative integrity of the Medi-Cal program. Federal audit findings have also levied fiscal penalties upon DHCS, requiring the state to repay the federal matching funds that were claimed because of erroneous Medi-Cal eligibility determinations.

As part of this CalAIM proposal, DHCS recommends a phased-in approach to working with the counties to increase program integrity with respect to eligibility and enrollment.

- **Reinstate County Performance Standards:** In response to audit findings, DHCS will reinstate the county performance standards required under state law as a means of addressing and correcting error rates and issues which may have a future impact on the timeliness and accuracy of Medi-Cal eligibility determinations. DHCS plans to implement a series of oversight programs throughout the course of the next 24 months. This includes the implementation of a statewide MEDS alerts monitoring program.
- **Develop an Updated Process for the Monitoring and Reporting of County Performance Standards:** In collaboration with County Welfare Directors Association (CWDA), SAWS and the counties, DHCS states it will define roles, responsibilities, and develop an updated written process for the monitoring and reporting of the existing county eligibility performance standards. DHCS states this process will clearly outline DHCS' performance expectations, taking into consideration the issues that are beyond the counties' control, but including potential consequences if standards are not met.
- **Ensure DHCS/County Partnership through Regular Meetings and Open Lines of Communication:** DHCS indicates it will work collaboratively with CWDA, counties, and SAWS to develop a communications plan that articulates a process for receiving and responding to county requests for technical guidance and assistance as necessary and appropriate to support counties through this transition. DHCS states it will look at leveraging existing meetings, and/or developing dedicated meetings to further open lines of communication related to county oversight and monitoring. DHCS will continue to encourage county feedback in identifying gaps or needed clarifications in policy guidance and automation issues. DHCS will also work closely with counties, SAWS and CalHEERS to identify and pursue needed automation changes to support counties in the effective administration of the Medi-Cal program.
- **Develop a Tiered Corrective Action Approach:** DHCS will work with county partners to establish a tiered corrective action approach that would require the submission of a CAP for counties that do not meet established performance expectations. DHCS remains committed to supporting counties and providing timely

policy guidance, along with technical assistance, as needed, in addressing and correcting error trends.

- **Incorporate Fiscal Penalties as Part of the Tiered Corrective Action Approach:** For counties that do not demonstrate sufficient improvement in performance, DHCS will take disciplinary action that could range from technical assistance to requiring CAPs to imposing financial penalties on counties that fail to show significant improvement and/or are unresponsive to CAPs.
- **Incorporate Findings/Actions in Public Facing Report Cards:** DHCS will work with CWDA, counties and the SAWS to further develop county performance reports that are publicly posted on the California Health and Human Services Agency (CHHSA) Open Data Portal and increase accountability by issuing annual public-facing report cards to all 58 counties.

DHCS states this proposal is envisioned to be a crucial step toward achieving DHCS' larger vision for CalAIM by ensuring Medi-Cal enrollment processes are applied in a standardized and consistent manner statewide. This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS is compliant with federal and state requirements.

Proposed Timeline

DHCS states that, given the Executive Order to halt all county renewal processes and negative actions through the duration of the PHE, the implementation timeline reflected for this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.

- **June 1 – August 31, 2021:** DHCS will reinstate County Performance Standards, including incorporation of MEDS alert monitoring statewide.
- **September 1 – December 30, 2021:** DHCS will develop and publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CAPs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties.
- **January 1 – March 31, 2022:** DHCS will begin assessing County Performance Standards, in keeping with the updated process.
- **April 1 – June 30, 2022:** DHCS will implement the county performance monitoring dashboard (a public facing report card). The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.

- **July 1 – September 30, 2022:** DHCS will begin publishing the county performance monitoring dashboard on the CHHSA Open Data Portal.
- **July 1 – December 31, 2023:** DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.

Proposed TBL:

1) Requires DHCS, subject to federal approval and in consultation with counties, to develop and implement one or more initiatives to enhance its oversight and monitoring of county performance in administering the determination of eligibility for Medi-Cal.

2) Permits the oversight and monitoring of county performance to include, but need not be limited to, the following:

   a) Increased oversight of existing county performance, reporting, and corrective action standards described in existing county Medi-Cal eligibility provisions;

   b) A statewide MEDS error alert reporting and monitoring program;

   c) A statewide, tiered enforcement framework, consistent with existing law, to ensure prompt corrective action for counties that do not meet DHCS-established performance or reporting standards, including the imposition of fiscal penalties; and,

   d) An annual, publicly available performance report for each county.

