



INFORMATIONAL HEARING
Senate Budget and Fiscal Review Subcommittee No. 3 and
Senate Health Committee

Medi-Cal: Oversight of Managed Care Plan Responsibilities and “Medi-Cal Healthier California for All” Proposal
Wednesday, February 26, 2020 – 1:30 PM
State Capitol Room 4203

PURPOSE

Medi-Cal managed care plans (MCPs) are responsible for delivering health care to 10.5 million Californians. State and federal laws require Medi-Cal MCP to maintain an adequate network of providers who can provide quality care in a timely manner to beneficiaries. However, beneficiaries continue to face challenges in receiving care and quality of care remains uneven. This year, the Department of Health Care Services (DHCS) intends to re-procure the contracts for commercial Medi-Cal MCP and to include additional provisions in all Medi-Cal MCP contracts. At the same time, DHCS has launched a multi-year initiative aimed at improving the health outcomes of beneficiaries, known as “Medi-Cal Healthier California for All,” (MHCfA) which includes a number of new responsibilities for Medi-Cal MCP. This informational hearing will review the responsibilities Medi-Cal MCP are currently tasked with and DHCS’s role in enforcing those obligations. The Committees will also focus on the new responsibilities proposed under the MHCfA proposal. The Committees will examine how Medi-Cal MCPs will deliver services to meet the needs of beneficiaries and how DHCS will hold plans accountable to their contractual obligations.

MEDI-CAL MANAGED CARE BACKGROUND

Nearly Forty Years of Medi-Cal Managed Care. The managed care model of health care service delivery in California began in the 1970s with legislation that culminated in passage of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). Beginning in 1981, the state began licensing different models of managed care delivery for Medi-Cal beneficiaries in different counties. Today, 10.5 million Medi-Cal beneficiaries are enrolled in a Medi-Cal MCP and receive services through one of six managed care models. The six models of managed care in the Medi-Cal program are:

- 1) County Organized Health Systems. In 1982, the Legislature authorized the creation of three county organized health systems (COHS), which are county-administered Medi-Cal MCP. Santa Barbara and San Mateo Counties were the first COHS plans to enroll beneficiaries (a COHS was planned in Monterey, but was never implemented), while Congress approved three additional COHS (Santa Cruz, Solano, and Orange) counties in 1990. The authorization for COHS requires that they be an independent, public entity and that they meet the regulatory requirements of the state's Knox-Keene Act. However, they need not obtain a license under the Knox-Keene Act, as they are specifically exempted. There are currently twenty-two counties in the COHS model: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo. Eight of these counties (Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity) were part of the expansion of Medi-Cal to rural counties implemented in 2012. Beneficiaries in these counties receive services through Partnership Health Plan of California.
- 2) Geographic Managed Care. In 1992, DHCS designated Sacramento County as a geographic managed care (GMC) county, which allowed many plans to operate within the county to provide services to Medi-Cal beneficiaries. In 1998, San Diego also became a GMC county, and both counties currently contract with several commercial health plans with the goal of providing more choice to beneficiaries. As these plans are commercial plans, they are required to be licensed under the Knox-Keene Act. Sacramento and San Diego remain the only two GMC counties in the state.
- 3) Two Plan Model. In 1995, as part of a significant expansion of Medi-Cal managed care, twelve counties were designated to participate in a new Two Plan Model for managed care delivery. Under this model, one county-developed plan, a local initiative, offers services alongside a commercial plan. Both plans are required to be licensed under the Knox-Keene Act. There are currently fourteen Two Plan Model counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Los Angeles' local initiative, L.A. Care, subcontracts with several other managed care plans to provide services to Medi-Cal beneficiaries.
- 4) Regional Model. AB 1467 (Committee on Budget, Chapter 23, Statutes of 2012) authorized the expansion of Medi-Cal managed care into 28 rural counties not previously operating managed care plans. These counties phased in between November 2013 and December 2014. Eight counties transitioned into the COHS model, while 18 counties transitioned into a new regional model, including: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba. Beneficiaries in these counties receive services through either Anthem Blue Cross or California Health and Wellness.
- 5) Imperial Model. Imperial County was one of the 28 county counties in the rural county expansion. Rather than join the 18 counties under the regional model or transition into a COHS, Imperial County established a Local Health Authority Commission (Commission) that provides oversight over the Medi-Cal managed care program in the county. Beneficiaries in

the Imperial County receive services through two commercial Medi-Cal MCPs. The Commission selects one commercial Medi-Cal MCP, which, in addition to the contract with DHCS, must also meet local contract provisions established by the Commission, and DHCS selects the other.

