Understanding The 2024 Medi-Cal Managed Care Plan (MCP) Transition

California Primary Care Association
December 12, 2023

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Today's Agenda

- 2024 MCP Transition Overview
- 2024 Contract Requirements and Changes
- Improvements for Members

2024 MCP Transition Overview

DHCS is Transforming Medi-Cal Managed Care Through Multiple Channels

New Mix of High-Quality Managed Care Plans Available to Members

New Commercial MCP Mix

- Contracts with commercial MCPs announced in Dec. 2022, operational readiness process has been underway since Jan. 2023

Model Change in Select Counties

- Approval for 17 counties to change their managed care model
- Includes a new Single Plan Model and expansion of COHS model

Direct Contract with Kaiser

- In 32 counties in which Kaiser operates
- Based on provider / plan linkage or population-specific criteria for active choice / assignment such as Dual-eligible, foster children

Restructured and More Robust Contract Implemented Across All Plans in All Model Types in All Counties

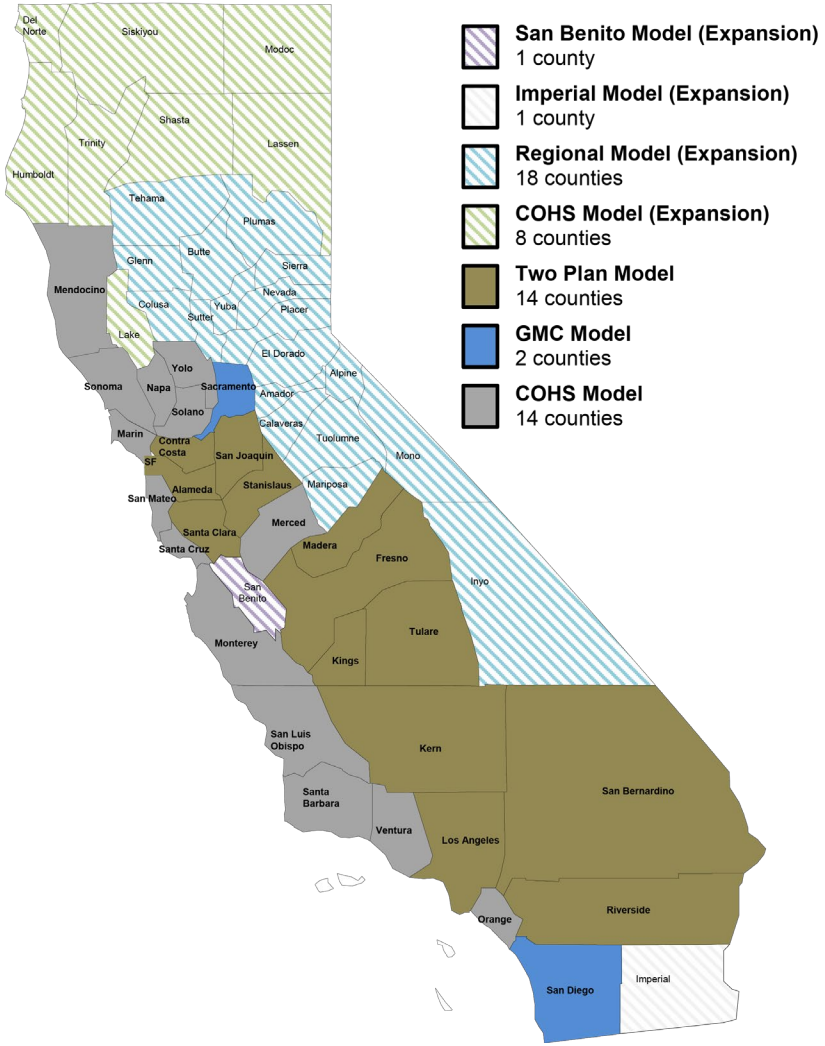
Improved Health Equity, Quality, Access, Accountability and Transparency

Managed Care Plan Transition

- Approximately 1.2 million members will transition to a new MCP on January 1, 2024
- These transitions will take place across 14 unique MCPs and 21 counties:
  - Alameda
  - Alpine
  - Butte
  - Colusa
  - Contra Costa
  - El Dorado
  - Glenn
  - Imperial
  - Kern
  - Los Angeles
  - Mariposa
  - Nevada
  - Placer
  - Plumas
  - Sacramento
  - San Benito
  - San Diego
  - Sierra
  - Sutter
  - Tehama
  - Yuba

