Tribal and Designee Medi-Cal Advisory Process Webinar on Proposed Changes to the Medi-Cal Program
May 28, 2021

Purpose

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

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

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

Agenda

Topics	Presenters
Welcome/Overview	Andrea Zubiate, Coordinator DHCS Primary, Rural, and Indian Health Division/Indian Health Program
CalAIM Section 1115 Demonstration & Section 1915(b) Waiver Update	
Waiver Update	Aaron Toyama, Senior Advisor, Health Care Programs
California Statewide Transition Plan (STP)	
California Statewide Transition Plan (STP)	Juliana Lowe, Policy Analyst, Integrated Systems of Care Division
SPAs Scheduled for Submission by June 30, 2021	
SPA 21-0028	Victoria Tereschenko, Pharmaceutical Consultant II, Pharmacy Benefits Division
SPA 21-0018	Oksana Meyer, Section Chief, Managed Care & Monitoring Division
SPA 21-0017	Rebecca Nix, Research Data Supervisor I, Fee-for-Service Provider Rates Development Division
Feedback/Closing	All

Waiver Overview

What are Medicaid Waivers?

- “Waive” specified provisions of Medicaid Law (Title XIX of the Social Security Act).
- Allow flexibility and encourage innovation in administering the Medicaid program to meet the health care needs of each State’s populations.
- Provide medical coverage to individuals and/or services that may not otherwise be eligible or allowed under regular Medicaid rules.
- Approved for specified periods of time and often may be renewed upon expiration.

CalAIM Section 1115 Demonstration & Section 1915(b) Waiver Update

California Advancing and Innovating Medi-Cal (CalAIM) Proposal

CalAIM will implement broad program, delivery system, and payment reforms for the Medi-Cal program to advance three primary goals:

1. Identify and manage member risk and need through whole-person care approaches and addressing social determinants of health (SDOH)

2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility

3. Improve quality outcomes, reduce health disparities and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform

CalAIM Proposal Vision for Medi-Cal Transformation

DHCS aims to improve and transform the Medi-Cal delivery system in order to meet the physical, behavioral, developmental, long-term services and supports, oral health, and health-related social needs of all Medi-Cal members in an integrated, patient-centered, whole-person fashion.

Depending on their needs, some Medi-Cal beneficiaries may access **six or more separate delivery systems** to get needed care

Care coordination needs increase with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care

DHCS is seeking to, over time, **integrate delivery systems and align funding, data reporting, quality, and infrastructure** to incentivize and move towards common goals

Moving from Section 1115 demonstration pilots to **statewide implementation of reforms** underpins the envisioned transformation

CalAIM Section 1915(b) Waiver

DHCS is seeking two federal waivers to implement many CalAIM initiatives and priorities:

CalAIM Section 1915(b) Waiver

- California currently has a Section 1915(b) waiver authorizing Specialty Mental Health Services (SMHS)
- DHCS will renew that waiver and **consolidate Medi-Cal managed care programs under the same authority;** the consolidated 1915(b) will include:
  - Medi-Cal Managed Care
  - Dental Managed Care
  - Specialty Mental Health Services
  - Drug Medi-Cal Organized Delivery System
- DHCS continues to develop the Section 1915(b) pre-print application and has posted the **Section 1915(b) waiver overview**, including **detailed attachments summarizing behavioral health policy improvements** developed through the CalAIM stakeholder engagement process:
  - Attachment 2: Medi-Cal Behavioral Health Changes *(see page 20)*
  - Attachment 3: DMC-ODS Program Description *(see page 31)*

Additional components of the CalAIM proposal will be implemented via **Medi-Cal State Plan, managed care contract reprocurement, and State guidance.**

Delivery System Changes

DHCS will align delivery systems by creating a consolidated Section 1915(b) waiver that advances delivery system integration and whole-person care.