Policy Question:

What additional oversight and monitoring is DHCS seeking beyond the performance standards in existing law?

Witnesses:
Jacey Cooper, Chief Deputy Director for Health Care Programs and State Medicaid Director, Department of Health Care Services
Ned Resnikoff, Fiscal and Policy Analyst, Legislative Analyst's Office
Cathy Senderling-McDonald, Executive Director, County Welfare Directors Association
David Kane, Staff Attorney, Western Center on Law & Poverty

6) Increasing DHCS Oversight and Monitoring of Local CCS and CHDP Program

The CCS program provides diagnostic and treatment services, physical and occupational therapy services to children and youth with serious eligible medical conditions. The CHDP

program delivers periodic health assessments and services to low-income children and youth; and provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

DHCS indicates it intends to provide enhanced monitoring and oversight of all 58 counties and three cities (Berkeley, Pasadena, and Long Beach) to ensure continuous, and unwavering optimal care for children. To implement the enhanced monitoring and oversight, DHCS indicates it will develop a robust strategic compliance program. DHCS states initial efforts will entail a review of all current standards and guidelines for both programs. Once the internal policy review is complete, DHCS will develop initial auditing tools to assess current county/city operations and compliance. DHCS will then evaluate and analyze the findings gathered during audits to identify gaps and vulnerabilities across the State within the programs. The information gathered will be the cornerstone for future efforts, and the basis for the development of the strategic compliance program.

DHCS indicates county and city variances in program operations and compliance with federal and state laws are also identified by tracking trends. DHCS will refine and update oversight policies and procedures and implement best practices. DHCS indicates it will establish goals, metrics, performance measures, and milestones to ensure counties/cities are providing the necessary provider oversight and medical/ dental care for beneficiaries. DHCS will provide training and technical assistance with internal and external partners to achieve statewide consistency of the compliance requirements and goals. In addition, DHCS will conduct ongoing quality assurance reviews, develop, and create county/city program specific dashboards, as necessary to meet internal and external reporting needs.

In alignment with technology trends, DHCS indicates it plans to shift counties/cities from annual hardcopy submission of plan and fiscal guidelines (PFG) budgets to a more efficient and streamlined automated electronic submission process. To better manage this population's health care and ensure targeted interventions are implemented, each county/city and DHCS will enter into a Memorandum of Understanding (MOU) with DHCS. The MOU, in conjunction with other supportive policies (such as information notices and numbered letters), will detail how the state will monitor county/city activities, policies and procedures, conduct audits, and implement CAPs. This MOU will be developed utilizing information obtained during the audits with the intent of having signed agreements with all counties/cities.

After initial deployment of the enhanced monitoring and oversight, DHCS will continue to conduct ongoing audits, stay proactive with emerging developments, and monitor trends to ensure high-quality consistent care. DHCS will allow sufficient time for counties to implement and adjust to this new structure prior to engaging in any sort of progressive action. DHCS will continue compliance oversight to preserve and improve the overall health and well-being of these vulnerable populations.

Proposed Timeline

- **Phase I: August 2020 – June 2021**
  - Review of current standards, policies, and guidelines;
  - Development of goals, performance measures, and metrics;

- Revision of current PFG guidance document; and,
- Continuation of the establishment of an electronic submission portal for the annual county/city budgets.

- **Phase II: July - September 2021**
  - Development of auditing tools;

- **Phase III: October 2021 – September 2022**
  - Shift to an electronic automated PFG submission by the counties/cities;
  - Develop training documents;
  - Evaluate and analyze findings and trends; and,
  - Identify gaps and vulnerabilities.

- **Phase IV: October 2022- Ongoing**
  - Initiate a MOU between the State and counties;
  - Continuous monitoring and oversight; and,
  - Continuous updates to standards, policies, and guidelines.

Proposed TBL:

1) Requires DHCS, during the CalAIM term and subject to federal approval, in consultation with counties, to develop and implement one or more initiatives to enhance oversight and monitoring of county administration of the CCS program and the CHDP program.

2) Permits this oversight and monitoring to include, but need not be limited to, the following:

   a) Establishing statewide performance, reporting, and budgetary standards, and accompanying audit tools, used to assess county compliance with federal and state requirements applicable to the CCS and CHDP programs;
   b) Conducting periodic CCS and CHDP quality assurance reviews and audits to assess compliance with the standards established;
   c) Establishing a statewide, tiered enforcement framework to ensure prompt corrective action for counties that do not meet standards established, including the imposition of fiscal penalties; and,
   d) Requiring each county to enter into Memoranda of Understanding with DHCS to document each county's obligations in administering the CCS and CHDP programs.