- 6) San Benito Model. The rural county expansion also brought managed care to San Benito County. Unlike the rest of the state, beneficiaries in San Benito County receive services through either Anthem Blue Cross, or fee-for-service Medi-Cal.

Procurement of Commercial Medi-Cal MCPs. DHCS has announced that it plans to conduct a procurement of commercial Medi-Cal MCPs this year. The procurement will impact commercial Medi-Cal MCPs operating in counties under the Two-Plan Model, GMC, and Regional expansion, including Imperial and San Benito counties. DHCS plans to release the Request for Proposal for these model types later this year and anticipates staggering implementation to occur in January 2023 or January 2024. Through procurement, DHCS will solicit proposals from commercial MCPs to provide Medi-Cal services under the new managed care contract. DHCS may continue to award contracts to plans currently providing services in each county, award contracts to different plans in each county, or consider changes to the Medi-Cal managed care model in a county. In addition, DHCS will likely incorporate several new service and oversight requirements into the new contracts, particularly those related to the department's MCHfA initiative (see section on *MCHfA* below).

NETWORK ADEQUACY AND QUALITY OVERSIGHT

All Medi-Cal MCPs contracted to provide services to beneficiaries must comply with federal and state Medicaid laws and regulations. Most Medi-Cal MCPs must obtain a license under the Knox-Keene Act and, therefore, must also meet regulations set by Department of Managed Health Care (DMHC), which provides oversight of the commercial managed care market. Only COHS plans are exempted from Knox-Keene licensure.

Knox-Keene Act Network Adequacy Requirements. The Knox-Keene Act imposes various network adequacy requirements on Medi-Cal MCPs, designed to provide timely access to necessary medical care for those plans' beneficiaries. These requirements generally include the following standards for appointment availability:

- 1) Urgent care without prior authorization: within 48 hours;
- 2) Urgent care with prior authorization: within 96 hours;
- 3) Non-urgent primary care appointments: within 10 business days;
- 4) Non-urgent specialist appointments: within 15 business days; and,
- 5) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition: within 15 business days.

MCPs are also generally required to ensure that:

- 1) Primary care physicians are located within 15 miles or 30 minutes of a beneficiary's place of residence; and,

2) MCP networks include one primary care provider for every 2,000 beneficiaries.

Although COHS plans are not required to have a Knox-Keene license, DHCS' sample contract with COHS plans includes the same or greater network adequacy and timely access requirements as the Knox-Keene Act.

Medicaid Managed Care Regulations Expanded Network Adequacy Requirements. In May 2016, the Center for Medicare and Medicaid Services (CMS) finalized regulations (known as the Final Rule) for state Medicaid programs with beneficiaries served by managed care organizations. AB 205 (Wood, Chapter 738, Statutes of 2017) and SB 171 (Hernandez, Chapter 768, Statutes of 2017) codified in state law specific requirements for Medi-Cal managed care related to implementation of the Final Rule. In particular, these bills manage the implementation of the 85% medical loss ratio for Medi-Cal MCPs and establish time and distance and appointment availability standards for the various classes of providers covered by the new federal regulations. These standards are as follows:

- Primary care providers: **10 miles or 30 minutes** from the beneficiary's place of residence;
- Hospitals: **15 miles or 30 minutes** from the beneficiary's place of residence;
- Dental managed care: **10 miles or 30 minutes** from the beneficiary's place of residence;
- Obstetrics and gynecology: **10 miles or 30 minutes** from the beneficiary's place of residence;
- Specialists, including cardiology/interventional cardiology, nephrology, dermatology, neurology, endocrinology, ophthalmology, ear, nose, and throat/otolaryngology, OB-GYN specialty care, orthopedic surgery, gastroenterology, physical medicine and rehabilitation, general surgery, psychiatry, hematology, oncology, and pulmonology, HIV/AIDS specialists/infectious diseases, and outpatient mental health services:
 - 1) **15 miles or 30 minutes** from the beneficiary's place of residence: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara;
 - 2) **30 miles or 60 minutes** from the beneficiary's place of residence: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura;
 - 3) **45 miles or 75 minutes** from the beneficiary's place of residence: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba;
 - 4) **60 miles or 90 minutes** from the beneficiary's place of residence: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne;
- Pharmacy services: **10 miles or 30 minutes** from the beneficiary's place of residence (all counties);
- Outpatient substance use disorder services other than opioid treatment programs:

- 1) **15 miles or 30 minutes** from the beneficiary's place of residence: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara;
 - 2) **30 miles or 60 minutes** from the beneficiary's place of residence: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura;
 - 3) **60 miles or 90 minutes** from the beneficiary's place of residence: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba;
- *Opioid treatment programs:*
 - 1) **15 miles or 30 minutes** from the beneficiary's place of residence: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara;
 - 2) **30 miles or 60 minutes** from the beneficiary's place of residence: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura;
 - 3) **45 miles or 75 minutes** from the beneficiary's place of residence: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba;
 - 4) **60 miles or 90 minutes** from the beneficiary's place of residence: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne;
 - *Skilled nursing facility and intermediate care facility services:*
 - 1) **Within five business days** of the request: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara;
 - 2) **Within seven business days** of the request: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura;
 - 3) **Within fourteen calendar days** of the request: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba;
 - 4) **Within fourteen calendar days** of the request: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne;
 - *County Drug Medi-Cal-Organized Delivery System (DMC-ODS):* appointment within **three business days** to an opioid treatment program;
 - *Dental managed care plan services:*
 - 1) **Routine pediatric services:** appointment within **four weeks** of a request; and,
 - 2) **Specialist pediatric services:** appointment within **thirty calendar days** of a request.

Alternative Access Standards. AB 205 allows DHCS to permit Medi-Cal MCPs to adhere to alternative access standards that deviate from any of the required time and distance requirements if either of the following occur:

- The MCP has exhausted all other reasonable options to obtain providers to meet the applicable standard; and,
- DHCS determines the MCP has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

In February 2018, DHCS released an All Plan Letter (18-005) that outlines the process for plans to request an alternative access standard. Plans must submit requests no later than 105 days prior to the beginning of the contract year and requests must be submitted for specific zip codes and provider types. The application requires plans to include a variety of information related to provider availability in the affected regions, including the impacted provider types, geographic information about the nearest in-network and out-of-network providers to affected beneficiaries, number of beneficiaries impacted, and the proposed alternative standards for time and/or distance.

The Knox-Keene Act also allows DMHC to permit health plans to adhere to an alternative access standard. According to DMHC, the Knox-Keene Act allows a health plan to request an alternate geographic access standard when it is unable to provide enrollee access to a primary care physician or a hospital within 15 miles or 30 minutes from where enrollees live or work. This occurs most frequently in rural areas of the state. DMHC considers alternate geographic access requests in accordance with the numerous factors set forth in timely access regulations, including but not limited to analyses of established patterns of practice in the marketplace, as well as the existence of geographically closer providers.

The initial implementation of the AB 205 time and distance standards resulted in nearly 80,000 requests for an alternative access standard submitted to DHCS. While the number of requests and approved standards decreased in the next year, the high volume of requests was significantly more than anticipated. As a result, the Legislature passed and the Governor signed AB 1642 (Wood), Chapter 465, Statutes of 2019, which requires DHCS to place more scrutiny on alternative access standard requests and requires plans to take additional steps to ensure beneficiaries are able to access covered services.

