Tribal and Designee Medi-Cal Advisory Process Webinar on Proposed Changes to the Medi-Cal Program

August 31, 2022

DHCS

Purpose

- The Department of Health Care Services (DHCS) is hosting this webinar regarding proposed changes to the Medi-Cal Program. This webinar will provide information and allow for feedback on State Plan Amendments (SPA) and Waiver Renewals/Amendments proposed for submission to Centers for Medicare and Medicaid Services (CMS).

- Background: Executive Orders recognize the unique relationship of Tribes with the federal government and emphasize the importance of States to work with Tribes on matters that may impact Indian health.

- This webinar is one way for DHCS to provide information about the Medi-Cal program and get feedback verbally and in writing.

Agenda

Topics	Presenters
Welcome/Overview	Andrea Zubiate, Acting Chief DHCS Office of Tribal Affairs/Indian Health Program
SPAs Scheduled for Submission by September 30, 2022	
SPA 22-0040	Serina Kung, Staff Services Manager I Fee-For-Service Rates Development Division
SPA 22-0043	Teresa Castillo, Program Policy Section Medi-Cal Behavioral Health Division
Feedback/Closing	All
California Advancing and Innovating Medi-Cal (CalAIM) Section 1915(b) Waiver & Section 1115 Demonstration Update	
Managed Care Plan Model Change Amendments Overview for Tribal Partners	Susan Philip, Deputy Director, Health Care Delivery Systems

State Plan Amendment Overview

Medicaid State Plan Overview

State Plan: The official contract between the state and federal government by which a state ensures compliance with federal Medicaid requirements to be eligible for federal funding.

The State Plan describes the nature and scope of Medicaid and gives assurance that it will be administered in accordance with the specific requirements of Title XIX of the Federal Social Security Act, Code of Federal Regulations, Chapter IV, and State law/regulations.

California's State Plan is over 1600 pages and can be accessed online at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx

State Plan Amendment (SPA) Overview

SPA: Any formal change to the State Plan.

Approved State Plans and SPAs ensure the availability of federal funding for the state's program (Medi-Cal).

The CMS reviews all State Plans and SPAs for compliance with:

- -Federal Medicaid statutes and regulations
- -State Medicaid manual
- -Most current State Medicaid Directors' Letters, which serve as policy guidance.

SPA 22-0040

Ground Emergency Medical Transport Quality Assurance Fee (GEMT QAF) Program

Serina Kung
Staff Services Manager I
Fee-For-Service Rates Development Division

Background for the GEMT QAF Program

The Program is a result of SB 523 (Chapter 773, Statutes of 2017).

» The GEMT QAF Program became effective July 1, 2018. Below is a table with the list of State Plan Amendments (SPAs) with the effective dates, affected procedure codes, and Centers for Medicare and Medicaid Services (CMS) approval dates:

SPA	Effective Dates	Affected Procedure Codes	CMS Approval Date
19-0020	July 1, 2019 through June 30, 2020	A0225, A0427, A0429, A0433, A0434	September 6, 2019
20-0009	July 1, 2020 through June 30, 2021	A0225, A0427, A0429, A0433, A0434	October 15, 2020
21-0017	July 1, 2021 through June 30, 2022	A0225, A0427, A0429, A0433, A0434	August 20, 2021

Background for the GEMT QAF Program (continued)

Effective January 1, 2023, public providers as defined in Assembly Bill (AB) 1705 (Chapter 544, Statutes of 2019) will no longer be eligible to participate in the GEMT QAF program. These providers will be transitioned into a new Public Provider Ground Emergency Medical Transportation Intergovernmental Transfer Program (PP-GEMT IGT) program.

- Providers are eligible for the PP-GEMT IGT program if they meet all of the following criteria:
  - provides GEMT services to Medi-Cal beneficiaries,
  - enrolled as a Medi-Cal provider for the period being claimed, and
  - are owned or operated by the state, a city, county, city and county, fire protection, special districts, community services districts, health care district, or a federally recognized Indian tribe.

What is QAF?