Policy Questions:

What additional oversight and monitoring is DHCS seeking?

Witnesses:
Jacey Cooper, Chief Deputy Director for Health Care Programs and State Medicaid Director, Department of Health Care Services
Michelle Gibbons, Executive Director, County Health Executives Association of California

Skyler Rosellini, Senior Attorney, National Health Law Program

7) Improving Medi-Cal Beneficiary Contact and Demographic Information

Medi-Cal has approximately 14 million enrolled beneficiaries each month, approximately 80% of whom are enrolled in a MCMC plan. As discussed previously, county social services departments are delegated by DHCS to process Medi-Cal applications and renewals, as well as to generally provide eligibility-related case management services. Counties use SAWS to support and maintain Medi-Cal enrollment processes. There are currently three SAWS, which contain contact and demographic information on enrolled individuals. The systems maintain electronic interfaces with the state-level eligibility and enrollment system (CalHEERS) and the state-level eligibility database (known as "MEDS"). MEDS is the system of record for purposes of Medi-Cal eligibility information, claims payment, and health plan assignment, among other things. When a beneficiary has a change in circumstances that affects their eligibility, the beneficiary is required to report changes to their county eligibility worker within ten calendar days of the change. Such changes include but are not limited to address and contact information updates, family size (increases or decreases), access to other health insurance, changes in income, and death. County eligibility workers are then responsible for ensuring the data maintained in the local county eligibility system is accurate and up to date.

Under current state law, MCMC plans have the ability to report updated contact information to the county when they have obtained consent from the beneficiary for such reporting.[15]

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which contact and demographic information can be updated by other entities and the means to accomplish this while maintaining compliance with all applicable state and federal privacy laws. DHCS states the goal of the workgroup will be to determine the best pathway for ensuring that reported updated data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services program, Medi-Cal beneficiaries, MCMC plans, and the provider community.

DHCS states accurate contact and demographic information is critical for purposes of ongoing program enrollment and care management for beneficiaries. This information is used by Medi-Cal FFS providers and MCMC plans, as well as other providers of care, for purposes of effective communication and interaction with Medi-Cal beneficiaries, including deploying care management strategies based on individual needs. Given the substantial volume of individuals in the process of enrolling in or renewing Medi-Cal coverage, DHCS argues it is critical that it, counties and plan and provider partners have accurate contact and demographic information. A more effective and efficient process for keeping this information up to date in California's systems is needed.

County eligibility workers play a key role in ensuring contact information is current; however, there are other entities that interact with Medi-Cal beneficiaries on a regular basis

who may have access to more current information. As a result, DHCS would like to leverage and explore the possibility of other entities having the opportunity to also update contact and demographic information about Medi-Cal beneficiaries.

Proposed TBL:

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

Policy Questions:

What are the legal and administrative barriers to improving Medi-Cal beneficiary contact and demographic information?

Witnesses:
Jacey Cooper, Chief Deputy Director for Health Care Programs and State Medicaid Director, Department of Health Care Services
Ned Resnikoff, Fiscal and Policy Analyst, Legislative Analyst's Office
Cathy Senderling-McDonald, Executive Director, County Welfare Directors Association
Cary Sanders, Senior Policy Director, California Pan-Ethnic Health Network

8) New Denti-Cal Dental Benefits and Pay for Performance

The Dental Transformation Initiative (DTI) was a new feature of Medi-Cal 2020, the state's Section 1115 Medicaid waiver from 2015. It was funded at $750 million total funds ($375 million in federal funds) generated from federal waiver funding drawn down for Designated State Health Programs. Of this amount, $10 million in total funds was contingent upon the state meeting statewide metrics. DTI consists of four domains: (a) Increase preventive services for children; (b) Carries risk assessment and disease management; (c) Increase continuity of care; (d) Local dental pilot programs. DHCS proposes, in order to progress toward achieving goals and based on lessons learned from the DTI, the following reforms for Medi-Cal dental be made statewide to provide better care and align with national dental care standards. The proposed new benefits include:

- Caries Risk Assessment Bundle for young children;
- Silver Diamine Fluoride for young children; and specified high- risk and institutional populations; and,
- Expanded pay-for-performance initiatives that a) reward increasing the use of preventive services and b) reward establishing/maintaining continuity of care through a dental home.