Oversight of Quality. The Final Rule also requires DHCS to implement a written quality strategy to assess and improve the quality of health care and services provided by its contracted managed care plans. In 2018, DHCS released two quality strategy reports: the Managed Care Quality Strategy Report, which was issued to comply with the Final Rule; and, the DHCS Strategy for Quality Improvement in Health Care, which has been released annually since 2012 and describes DHCS quality strategy for both managed care and fee-for-service. In 2019, DHCS announced a new 2020 Comprehensive Quality Strategy that will combine the content of the two 2018 reports.

To measure and assess quality, beginning in 2019, DHCS requires all Medi-Cal MCPs to report yearly on a set of quality measures derived from measures established by CMS, known as the CMS Child and Adult Cores Sets. In these measures, Medi-Cal MCPs are required to perform at least as well as 50% of Medicaid plans (50th percentile) in the United States. For measures where there is

not enough information to establish a 50th percentile, DHCS intends to establish alternative benchmarks for those measures in the future. Previously, Medi-Cal MCPs were only required to perform at the 25th percentile to meet DHCS's minimum performance level benchmark. DHCS also contracts with an External Quality Review Organization (EQRO) to prepare an annual, independent technical report on beneficiary access to and quality of care, which in part, includes an analysis of the reported managed care quality measures. The EQRO also performs an encounter data validation report, to ensure that data being reported by plans reflects beneficiary medical records, and reports health disparity information for select performance measures. When a Medi-Cal MCP is out of compliance with quality benchmarks, DHCS can place plans on a corrective action plan, impose sanctions (including financial penalties), or both at the same time.

MEDI-CAL MANAGED CARE RATES

Like other managed care plan arrangements, Medi-Cal MCPs are paid a set monthly premium for every enrolled beneficiary in a plan for a given plan. This is also known as the base capitation payment or the per-member-per-month payment. DHCS develops plan rates by four primary managed care models (COHS, GMC, Two-Plan and Regional Expansion¹). Rates within each model are developed at a county specific or regional level. Medi-Cal MCPs then determine how much to pay their contracted providers. Federal rules prohibit DHCS from directing how much a plan pays its providers unless the payment has been approved by the CMS and meets certain guidelines.

DHCS' Capitated Rate Development Division develops capitation rates in consultation with its contracted actuary, Mercer. Once rates have been developed, Mercer provides the actuarial soundness certification required by federal regulations. Historically, the rate development process resulted in a rate range, which represented the minimum and the maximum actuarially sound capitation payment that could be supported by encounter and claims data. DHCS typically paid the minimum rate in the range, which allowed for other governmental entities to provide additional nonfederal dollars up to the maximum of the rate range to draw down additional federal matching funds. Since 2016, the Final Rule requires certification of a single rate. As a result, DHCS is implementing a prospective rate-setting process, with a one-time 18-month bridge rate-setting period from July 1, 2019 to December 31, 2020. Beginning calendar year 2021, all rates will be developed prospectively on an annual basis.

Actuarially Sound Capitation Rates. Federal law² requires federal matching funds paid to a state for MCP capitation payments be actuarially sound. Federal regulations³ define actuarially sound capitation rates as rates that:

- Have been developed in accordance with generally accepted actuarial principles and practices;
- Are appropriate for the populations to be covered and the services to be furnished under the contract; and,

¹ Regional expansion includes San Benito and Imperial Counties.

² Section 1396b(m)(2)(A)(iii) of Title 42 of the United States Code

³ Section 438.6(c)(1)(i) of Title 42 of the Code of Federal Regulations

- Have been certified as meeting these requirements by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

In addition, federal law⁴ requires state Medicaid programs to provide payment for available care and services “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”

CHALLENGES IN RECEIVING CARE

A number of recent reports highlight challenges Medi-Cal beneficiaries face when seeking to access care. Some reports indicate there are access and delivery of care issues across the Medi-Cal system. For instance, in March 2019 and January 2020, the California State Auditor’s Office (CSA) released two reports related to preventive services for children covered under Medi-Cal. Report 2018-111, released in March, concluded that millions of children in Medi-Cal did not receive preventive services to which they are entitled. The report noted low utilization of required children’s preventive services and indicated especially poor performance for mandatory services where DHCS did not establish standards to monitor performance. Moreover, the report indicated a lack of awareness for children’s preventive services among plans, providers, and beneficiaries, and recommended DHCS do more to enforce the contractual obligations of Medi-Cal MCPs to make sure children receive services. CSA also noted that a lack of providers, especially providers who meet beneficiaries’ cultural and linguistic needs, contributes to poor utilization and outcomes. Further highlighting the challenges for children receiving care under Medi-Cal, CSA issued another audit in January 2020, Report 2019-105, that reported millions of children in Medi-Cal have not received required testing for lead poisoning.

