# Transforming Med-Cal Managed Care Through Statewide Procurement

*February 15, 2022*

## Transcript

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| VISUAL | TIME AND SPEAKER | AUDIO |
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| Slide 1 | 00:00:00 – Julian Ward | Hello and welcome. My name is Julian and I will be in the background answering any Zoom technical questions. If you experience difficulties during this session, please type your question into the Q&A and a producer will respond. We encourage you to submit written questions for your speakers at any time using the same Q&A panel. During today's event, live closed captioning will be available. You can find the link in the chat field. With that I would like to introduce Michelle Baass. Michelle, you now have the floor. |

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| Slide 1 | 00:00:37 -- Michelle Baass | Thank you and welcome. Before we begin, we wanted to note that today's webinar is an all-comer webinar. Given the breadth of changes to the Medi-Cal managed care contract starting on January 1st, 2024, we wanted to provide an opportunity to review the new contract with our valued stakeholders. At today's meeting we will not answer RFP or technical questions. Next week on February 24th, we will have the proposer or bidder conference where RFP and technical questions can be answered.<br><br>Last week on February 9th, we released a request for proposal to commercial managed care contractors and a new restructured, more robust contract. This new contract will be implemented across all plan model types, commercial and managed-care plans, county organized health systems local initiative plans, and the new single plan model type.<br><br>With this new contract the State is embarking on new relationships with managed-care plans. The goal is to enhance how care is delivered to Medi-Cal enrollees by addressing health equity, quality, access, accountability and transparency of the healthcare delivery system. We will discuss the new requirements related to these priorities in greater detail today.<br><br>California relies on our Medi-Cal managed-care plans to implement the State's responsibility to provide Medicaid services. As such we must insist on partners committed to this charge. With over 14 million Californians enrolled in Medi-Cal and over 99 percent expected to be enrolled in managed care in 2024, it is a cornerstone of the state healthcare system and can set the pace for transformation of |

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| | | the entire sector. Partnering with managed-care plans that meet or exceed these requirements, further amplifies and strengthens the state's unprecedented recent investment in California's health and well-being. These investments are centered around the administration and department's vision for Medi-Cal, which is founded on equity, better health outcomes, improved accountability for results, capacity building and overall advancement of opportunities for vulnerable Californians.<br><br>Some of these investments include CalAIM, the expansion of Medi-Cal to undocumented individuals, investments in the behavioral health continuum and our comprehensive quality strategy. This contract is a point in time document and will be updated before final execution and as policies are refined, such as to fully reflect CalAIM requirements by the federal CMS. This contract serves as the minimum definition of requirements, as All Plan Letters will be used to implement many of the provisions of this contract and will include additional details and guidance necessary to operationalize these requirements or appropriately evolve expectations on the needs of beneficiaries and additional opportunities to improve services.<br><br>Thank you again for joining us today, we look forward to the discussion and partnership as we transform our healthcare delivery system and get closer to achieving our vision for quality and equitable health care in California. Thank you. With that, I turn it over to deputy director Susan Philip. |

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| Slides 2 -12 | 00:03:45 - Susan Philip | Hello, I am Susan Philip, Deputy Director for Healthcare Delivery Systems at the Department of Health Care Services. Today we will be giving a broad overview of the transformation underway in Medi-Cal managed care, as Michelle said specifically through the recently released commercial managed-care procurement and the new requirements that will be in place for all managed-care plan partners.<br><br>As Michelle did mention, there will be a specific call for proposers who are interested in responding to the procurement and that will be on February 24th so please tune into that if you are interested in responding. This call is not specific to responding to questions for the procurement but is really about providing an overview of the key contract requirements.<br><br>So, I just wanted to give an overview of the timeline. For commercial managed-care plans participating in the RFP, responses are due April 11th and DHCS intends to announce the intent to award in August. The procurement is for commercial plans, but all managed-care plans will be subject to a contract in 2024. In addition, all plans will need to go through the readiness assessment including those participating in the RFP and those participating in model-change counties. So, readiness is again for all plans in all counties and will be conducted later in 2022 and through 2023. So throughout 2022, we will be engaging with counties and plans that are interested in participating in the county plan model change and will be keeping our website updated with additional information on county plan model change information as well as our plan readiness submission requirements and timeline. |

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| | | So as Michelle said, Medi-Cal is essential to California's delivery system, and Medi-Cal managed care plans are really core to how Medi-Cal delivers services to our members. By 2024, 99 percent of our Medi-Cal beneficiaries will be enrolled in Medi-Cal managed care and so therefore it is really essential to how we deliver care for our members, Medi-Cal beneficiaries, and really sets the pace for transforming the state's entire healthcare system.<br><br>Medi-Cal managed-care today offers six models and varies by county. By 2024, we anticipate having four planned models. Seventeen counties have opted to change the type of managed-care model type that they participate in and they all have received approval from DHCS, conditional approval, including new single-plan models that are similar to the current county organized health care system models or COHS. So, these changes will all take effect January 2024, pending federal approval and plan readiness, as I mentioned before. And that will all take place -- the plan readiness review will be conducted in parallel with the new commercial managed-care RFP process as well.<br><br>So the ultimate result of all these changes is that really, Medi-Cal members in many counties will have a new mix of managed-care plans available to them to select from in January 2024 and those plans, statewide, will be held to new standards as outlined in the contract which we will be reviewing. And together, DHCS anticipates that these changes will drive improved health equity, quality, access and accountability and transparency for all our Medi-Cal members. |