Delivery System	Current Authority	Transition to New Authority
Medi-Cal Managed Care (MCMC) & Dental Managed Care	Medi-Cal 2020 Section 1115 Demonstration	**Consolidated Section 1915(b) Waiver** *(January 1, 2022 – December 31, 2026)* and **Medi-Cal State Plan Amendments (SPAs)** *(where applicable)*
Specialty Mental Health Services (SMHS)	SMHS Section 1915(b) Waiver	
Drug Medi-Cal Organized Delivery System (DMC-ODS)	Medi-Cal 2020 Section 1115 Demonstration	

DMC-ODS will be authorized in the Section 1915(b) waiver; the Section 1115 demonstration will include two key DMC-ODS provisions: (1) Traditional Healers and Natural Helpers and (2) Medicaid services provided to short-term residents of institutions for mental diseases (IMDs). DMC-ODS benefits will be authorized by the Medi-Cal State Plan.

CalAIM Section 1115 Demonstration

DHCS is seeking two federal waivers to implement many CalAIM initiatives and priorities:

CalAIM Section 1115 Demonstration

- Five year renewal and amendment of Medi-Cal 2020 1115 demonstration
- Will include **innovative initiatives that are not implemented via State Plan authority or a Section 1915(b) waiver:**
  - Coverage for low-income pregnant women and out-of-state former foster care youth*
  - Community-Based Adult Services*
  - Global Payment Program*
  - Designated State Health Care Programs*
  - Services for justice-involved populations 30-days pre-release
  - Peer support specialists
  - Traditional Healers and Natural Helpers (in DMC-ODS)
  - Providing Access and Transforming Health Supports
- The Section 1115 demonstration application is the **draft application**

** Represents existing Medi-Cal 2020 1115 demonstration initiatives that will be continued in the CalAIM 1115 demonstration.*

Timeline & Next Steps

Milestones	Proposed Timeline
Conduct 30-day State public comment	April 6 – May 6, 2021
Conduct 30-day Tribal State public comment	April 7 – May 7, 2021
Public Hearing (1 of 2)	April 26, 2021 (1:00 – 2:30 PM PT)
Tribal Public Hearing	April 30, 2021 (2:00 – 3:30 PM PT)
Public Hearing (2 of 2)	May 3, 2021 (2:00 – 3:30 PM PT)
Review public comments and finalize documents for CMS submission	May – July 2021
Submit 1115 and 1915(b) applications	***By July 2021***
CMS conducts federal 30-day public comment period	July/August 2021
Negotiations with CMS	August – December 2021
Effective date of Section 1115 demonstration and Section 1915(b) waiver	***January 1, 2022***

Contact Information

Written comments or questions may be sent by email to: CalAIMWaiver@dhcs.ca.gov

California Statewide Transition Plan (STP)

Juliana Lowe
Policy Analyst
Integrated Systems of Care Division

Background

- CMS issued regulations that define the settings in which states can pay for Medicaid Home and Community-Based Services (HCBS) effective March 17, 2014.
- HCBS are types of person-centered care delivered in the home and community as an alternative to nursing homes.
- The purpose of the regulations is to ensure that individuals receive Medicaid HCBS in settings that are integrated and that support full access to the greater community.

Purpose

- DHCS, in collaboration with the California Department of Aging (CDA) and Department of Developmental Services (DSS), have created an STP that describes timelines and strategies for how the State will come into compliance with the HCB Settings Final Rule.
- CMS granted initial approval of California's STP on February 23, 2018. Since that time modifications have been made to the plan with the intent to submit it to Centers for Medicare and Medicaid Services (CMS) for final approval.
- The STP can be viewed on the DHCS STP webpage.

Summary of Proposed Changes

The following sections of the STP / CBAS attachment were updated:

- Clarification was added regarding the provider self-assessment process.
- Information added regarding the validation of settings, including on-site reviews.
- Explanation of Member Surveys.
- Explanation of the site assessment process.
- A timeline and description of reverse integration.
- Addition of Final Validation Results.
- Site-specific remedial actions (non-compliant settings).
- Timeline and information regarding remediation work plans.
- The states work to ensure that beneficiaries have access to non-disability-specific settings.
- Remediation activities and timelines.
- The process for ongoing monitoring.
- Heightened Scrutiny, and the timeline for submission

Impact to Tribal Health Programs

- If a tribal health program participates in any of the HCBS programs they may need to modify where and how the services are delivered to meet the HCBS Settings Final Rule requirements by March 17, 2023.