Other reports suggest that Medi-Cal system-wide issues are being exacerbated by regional or Medi-Cal managed care model specific challenges. Report 2018-122, released in August by CSA, concluded that Medi-Cal beneficiaries residing in rural counties under the Regional Model received inadequate access to care and quality of care. Rural areas, in general, struggle to attract and maintain a sufficient number of providers to meet the needs of residents. CSA’s report found that some beneficiaries receiving care may have had to travel hundreds of miles to receive medical care from in-network providers, even though another out-of-network provider, who was contracted with a different Medi-Cal MCPs, may have been closer. Therefore, in a region that especially lacks providers, the inability of Medi-Cal managed care to contract with providers who do reside in the area worsens access challenges for beneficiaries.

Provider Participation May Not Be Keeping Pace With Enrollment. In 2012-13, just prior to the implementation of the Affordable Care Act, 5.1 million Californians were enrolled in Medi-Cal managed care. According to the Governor’s January budget, 2019-20 enrollment in Medi-Cal managed care is projected to be 10.5 million, an increase of 206% over 2012-13. While this significant increase in coverage has provided measurable health benefits to lower-income Californians, it is unclear whether Medi-Cal managed care plan provider networks have been able

⁴ Section 1396a(a)(30)(A) of Title 42 of the United States Code

to keep pace with the sharp rise in enrollment. A June 2017 report from the California Health Care Foundation titled “*Physician Participation in Medi-Cal: Is Supply Meeting Demand?*” surveyed physicians renewing licensure in 2015 to gauge participation in the Medi-Cal program. The report found that, between 2013 and 2015, the percentage of physicians serving Medi-Cal patients decreased from 69% to 64%, although the overall number of full-time equivalent physicians serving Medi-Cal patients increased by nine percent, likely due to previously uninsured patients seen by these physicians gaining coverage under the Medi-Cal expansion. However, the report also found this modest increase in full-time equivalent physician participation did not keep pace with the growth in enrollment, as the number of full-time equivalent physicians for each 100,000 Medi-Cal beneficiaries declined significantly. For primary care physicians, there were 39 full-time equivalents in 2015 compared to 59 in 2013, a 33.9% decline. For non-primary care physicians, there were 63 full-time equivalents in 2015 compared to 91 in 2013, a 30.8% decline.

MEDI-CAL HEALTHIER CALIFORNIA FOR ALL

In October 2019, DHCS released a broad, sweeping, multi-year initiative aimed at improving the health outcomes of beneficiaries in Medi-Cal, known as MHCfA. MHCfA anticipates the end of Medi-Cal 2020, California’s current section 1115 waiver and transfers the state’s Medi-Cal managed care program under the authority of a federal 1915(b) waiver. It also proposes a number of initiatives on system delivery and payment reform, which will impact the Medi-Cal program broadly, including Medi-Cal MCPs, county behavioral health, beneficiary eligibility and benefits, county administration and services, and many other parts of the health care safety net. Since the release of MHCfA, DHCS has convened stakeholder workgroups to receive feedback on various components of the proposal. Implementation activities for MHCfA initiatives have been proposed for 2020 through 2026. DHCS continues to receive feedback on MHCfA proposals and intends to share updated versions in early April 2020. DHCS intends to submit its 1915(b) waiver to CMS in June 2020.