- **A QAF is assessed on all ground emergency transports, including:**
  - Medi-Cal, Medicare, and all other payers.
  - All GEMT providers with an eligible transport

- **Benefit to providers**
  - The QAF revenue is matched with federal funds.
  - Allows for increased reimbursements in the form of an add-on to the current Medi-Cal ground emergency transport rates.

QAF Calculations and Data Collection

- For the purposes of calculating the GEMT QAF, GEMT providers are required to submit to DHCS:
  - Total number of emergency medical transports for Codes A0427, A0429, A0433, A0225, and A0434. This data shall be submitted quarterly through the online portal.
  - Gross Receipt received from the provision of emergency medical transports for Codes A0427, A0429, A0433, A0225, and A0434. This data shall be submitted annually through the GEMT QAF email box using a submission form found on the GEMT QAF website.
  - GEMT providers transitioning into the PP-GEMT IGT program must still submit the data reports and QAF payments to DHCS by the due dates for dates of service through December 2022. Please note some of the payment due dates will fall after December 2022.

Purpose

To seek federal approval for the continuation of the existing GEMT QAF program and the reimbursement add-on provided for Medi-Cal ground emergency medical transports, effective for the service period of July 1, 2022 through June 30, 2023.

Summary of Proposed Changes

- The proposed SPA will seek federal approval to continue the current GEMT QAF Program for the period of July 1, 2022 through June 30, 2023.
- Eligible public GEMT providers that opt into the new PP-GEMT IGT program will no longer be eligible for the GEMT QAF program effective January 1, 2023, will not be assessed QAF, and will not receive the GEMT QAF add-on.

Impact to Tribal Health Programs (THPs)

- Tribally owned and operated GEMT providers must submit the required data reports and QAF payments to DHCS by the due dates.
- Tribally owned and operated GEMT providers will receive the increased reimbursement for each Medi-Cal GEMT service provided based on the five available codes.

Impact to Federally Qualified Health Centers (FQHCs)

- FQHC owned and operated GEMT providers must submit the required data reports and QAF payments to DHCS by the applicable due dates.
- FQHC owned and operated GEMT providers will receive the increased reimbursement for each Medi-Cal GEMT service provided based on the five available codes.

Impact to Indian Medi-Cal Beneficiaries

- There is no impact to Indian Medi-Cal beneficiaries who receive GEMT services.

Resources

- **GEMT QAF Website:**
https://www.dhcs.ca.gov/provgovpart/Pages/GEMTQAF.aspx

- **GEMT QAF Portal:**
https://www.dhcs.ca.gov/provgovpart/Pages/QAF.aspx

- **SB 523:**
http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB523

Contact Information

Email to:
GEMTQAF@DHCS.ca.gov.

Mail to:
Department of Health Care Services
Fee-For-Service Rate Development Division
1501 Capitol Avenue
MS 4600
P.O. Box 997417
Sacramento, CA 95899-7417

SPA 22-0043

Qualifying Community Based Mobile Crisis Intervention Services

Teresa Castillo
Program Policy Section
Medi-Cal Behavioral Health Division

Background

- Community-based mobile crisis intervention services are an important part of a strong and effective behavioral health care system.
- Benefit is designed to ensure that all Medi-Cal members have access to a continuum of crisis care 24 hours a day, 7 days a week, 365 days a year.
- The purpose is to provide rapid response, assessment, and community-based stabilization to individuals experiencing behavioral health crises.
- DHCS conducted engagement with Tribal partners including key informant interviews with representatives of Tribes, Tribal health programs, and urban Indian organizations to inform the design of the mobile crisis benefit.

Purpose

- Seek federal approval to add qualifying community-based mobile crisis intervention services as a covered behavioral health benefit in the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services programs.

- The proposed effective date for SPA 22-0043 is January 1, 2023.

Summary of Proposed Changes

- SPA 22-0043 proposes to define mobile crisis intervention services* so that it includes the following components: crisis assessment, mobile crisis response, facilitating warm handoff, crisis planning, connections to ongoing supports, and follow up.