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| | | And there are really three pillars of changes underway. First, we've got the commercial plan procurement, as we mentioned, and again this is the first statewide re-procurement of commercial managed-care plans through the RFP released last week. The second is the model change, and again this is in 17 counties. There is expansion of partnership health plan and Central California Alliance for Health and COHS in new counties. There is the establishment of new local initiatives for regional counties that are moving to two-plan models and a selection by counties to operate in new single plan model types. So, again, all these plan model changes will need to meet the same readiness standards and contract provisions as the commercial plans procured through the RFP process before the model change can take effect in January 2024.<br><br>And then we have the third, which is the Kaiser contract. So DHCS plans to enter into a direct contract with Kaiser. This is in addition to the Medi-Cal managed-care models. And, so, in January 2024, a new Kaiser contract option will be available for members who are enrolled in a Kaiser plan, so there can be continuity of care. So, this will be an option for members who are enrolled in another Kaiser line of business and then are becoming Medi-Cal eligible. It will be available for dually eligible members who have Medicare and Medi-Cal coverage, and Kaiser will also be an option for foster children and youth. To make clear, Kaiser will be subject to the same contract. The one exception is that Kaiser will not be open to traditional Medi-Cal plan choice options, but all other standards and requirements in the new managed-care plan contract will apply. |

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| | | The Kaiser contract will operate in 22 counties where Kaiser currently participates as a Medi-Cal managed care plan, as well as eventually in an additional ten counties where Kaiser operates in other lines of business. By directly contracting with Kaiser as opposed to the current subcontracting status with other managed care plans, DHCS really anticipates removing layers of complexity and bureaucracy to the system. So, this change will also need to go through federal approval and will be working through that over the next several months. Let's go to the next slide.<br><br>So as Michelle said, this is really aligning with DHCS's vision for Medi-Cal. It's really aligning with CalAIM and the overall framework on the infrastructure and tools that CalAIM makes available statewide, really driving that whole system, whole person population health approach, and driving that integrated system of care. It builds on investments, as Michelle pointed out earlier, through the children and youth behavioral health initiative, through the behavioral health continuum infrastructure. There are investments into our home and community-based services that the procurement is really driving. And there is also, of course, the comprehensive quality strategy, which includes program specific objectives and metrics that really demonstrate the state's commitment to quality and equity. So all of these efforts are aligned in the procurement and the plan contract is many ways to anchor these initiatives and drive these initiatives through the contract and through the work of our plan partners who will work with DHCS and our communities to drive these initiatives. We can go to the next slide, and then the next slide. |

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| | | So for the rest of the presentation, we will walk through each of the different areas where the contract -- where there are new initiatives and new provisions and where there are those robust provisions to really improve and drive improvements in our Medi-Cal delivery system as a whole. The first one I will walk through is transparency. Next slide.<br><br>So, to ensure transparency, plan partners will be required to publicly report on access, quality improvement and health equity activities. This includes not only their own activity, but also the activity of their subcontractors in terms of their performance, including consumer satisfaction. Specifically, managed-care plans will be required to post their community investment plan, their population needs assessment, the results of the consumer assessment of healthcare providers and systems or CAHPS, which is a survey, as well as community advisory committee activities, which includes meeting minutes, notices, as well as the activities from the community advisory committee. This is really to demonstrate that the input that is provided by the community advisory committee has really considered when the plan is making decisions and really making policy decisions for the plan as a whole and for members.<br><br>Managed care plans will be required to share more information about their quality improvement and health equity activities, as well as their financial performance, such as profits and reserves. Managed care plans will also need to be more transparent about their arrangements with subcontractors, including posting quality and financial performance results, other subcontractors and having a memorandum of understanding with |

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| | | third parties. We will get into that in a little more detail.<br><br>So, our goal is really, in terms of transparency, is to help ensure that the public posting and reporting will not only further transparency, but ultimately help inform members' choice of health plans. You can go to the next slide and I will turn it over to Dr. Palav Babaria. |

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| Slides 13 – 16 | 00:14:50 – Palav Babaria | Hello, I am Palav Babaria, Chief Quality Officer and Deputy for Quality and Health Management for DHCS. So, in terms of high-quality care, this is obviously one of the key goals of the procurement. The new contract strengthens quality expectations for MCPs in several ways. Generally, plan partners must create a culture of continuous quality improvement with primary care, physical, behavioral health access to and engagement of providers, continuity and coordination across settings in all levels of care, as well as care coordination for dental care and specialty mental health and substance use treatment.<br><br>Our plan partners are expected to exceed quality improvement benchmarks and will be held accountable for their own quality, as well as those of their subcontractors so that every level is hitting the quality benchmarks we set. In addition, plans that are failing to meet quality metrics will face sanctions and surrender a portion of their profits. We are moving further, both through this procurement and other initiatives at the department, towards value-based payments. So, plan payment will be linked to quality and equity and MCPs will be required to comply with new provider shared risk and savings and incentive arrangements.<br><br>As Susan mentioned earlier, we also want to increase transparency around our quality and health equity activities, so MCPs will be required to publicly post their annual quality improvement and health equity plan and committee meeting minutes. We're also working to really focus on utilization and access. We already know there is significant under-utilization for specific populations within the Medi-Cal program which results in health inequities. So MCPs will now |