DHCS states these policy proposals align with the Legislature's charge to achieve at least a 60% dental utilization rate for Medi-Cal eligible children, CMS Oral Health Initiative goals

for Medicaid (increase by ten percentage points the proportion of Medicaid and CHIP children ages one to 20 who receive a preventive dental service), and lessons learned from the DTI.

For example, in the DTI - Domain 1, incentive payments were made to service office locations that increased the utilization of the top eleven preventive services available to children. As a result, not only has utilization of preventive services continued to increase year after year, but since the baseline year of 2014, the number of services has increased 8% and the number of services per member has also increased by 7%.

Furthermore, DHCS indicates data comparing a control group of children in DTI counties who did not receive Caries Risk Assessment with children who did receive Caries Risk Assessment over two calendar years yielded staggering results. The Medi-Cal enrolled children who had a Caries Risk Assessment received over 300% more preventive services compared to 189% for non-Caries Risk Assessment children. Additionally, in this same period, the number of restorative services was almost half that of the control group. Medi-Cal children receiving Caries Risk Assessment had a 263% increase in restorative services while the control group with no Caries Risk Assessment had a 475% increase in restorative services.

Proposed TBL:

1) Requires DHCS to implement the State Plan Dental Improvement Program in accordance with the CalAIM T&C and as described below, with the goal of further improving accessibility of Medi-Cal dental services and oral health outcomes for targeted populations, as a successor program to the DTI.

2) Requires, commencing no sooner than January 1, 2021 and subject to federal approval, the following services to be covered Medi-Cal benefits for the specified populations, when medically necessary and subject to utilization controls:

    a) Caries Risk Assessment bundle for eligible children 0 to 6 years of age, inclusive.
    b) Silver diamine fluoride for eligible children 0 to 6 years of age, inclusive, and for eligible adults residing in SNFs or ICFs or that receive services in facilities overseen by the Department of Developmental Services, as determined by DHCS.

3) Requires DHCS, commencing no sooner than January 1, 2021 and subject to federal approval, to make supplemental payments to qualified dental providers for increased utilization of certain preventive dental services, and for the establishment or maintenance of beneficiary continuity of care through a Dental Home.

4) Requires DHCS to develop the methodology for making supplemental payments, including, but not limited to, the eligibility criteria for receiving payments, the amount of payments, and the applicable preventive dental services that are eligible for payments.

5) Requires DHCS, for payments for increased utilization of certain preventive services, to make a flat-rate supplemental payment to a qualified dental service office location for each eligible paid claim made for those Current Dental Terminology (CDT) codes specified by DHCS and approved in the CalAIM T&C. Requires, to the extent DHCS deems practicable, the supplemental payment to be applied at the same time as the underlying eligible paid claim is made.

6) Requires DHCS, for payments for the establishment or maintenance of beneficiary continuity of care through a Dental Home, to make a single annual supplemental payment to each eligible service office location based on the number of Medi-Cal beneficiaries for which eligible paid claims were submitted using at least one of CDT exam codes, as specified by DHCS, in two or more consecutive calendar years.

7) Permits, to the extent permissible under federal law and authorized under the CalAIM T&C, for purposes of eligibility for payments described above, qualified dental providers to include safety net clinics (federally qualified health centers [FQHC] and rural health clinics [RHCs]) that provide services.

8) Requires supplemental payments made to safety net clinics to be considered separate and apart from either the Prospective Payment Service reimbursement for FQHCs or RHCs, or Memorandum of Agreement reimbursement for Tribal Health Centers.

9) Requires DHCS to shall seek federal approval of any state plan amendments it deems necessary to implement the changes above.

Policy Questions:

1) What are the findings and measurable outcomes from the Dental Transformation Initiatives?

2) Should the state have a target for adult dental utilization in Denti-Cal?