Impact to Federally Qualified Health Centers (FQHCs)

- If an FQHC participates in HCBS programs, they may need to modify where and how the services are delivered to meet the HCBS Settings Final Rule by March 17, 2023.

Impact to Indian Medi-Cal Beneficiaries

- If a Medi-Cal Member is receiving HCBS services they will have increased protections relating to where they receive HCB services.
- The HCBS Final rules ensure that individuals are afforded opportunities to be fully integrated into their communities.

Contact Information

STP@dhcs.ca.gov
Juliana Lowe
Policy Analyst, Home and Community Based Services Section
Integrated Systems of Care Division
Department of Health Care Services
PO Box 997437, MS 0018
Sacramento, CA 95899-7437

State Plan Amendment Overview

Medicaid State Plan Overview

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

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

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

State Plan Amendment (SPA) Overview

SPA: Any formal change to the State Plan.

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

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

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

Medication Therapy Management as a Medi-Cal Pharmacist Services Benefit

SPA 21-0028

Victoria Tereschenko
Pharmaceutical Consultant II
Pharmacy Benefits Division, DHCS

Background

- Centers for Medicare & Medicaid Services (CMS) Final Rule for Covered Outpatient Drugs (CMS-2345-FC) California adopted CMS' National Average Drug Acquisition Cost (NADAC), Effective April 1, 2017
- DHCS notified of complaints of under-reimbursement by multiple pharmacies following implementation of NADAC for specialty drugs and services associated with dispensing them.

Background (cont.)

- DHCS contracted with a vendor to conduct a survey to compare the NADAC price benchmark against the AAC in California for specific specialty drugs in February 2020.
- The vendor helped DHCS determine what types of services pharmacies provided in association with the dispensing of these specialty drugs.
- The survey found that the reimbursements given to pharmacies (for ingredient cost and professional dispensing fees) did not sufficiently cover the costs of providing these special services to beneficiaries.
- The survey report concluded that these services could be reimbursed separately through a contracted MTM methodology.
- DHCS proposed MTM reimbursement methodology to supplement Medi-Cal payments to pharmacies and ensure beneficiary access to specialty drugs and services.

Background (cont.)

- Group of services provided by pharmacists to maximize the effectiveness of drug therapies, and prevent medication related problems.
- An MTM session typically includes a patient/beneficiary sitting down with a pharmacist to discuss their prescribed medications in depth.
- Especially effective for patients
  - On multiple medication therapies
  - High prescription costs
  - or have multiple chronic illnesses
  - Other risk factors that result in impediments to positive clinical outcomes

Background (cont.)

- MTM has 5 key elements
  - ✓ A review of the beneficiary's current medications
  - ✓ Creation of a personal medication record
  - ✓ Developing a medication-related action plan
  - ✓ Interventions and/or referrals to other health care providers
  - ✓ Documentation of all actions taken by the pharmacy and the related follow-ups

Purpose

- The Department of Health Care Services (DHCS) proposes to submit a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services (CMS) to provide MTM reimbursement as an added pharmacist service

Summary of Proposed Changes

SPA 21-0028 with an effective date of July1, 2021, seeks to:

- Add MTM as a covered pharmacist service
- DHCS is directed to establish and maintain a list of covered specialty drug categories, patient eligibility criteria and conditions
- DHCS is required to publish protocols and utilization controls
- MTM pharmacist services will be available to Medi-Cal beneficiaries who meet the eligibility criteria.
- DHCS may enter into contracts with willing Medi-Cal enrolled pharmacy providers

Summary of Proposed Changes (Continued)

- DHCS will establish and maintain the rates of reimbursement
- MTM program neither restricts nor prohibits any service currently provided by pharmacists

Impact to Tribal Health Programs

- MTM is not reimbursable at the all-inclusive rate by tribal health programs.