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| | | be required to review utilization reports and identify members who are not using primary care and address those members' needs and reduce these health disparities that arise from underutilization. We also are adding new requirements for managed-care plans to report on primary care spending as a percentage of total spending to really promote primary care and prevention activities, as well as integrated care spending and spending tied to alternative primary care payment models. We also expect as a part of CalAIM that all plans will be expected to achieve national committee for quality assurance (or NCQA) health plan accreditation by 2026.<br><br>This new contract also clarifies existing requirements for training network providers, that we are investigating and acting upon systemic improper service denials and other trends that have been impacting healthcare delivery and sanctioned authority indemnification and post-payment recovery for members with other healthcare coverage.<br><br>So, another key feature of this procurement is really focused on access to care and alignment with CalAIM. So, we are increasing our expectations for plans' roles in providing access across the continuum of care, especially around social services. This includes additional requirements and language around navigation and care management services. There is a new transitional care services section that really adds requirements to reduce discharge risk by standardizing discharges from institutional settings, such as hospitals. The discharge risk assessment will be brought in from members who are at risk from deinstitutionalization, rehospitalization and risk of mental health or substance use disorder relapse, |

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| | | and really focused on ensuring improved beneficiary outcomes of these risky points of transition.<br><br>Plan partners are going to implement and support CalAIM initiatives such as enhanced care management, community supports, and newly carved in benefits such as major organ transplants and long term care services to improve quality of life as well as health outcomes for member populations by establishing really broad delivery system program and payment reform across Medi-Cal as a part of CalAIM.<br><br>Plan partners are also going to be obligated to strengthen their coordination and continuity of care for out-of-network providers and educate members on their rights such as what an advance directive is and their right to have one. We also will continue to require MCPs to maintain comprehensive networks that provide timely access to care for all members, and we are also adding provisions within those procurement to ensure that networks are high quality and meet geographic access standards.<br><br>I'll flag that there are provisions to ensure that networks have capabilities to provide culturally and linguistically competent care, and as a part of our comprehensive quality strategy and health equity roadmap, we are really digging into where some of those disparities are around not having access to culturally and linguistically competent care is going to be a key focus area for our quality and population health management program area.<br><br>We know that MCPs will help members manage their health over time through a comprehensive array of person-centered care and social services. And a |

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| | | purpose of the procurement is making sure we are doing that spanning all levels of care from the first days of infancy all the way through the end of life.<br><br>So, in terms of coordinated and integrated care, similarly to some of the provisions we just talked about in the last section, we have strengthened these provisions significantly in new contracts. MCPs will systematically coordinate services and provide comprehensive care management for the whole person, interdisciplinary approach for populations with complex healthcare needs. This will be accomplished through care coordination and comprehensive case management. Specifically, MCPs will be responsible for coordinating health and social services between settings of care (so different types of institutionalization, community-based settings), across delivery systems including other delivery systems such as dental, mental health, and substance use delivery systems. Especially and including if they are carved out of the contract so that there is a single point of coordination for all members.<br><br>The contract additionally really advances the principles of CalAIM of moving healthcare upstream and into the community, which is where our members live and reside and what really affects a lot of their quality of health outcomes. The contract requires all managed-care plans will have MOUs with jails, juvenile facilities, probation departments, CDCR, area agencies on aging, caregiver resource centers, local education agencies, IHSS departments, CPS waiver agencies, continuums of care, first five-county social services and/or child welfare departments and counties that are participating in drug Medi-Cal ODS, so we really, |

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| | | truly can have a coordinated delivery system for our members that spans all of their social and healthcare related needs.<br><br>MCPs will also facilitate warm handoffs to public benefit programs where we know there are many individuals eligible, but not receiving public benefits that they are entitled to, coordinating closed-loop referrals to available community resources, and following up to ensure these services are actually rendered. We can go to the next slide.<br><br>So obviously, a big part of our quality and health equity roadmap is not just reducing or closing but eliminating health care disparities. So, there is significantly strengthened language throughout this procurement to really help us advance that goal. So first, we want to recognize that health equity is central to Medi-Cal managed care transformation and I know this is a value shared by our plan partners and many if not all of you on this call. So, plan partners will meet new requirements related to reducing health disparities among specific populations based off of measures we have identified in our comprehensive quality strategy to be stratified initially by race and ethnicity for calendar year 2022, and by other stratifications in the future. In addition, the plans will identify physical and behavioral health disparities, inequities in access, utilization and outcomes by race, ethnicity, language, including limited English proficiency, or sexual orientation, and engage in focused efforts to improve these health outcomes with the most impacted groups and communities.<br><br>All managed care plans will also be required to appoint a chief health equity officer and both the |

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| | | plans, and their subcontractors, are required to achieve a newly developed NCQA health equity accreditation. In addition to further transparency on this work, plans will publicly report their health equity activities and findings and broaden their cultural competency training to address health equity concepts.<br><br>So, in terms of addressing social drivers of health, as mentioned, this is a key part of CalAIM to really push beyond the boundaries of just the clinic or healthcare facility and address the upstream drivers of health that affect our members. So, aligned with these broader reforms MCPs will implement new population health strategies, including community supports, to address unmet social needs like food security and housing. All of you are already actively engaged in this effort. Provisions in the contract also require that care management and population health processes evaluate and address members' social needs, including by requiring that the new enhanced care management eligibility and needs assessment process takes social services into account.<br><br>Additionally, the contract includes provisions requiring data collection of members' social drivers of health needs and services provided to address them, consistent with current APL and policies regarding social drivers of health data collection efforts. I know that was a lot. We will pass it back over to Susan. |