New MCP Responsibilities. DHCS indicates a number of changes proposed under MHCfA would be implemented as new Medi-Cal managed care plan contract requirements. These proposals would constitute a significant expansion of Medi-Cal managed care plan responsibilities. Key initiatives slated to fall under the Medi-Cal managed care plan responsibility include:

- *Population Health Management (PHM).* MHCfA requires Medi-Cal MCPs to develop and maintain a population health PHM program, defined as a model of care and a plan of action designed to address member health needs at all points along the continuum of care. The PHM program requires plans to annually file a PHM plan with DHCS, which would include a description of how the plan assesses the health status of plan members and a description of services to meet member needs, including existing wellness and prevention services and case management. Among the PHM program requirements, the member health status assessment requirement includes:
 - Risk Assessment and Stratification – The PHM program requires a Medi-Cal MCPs to conduct an individual assessment of each plan member using DHCS-specified and other data sources. The plan will then stratify or segment their members into four categories of risk (low, medium/rising, high, or unknown). The criteria for each tier of risk will be

determined by DHCS. Each MCP member will be assigned a risk tier based on a risk assessment algorithm. Each MCP may have a different algorithm to stratify or segment their member population but must adhere to DHCS guidelines for identifying and mitigating algorithm bias (such as race, language, functional status or other disparities). At this time, it is unclear how or if risk tiers will be consistent across MCPs. Moreover, DHCS currently intends for risk assessment and stratification to be used for reporting purposes only.

- Individual Risk Assessment (IRA) – For a plan member with medium/rising, high, or unknown risk, or if a plan assesses a member to have medium/rising or high risk, the plan must administer an IRA survey tool. DHCS would develop a standardized, 10-15 question survey—one for adults and one for children. The IRA would replace a number of existing member evaluation and survey assessment tools. The MCPs would be required to make at least three attempts to contact the member to administer the IRA or to partner with providers to complete the assessment on the MCP’s behalf.
- *Enhanced Care Management (ECM)*. The PHM plan would also require a plan to describe how it will deliver a newly created ECM benefit, which is intended to build upon and ultimately replace the Whole Person Care (WPC) and Health Homes pilot programs. ECM would be a mandatory benefit for beneficiaries determined by the MCP to be at the highest level of risk and for designated mandatory populations including: 1) high utilizers with frequent hospital or emergency room visits; 2) individuals at risk for institutionalization with serious mental illness, children with serious emotional disturbance or substance use disorder with co-occurring chronic health conditions; 3) individuals at-risk for institutionalization and eligible for long-term care; 4) nursing facility residents who want to transition to the community; 5) children or youth with complex physical, behavioral, developmental, and oral health needs; and 6) individuals experiencing chronic homelessness or at risk of becoming homeless.

Under ECM, care managers would engage in frequent and in-person contact with beneficiaries and their families. The care managers would conduct needs assessments, coordinate care planning processes, and be the beneficiary’s primary point of contact for securing all physical, behavioral, long-term care, developmental, oral, social, and psychosocial care. Care managers would connect beneficiaries with providers and social service systems, identify and coordinate in-lieu-of services, assist in transitions between care settings, provide beneficiary and family education and support to improve treatment adherence and medication management, navigate beneficiaries’ connection to community and social services, and assist beneficiaries in obtaining housing.

- *In Lieu of Services (ILOS)*. DHCS is proposing to use existing federal authority to allow plans to provide ILOS benefits. ILOS are medically appropriate and cost-effective alternatives to covered Medi-Cal services and are typically delivered by a different provider, or in a different setting than a traditional Medi-Cal service. DHCS proposes ILOS to dovetail with ECM to replace services currently offered under WPC and Health Homes. ILOS services would be voluntary for Medi-Cal MCP to provide and for beneficiaries to accept. However, a Medi-Cal MCP would be required to identify which ILOS services it intends to provide from a list of 13 ILOS services designated by DHCS. Once an ILOS service is identified by a plan, it must be

offered to all eligible beneficiaries if medically appropriate and cost-effective. The 13 ILOS services are as follows:

- Housing Transition/Navigation Services – These services assist beneficiaries with obtaining housing and include assessing a beneficiary’s housing needs, developing a housing support plan, navigating housing options and applications, assisting with advocacy and securing available income and housing subsidy resources, assisting with reasonable accommodation and move-in readiness, and coordinating necessary environmental modifications;
- Housing Deposits – These services assist beneficiaries with securing or funding one-time housing services that do not constitute room and board including security deposits, setup fees or deposits for utilities or other services, first month coverage of utilities, first and last month’s rent if required for occupancy, health and safety services such as pest eradication or cleaning upon moving in, and medically necessary adaptive aids and services such as air conditioners or air filters;
- Housing Tenancy and Sustaining Services – These services assist beneficiaries in maintaining safe and stable tenancy after housing is secured including early identification and intervention for behaviors that may jeopardize housing, education and training on rights and responsibilities of tenants and landlords, coordination and assistance to maintain relationships with landlords and resolve disputes, advocacy and linkage to community resources to prevent eviction, health and safety visits, unit habitability inspections, and training for independent living and life skills;
- Short-Term Post-Hospitalization Housing – These services may include supported housing in an individual or shared interim housing setting and are designed to assist beneficiaries who are homeless and who have high medical or behavioral health needs with the opportunity to continue their recovery immediately after exiting an inpatient hospital, substance abuse or mental health treatment facility, custody facility, or recuperative care;
- Recuperative Care (Medical Respite) – These services provide short-term residential care for beneficiaries who no longer require hospitalization, but still need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment. At a minimum, the service would include interim housing with a bed and meals with ongoing monitoring of the beneficiary’s condition. The service may also include limited or short-term assistance with activities of daily living, coordination of transportation to post-discharge appointments, connection to other necessary health and human services benefits or housing, or stabilizing case management relationships and programs;
- Caregiver Respite – These services provide relief to caregivers of beneficiaries who require intermittent temporary supervision and may be provided by the hour on an episodic basis, by the day or overnight, or include services that attend to the beneficiary’s basic self-help needs or other activities of daily living;

- Day Habilitation Programs – These services assist beneficiaries in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the beneficiary’s natural environment. These services may include training or assistance with the use of public transportation, personal skills development in conflict resolution, community participation, developing and maintaining interpersonal relationships, daily living skills, community resource awareness (e.g. police, fire, other local services), selecting and moving into a home, locating and choosing suitable housemates, locating household furnishings, settling disputes with landlords, managing personal financial affairs, managing needs for personal attendants, dealing with and responding to governmental agencies and personnel, asserting rights through self-advocacy, and coordinating health and human services benefits;
- Nursing Facility Transition/Diversion to Assisted Living Facilities – These services assist beneficiaries to live in the community or avoid institutionalization by transitioning to a Residential Care Facility for Elderly and Adult (RCFE) or Adult Residential Facility (ARF). These services, which do not include room and board, may include assessing housing needs and presenting options, assessing onsite service needs at the RCFE or ARF, assisting in securing a residence, communicating with facility administration and coordinating the move, establishing procedures and contacts to maintain housing placement, and coordinating with enhanced care management or other ILOS necessary for stable housing;
- Nursing Facility Transition to a Home – These services assist beneficiaries to live in the community and avoid institutionalization by transitioning to a private residence. These services, which do not include room and board, may include assessing housing needs and presenting options, assisting in securing housing, communicating with landlords and coordinating the move, establishing procedures and contacts to maintain housing placement, and coordinating with enhanced care management or other in-lieu-of services necessary for stable housing;
- Personal Care and Homemaker Services – These services assist beneficiaries with activities of daily living such as bathing, dressing, toileting, ambulation, or feeding. These services also assist beneficiaries with instrumental activities of daily living such as meal preparation, grocery shopping and money management. These services are provided in addition to any approved In-Home Supportive Services (IHSS) benefits approved by the county or during any IHSS waiting period;
- Environmental Accessibility Adaptations (Home Modifications) – These services provide physical adaptations to a home that are necessary to ensure the health, welfare, and safety of a beneficiary, or enable the beneficiary to function with greater independence in the home. Adaptations may include installation of ramps and grab-bars, doorway widening for beneficiaries who require a wheelchair, installation of stair lifts, bathroom or shower accessibility, installation of specialized electric or plumbing systems to accommodate medical equipment or supplies, installation and testing of a Personal Emergency Response System for beneficiaries who are alone for significant parts of the day without a caregiver and otherwise require routine supervision;