- Tribal Health programs that operate a retail pharmacy may see an increase in Medi-Cal beneficiaries accessing MTM

Impact to Federally Qualified Health Centers (FQHCs)

- The proposed SPA may require a change in scope of services of pharmacies to be filed to include MTM
- MTM services are not separately billable by the FQHC
- Those FQHC's whose PPS rate does not include MTM services may experience an increase in Medi-Cal beneficiaries accessing MTM
- Pharmacy programs and organizations may also experience an increase in the time spent with beneficiaries who need services associated with this benefit

Impact to Indian Medi-Cal Beneficiaries

- The proposed SPA will provide multiple benefits to American Indian Medi-Cal beneficiaries.

- These benefits include:
  - Increasing access to MTM services
  - Increasing access to specialty drugs
  - Reducing preventable medication-related problems
  - Improving medication adherence
  - Reducing emergency room visits
  - Reducing hospitalization and related costs
  - Optimizing clinical outcomes

Contact Information

- Written comments or questions concerning this proposal may be sent by email to angeli.lee@dhcs.ca.gov, or by mail to:

Department of Health Care Services
Directors Office
ATTN: Angeli Lee
MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Health Homes Program
Notice of Intent to Submit
SPA 21-0018

Oksana Meyer

Section Chief

Managed Care Quality & Monitoring Division

Background

- DHCS is implementing a new initiative called *California Advancing and Innovating Medi-Cal* or CalAIM.
- With CalAIM, DHCS seeks to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program and payment reform across the Medi-Cal program.
- As a component of CalAIM, DHCS is proposing the implementation of a single, statewide comprehensive Enhanced Care Management (ECM) benefit within Medi-Cal Managed Care which will replace the current Health Homes Program (HHP).
  - HHP provides extra care coordination services to certain Medi-Cal patients with complex medical needs and chronic conditions

Purpose

- Effective December 31, 2021, DHCS will terminate the HHP in all counties of operation (Alameda, Imperial, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Tulare).
- ECM will launch January 1, 2022 and will provide a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members through systematic coordination of services and comprehensive, community-based care management. For details, see Revised CalAIM Proposal, Appendix I.
- Lessons learned from HHP have been incorporated to ensure that the new ECM benefit is designed to meet the clinical and non-clinical needs for the highest cost/highest need beneficiaries in Medi-Cal and is available as a statewide managed care benefit.

Impact to Tribal Health Programs

- All Medi-Cal Managed Care Health Plans (MCPs) who have contracted with Community-Based Care Management Entities (CB-CMEs) for provision of HHP services will be required to contract with the same providers under ECM with few allowable exceptions.
- All MCPs participating in the HHP will be required to submit a Model of Care (MOC) describing how the MCP plans to design, implement, and administer ECM, including member transitions from HHP to ECM.
- All MCP Model of Care submittals will be reviewed and approved by DHCS prior to the implementation of ECM.

Impact to Federally Qualified Health Centers (FQHCs)

- All MCPs who have contracted with CB-CMEs, many of which are FQHCs, for the provision of HHP services will be required to contract with the same providers under ECM with few allowable exceptions.
- If an FQHC serves as an HHP CB-CME, there may be negotiations between the two entities to discuss continuing serving as an ECM Provider under ECM.
- Additionally, the implementation of ECM allows for a new opportunity for FQHCs that have an interest in serving as providers to enter into contracts with MCPs.

Impact to Indian Medi-Cal Beneficiaries

- In general, DHCS expects there to be minimal to no impact to Indian Medi-Cal beneficiaries that are receiving services through HHP.
- DHCS will require that all members receiving HHP services are grandfathered in and seamlessly transitioned to continue receiving care coordination services by way of the new ECM benefit.
- MCPs will provide advance notification to all HHP enrollees, including Indian Medi-Cal managed care members enrolled in HHP, of the termination of HHP and their opportunity to transition to ECM on January 1, 2022.

Contact Information

Indian Health Programs and Urban Indian Organizations may submit written comments or questions concerning this proposal within 30 days from the receipt of notice. Comments may be sent by email to HHP@dhcs.ca.gov or by mail to the address below:

Department of Health Care Services
MCQMD
Attn: Bambi Cisneros
P.O. Box 997413, MS 4400
Sacramento, California 95899−7413

Please note that the Indian Health Programs and Urban Indian Organizations may also request a consultation on this proposal at any time, as needed.