Medi-Cal Managed Care Model Change

Current Models



San Benito Model (Expansion)
1 county

Imperial Model (Expansion)
1 county

Regional Model (Expansion)
18 counties

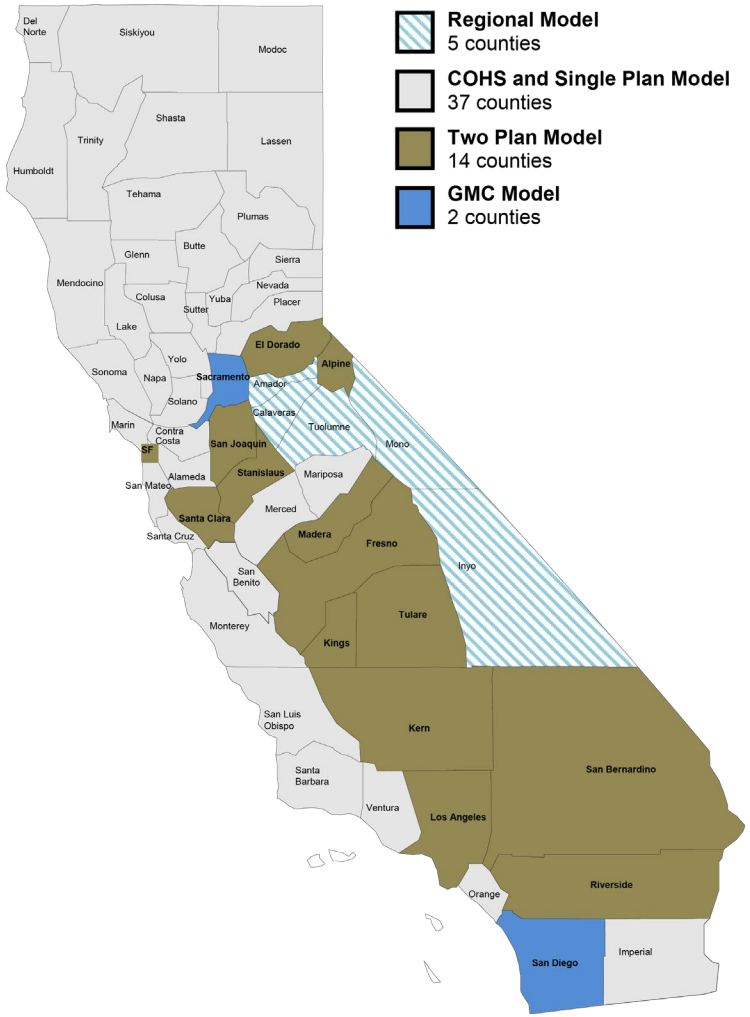
COHS Model (Expansion)
8 counties

Two Plan Model
14 counties

GMC Model
2 counties

COHS Model
14 counties

2024 Models



Regional Model
5 counties

COHS and Single Plan Model
37 counties

Two Plan Model
14 counties

GMC Model
2 counties

Kaiser Direct Contract

- In 2024, Kaiser is expanding its Medi-Cal prime plan participation through a direct contract with DHCS
- **Eligible members* may actively choose** to enroll in Kaiser in any county in which Kaiser operates, including GMC, Regional, Two Plan, COHS and Single Plan counties
- **Members already in a Kaiser subcontract** to another MCP as of September 2023, will stay with Kaiser and receive 60- and 30-day notices from Kaiser notifying them of their transition
- **Medi-Cal Matching Plan** policy will apply to Kaiser; Kaiser Medicare Advantage members in relevant counties will be automatically assigned or transitioned to the Kaiser Medi-Cal MCP
- **Default Assignment:** New members who do not make an active choice or are in a COHS or Single Plan county where Kaiser participates may be default enrolled into Kaiser, on the basis of:
  - ***Plan / family linkage:*** Members who have a history of enrollment with Kaiser or a family member enrolled in Kaiser may be default assigned to Kaiser in any county where it operates
  - ***Auto-assignment:*** New members in certain counties may be assigned to Kaiser as part of the Auto-Assignment Incentive Program, up to a specific limit set annually based on Kaiser's growth targets and capacity. Auto-assignment is not limited to the Kaiser eligible population groups

* Members are eligible to actively choose Kaiser if they: (1) have previously enrolled with Kaiser at any point during CY 2023 or have existing Kaiser membership; (2) have family linkage to Kaiser; (3) are dually-eligible for Medi-Cal and Medicare; or (4) are a foster care child or youth.