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| Slides 17 – 31 | 00:25:05 – Susan Philip | Thanks, and there's still more. So, a few more slides to go through here. So, the next is we are going to get into local presence and engagement. So, the revised contract has a new community engagement section that includes requirements for plans to really develop a strategy for member and family engagement which includes partnering with community-based organizations, as well as ensuring that member and family input is incorporated as part of decision-making.<br><br>Managed care plans will also be required to develop a population health management program. Which as Palav mentioned will include a member assessment for social drivers of health and really getting local input from public health entities, social services, and behavioral health departments.<br><br>In addition, managed care plans and their subcontractors -- fully delegated subcontractors -- with positive net income will be required to allocate 5 to 7.5 percent of profit towards community activities to really help drive the infrastructure to support Medi-Cal members. So, this is really part of the community reinvestment.<br><br>So, the contract also includes a new children's services set of provisions. There are provisions throughout the contract and then there's a subsection under the quality improvement health equity transformation program section which highlights children as a member population and obligates these plans to implement methods to ensure care management and coordination with appropriate programs for children. |

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| | | There is also a specific program for -- provisions rather -- for managed care plans to partner with local education agencies to provide medically necessary behavioral health services including mental health and substance use disorder treatment across settings including the home, school, and the community. You can go to the next slide.<br><br>Building on investments made to improve behavioral health care in California, the new contract will expand access to behavioral health services with a focus on early intervention and timely treatment for children and adults, and behavioral healthcare that is integrated with physical healthcare. The contract references Department of Health Care Services “no wrong door” policies which will be established to support access to diagnosis and treatment and help ensure minimal disruption of mental health care services regardless of delivery system.<br><br>Members' coverage will include use of DHCS approved standardized screening and transition tools for adults and children and the provision of non-specialty and specialty mental health services. So, making sure that those standardized screening tools are used across the delivery systems. The new contract also includes language to clarify substance use disorder coverage including screening, brief intervention, and referral to treatment, and medication assisted treatment services across settings. Next slide.<br><br>The new contract really has a set of provisions that significantly strengthens the expectations related to accountability for and oversight of delegated entities. And this includes oversight compliance for the subcontractor quality improvement, health equity |

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| | | activities. As mentioned earlier subcontractors will also need to report on their annual population needs assessment, and there are also provisions that clarify DHCS's authority to levy corrective action plans and sanctions when it comes to delegated entities as well.<br><br>So, one major change in the contract is that plans related to report on who they subcontract with and whether their subcontractors use downstream subcontractors to provide care to our Medi-Cal members. This is really to allow DHCS to have a full view of the plans full delegation model and the reporting requirements will require plans to provide justification for the need for subcontractors. And this is in line with an overarching goal to really enhance the efficiency and reduce that administrative layer and waste in the Medi-Cal managed care program. Next slide.<br><br>So, we have a new section in the contract focused on emergency preparedness and essential services. As we have learned in California, of course, disasters and emergencies can really disrupt access and delivery of care. So, managed care plans will be required to have an emergency preparedness and response plan to ensure members have access to essential care and services before and after emergencies. And the contract also clarifies that telehealth modalities are available. Next slide.<br><br>So, there's a set of provisions related to value-based payment and this is part of the department's and administration's goal to really move the needle from -- to value-based services and value-based payment models. The plan partners will be required to report on how their payment models will link to value in the |

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| | | form of higher quality of care or better healthcare outcomes. In addition, managed care plans will be required to provide more visibility into their payments for value, including reporting on their primary care spending, including what proportion of overall spending is tied to primary care. Next slide.<br><br>So ultimately, our collective goal is to ensure that managed care members' experience will be enhanced through more information and having access to holistic care which really takes social drivers of health factors into account and really ultimately delivers on care that is appropriate, high-quality, and timely. So, with this new mix of available high-quality plans, and the implementation of the new managed care plan contract, we are really hoping to improve members' experience with Medi-Cal in many ways through improving transparency and reporting.<br><br>Members should have more insight to inform their plan choice. Members can also expect a more holistic approach to their care, which again considers social drivers of health and should consider cultural and linguistic differences and consider the physical and behavioral health needs throughout their lives. And the consideration of social services needs as well. So, the members, we believe, can expect appropriate high-quality care that is timely and expect their access to appointments, interpreter services, and services that also include telehealth. Next slide.<br><br>So, with these new provisions in place, DHCS is also undertaking an effort to enhance our oversight and compliance capabilities and our own efforts as well. So, we are committed to enforcing the contracts and |

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| | | ensuring that we are meeting our obligations to our members. In addition, the new waiver special terms and conditions that the federal government has just put in place with us as the new waivers were just approved at the end of last year. Those new waivers will require that DHCS regularly report to CMS on how we are monitoring and ensuring the accountability of managed care plan performance. The new waiver will improve our transparency and accountability to CMS on managed care plan performance.<br><br>This specifically includes reporting regarding a variety of model oversight activities. And it also includes an independent assessment that contains comparison of, for example, network adequacy compliance for our managed care plans and even across different lines of business. So those are a couple of examples of the special terms and conditions in the waiver. Next slide.<br><br>As I just said earlier, there's several key areas that managed care plans will be required to report on and post new elements about activities and performance and this will be part of our reporting to CMS. So, this includes new reporting related to delegation, including the delegation compliance plan, that gives us an overview of the plan's delegation structure and how plans will ensure that there is compliance at the subcontractor and downstream subcontractor levels.<br><br>Plans will also be, as I mentioned, needing to report on their primary care spending as a percentage of their total expenditures for us to really understand the investment that plans are making in upstream and preventative care. And to encourage a focus on value and quality and outcomes at the provider level, |