- Mobile crisis services will be provided by a multidisciplinary team at the location where an individual is experiencing a mental health or substance use crisis (e.g., at the individual's home, workplace or school, on the street, or where the individual socializes).
  - Services will not be provided in hospitals or other facility settings.

*Existing Medi-Cal crisis intervention services that do not meet the qualifying conditions for this new statewide benefit are not impacted by it. The existing services are still covered and available for reimbursement.

Impact to Tribal Health Programs (THPs)

- Tribal health programs could establish a separate line of business to deliver qualifying mobile crisis services in a community setting.
- Additionally, mobile crisis teams can connect beneficiaries with THPs that provide Medi-Cal-covered behavioral health or substance use disorder services for follow-up care.

Impact to Federally Qualified Health Centers (FQHCs)

- FQHCs could establish a separate line of business to deliver qualifying mobile crisis services in a community setting.

- Additionally, mobile crisis teams can connect beneficiaries with FQHCs that provide Medi-Cal-covered behavioral health or substance use disorder services for follow-up care.

Impact to Indian Medi-Cal Beneficiaries

- American Indian Medi-Cal beneficiaries may have increased access to mobile crisis services, which is expected to improve health outcomes for beneficiaries receiving these services.

Contact Information

- Indian Health Programs and Urban Indian Organizations may submit written comments or questions within 30 days from the receipt of notice

- Comments may be sent by email to: PublicInput@dhcs.ca.gov

- Or by mail at:
  Department of Health Care Services
  Director's Office
  1500 Capitol Avenue, MS 0000
  Sacramento, CA 95814

California Advancing and Innovating Medi-Cal (CalAIM) Section 1915(b) Waiver & Section 1115 Demonstration

Managed Care Plan Model Change Amendments Overview for Tribal Partners

Susan Philip
Deputy Director
Health Care Delivery Systems

Welcome and Webex Logistics

Dos & Don’ts of Webex

- Participants are joining by computer and phone
- Everyone will be automatically muted upon entry
- Use the Q&A box to submit public comments

Today's Agenda

- Overview of CalAIM 1115 Demonstration & 1915(b) Waiver
- Proposed Amendments to CalAIM 1115 Demonstration & 1915(b) Waiver for Managed Care Plan Model Changes
- Timeline and Public Comment Period for Amendments

Today's Objective

California is seeking amendments to the CalAIM Section 1115 demonstration and Section 1915(b) waiver to implement county-based model changes in the Medi-Cal Managed Care (MCMC) program. In today's webinar, we will summarize the planned amendments, and receive comments from Tribal partners on the proposed approach.

How to Access Public Comment Materials

- **CalAIM Section 1115 Demonstration & Section 1915(b) Webpage**
  - Public notice
  - Tribal and Designees of Indian Health Programs public notice
  - Section 1115 demonstration amendment draft
  - Section 1915(b) waiver amendment overview
- **CalAIM Indian Health Program Webpage**
- **CalAIM Homepage**

Submitting Public Comments

The Tribal and Designees of Indian Health Programs public comment period for the CalAIM Section 1115 and Section 1915(b) amendments is from August 12, 2022 to September 12, 2022. To be considered prior to CMS submission, all public comments must be received by 11:59 p.m. PDT on September 12, 2022.

» **Mail:** Indicate "CalAIM Section 1115 & 1915(b) Waivers Amendment" in the address line
Department of Health Care Services
Director's Office
Attention: Jacey Cooper
P. O. Box 997413, MS 0000
Sacramento, California 95899-7413

» **Email:** Indicate "CalAIM Section 1115 & 1915(b) Waivers Amendment" in email's subject line
CalAIMWaiver@dhcs.ca.gov

» **Today's Public Hearing:**
- **Q&A Box.** All information and questions received through the Q&A box will be recorded as public comments
- **Spoken.** Participants will have the opportunity to verbally share public comments in the second half of the webinar

Overview of CalAIM Section 1115 & Section 1915(b) Waivers

California's Section 1115 Demonstration and 1915(b) Waiver Support the CalAIM Vision

CalAIM is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory.

