State of California

Department of Health Care Services

Medicaid Section 1115 Demonstration

Amendment Request:

CalAIM Medi-Cal Managed Care Model Changes

DRAFT FOR PUBLIC COMMENT

August 12, 2022

Section 1 – Historical Narrative Description of the Demonstration

Introduction

The California State Department of Health Care Services (DHCS) is seeking an amendment to the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration to implement county-based model changes in its Medi-Cal Managed Care program. This request is in conjunction with related changes to the CalAIM Section 1915(b) waiver.

Through the CalAIM Section 1115 demonstration and Section 1915(b) waiver approvals in December 2021, DHCS transitioned authority for California's managed care delivery systems — Medi-Cal Managed Care, Dental Managed Care, Specialty Mental Health Services, and Drug Medi-Cal Organized Delivery System — from the State's longstanding Section 1115 demonstration to authority under the CalAIM 1915(b) waiver to simplify and align the programs, enhance oversight, and standardize benefits and enrollment into Medi-Cal.

California's Medi-Cal Managed Care delivery system consists of multiple managed care models that vary by county. Each county offers one of these models: one plan operated by the county (County Organized Health System (COHS)); one local initiative plan operated by the county and one commercial plan (Two Plan); multiple commercial plans (Geographic Managed Care, Regional, and Imperial model); or one commercial plan and a Fee-for-Service option (San Benito model). Today, 22 counties[1] offer one plan operated by the county, all implemented through a COHS model. 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. As part of this process, DHCS conditionally approved model changes in 17 counties; 15 of these 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 effective January 1, 2024.

To effectuate the expanded COHS and new Single Plan models, DHCS is requesting to amend the CalAIM Section 1115 demonstration to include expenditure authority to limit choice of managed care plans in these relevant geographic regions. This authority would apply in the Metro, Large Metro, and Urban counties operating under the COHS and Single Plan models. Through a separate submission, DHCS is also requesting an amendment to the CalAIM 1915(b) waiver to reflect use of the rural area

[1] The 1915(b) waiver approved in December 2021 lists 23 counties as COHS in error. DHCS intends to include a technical correction in the 1915(b) amendment to update Stanislaus as a Two-Plan county instead of a COHS.

exemption for plan choice in rural counties with existing and/or expanding COHS, and rural counties intending to operate a Single Plan. Implementing these models is consistent with the goals of CalAIM, including improving quality, access, and accountability.

For more information on the COHS and Single Plan models, including information on which counties are currently seeking to adopt these models, please visit the MCP Model Change website here.

Background

The expansion of the COHS model and new Single Plan model to counties as proposed by DHCS will build on the existing COHS model in the State, which are among California's highest performing plans. Currently, DHCS has authority relating to the existing COHS to limit Medi-Cal managed care plan choice under federal law provisions[2] that exempt them from the otherwise applicable managed care choice requirements set forth in or derived from Section 1903(m)(2)(A) of the Social Security Act. Four of these COHS are health insuring organizations (HIOs) under federal law; their statutory exemption from 1903(m)(2)(A) and associated Medicaid requirements is conditioned on not exceeding a 16% enrollment level in those four COHS as a share of all Medi-Cal beneficiaries. Once the 16% enrollment level is exceeded, the managed care requirements in 42 CFR Part 438, including choice provisions, would apply to all HIOs currently operating under federal statute. DHCS projects that enrollment will likely be close to or exceed the aggregate 16% level following the expansion of two of those four COHS/HIOs into new counties.

Given enrollment will be close to or in excess of the aggregate 16% level following the expansion of the COHS model, DHCS is seeking expenditure authority through this Demonstration Amendment to limit plan choice in non-rural areas for all COHS.

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[2] SSA 1932(a)(3): requires choice of at least two MCOs, with specific exceptions including:

- COHS / HIOs that became operational prior to Jan 1, 1986, so long as a choice between at least two providers;
- HIOs as described in Sec. 9517(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended by Section 4734 of the Omnibus Budget Reconciliation of 1990, Section 704 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, and Section 205 of the Medicare Improvements for Patients and Providers Act of 2008, subject to certain conditions including that total membership in those HIOs is under 16% of Medi-Cal beneficiaries; and
- Rural areas if >2 physicians or case managers (if available in the area) and may go out-of-network in appropriate circumstances.

The proposed Single Plans are not subject to federal statutory exemption from plan choice requirements as existing COHS/HIOs are. Therefore, expenditure authority through this Demonstration Amendment is also needed to limit plan choice in Single Plan model counties in non-rural areas.

Through a separate submission, DHCS is also requesting an amendment to the CalAIM 1915(b) waiver to reflect use of the rural area exemption for rural counties in existing and expanding COHS and rural counties intending to operate a Single Plan, and to include language memorializing the model changes and plans operating in each county following re-procurement.