Witnesses:
Jacey Cooper, Chief Deputy Director for Health Care Programs and State Medicaid Director, Department of Health Care Services
Ben Johnson, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
Dharia McGrew, Senior Legislative Advocate, California Dental Association
Katie Andrew, Senior Health Policy and Outreach Associate, Children Now

9) Extension of Hospital Quality Improvement Program to District Hospitals, and Extension of Global Payment Program

Quality Incentive Program

The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program built on previous delivery system transformation efforts focused on strengthening patient-centered primary and specialty outpatient care, improving care coordination, and providing the right care in the most appropriate settings. A total of 17 Designated Public Hospitals (DPHs are University of California and county hospitals) and 34 District and Municipal Public Hospitals (referred to as "District Hospitals") participated in PRIME. PRIME was designed to accelerate efforts by participating entities to change care delivery, maximize health care value, and strengthen their ability to successfully perform under risk-based alternative payment models. PRIME was intentionally designed to be ambitious in scope and time-limited. Using evidence-based quality improvement methods, the initial work required the establishment of performance baselines followed by target-setting, and the implementation and ongoing evaluation of quality improvement interventions.

In 2017, California created a QIP. The QIP is a MCMC plan directed payment program for the state's DPHs. Under the directed payment program, DHCS directs MCMC plans to make QIP payments tied to designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The QIP measures do not directly overlap with any of the quality measures being used in PRIME, rather they are designed to be complementary. The QIP promote access to care, value-based purchasing, and to tie funding to quality outcomes, while at the same time further aligning state, MCMC plan, and hospital system goals. The QIP also creates incentives to build data and quality infrastructure and ties funding directly to these goals, allowing the state to pay for quality and build capacity.

DHCS is in the process of transitioning the quality improvement work and funding that has been available through PRIME into the QIP and permitting the District Hospitals to begin participating in the program, which has enabled hospitals to continue quality improvement efforts underway at all 51 PRIME entities after PRIME expired on June 30, 2020. This transition promotes value-based purchasing, ties funding to quality outcomes, and aligns PRIME entities' transition to the QIP with California's transition to the calendar year rating period for MCMC plans.

DHCS indicates there are two key phases in the PRIME-to-QIP transition:

- Phase I: Alignment with the calendar year health plan rating period, July 1, 2020 through December 31, 2020; and,
- Phase II: Merge to QIP, January 1, 2021 through December 2021, and beyond.

Phase I: Alignment with Calendar Year Rating Period

All 51 PRIME entities transitioned into a six-month transitional program on July 1, 2020 to calibrates the new program to end on the same date as Bridge Period 2019-20, an 18-month rate year for MCMC plans that ended on December 31, 2020. For performance on both the original QIP quality metrics (for DPHs) and the PRIME transition metrics (for DPHs and

34 District and Municipal Public Hospitals) during this period, the 51 entities will be paid through MCMC plans via state-directed MCMC plan payments. CMS approval for this six-month program was obtained on September 14, 2020.

To earn funds for PRIME transition metrics, all 51 PRIME entities will continue to report to DHCS on quality improvement projects and measures from PRIME. The six-month transition will use a twelve-month measurement period to ensure that performance can be fairly compared to benchmarks set by DHCS. Due to the COVID-19 PHE, entities will use the March 1, 2019 to February 29, 2020 measurement period and be held to achieving the minimum performance benchmark established by DHCS from PRIME Demonstration Year 15. The DPHs will also continue activities on the original QIP quality metrics during this six-month period, utilizing the same modifications due to the COVID-19 PHE outlined for PRIME above.

Phase II: Merge to QIP

Subject to obtaining the necessary federal approvals, January 1, 2021 was the proposed start of QIP Year 4 and will include the DPH and 34 District and Municipal Public Hospitals, totaling 51 QIP entities. Similar to Phase I, payments to the 51 QIP entities will be directed payments through the MCMC plans. Program Year 4 will align with Rate Year 2021, corresponding to calendar year 2021.

DHCS indicates PRIME Policy Letters and associated PRIME reporting guidance will no longer apply to QIP. DHCS will review all prior PRIME Policy Letters and QIP Policy Letters for relevance and issue updated Policy Letters and reporting guidance to DPHs and District and Municipal Public Hospitals.

DHCS worked with stakeholders to develop a revised metric set for Program Year 4 that prioritizes CMS Adult and Child Core Set measures, HEDIS measures, other nationally vetted and endorsed measures, and measures in wide use across Medicaid quality initiatives. The measures align with well-established benchmarks and State, MCMC plan, and hospital system goals. The Program Year 4 metric set meaningfully reflects the goals and priorities of CalAIM.

DHCS argues the QIP Program is intended to promote access to care, value-based payments, and tie funding to quality outcomes, while at the same time further aligning state, MCMC plan, and hospital system goals. The PRIME to QIP transition will engage both DPHs and 34 District Hospitals to continue quality improvement work for select priority metrics in QIP As such, DHCS argues this proposal will help achieve the following goals of CalAIM:

- Enhance coverage expansion to address health disparities among vulnerable populations;
- Drive delivery transformation across DPHs and District Hospitals toward value-based care and away from volume-based care, and
- Reduce variation and complexity across hospital systems through alignment of quality measures with those required of health plans.