Goals of CalAIM

- Identify and manage comprehensive needs through whole person care approaches and social drivers of health
- Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform
- Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility

California's Section 1115 demonstration and Section 1915(b) waiver, along with California's State Plan and managed care contracts, authorize the various components of CalAIM.

Overview of CalAIM 1115 Demonstration

On December 29, 2021, CMS approved California's CalAIM Section 1115 demonstration. The five-year approval renewed components of the state's existing Medi-Cal 2020 demonstration, and authorized new components, consistent with the goals of the Medi-Cal program.

CalAIM Section 1115 Demonstration Components

- Community Supports Services for Recuperative Care and Short-Term Post-Hospitalization Housing
- Providing Access and Transforming Health (PATH) Supports
- Contingency Management
- Dual Special Needs Plan (D-SNP) Exclusively Aligned Enrollment Model
- Continuation of Drug Medi-Cal Organized Delivery Systems (DMC-ODS) Services for Short-Term Residents of Institutions for Mental Diseases (IMDs)
- Continuation of Global Payment Program
- Continuation of Community-Based Adult Services (CBAS)
- Continuation of Chiropractic Services for Indian Health Service and Tribal Facilities
- Authority to Increase and Eventually Eliminate Asset Limits for Certain Low-Income Individuals (*2022 Amendment*)

CMS is still reviewing California's requests to provide in-reach services to justice-involved populations, leverage federal funding of Designated State Health Programs (DSHPs) for PATH, and offer traditional healer and natural helper services.

Overview of CalAIM 1915(b) Waiver

On December 29, 2021, CMS approved California's CalAIM Section 1915(b) waiver. The five-year approval transitioned authority for California's managed care delivery systems from the state's longstanding Section 1115 demonstration to authority under the CalAIM 1915(b) waiver.

CalAIM Section 1915(b) Waiver Components

- Authorized all four Medi-Cal managed care delivery systems:
  - Medi-Cal Managed Care (MCMC)
  - Dental Managed Care (Dental MC)
  - Specialty Mental Health Services (SMHS)
  - Drug Medi-Cal Organized Delivery Systems (DMC-ODS)
- Standardized enrollment, benefits, and payment across managed care delivery systems

Proposed Amendments to CalAIM 1115 Demonstration & 1915(b) Waiver for Managed Care Plan Model Changes

Medi-Cal Managed Care is Central to California's Health Care Delivery System

Medi-Cal Provides Coverage for:

- One in three Californians
- More than half of school-age children
- Half of California births
- More than two-thirds of long-term care patient days

Medi-Cal Managed Care Plans (MCPs):

- Partner with the state to deliver health care services for Medi-Cal members
- Will enroll approximately 99 percent of Medi-Cal beneficiaries by 2024
- Operate within multiple managed care models that vary by county

Overview of MCMC Model Changes

Prior to the launch of the state's commercial plan re-procurement process in 2022, counties had the opportunity to request a change to their managed care model effective January 1, 2024.

- **Today, each county offers one of these MCMC models:**
  1. One plan operated by the county (County Organized Health System (COHS) model)
  2. One local initiative plan operated by the county and one commercial plan (Two Plan model)
  3. Multiple commercial plans (Geographic Managed Care, Regional, and Imperial model)
  4. One commercial plan and a Fee-for-Service option (San Benito model)