2024 Contract Requirements and Changes

More Robust MCP Contract Includes Provisions Strengthening:

- Transparency
- Quality of Care
- Access to Care
- Continuum of Care
- CalAIM Initiatives
- Coordinated / Integrated Care
- Increasing Health Equity and Reducing Health Disparities
- Addressing Social Drivers of Health (SDOH)
- Local Presence and Engagement
- Children's Services
- Behavioral Health Services
- Accountability and Commitment to Compliance
- Administrative Efficiency
- Emergency Preparedness and Essential Services
- Value-Based Payment

Access to Care & Continuum of Care, Aligned with CalAIM

MCPs will be required to meet more robust expectations for providing access to high-quality care across a comprehensive array of person-centered health care and social services, including by:

- Assisting members and families in navigating delivery systems and care management services
- Providing new Transitional Care Services to reduce discharge risks
- Ongoing implementation of CalAIM initiatives including Enhanced Care Management (ECM), Community Supports, and newly carved-in benefits (major organ transplants, long-term care services)
- Strengthening coordination and continuity of care for out-of-network providers
- Continuing to maintain comprehensive networks providing access to appropriate, culturally and linguistically competent, high-quality care
- Providing stronger care management across the continuum of care, including coordination with health and social services

Coordinated and Integrated Care

MCPs will systematically coordinate services and comprehensive care management through:

- Expanded Basic Population Health Management, Complex Care Management, and ECM to ensure needs of entire population are met across the continuum of care
- A whole-person, interdisciplinary approach for populations with complex health care needs, including through ECM
- Strengthened care coordination for all members
- Enhanced coordination with local health departments, county behavioral health plans, schools, justice systems and community-based organizations
- Facilitation of warm hand-offs to public benefit programs and follow-up to ensure members receive needed services

Behavioral Health Services Expansion

MCPs will expand access to evidence-based behavioral health services that focus on:

- Earlier identification and engagement in treatment for children, youth, and adults
- Integration of behavioral and physical health care, including No Wrong Door policies to support access
- Increased access to providers within public schools

The new contract also clarifies substance use disorder coverage and medication-assisted treatment services across settings.

Local Presence and Engagement

MCPs will ensure they and their network providers understand and meet community needs, including through:

- Stronger provisions for member and family engagement and participation in MCP advisory committees and the new statewide DHCS Member Stakeholder Committee
- Deeper engagement with local public health, social services and behavioral health departments for population health management and efforts to address SDOH
- Allocation of 5-7.5% of profits by MCPs and fully-delegated subcontractors with positive net income to community infrastructure development activities that support Medi-Cal members

Transparency

MCPs will be required to publicly post additional information about their own and subcontractors' activities, including:

- Community Investment Plan and related annual report
- Quality improvement and health equity activities
- CAHPS survey results
- Population Needs Assessment
- Fully delegated subcontractors' performance and consumer satisfaction
- Financial information, such as profits and reserves
- Memoranda of Understanding with third parties

DHCS Transparency and Accountability

In accordance with the Special Terms and Conditions of the Medi-Cal 1115 Demonstration Waiver with CMS, DHCS will:

- Regularly report to the federal government and on the DHCS website its progress related to monitoring and overseeing MCPs
- Expand its oversight responsibilities, including by publishing an independent access assessment comparing network adequacy compliance across lines of business

Improvements For Members

Medi-Cal Managed Care Members Can Expect:

- **Care management** based on their health care needs, including having a designated care manager to assist them and their families with navigating the health care system
- More **culturally competent care and services** that take into account their culture, sexual orientation, gender and gender identity, and preferred language
- **Better integration of behavioral and physical health care**, and improved access to mental health support and substance use disorder treatment
- **Focus on primary care** to ensure they get appropriate screenings, preventive care, or help managing their health needs
- **Increased transparency** and access to information that can guide them in choosing the best plan for their families and/or individual needs
- **Reinvestment in their communities** by MCPs and their subcontractors, who will be required to allocate a portion of their profits to develop community infrastructure to support members
- Robust **MCP engagement with community advisory groups**, including through additional support and responsibilities for MCPs' Community Advisory Committees, which inform plans' cultural and linguistic services programs

2024 MCP Transition Resources

- DHCS web pages with information for various audiences:
  - County Look-Up Tool
  - Continuity of Care FAQs
  - Provider FAQs
  - Members:
    - Member FAQs
    - Member notices sent by DHCS
    - Notice of Additional Information (NOAI) sent by DHCS*
  - MCPs & Stakeholders:
    - News
    - Webinars & Meetings
    - Policy resources

*Available in English and 19 threshold languages

Questions?