Proposed Timeline

January 1, 2021: Complete transition from PRIME to QIP for Designated Public Hospitals and District Hospitals using new CMS Adult and Child Core Set measures, HEDIS measures, and other nationally-vetted and endorsed measures.

Proposed TBL:

1) Require DHCS, commencing with the 2020–21 state FY for District Hospitals, and for each state FY or rate year, as applicable, thereafter, DHCS, in consultation with District Hospitals, and applicable MCMC plans, as applicable, to establish and implement a program or programs under which a District Hospital may earn performance-based quality incentive payments from the MCMC plan they contract with.

2) Requires, commencing with the 2020–21 state FY, quality incentive payments from MCMC plans to be earned by a District Hospital based on its performance in achieving identified targets for quality of care.

3) Requires DHCS, in consultation with District Hospitals, to establish a class of District Hospitals, or multiple classes to the extent federal approval is available, for purposes of payments.

4) Requires DHCS, in consultation with District Hospitals, to determine a maximum amount that the class, or classes, of district and municipal hospitals may earn in quality incentive payments for an applicable state FY.

5) Requires DHCS, in consultation with District Hospitals and applicable MCMC plans, to establish and provide a method for updating uniform performance measures for the performance-based quality incentive payments and parameters for District Hospitals to select the applicable measures. Requires the performance measures to advance at least one goal identified in the state's Medicaid quality strategy.

6) Requires each District Hospital to submit reports to DHCS containing information required to evaluate its performance on all applicable performance measures, at the time and in the form and manner specified by DHCS.

7) Requires a MCMC plan to assist a District Hospital in collecting and distributing information necessary for these reports.

8) Requires DHCS to calculate the amount earned by each District Hospital based on its performance score, and requires this amount to be paid to the District Hospital by each of its contracted MCMC plans.

9) Requires DHCS, if a District Hospital contracts with multiple MCMC plans, to identify each MCMC plan's proportionate amount of the District Hospital's payment. Requires

the timing and amount of the distributions and any related reporting requirements for interim payments to be established and agreed to by the District Hospital and each of the applicable MCMC plans.

10) Prohibits a contract between a MCMC plan and District Hospital from being terminated by either party for the specific purpose of circumventing or otherwise impacting the above-described payment obligations.

11) Requires each MCMC plan to be responsible for payment of the quality incentive payments, subject to funding by DHCS.

12) Requires quality incentive payments to District Hospitals to cease to be operative on the first day of the state FY beginning on or after the date DHCS determines, after consultation with the District Hospitals, that implementation of the QIP requirements is no longer financially and programmatically supportive of the Medi-Cal program. Requires DHCS' determination to be based solely on both of the following factors:

    a) The projected amount of nonfederal share funds available is insufficient to support implementation of the quality incentive payments to district and municipal hospitals in the subject state FY or rate year;
    b) The degree to which the payment arrangement for district and municipal hospitals will no longer materially advance the goals and objectives of the QIP and in DHCS' managed care quality strategy in the subject state FY or rate year.

13) Requires DHCS, in making its determination, to consider all reasonable options for mitigating the circumstances set forth above, including, but not limited to, options for curing projected funding shortfalls and options for program revisions and strategy updates to better coordinate payment requirements with the goals and objectives and the DHCS managed care quality strategy.

14) Requires DHCS to post notice of the determination on its internet website, and provide written notice of the determination to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

Global Payment Program (GPP) Extension

The GPP is a five-year pilot program established in California's Medi-Cal 2020 Section 1115 demonstration waiver. The GPP establishes a statewide pool of funding by combining a portion of California's federal Disproportionate Share Hospital (DSH) allotment with available uncompensated care funding. Under federal law, DSH funding is limited to eligible hospitals based on Medicaid and uninsured utilization. Under the GPP, the federal limitation on DSH funds for hospital care are waived to instead provide global budgets to county public health care systems to support efforts to provide health care for California's uninsured population, and to promotes the delivery of more cost-effective and higher-value care to the uninsured. Under the GPP, counties make intergovernmental transfers (IGTs) to

fund the non-federal of funds needed to draw down federal funds.[16]

Under GPP, global budgets are allocated to public health care systems based on available funding and service point thresholds to be achieved. Public health care systems can achieve their hospital specific global budget by meeting a service point threshold that incentivizes movement from high cost, avoidable services to providing higher value and preventive services in the most appropriate setting. The GPP's requirements are established in the Special T&Cs for California's Medi-Cal 2020 Section 1115 demonstration and the program funding is authorized until December 31, 2021 under the one year Medi-Cal 2020 extension proposal, submitted to CMS on September 16, 2020.