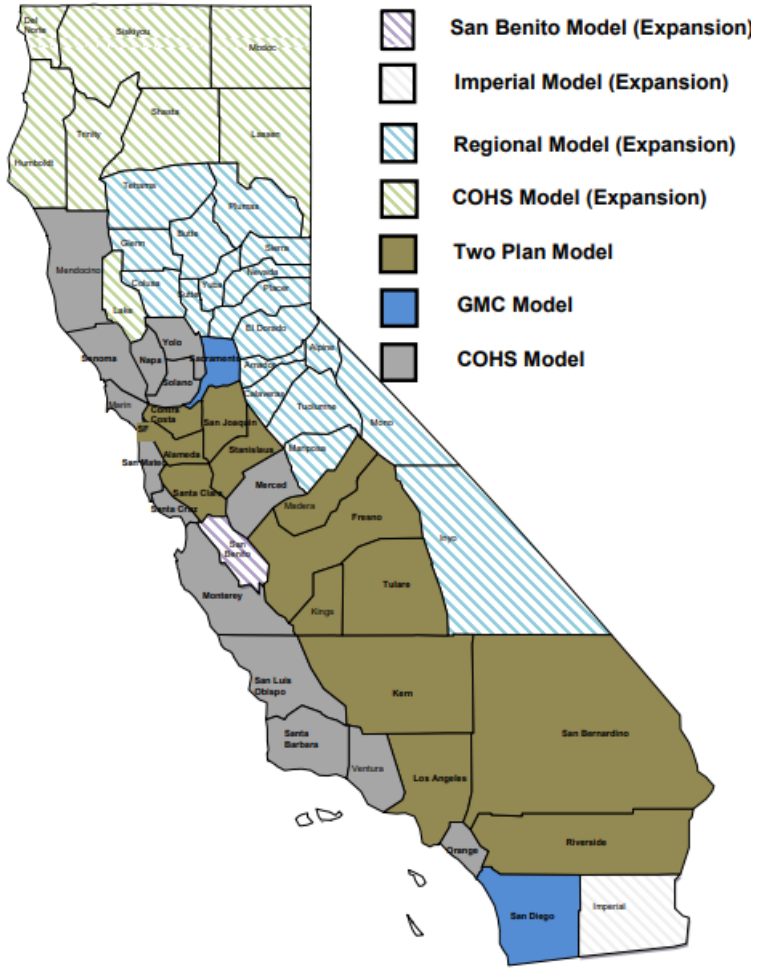
- DHCS has conditionally approved model changes in 17 counties; **15 counties seek to move to a managed care model that involves one plan per county**, either via expansion of an existing COHS model or establishment of a "Single Plan" model

- Single Plan models will be expansions of plans currently operating as county-driven local initiatives or will otherwise be operating under a county or local authority