Summary of Current CalAIM Section 1115 Demonstration

On December 29, 2021, CMS approved the CalAIM demonstration. This five-year demonstration authorized the renewal of components of the State's prior Medi-Cal 2020 Section 1115 demonstration, in addition to new authorities, to continue advancing the State's goal of improving health outcomes and reducing health disparities for Medicaid and other low-income populations in the State. Building on the successes of the Medi-Cal 2020 demonstration, California has moved to implement whole person care strategies statewide through the State's CalAIM 1915(b) managed care delivery system (with some aspects authorized through Section 1115 demonstration authority) and moved other aspects of the Medi-Cal 2020 demonstration into the Medi-Cal State Plan. The CalAIM Section 1115 demonstration initiatives include:

- Renewing the Global Payment Program (GPP) to streamline funding sources for care for California's remaining uninsured population with a renewed focus on addressing social needs and responding to the impacts of systemic racism and inequities on the uninsured populations served by California's public hospitals.

- Authorizing Community Supports services for recuperative care and short-term post-hospitalization housing.

- Authorizing the Providing Access and Transforming Health (PATH) Supports expenditure authority to (1) sustain, transition, and expand the successful Whole Person Care (WPC) Pilot and Health Home Program (HHP) services initially authorized under the Medi-Cal 2020 demonstration as they transition to become Enhanced Care Management (ECM) and Community Supports and (2) sustain justice-involved pre-release and post-release services provided through existing WPC pilots and support Medi-Cal pre-release application planning and IT investments.

- Continuing short-term residential treatment services to eligible individuals with a

substance use disorder (SUD) in the Drug Medi-Cal Organized Delivery System (DMC-ODS).

- Authorizing Contingency Management as a DMC-ODS benefit, to offer Medi-Cal beneficiaries this evidence-based, cost-effective treatment for SUD that combines motivational incentives with behavioral health treatments.

California also has requested authority to provide in-reach services to justice-involved populations, leverage federal funding of Designated State Health Programs (DSHPs) to support the non-federal share funding for the PATH program, and offer traditional healer and natural helper services; these requests are still pending with CMS.

On June 29, 2022, CMS approved an amendment to the CalAIM 1115 demonstration to permit the state to increase and eventually eliminate asset limits for certain low-income individuals whose eligibility is not determined using the modified adjusted gross income (MAGI)-based financial methods.

Section II. Proposed Amendment

This Demonstration Amendment seeks expenditure authority to allow COHS and Single Plan models to operate in select Metro, Large and Urban counties starting January 1, 2024. These changes are intended to improve access to and quality of care and accountability. No other changes to the CalAIM demonstration are being requested at this time.

Summary of Proposed CalAIM Section 1115 Demonstration Amendment Features

DHCS is requesting an amendment to the CalAIM 1115 demonstration to secure expenditure authority to allow DHCS to limit choice of managed care plans in Metro, Large Metro, and Urban counties in order to allow counties to participate, or continue participating, in the COHS and Single Plan models.

Summary of Current Demonstration Features to Be Continued Under the Section 1115 Demonstration Amendment

California is not seeking to modify any other features in the currently approved CalAIM Section 1115 demonstration. The demonstration will continue to operate pursuant to the Special Terms and Conditions (STCs) issued by CMS on December 29, 2021 and amended on June 29, 2022.

Eligibility

The State is not proposing any changes to Medi-Cal eligibility requirements through this Section 1115 demonstration amendment request. The amendment impacts approximately 1,001,400 Medi-Cal managed care enrollees residing in the select Metro, Large and Urban counties that would be limiting plan choice (based on enrollment figure as of February 2022) by adopting the COHS or Single plan models.

Medicaid Delivery System

Through this Section 1115 amendment request, the State is proposing changes to the Medi-Cal managed care delivery system to strengthen quality, access to care, and accountability as described here. While most Medi-Cal beneficiaries will not be impacted by the proposed change, the proposed model transition will limit choice of plans for the Medi-Cal enrollees living in the counties that employ the COHS or Single Plan model.

Medicaid Covered Benefits

The State is not proposing any changes to the benefits available to Medicaid enrollees in the Medi-Cal program.

Medicaid Cost-Sharing

The State is not proposing any changes to cost-sharing under the Medi-Cal program.

Section III. Implementation of Amendment

The model changes proposed in this Demonstration would take effect January 1, 2024, consistent with the corollary CalAIM Section 1915(b) waiver amendment. DHCS has been actively engaged since Fall 2020 to ensure full MCP and county readiness and member and stakeholder engagement, under the condition of CMS approval. Below is the State's general timeline for engagement and implementation:

- March – April 2021: Counties submitted letters of intent to DHCS
- August 2021: DHCS issued conditional decision letters to enable counties to progress in seeking model change
- October 2021: Counties seeking model changes submitted approved County ordinances seeking model change to DHCS, verified by DHCS
- November 2021: DHCS announced conditional approvals for county model changes
- December 2021: Affected counties and their plan partners submitted a network contracting strategy to be considered as part of operational readiness

- June 2022 through October 2023: MCP operational readiness process and related technical assistance to plan and county partners underway, including network development and adequacy evaluations
- October 2023 – January 2024: Member noticing, outreach, and continuity of care activities

Model changes are advancing in parallel to the statewide procurement of commercial MCPs. With the exception of El Dorado and Alpine counties, which are conditionally approved to transition from a Regional to a Two-Plan model for which the commercial plan is being procured, the other conditionally approved model change counties are not participating in the procurement underway, nor are existing COHS and Local Initiatives in other counties. Once selection has been completed for commercial plans, the MCP operational readiness process already begun for model change plans will proceed largely in parallel with awarded commercial MCPs to ensure statewide MCP readiness across all plan types and models prior to the January 1, 2024 effective date.