DHCS proposes to extend the GPP under CalAIM through a renewal of the Medi-Cal Section 1115 waiver demonstration. The program operates under "Program years" starting with the 2015 waiver. The GPP will operate under the following assumptions:

- The start date of Program Year 7 will begin on January 1, 2022, and end on December 31, 2022. The GPP was originally approved through June 30, 2020. On August 3, 2020, CMS approved a waiver amendment extending the program and authorizing the program for the period of July 1, 2020 through December 31, 2020. The Medi-Cal 2020 one-year extension proposal extended the program through December 31, 2021.
- The GPP under CalAIM will be funded solely by a portion of the State's DPH DSH allotment allocation and will no longer incorporate uncompensated care funding;
- The percentage of DPH DSH allotment funds to be split amongst UC hospitals and GPP public (county) health care systems will remain constant for the entirety of the waiver with 78.104% allocated to the GPP and 21.896% allocated to UC hospitals;
- The GPP will include an evaluation to continue to assess whether the program is achieving its stated goals;
- The GPP will continue the shifting of point values for specific services to incentivize the provision of care in the most appropriate and cost-effective settings;
- DHCS may recalibrate the initial point thresholds for each hospital. Some public health care systems consistently exceed their thresholds, while others do not. Recalibration of the initial point thresholds will serve to minimize payment adjustments; and
- All other facets of the GPP in the CalAIM period will operate per the Medi-Cal 2020 waiver STCs.

The GPP was established to accomplish the following goals:

- To improve health of the remaining uninsured through coordination of care and to move away from the cost-based payment methodology restricted to mostly hospital settings to a more risk-based and/or bundled payment structure;
- To encourage public health care systems to provide greater primary and preventive services, as well as alternative modalities such as phone visits, group visits, telemedicine, and other electronic consultations; and,

- To emphasize the value of coordinated care and alternative modalities by recognizing the higher value of primary care, ambulatory care, and care management as compared to the higher cost, avoidable emergency room visits and acute care hospital stay. DHCS indicates it collaborated with the RAND Corporation to conduct an evaluation of the GPP from the onset of the program through March 2019. The evaluation assessed whether and to what extent, changing the payment methodology resulted in a more patient-centered system of care. DHCS indicates results show that there has been an increase in outpatient services, an increase in access to care for the uninsured, an improvement in the coordination of care, advancements in data collection and tracking, and an appropriate allocation of resources to effectively tailor care to more appropriate settings. DHCS argues these findings provide strong support for the argument that the GPP is a powerful catalyst in helping the public health care systems deliver more cost-effective and higher-value care to California's remaining uninsured individuals and will continue to move in this direction over the next five years.

Proposed Timeline: DHCS proposes to extend the GPP for the next five years.

Proposed TBL:

1) Requires DHCS, to the extent FFP is available, to continue to implement the GPP as described in existing law during the CalAIM term. Requires DHCS to continue to administer the GPP in accordance with existing law, except to the extent changes are approved in the CalAIM T&C and except as described below:

    a) Requires, commencing January 1, 2021, the GPP program year to be aligned with the calendar year. Requires DHCS to provide to the GPP systems a revised schedule for the reporting, notification, intergovernmental transfer (IGT), and payment requirements set forth existing GPP provisions, and requires the same conditions and timeline, adjusted by six months to align with the calendar year, and consistent with the CalAIM T&C.
    b) Requires, commencing January 1, 2021, the GPP system-specific IGT factors identified in existing law to be inapplicable and the initial transfer amount calculated for each GPP system to be identified by DHCS and communicated in writing to each GPP system for each applicable GPP program year.
    c) Requires, commencing January 1, 2021, for purposes of determining the applicable GPP's aggregate annual limit, applicable portions of the federal DSH allotment for the federal FY that ends in the GPP program year, and for the federal FY that commences in the applicable GPP program year, to be appropriately aligned with the GPP program year.

2) Requires DHCS, prior to implementing any of the modifications described above, to consult with the GPP systems.