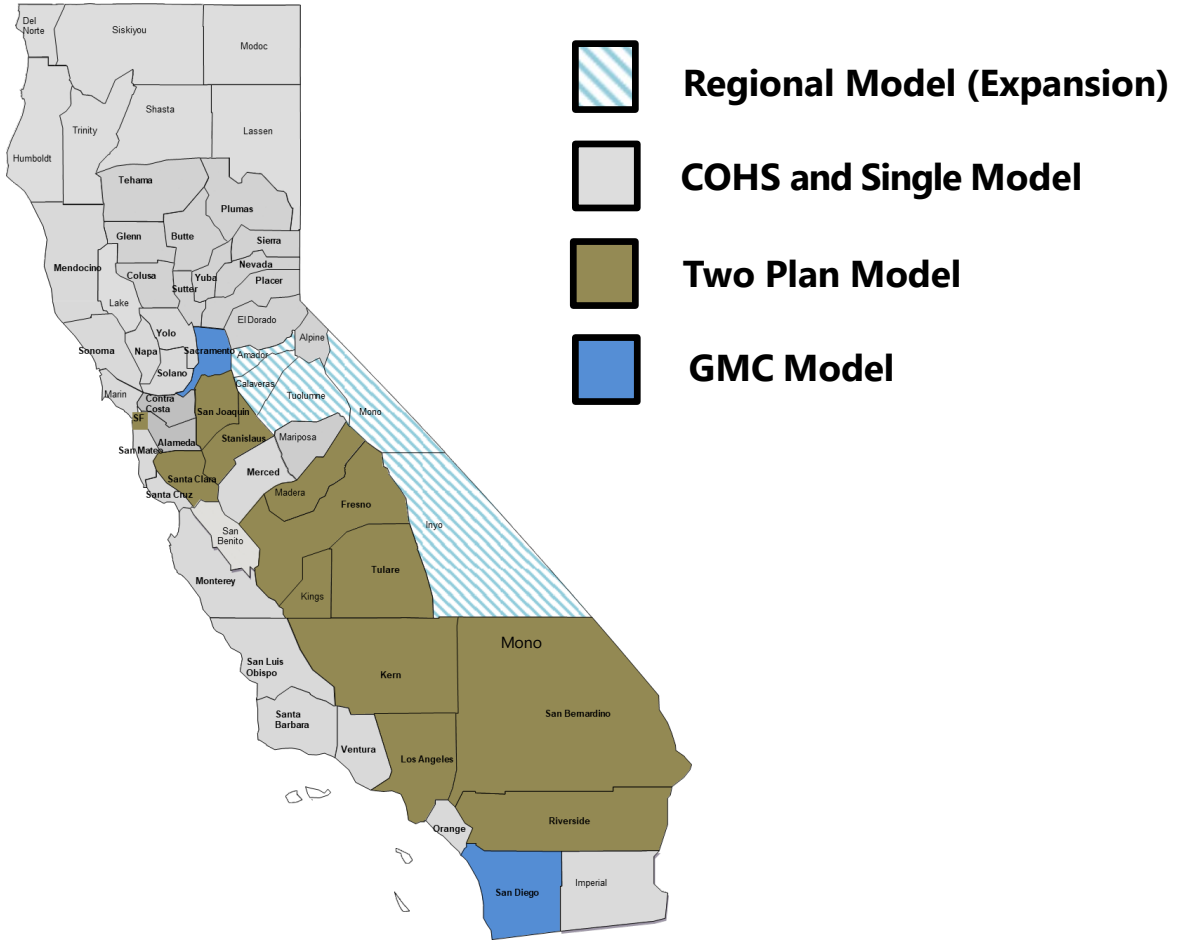
DHCS is seeking Section 1115 and 1915(b) authority to limit choice of MCPs for enrollees residing in counties participating in the COHS and Single Plan models.

Conditionally Approved Changes to County MCMC Models

Current Models:



Conditionally Approved 2024 Models:*



** Pending plan readiness and federal authorization*

Authorities and Other Updates Requested in the Section 1115 and 1915(b) Amendments

Section 1115 Amendment

- **Expenditure authority to limit plan choice in metro, large metro, and urban counties** to allow counties to participate, or continue participating, in the COHS and Single Plan models

Section 1915(b) Amendment

- **Authority to limit plan choice in rural counties** to allow counties to participate, or continue participating, in the COHS and Single Plan models
- **Updates to policies and program descriptions memorialized in the CalAIM 1915(b)**, including to reflect:
  - MCMC model changes in select counties
  - Direct contracts with Kaiser Foundation Health Plan available to certain Medi-Cal beneficiary populations in 32 counties, where Kaiser Foundation Health Plan currently operates as a commercial plan

The Section 1115 and 1915(b) amendments will <u>not</u> impact Medi-Cal eligibility or benefits.

Ensuring Smooth Transitions for Members

DHCS is committed to ensuring a smooth transition among plans for Medi-Cal members transitioning to a new plan following the planned model changes.

- **Member noticing, outreach and continuity of care policies and procedures are being carefully considered** and will be included in a transition plan developed with substantial input from stakeholders
- **MCPs are required to ensure access and member rights; DHCS will provide plans with monitoring and oversight standards and processes**
  - DHCS will communicate the standards and processes through a variety of mechanisms including, but not limited to, policy guidance, contract amendments, All Plan Letters, and Frequently Asked Questions (FAQs), as well as provide ongoing training and technical assistance
- **Throughout 2022, DHCS has engaged with stakeholder and advocacy groups, and will continue to do so to keep them informed with timely information about the transition**

Impact to American Indians, Indian Health Programs, and Urban Indian Organizations

Impact to Tribal Health Programs

- **There is no direct impact to Tribal Health Programs**; DHCS is not proposing changes to Tribal health program services, rates, benefits, eligibility, or any other related requirement