DHCS is committed to ensuring a smooth transition among plans for members, with particular attention to those members most vulnerable to disruptions in care. 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 plans, providers, counties, consumer advocates and other stakeholders.

Section IV. Requested Waivers and Expenditure Authority

DHCS is requesting 1115 demonstration expenditure authority to limit choice of managed care plans for managed care enrollees residing in the Metro, Large Metro, and Urban counties participating in the COHS and Single Plan models effective January 1, 2024.

Expenditure Authority

Expenditures under contracts with managed care entities that do not meet the requirements in 1903(m)(2)(A) and 1932(a)(3) of the Act, including as it is implemented and interpreted in 42 CFR 438.52(a)(1), to the extent necessary to allow the state to limit choice of managed care plans to a single managed care entity in Metro, Large Metro, and Urban counties that have been approved by the state to implement County Organized Health System (COHS) and Single Plan models. For Health Insuring Organizations (HIO) described in Section 1932(a)(3)(C)(i)(II) authorized under the COHS model, this expenditure authority shall apply for any time period during the demonstration term in which aggregate enrollment in such HIOs meets or exceeds the sixteen percent threshold described in Section 9517(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985, as subsequently amended.

Section V. Financial Data

The expanded COHS and Single Plan model changes proposed in this Demonstration Amendment are not expected to impact the overall number of people enrolled in the Medi-Cal program or the Medi-Cal managed care delivery system or increase the expenditures on enrollees in these counties. For that reason, the State does not anticipate this Demonstration Amendment will have any appreciable financial impact.

Section VI. Evaluation and Demonstration Hypotheses

The performance of the managed care plans operating under the expenditure authority requested in this amendment will be evaluated as part of the CalAIM Section 1115 Demonstration evaluation. These managed care plans will play an important role in testing the CalAIM Section 1115 Demonstration's existing hypotheses, including to improve quality, access, and accountability in line with the goals of the Medi-Cal program. DHCS will update the CalAIM Section 1115 Demonstration evaluation plan to incorporate this amendment and clarify the applicability of Demonstration hypotheses to these managed care plans. In addition, DHCS will continue to evaluate and monitor managed care plan performance as required under the CalAIM Section 1915(b) waiver's STCs.

Section VII. Oversight, Monitoring, and Reporting

Upon approval, California will update regular CalAIM Demonstration monitoring and reporting to reflect this amendment, consistent with the STCs and CMS policy. DHCS is committed to ensuring smooth transitions for individuals required to switch plans following implementation of the expanded COHS and Single Plan models, including through continuity of care requirements to support continued beneficiary access to providers and prevent disruptions in treatment, robust appeals and grievances processes, member communication and data sharing of member information prior to plan transition.

Section VIII. Compliance with Public Notice Process

DHCS has engaged and will continue to engage in robust stakeholder engagement around the proposed managed care model changes. Starting in mid-2021, DHCS announced the process for counties to propose model changes on its website and through its newsletter to stakeholders. Additionally, in October 2021 DHCS hosted a webinar to provide technical assistance to counties potentially interested in a model change. DHCS required counties to submit their county ordinance to demonstrate local support for the model change. DHCS reviewed the county ordinance to determine that it meets the intent of the county proposing to change their county model type effective January 1, 2024. The conditional approvals have also been posted on the model

change website, which will be updated to add other information about model changes (e.g., FAQs, timelines) as they become available. In the first half of 2022, DHCS has convened meetings to discuss model changes with stakeholders representing providers, consumer and children's advocates, and county organizations. DHCS has also convened stakeholders in model change counties and will meet with them quarterly through the end of 2022.

In July 2022, DHCS released the requisite notice for this demonstration amendment proposal, with the state public comment of August 12, 2022 through September 12, 2022. In addition to the formal public comment period, starting in the second half of 2022 and continuing into 2023, DHCS will present and discuss the model change proposal and implementation, in the context of the changes associated with both model change and the procurement results, quarterly at two of its standing advisory committees – the Stakeholder Advisory Committee (SAC) and the Managed Care Advisory Group (MCAG) – in addition to quarterly discussion with Tribal and Indian Health Program partners. DHCS will also continue to meet with other stakeholders (those not represented on the SAC and MCAG) on a regular basis. Finally, DHCS is preparing a robust member outreach and stakeholder engagement plan for 2023 to inform members and stakeholders about the model change implementation and what it will mean for members.