General Questions/Comments on CalAIM: Contact CalAIM@dhcs.ca.gov. Also, for more PHM, ECM, or ILOS initiative details see the CalAIM Proposal online at: https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

SPA 21-0017

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

Presented by:
Rebecca Nix
Research Data Supervisor I
Fee-for-Service Provider Rates Development Division

Purpose

- Continuation of the Ground Emergency Medical Transport (GEMT) program that assesses a Quality Assurance Fee (QAF) and provides increased payments for GEMT services.

Background: GEMT QAF Program

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

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

SPA	Effective Dates	Affected Procedure Codes	CMS Approval Date
18-0004	July 1, 2018 through June 30, 2019	A0427, A0429, A0433	February 7, 2019
19-0020	July 1, 2019 through June 30, 2020	A0225, A0427, A0429, A0433, A0434	September 6, 2019
20-0009	July 1, 2020 through June 30, 2021	A0225, A0427, A0429, A0433, A0434	October 15, 2020

Background: GEMT QAF Program (continued)

Effective January 1, 2022, public providers as defined in Assembly Bill (AB) 1705 (Chapter 544, Statutes of 2019) will no longer be eligible to participate in the GEMT QAF program. These providers will be transitioned into a new Public Provider Intergovernmental Transfer (PPIGT) program.

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

What is QAF?

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

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

QAF Calculations and Data Collection

- For the purposes of calculating the GEMT QAF, GEMT providers are required to submit to DHCS:
  - Total number of emergency medical transports for Codes A0427, A0429, A0433, A0225, and A0434. This data shall be submitted quarterly through the online portal.
  - Gross Receipt received from the provision of emergency medical transports for Codes A0427, A0429, A0433, A0225, and A0434. This data shall be submitted annually through the GEMT QAF email box using a submission form found on the GEMT QAF website.
  - GEMT providers transitioning into the PPIGT program must still submit the data reports and QAF payments to DHCS by the due dates for dates of service through December 2021. Please note that the payment due dates for the fourth quarter of 2021 will fall after December 2021.

Summary of Proposed Changes

- The proposed SPA will seek federal approval to continue the current GEMT QAF Program for the period of July 1, 2021 through June 30, 2022.
- Eligible public GEMT providers that opt into the new PPIGT program will no longer be eligible for the GEMT QAF program effective January 1, 2022, will not be assessed QAF, and will not receive the GEMT QAF add-on.

Next Steps

- DHCS will submit SPA 21-0017 to CMS for the July 1, 2021 through June 30, 2022 period.
- June 15, 2021
  - DHCS will post the 2021-22 QAF amount to the GEMT QAF webpage.

Impact to Tribal Health Programs

- Tribally owned and operated GEMT providers must submit the required data reports and QAF payments to DHCS by the due dates
- They will receive the increased reimbursement for each Medi-Cal GEMT service provided.
- Tribally owned and operated GEMT providers will be assessed a penalty if they do not submit the required data reports to DHCS by the established due dates.
- Public GEMT providers transitioning into the PPIGT program are still required to submit the data reports and QAF payments to DHCS by the due dates for dates of service through December 2021. Please note that the payment due dates for the fourth quarter of 2021 will fall after December 2021.

Impact to Federally Qualified Health Centers (FQHCs)

- FQHC owned and operated GEMT providers must submit the data reports and QAF payments to DHCS by the due dates.
- They will receive the increased reimbursement for each Medi-Cal GEMT service provided.
- FQHC owned and operated GEMT providers will be assessed a penalty if they do not submit the required data reports to DHCS by the established due dates.
- Public GEMT providers transitioning into the PPIGT program must still submit the data reports and QAF payments to DHCS by the due dates for dates of service through December 2021. Please note that the payment due dates for the fourth quarter of 2021 will fall after December 2021.

Impact to Indian Medi-Cal Beneficiaries

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

Resources

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

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

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

Contact Information

Email to:
GEMTQAF@DHCS.ca.gov.

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

Thank You

Feedback/Questions