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| | | managed care plans will be reporting on the percentage of payments to providers that are tied to alternative payment models. Next slide.<br><br>Plan partners will be held accountable for exceeding the minimum performance level for a host of pediatric and maternal specific metrics. That will be specifics that they will also be reporting on. As a new enforcement tool and as required by our special terms and conditions, all prime managed care plans will provide remittances if they do not meet the medical loss ratio minimum of 85 percent by January 2024. And all fully or partially delegated plans will provide remittances if they do not meet the 85 percent minimum by January 2025. So that is a set of requirements that is in our STCs under the waiver.<br><br>Plans and subcontractors will be expected to meet the minimum performance level for pediatric and maternal specific metrics at the 50th percentile and will face financial penalties and submit corrective action plans if they do not meet those metrics. Managed care plans that do not meet quality metrics and who have positive net income will be required to allocate an additional 7.5 percent of their profits to community reinvestment and this is again to safeguard the public resources for the good of our Medi-Cal members and the community. We really want to ensure that there is reinvestment back into the community and ensure the managed care plans are meeting their quality requirements. Next slide.<br><br>So, over the next couple of years, as we are looking forward to 2024, selected health plans and our existing public plans will prepare and demonstrate their readiness to meet the new contract requirements. This year DHCS will, as I mentioned, |

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| | | conduct the RFP process and we intend to award notices in August. And throughout the period leading up to January 2024, we really intend to conduct careful planning on the transition and communicate updates about the transition process.<br><br>We will make sure that this presentation has links to websites with additional information and resources and make sure that this is available on our website once this deck is ready. And then we will also just encourage all the commercial plans who are interested in responding to the RFP to attend the voluntary pre-proposal web conference to learn more specifics about the proposal process. So, with that I will turn it back over to Megan who will walk us through some Q&A. |
| N/A – Q&A | 00:39:22 – Megan Ingraham | Thank you, Susan. We have several questions that have come through and first we'll focus on quality. So, reaching back out to Palav, the first question is: what are the quality improvement benchmarks and where can we find them? |
| N/A – Q&A | 00:39:40 – Palav Babaria | Great question. Our final comprehensive quality strategy and health equity roadmap, which is our strategic plan for the next three years, was posted publicly last week. In section 2 it has specific quality measures for each of our managed care delivery systems, Medi-Cal managed care but also dental and behavioral health. So, you can see specific measures and what the targets are by measure. |
| N/A – Q&A | 00:40:10 – Megan Ingraham | Thanks. And can you dive a little deeper into what it means around strengthening of coordination and continuity? |

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| N/A – Q&A | 00:40:18 – Palav Babaria | Absolutely. So, we know that our members have whole-person care needs. They don't think of their needs as this is a physical health need, this is a behavioral health need, and this is an oral health need. Based off our population health management program, which is launching in January 2023 which will strengthen requirements for all the managed-care plans to really provide comprehensive proactive assessment of their members, their needs and then linking them to those services -- care coordination may take on different forms. For someone who is otherwise well and healthy and needs preventive services care coordination may mean helping the individual beneficiary navigate to figure out where they can get dental services for routine oral health checkups every six months. For a beneficiary that is high need and complex and is in and out of the emergency room every other week and has frequent hospitalization -- that care coordination may come in the form of an enhanced care manager that is assigned through the ECM benefit for the plan. It will be tailored to the healthcare needs of each of the individual members. It will be data informed by the risk assessment and stratification that we do as a part of our PHM program for all members. But it really is designed to underscore that we should be helping navigate our members to receive all the services that they need, and they are eligible for, independent of which system is responsible for providing those services. |
| N/A – Q&A | 00:41:46 – Megan Ingraham | Another question relates to access and how MCPs can improve access with a finite number of providers? |

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| N/A – Q&A | 00:41:55 – Palav Babaria | I think this is a great question. All I did in my previous life before coming to DHCS is work on access. It's a topic I am passionate about. I think for better or worse that the public health emergency has afforded us to think outside of the box in how we think about access and provider networks and network adequacy.<br><br>So we know that e-consult has been leveraged by many of our MCPs to help bridge some of the gaps between primary care and specialty care to strengthen the capacity of primary care providers to take care of patients within their primary care setting and not even need a specialty referral. Many of our plans have been leading the way with launching that type of service across their networks.<br><br>In addition, now that telehealth is an option, many of our plans similarly have been thinking creatively about how -- within our requirements and telehealth policy -- how they can leverage virtual care and telehealth networks to meet the access needs of their individuals. So, we have a lot more options and flexibility than we did 30 or 50 years ago around access. Obviously as a department, we partner and think through workforce issues, but we encourage all the plans to leverage some of these best practices that have been piloted and shown to be successful within our state. |
| N/A – Q&A | 00:43:09 – Michelle Baass | I would also add the addition of some of our new benefits like community health worker benefits, peer support specialists -- we're broadening our workforce to get at some of these access issues and introduce some of these new workforce to assist in terms of our access upstream and preventative as much as possible. |