3) Requires the rights, obligations, and limitations set forth in the existing GPP statute to apply to the GPP as continued under this bill, except as otherwise provided in the CalAIM T&C and the requirement for federal approval.

4) Requires the payment methodologies and requirements described in the existing GPP provisions (as modified by this bill), to continue to apply during the entirety of the CalAIM term and any extension periods in which the GPP is authorized.

Policy Questions:

1) What has the evaluation of the GPP shown
2) What is the benefit of extending the quality improvement program provisions to district hospitals?

Witnesses:
Jacey Cooper, Chief Deputy Director for Health Care Programs and State Medicaid Director, Department of Health Care Services
Sarah Hesketh, Senior Vice President of External Affairs, California Association of Public Hospitals and Health Systems
Sherreta Lane, Senior Vice President, Finance Policy, District Hospital Leadership Forum

Public Comment

Index of Abbreviations

ACA	Federal Patient Protection and Affordable Care Act
BCM	Basic Case Management
CalAIM	California Advancing and Innovating Medi-Cal
CalHEERS	California Healthcare, Eligibility, Enrollment and Retention System
CAP	Corrective Action Plan
CCI	Coordinate Care Initiative
CCM	Complex Case Management
CCS	California Children's Services
CHDP	Child Health Disability Prevention
CMC	Cal MediConnect
CMS	Centers for Medicare and Medicaid Services
DHCS	Department of Health Care Services
DHS	Disproportionate Share Hospital
DMHC	Department of Managed Health Care
D-SNP	Dual Eligible Special Needs Plan
DTI	Dental Transformation Initiative
ECM	Enhanced Care Management
ED	Emergency Department
FFP	Federal Financial Participation
FFS	Fee-for-Service
FY	Fiscal Year
GF	General Fund
GPP	Global Payment Program
HEDIS	Healthcare Effectiveness Data and Information Set
HHP	Health Homes Program
IHSS	In-Home Supportive Services
ILOS	In Lieu of Services
IGT	Inter-governmental transfer
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MA	Medicare Advantage
MEDS	Medi-Cal Eligibility Data System
MCO	Managed Care Organization
MCMC	Medi-Cal Managed Care
MCQMD	Managed Care Quality and Monitoring Division
MLTSS	Managed Long Term Services and Supports
MOU	Memorandum of Understanding
MSSP	Multipurpose Senior Services Program
NCQA	National Committee for Quality Assurance
PACE	Program of All-Inclusive Care for the Elderly
PCP	Primary Care Provider
PFG	Plan and Fiscal Guidelines
PHE	Public Health Emergency
PHM	Population Health Management
PIHP	Prepaid Inpatient Health Plan
PRIME	Public Hospital Redesign and Incentives in Medi-Cal
RDT	Rate Development Template
SAWS	Statewide Automated Welfare System
SDOH	Social Determinants of Health
SMAC	State Medicaid Agency Contract
SNF	Skilled Nursing Facility
T&Cs	Terms and Conditions
TBL	Trailer Bill Language
URAC	Utilization Review Accreditation Commission
WPC	Whole Person Care

[1] AB 2032 (Wood), AB 2042 (Wood), AB 2055 (Wood), SB 910 (Pan), and SB 916 (Pan).
[2] Title 42 of the Code of Federal Regulations, Part 438 contains requirement for Medicaid managed care plans.
[3] Welfare and Institutions Code Section 14456.
[4] DHCS Two Plan Non-CCI Boilerplate, Exhibit A, Attachment 4 Quality Improvement System https://www.dhcs.ca.gov/provgovpart/Documents/2-Plan-Non-CCI-Boilerplate-Final-Rule-Amendment.pdf
[5] Title 42 of the Code of Federal Regulation, Section 438.360.
[6] Welfare and Institutions Code Section 14301.1.
[7] Title 42 of the Code of Federal Regulations, Section 438.2.
[8] Title 42 of the Code of Federal Regulations, Section 438.4.
[9] "A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care," Amber Christ, JD and Georgia Burke, JD, Justice in Aging, September 2020.
[10] Title 42 of the Code of Federation Regulations, Section 422.2.
[11] Title 42 of the Code of Federation Regulations, Section 422.2.
[12] Section 4011.11 of the Penal Code.
[13] Welfare and Institutions Code Section 14054.
[14] Welfare and Institutions Code Section 14054.5.
[15] Welfare and Institutions Code Section 14005.36.
[16] Welfare and Institutions Code Section 14184.40.