Impact to Federally Qualified Health Centers (FQHCs)

- **There is no direct impact to FQHCs**; DHCS is not proposing changes to FQHC or Rural Health Center (RHC) services, rates, eligibility, or any other related requirement

Impact to American Indian Medi-Cal Beneficiaries

- **Like other Medi-Cal members residing in counties implementing a COHS or Single Plan model, the requested changes will limit plan choice for American Indian/Alaska Native individuals enrolled in MCMC**
- American Indians and Alaska Natives have the option but are not required to enroll in MCMC (voluntary enrollment); the proposed model changes will not change voluntary enrollment, eligibility for Medi-Cal, or reduce benefits
- DHCS is committed to working with Tribal and Indian Health Programs to ensure a smooth transition among plans for all members transitioning to a new MCP following the MCMC model changes, with a focus on those most vulnerable to disruptions in care

Timeline and Public Comment

Timeline and Next Steps

Milestones	Proposed Timeline
Conduct 30-day State public comment	August 12– September 12, 2022
Distribute Tribal and Designees of Indian Health Programs Notice (Allow 30-day comment period)	August 12– September 12, 2022
Public Hearing	August 22, 2022 *10 a.m. – 11 a.m.*
Tribal Webinar	August 31, 2022 *2 p.m. – 3 p.m.*
Review public comments and finalize documents for CMS submission	September – October 2022
Submit Section 1115 and 1915(b) amendments to CMS	***November 2022***
CMS conducts federal 30-day public comment period	November – December 2022
Negotiations with CMS	December 2022 – early 2023
Effective date for MCMC Model Changes	***January 1, 2024***

CalAIM Waiver Public Comment Period

To be considered prior to CMS submission, public comments on the CalAIM 1115 and 1915(b) amendments must be received by 11:59 p.m. PDT on September 12.

Email Comments

Email **CalAIMWaiver@dhcs.ca.gov** and include "**CalAIM 1115 & 1915(b) Waivers Amendment**" in the email subject line

Write-In Comments

Mail written comments to:

Department of Health Care Services
Director's Office
Attention: Jacey Cooper
P. O. Box 997413, MS 0000
Sacramento, California 95899-74173

CalAIM Waiver Resources

- **CalAIM Section 1115 Demonstration & Section 1915(b) Webpage**
  - Public notice
  - Tribal and Designees of Indian Health Programs public notice
  - Section 1115 demonstration amendment draft
  - Section 1915(b) waiver amendment overview
- **CalAIM Indian Health Program Webpage**
- **CalAIM Homepage**

Thank You!

Appendix

Background on Section 1115 Demonstration Authority

Under **Section 1115 of the federal Social Security Act**, the U.S. Secretary of Health and Human Services (HHS) has authority to approve a state's request to waive compliance with provisions of federal Medicaid law.

A Section 1115 demonstration (or waiver) must be:

- ✓ An experimental, pilot or demonstration project.
- ✓ Likely to assist in promoting the objectives of the Medicaid program.
- ✓ Budget neutral to the federal government.
- ✓ Limited in duration to the extent and period necessary to carry out the demonstration.

States must provide a **public process for notice and comment** on proposed demonstration applications and extensions.

Source: Social Security Act § 1115.

Background on Section 1915(b) Waiver Authority

Under **Section 1915(b) of the federal Social Security Act**, the U.S. Secretary of HHS has authority to approve a state's request to waive requirements for implementation of Medicaid managed care delivery systems. **States often authorize Medicaid managed care through Section 1915(b) waiver authority.**

A Section 1915(b) waiver must be:

- ✓ Likely to assist in promoting the objectives of the Medicaid program.
- ✓ Cost effective for the federal government.
- ✓ Limited in duration for up two years, or five years if the waiver authorizes enrollment of enrollees dually eligible for Medicare and Medicaid.

States submit Section 1915(b) waivers and any amendments using a "**pre-print**" and CMS has 90 days to review and decide on the waiver.

Source: Social Security Act § 1915(b).

Feedback/Questions