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| N/A – Q&A | 00:43:33 – Megan Ingraham | Thank you. Let's see. So, we have another question about coordination. Can you review what enhanced coordination with local health departments, county behavioral health plans and others will look like? |
| N/A – Q&A | 00:43:48 – Susan Philip | I can take that. One of the requirements in the managed care plan contract is really to enhance the MOUs. So, we really want to ensure that the memorandum of understanding in the managed-care plan and local entities reflect provisions that really will enable the two entities to work together.<br><br>There is just a greater expectation, for example, that the consumer advisory committee really reflects the community and that there is real engagement from members, from the family, and as I mentioned that the input from the advisory committee is really taking into account as the plan is developing policy and procedures and making decisions. It is not just one-way listening but really incorporating the input from the community and developing policies and procedures in the day-to-day delivery of care. |

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| N/A – Q&A | 00:45:00 – Palav Babaria | Maybe to just add, I think we have seen some great models of this during the pandemic. At the end of the day, for many of our local health jurisdictions and public health programs upwards of 90 percent of the members that they are serving are Medi-Cal members. So, there is a great degree of overlap between our managed care plans and populations they are responsible for caring for, and the activities that are happening in public health departments and other local social service agencies and through the pandemic, especially around vaccination efforts. We saw some of that alignment where people came together, aligned their activities and were not working in their silos with much better results and I think a lot of this language has the same vision for numerous other topics. |
| N/A – Q&A | 00:45:45 – Megan Ingraham | Thank you. This question is for Michelle Retke, I believe, how will this RFP be used for the seven CCI and Cal MediConnect counties - so LA, Orange, Riverside, San Bernardino, San Mateo, and Santa Clara? |
| N/A – Q&A | 00:46:01 – Michelle Retke | There's a couple pieces I think I can help answer. The CCI counties are both COHS and non-COHS -- county organized health system and not. So, this RFP, as a reminder, it's just for counties where commercial plans operate. The piece about CCI or Cal MediConnect demonstration. That will be going away at the end of 2022. And so those counties will no longer have the Cal MediConnect program operating there. Part of the CalAIM process is moving forward with a dual special-needs plan being operated in those counties in January 1, 2023. Hopefully, that helps answer the question. |
| N/A – Q&A | 00:46:50 – Megan Ingraham | Thank you. Susan, I have several questions for you. I think just to begin, can you give a little more information about what community reinvestment means? |

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| N/A – Q&A | 00:47:02 – Susan Philip | Sure. The dollars that we are putting essentially at risk through the contract in terms of meeting the quality metrics -- those dollars should be included as part of the community reinvestment fund. And there will be, in terms of how that money will be dispersed, will require some planning and that all hasn't been worked out yet, but that is something that we would expect the plans and communities to really determine how that money will be spent.<br><br>So, when we are talking about community reinvestment, we really are addressing social determinants, social drivers of health and really looking at the specific community needs and how we can close those gaps. So I would say the population needs assessment will be a big factor in how one can consider how to develop those community reinvestment plans, and that will be one of the areas that ought to be looked at when thinking about how to invest. |
| N/A – Q&A | 00:48:23 – Megan Ingraham | Good. Thank you. And can you describe what a fully delegated subcontractor is? |

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| N/A – Q&A | 00:48:27 – Susan Philip | Sure. So, we have in some counties where a plan will delegate directly to a plan. And so that is a model where it is fully delegated in the sense that the plan says here are the members and here are the functions that we are delegating to a plan and in that sense all the functions of a plan is then delegated to another plan. So, that is a fully delegated plan. There is also a notion of the partially-delegated plan which is -- there might be a subset, for example, an IPA or large medical group that takes risk for a specific subset of members, but then doesn't necessarily take all the services, but maybe a partial set of services and then they are partially delegated. So, there are others, a robust definition term section in the contract that I would encourage everyone to review. |
| N/A – Q&A | 00:49:35 – Megan Ingraham | Okay. Thank you. And can you speak to how high quality is defined as it relates to providers? |
| N/A – Q&A | 00:49:45 – Susan Philip | Palav, if you want to take that one? |
| N/A – Q&A | 00:49:51 – Palav Babaria | I think there may have been specific language in the network adequacy section, otherwise we can take that one back. |
| N/A – Q&A | 00:49:59 – Susan Philip | I would also say that there's standards. In our quality strategy we are setting standards and we have very clear metrics. So, all those metrics will be made transparent. |

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| N/A – Q&A | 00:50:23 – Bambi Cisneros | If I could just add something to that as well. This contract is really for -- between the state and the plans, but we would want them to work with providers that can provide timely access to services, provide culturally and linguistically appropriate care, and also just taking into account that we are really moving towards patient-centered care throughout the contract. And I think all of those same values, we would want the plans to work with providers who can also share those values and provide that kind of care for our Medi-Cal members. |
| N/A – Q&A | 00:50:58 – Megan Ingraham | And Bambi, while we have you off mute, I'd like to ask you another question. What will the anticipated MOU with social and human service agencies require, for example, will it require the MCPs see these as covered services or simply align agencies for coordination? |

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| N/A – Q&A | 00:51:19 – Bambi Cisneros | Okay. Thank you. So, the MOUs really are a partnership between plans and all the different agencies that we would expect that they work with in order to provide that whole-person care. So, you will see MOU requirements of social services agencies, behavioral health, local programs, etc. So the plan responsibility to provide healthcare services will still remain with the plan, but I think what the MOU really does is ensure that the other services they would need to ensure that their whole being is taken care of is really addressed in the MOU. And that MOU would speak to regular meetings that they would have with all of these different kinds of entities, outline conflict resolution processes for when you are working with the same member and how to ensure that we know which party is working with which – there's going to be a liaison because there's always going to be a point of contact within the plan. And the other agencies would have a contact list so that that data and information sharing is happening. So, we are also looking at those requirements as well and ensuring we are providing resources and support for the plans through this work. |
| N/A – Q&A | 00:52:41 – Megan Ingraham | Thank you. I think this is another question for you, Susan. Will there be a directory where patients can be enrolled or assessed for ECM care coordination? |