For more information on the 2024 MCP Transition, please visit Members | Managed Care Plan Transition | DHCS

Appendix

Transition Policies

New Enrollment Freeze for Exiting MCPs

- DHCS stopped **new** enrollment into exiting MCPs (both for active choice and default assignment) three months prior to January 1, 2024
- Exiting MCPs will retain their existing membership though December 31, 2023
- In Two-Plan, GMC, and Regional model counties, new Medi-Cal members in late 2023 will have the choice of all MCP operating in their county in 2024
- In COHS and Single Plan model counties—dually-eligible members in Medi-Cal Matching Plan counties and new Medi-Cal members in late 2023 will be automatically enrolled into an MCP for 2024.
  - If the new member chooses or is assigned to a 2024 MCP that is not yet operating in the county as a prime MCP, they will access care through the fee-for-service delivery system until the MCP is available in January 2024

MCP Transition Principles

DHCS is applying the following principles to guide the planning, implementation and oversight of the 2024 transition:

- Plan for a smooth and effective transition
- Minimize service interruptions for all members, especially for vulnerable groups most at risk for harm from interruptions in care
- Provide outreach, education and clear communications to members, providers, MCPs and other stakeholders
- Proactively monitor MCPs' implementation of transition responsibilities

Member Enrollment and Noticing

Member Enrollment Process for Counties with an Exiting MCP

In "Choice" Counties (GMC, Two Plan and Regional Models):

- **Members enrolled in an MCP that will continue to operate in 2024** will remain in their MCP unless they opt to change MCPs, as they are allowed to do today
- **Mandatory managed care members enrolled in an exiting MCP will need to enroll in a new MCP:**
  - Dual-eligible members in Medi-Cal Matching Plan counties will be automatically enrolled in a Medi-Cal MCP that matches their Medicare Advantage plan, where relevant
  - Other exiting MCP members will receive 90/60/30-day notices and a choice packet with their 60-day notice.
  - ***Default Assignment:*** If a member does not make an active choice, they will be enrolled in a MCP based on the following assignment hierarchy: (1) provider linkage, (2) plan linkage, and (3) family linkage. Absent a member meeting any of the "linkage" criteria, their default MCP will be based on the Auto-Assignment Incentive Program algorithm, which includes quality and other adjustments to an annually defined ratio for auto-assignment among MCPs in each county

In COHS Expansion and Single Plan Counties:

- **Members enrolled in a continuing MCP** (i.e., Alameda Alliance for Health, Contra Costa Health Plan, Kaiser) will remain in their MCP
- **Members enrolled in an exiting MCP** will be automatically enrolled into the COHS, Single Plan or – where relevant – Kaiser
  - Kaiser will receive default assignment for exiting MCP members in COHS and Single Plan counties where it participates on the basis of plan / family linkage and Medi-Cal Matching Plan policy (where relevant)

Noticing for Transitioning Members

- Members of exiting MCPs are receiving a:
  - 90-day notice from their exiting MCP
  - 60-day and 30-day notices from Medi-Cal Health Care Options (HCO), DHCS's enrollment broker
  - A choice packet will be sent with the 60-day notice when appropriate
  - Welcome packet from their new MCP in early January 2024
  - Notices will include a QR code to an online Notice of Additional Information that will provide more details, which members can request to receive in print or alternative format
- The notices received stakeholder feedback and were reviewed by the Center for Health Literacy
- Notices are posted on the DHCS Transition member webpage

Continuity of Care

Continuity of Care Policy Design Principles

The 2024 CoC Policies outlined in the 2024 Medi-Cal Managed Care Plan Transition Policy Guide released on June 23, 2023 aim to **minimize**:

- Service interruptions for all members required to transition MCPs on January 1, 2024, especially for groups most at risk for harm from disruptions in care (i.e., special populations)
- Member, provider, and MCP confusion
- Administrative burden while ensuring operational feasibility for DHCS and MCPs

The 2024 CoC policy for members required to transition MCPs largely aligns with current CoC policy,* with some additional protections.

*APL 23-022

Special Populations

All members required to transition MCPs January 1, 2024, have Continuity of Care protections, but some members – *Special Populations* will have enhanced protections to minimize the risk of harm.