- Meals/Medically Tailored Meals – These services help beneficiaries achieve nutrition goals at critical times to help them regain and maintain their health and may include meals delivered to the home immediately following discharge from a hospital or nursing facility, or medically-tailored meals provided to the beneficiary at home to meet the unique dietary needs of a chronic condition; and,
- Sobering Centers – These services provide a safe, supportive environment to become sober for individuals found to be publicly intoxicated and who would otherwise be transported to an emergency department or jail. These services also include medical triage, lab testing, a temporary bed, rehydration, and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, homeless care support services, and screening and linkage to ongoing supportive services.
- *Long-term Services and Supports (LTSS) Integration.* DHCS proposes to make several changes to the delivery system for LTSS that build upon the state’s dual demonstration project, the Coordinated Care Initiative (CCI). In the seven CCI demonstration counties, all Medi-Cal beneficiaries currently are required to receive LTSS benefits through a MCP, including institutional long-term care provided in skilled nursing facilities, pediatric and adult subacute care facilities, intermediate care facilities for individuals with developmental disabilities, disabled/habilitative/nursing services, and specialized rehabilitation in a skilled nursing facility or intermediate care facility. Beginning January 2021, DHCS would transition all LTSS services into managed care for non-dual-eligible managed care beneficiaries statewide. In addition, DHCS plans to discontinue Cal MediConnect, the MCPs under CCI that coordinate Medi-Cal and Medicare benefits for dual eligible beneficiaries, on December 31, 2022, at the end of the federal demonstration period. The proposal would require Medi-Cal MCPs to operate Dual Eligible Special Needs Plan, federally authorized health plans that coordinate Medi-Cal and Medicare services for dual eligible beneficiaries, and transition dual eligible into managed care for LTSS benefits, beginning January 1, 2023.

Regional rate setting. Under MHCfA, DHCS would move towards a regional managed care rate-setting methodology to simplify capitation payments for Medi-Cal MCPs. DHCS reports that it currently calculates more than 4,000 individual rates, one for each beneficiary category in each MCP. According to DHCS, this level of complexity limits the ability to advance value-based and outcomes-focused rate setting methodologies and complicates annual federal approval of managed care rates. DHCS believes regional rate-setting would incentivize efficiencies through competition with other regional plans and provide a larger, multi-county base for averaging rate components. DHCS proposes a two phased approach to the transition to regional capitated rate-setting:

- Phase I: Targeted Counties – During calendar year 2020, DHCS would engage and collaborate with Medi-Cal MCPs to advance new regional rate-setting approaches and streamline rate processes and methodologies in targeted counties. Beginning January 1, 2021, DHCS would implement regional rate-setting in targeted counties. The MHCfA proposal does not identify these counties or what aspects of a county would be make it eligible for this targeted approach; and,

- Phase II: Statewide – After evaluating and refining the regional rate-setting processes implemented in Phase I, DHCS would implement regional rate-setting statewide beginning no sooner than January 1, 2023.

National Committee for Quality Assurance Accreditation. The National Committee for Quality Assurance (NCQA) is a private, non-profit organization that reports measures of healthcare quality and offers accreditation for MCPs. NCQA is responsible for the Healthcare Effectiveness Data and Information Set (HEDIS), which measures more than 90 measures across six domains of care for managed care plans, consumers, and public agencies to evaluate and encourage performance improvement. NCQA also offers accreditation to MCPs and other health care-related entities in the areas of quality improvement, population health management, network management, utilization management, credentialing, member rights and responsibilities, and member connections. Under MHCfA, DHCS would require all Medi-Cal MCPs to be accredited by the NCQA by 2025 and to meet NCQA standards as part of the new PHM program. In addition to requiring accreditation, DHCS would use information obtained from the accreditation review to satisfy certain state and federal oversight requirements of Medi-Cal MCPs. DHCS would no longer conduct independent oversight of these requirements, but would instead focus on more robust oversight of other requirements, such as annual medical audits. For example, DHCS would no longer conduct independent oversight of denials of limits on services, compliance with procedures for grievances and appeals, appropriate translation of written materials, and updates to plan provider directories. These requirements and others have been the subject of recent legislation as well as legislative oversight hearings.