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| N/A – Q&A | 00:52:59 – Susan Philip | There is a robust set of provisions for ECM in the contract. The plans are generally required to provide a provider directory. So, we are currently -- for plans that are -- ECM has gone live in 2022 for Whole-Person Care counties, and we are phasing in the go-live of ECM for populations of focus. So, this year we will expect plans to have plans have the ECM provider directory available through their current directories. And that is also similar to community supports and so community supports that plans are opting to provide -- where there are community support services – those should also be available through the directories. |
| N/A – Q&A | 00:54:11 – Megan Ingraham | Okay. Thank you. Another couple for you, Susan. One is around will CalAIM expand the assisted-living waiver program into all California counties? |
| N/A – Q&A | 00:54:23 – Susan Philip | Well, there is assisted-living waiver program that has a waiting list and actually this is through the home and community-based -- the HCBS spending plan which is another investment initiative that we spoke to earlier that will allow an increase in the number of slots so that we can reduce the waiting list. So, I would direct folks to the HCBS spending plan and our plans to roll that out. And we are expanding the waiver and increasing the number of slots there. |
| N/A – Q&A | 00:55:03 – Megan Ingraham | Thank you. And does all of this have implications for the California regional centers? Will they be going away? |
| N/A – Q&A | 00:55:11 – Susan Philip | No, the regional centers will not be going away. And there's provisions in the contract to strengthen relationships with regional centers through MOUs. |
| N/A – Q&A | 00:55:28 – Megan Ingraham | And then can you speak to when or if California Children's Services will be incorporated into managed care? |

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| N/A – Q&A | 00:55:38 – Susan Philip | So, the provisions that we spoke to are specific to the behavioral health services that will be available for January 1st, 2024. So, we are expecting that plans will be required to provide behavioral health services, as I mentioned through home, community, school and in partnership with local educational entities. So, 2024. |
| N/A – Q&A | 00:56:15 – Megan Ingraham | Thank you. How will behavioral health access for youth occur? Do you expect that having a clause in the contract will support those? Or will you talk a little bit more about what that process will look like in terms of ensuring access to behavioral health services for youth? |
| N/A – Q&A | 00:56:38 – Susan Philip | Well, we expect managed care plans to really engage with their local educational entities and their communities to really conduct that population needs assessment and these are the provisions that are included in the contract. We are not necessarily going to be prescriptive about that, but we do expect plans to work within their communities to really drive that improved access. So, again, through population needs assessments or ensuring that as they are thinking about programs that they are considering the needs of children and youth especially when developing a quality and equity strategy, for example. So that really, the focus on children and youth is woven throughout the population health management strategy. |
| N/A – Q&A | 00:57:24 – Michelle Baass | I would also want to reemphasize the link between our comprehensive quality strategy where we have specific metrics there that, while maybe not part of this contract, all link together in terms of how we plan to hold the plans accountable for delivery of these services. I think we need to think about that. We are packaging these things together because they interlink between the outcomes we are expecting in terms of quality and access, as well as the contract. |

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| N/A – Q&A | 00:57:50 – Megan Ingraham | Thank you. So, Susan, a couple more here. So, another is around dental care. Can you speak to what the expectations are around dental, and will that be maintained separately through dental managed-care plans after 2024? |
| N/A – Q&A | 00:58:31 – Michelle Baass | We have a separate process for dental managed care procurement, and we have a trailer bill language in our budget proposal, so these contract terms are separate from that. |
| N/A – Q&A | 00:58:44 – Megan Ingraham | Great. Thank you. This may be another question for Susan but may be open to others as well. For subcontractors who are interested in partnering with MCPs right now, this particular individual has community health workers, peer support specialist, enhanced care management capacity and other services available. How would you recommend that they get connected to an MCP? |

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| N/A – Q&A | 00:59:09 – Susan Philip | That's a great question. And I would encourage first that they reach out to their local managed care plan and just have those conversations. I know that managed care plans are looking to find that capacity of community-based organizations and those partners within the community that could really help with the delivery of ECM, with the delivery of community support services, and really thinking about how to leverage that wealth of experience and knowledge that community-based organizations bring in caring for our members. So, plans are interested in partnering and I would encourage CBOs to reach out directly to their managed care plans and say here is what we bring to the table and look for those opportunities. I would also say that one of the -- not the focus of this presentation -- but we will be speaking about this later on as part of our CalAIM initiatives under PATH which is one of our large initiatives to really improve capacity building at the county level and among community-based organizations and ECM providers and to really connect those organizations with plans to really deliver on the promise of CalAIM. We will be launching PATH soon and will be providing key information about that. But one of the key initiatives under PATH will be to connect plans and CBO's and organizations that are looking to provide those kinds of services and support CBO's that are interested in, for example, getting technical assistance. So how do I set up a contract with the plan? How do I do billing? All those kinds of technical questions, we are looking to support that planning and development among ECM providers and community-based providers through the PATH initiative. Please stay tuned for that. |

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| N/A – Q&A | 01:01:30 – Megan Ingraham | Thank you. We will give you a little bit of a break and turn it back to Palav. So, when plans are required to report the percent of primary care physicians paid through value-based payments, do primary care clinicians include behavioral health providers? |
| N/A – Q&A | 01:01:50 – Palav Babaria | We will be issuing formal guidance around these reporting requirements, but generally it is to whom the member is assigned for primary care, so it may be a medical home or individual PCP. So inasmuch as some of our PCPs and medical homes provide integrated behavioral health services, yes. But every member in Medi-Cal is assigned a PCP, and that's what we mean by what percentage of those assignments are in alternative payment model contracts. |
| N/A – Q&A | 01:02:18 – Megan Ingraham | And another along the lines of value-based payment, regarding primary care delivery through APM models. Could you talk about how DHCS will identify the five largest medical groups? Is that in the state? County? Rate region? |
| N/A – Q&A | 01:02:37 – Palav Babaria | Again, more detailed requirements on all these reporting elements will be coming out before they go into effect in 2024, but they would likely be based off of the number of assigned members to that medical group or medical home. |
| N/A – Q&A | 01:02:53 – Megan Ingraham | Great. Thank you. And Bambi, I had another question for you on MOUs. So is DHCS going to be drafting MOU templates that the managed-care plans can use with various entities to ensure consistency across the state? |
| N/A – Q&A | 01:03:10 – Bambi Cisneros | Thank you. Yes, the department will be doing that to establish the minimum requirements that the MOU should have but of course we would also still want to see some flexibility with what works best at the local level. |

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| N/A – Q&A | 01:03:27 – Megan Ingraham | Okay. Very good. I think some of our questions are slowing down. I just need another minute to catch up here. Another question, Bambi along the lines of MOUs relates to closed loop referral systems. So, will these MOUs require a closed loop referral and what types of data will get shared back to the plan, for example, the types of services provided or other data particularly related to outcomes? |
| N/A – Q&A | 01:04:02 – Bambi Cisneros | Those are good questions and I think when we are ready to roll out the MOU templates will have more detailed guidance of what that entails. But closed looped referrals are very much a priority for the department because we want to make sure members are actually getting the services that they're being referred to so that will be an element and there will be more to come on that. |
| N/A – Q&A | 01:04:26 – Megan Ingraham | Okay. Right. And I have another clarifying question around CCS. I think we may have already covered this, but if not, if there is more to elaborate on that would be helpful, will the 24 or so CCS conditions for children be incorporated in managed-care and 2024? |
| N/A – Q&A | 01:04:46 – Jacey Cooper | So, the short answer is no, we're not making any changes with regard to the managed-care plan responsibilities for CCS other than the counties who are already participating in whole child model which is COHS counties. Other than that, there are no changes other than the mentioned MOUs which are important and critical, but with regard to the managed care plans responsibility for CCS services, there are no changes in this contract. |
| N/A – Q&A | 01:05:15 – Megan Ingraham | One more question just came in related to vision care and how does vision care fit into this new model. Anyone want to take that one? |
| N/A – Q&A | 01:05:30 – Jacey Cooper | I'll take it. There's no change in from our existing benefit as rolled out in CalAIM, so there is no change to the vision benefit. |

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| N/A – Q&A | 01:05:39 – Palav Babaria | I would just piggyback to add that we do recognize that vision screenings and vision services are a critical part of our EPSDT required services for children and we have flagged that in our comprehensive quality strategy as an area we are really going to be digging into and seeing what quality improvement efforts we can initiate in the area. |
| N/A – Q&A | 01:05:59 – Megan Ingraham | Okay. Very good. We had one question come through here related to Kaiser and what will happen to individuals who are enrolled in a Medi-Cal managed care plan but have Kaiser as their provider. Will they be able to stay with Kaiser if they're not one of the special groups mentioned whether it is duals or foster? |
| N/A – Q&A | 01:06:25 – Michelle Baass | I think generally all the transition planning with all the different model changes, with the Kaiser proposal, etc. There's more to come on how do we plan for the transition of enrollees based across the different model changes, different plan selections etc. So, I think more to come as we plan through those pieces. I don't want to get into the nuances of this question, but just generally speaking they are all related to how we are going to plan for our transitions. |
| N/A – Q&A | 01:06:54 – Megan Ingraham | Thanks. One final one here about cross-walking contract requirements. And this may be more specific and something that will be covered or could be covered in next week's session. But will there be a crosswalk provided by DHCS comparing all contract requirements with new ones? |

# Transforming Med-Cal Managed Care Through Statewide Procurement

*February 15, 2022*

## Transcript

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| N/A – Q&A | 01:07:18 – Susan Philip | I will jump in here. The contract has been completely restructured, so crosswalk would not have been very useful. So, I would just encourage folks to review the contract as it is. What we have done is really pull out the different sections and really put a prelude in front of each section so before you even dig in, you can read the prelude and get a sense of what is in it and then -- that will really provide you a roadmap. And, again, the specifics on the procurement, if you have specific questions on that, do come to the webinar next week as well for proposers. |
| N/A – Q&A | 01:08:08 – Megan Ingraham | Great. Thank you. I think we have made our way through the questions. I appreciate everyone in the audience for raising those. And, also, I want to follow on Susan about next week -- on the 24th from 1:00 until 2:30, there will be a voluntary preproposal web conference and you can register on DHCS website. So, again, thank you all for joining us and we are looking forward to you joining future webinars. Take care. |
| N/A – Q&A | 01:08:40 – Julian Ward | Thank you for joining, you may now disconnect. |