- Special Populations are generally individuals living with complex or chronic conditions. Transitioning members will be identified using DHCS or Previous MCP data, including program enrollment, pharmacy claims, DME claims, screening and diagnostic codes, procedure codes, or aid codes. The Receiving MCP will receive these data in advance of the 2024 Transition.[1]
  - Data guidance, including member identification and transfer responsibility, was issued via August 7 Policy Guide update.
- MCPs will be required to take proactive steps to implement CoC or members of "Special Populations" through MCP outreach to members' providers and data transfer between MCPs.
- DHCS will monitor CoC for Special Populations as part of the monitoring that will happen for all members experiencing a Transition.

1. See Appendix for full list of Special Populations

Special Populations

- Adults and children with authorizations to receive Enhanced Care Management services
- Adults and children with authorizations to receive Community Supports
- Adults and children receiving Complex Care Management
- Enrolled in 1915(c) waiver programs
- Receiving in-home supportive services (IHSS)
- Children and youth enrolled in California Children's Services (CCS)/CCS Whole Child Model
- Children and youth receiving foster care, and former foster youth through age 25
- In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
- Taking immunosuppressive medications, immunomodulators, and biologics
- Receiving treatment for end-stage renal disease (ESRD)
- Living with an intellectual or developmental disability (I/DD) diagnosis
- Living with a dementia diagnosis
- In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months (referred to as "members accessing the transplant benefit" hereafter)
- Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
- Receiving specialty mental health services (adults, youth, and children)
- Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
- Receiving hospice care
- Receiving home health
- Residing in Skilled Nursing Facilities (SNF)
- Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)20
- Receiving hospital inpatient care
- Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
- Newly prescribed DME (within 30 days of January 1, 2024)
- Members receiving Community-Based Adult Services

See the MCP Transition Policy Guide, Figure 2 for more detail

Continuity of Care for Providers

All members required to transition MCPs will be eligible to keep their Out-of-Network (OON) providers for 12 months when transitioning to the Receiving MCP. Additional enhanced protections will apply to Special Populations.

» CoC Policy for Providers for <u>all members</u> required to transition MCPs, including Special Populations

- Members of Previous MCPs may continue seeing their OON Medi-Cal providers[1] for 12 months[2] following the member's Transition if certain requirements are met:
  - Member and provider have a pre-existing relationship
  - Provider is willing to accept the Receiving MCP's contract rates or Medi-Cal FFS rates
  - Provider meets professional standards and there are no quality-of-care issues
  - Provider is CA State Plan approved

» Enhanced Protection for <u>Special Populations</u>

- MCPs contact providers treating Special Populations to initiate the process for entering a CoC agreement.
- Extended CoC period for certain populations[3]

[1]Depending on provider type
[2]With some exceptions to this timeframe per Knox Keene. See Appendix.
[3]In alignment with Knox Keene. See Appendix.

Continuity of Care for Providers

Eligible Providers:

- Primary care providers (PCPs)
- Specialists
- Select ancillary providers:
  - Dialysis centers
  - Physical therapists
  - Occupational therapists
  - Respiratory therapists
  - Mental health providers
  - Behavioral health treatment (BHT) providers
  - Speech therapy providers
  - Doulas
  - Community Health Workers
- Enhanced Care Management providers
- Community Supports providers
- Skilled Nursing Facilities (SNFs)
- Community-Based Adult Services providers.
- Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)*

Excluded providers:

- All other ancillary providers, such as:
  - Radiology
  - Laboratory
  - Non-emergency medical transportation (NEMT)
  - Other ancillary services
- Non-enrolled Medi-Cal Providers.

*The 2024 MCP Transition CoC policy only applies to members residing in ICF/DD who are in managed care as of December 31, 2023, which occurs only in COHS and Single Plan counties.

Continuity of Care Policy Levers

All members required to transition MCPs January 1, 2024, are eligible for CoC protections using the following policy levers.

- **CoC for Providers** – The member can keep their provider even if the provider is out of network for the Receiving MCP.
- **CoC for Covered Services** – The member can continue an active course of treatment and the Receiving MCP must honor prior authorizations from the member's Previous MCP.
- **CoC Coordination/Care Management Information** – Previous MCP and Receiving MCP work together to transfer additional supportive information (e.g., care plans).
- **Additional Continuity of Care Protections for All Transitioning Members** - All transitioning members are eligible for additional protections related to Durable Medical Equipment (DME) rentals and medical supplies, non-emergency medical transportation (NEMT) and non-medical transportation (NMT), and scheduled specialist appointments

These levers are currently deployed in policies through the Knox Keene Act,* APL 23-022 covering CoC, and the Policy Guides for ECM and Community Supports.

*Knox Keene CoC policy provides protection for some members who will transition to new MCPs in 2024: Members with an acute condition, serious chronic condition, pregnancy and postpartum, care of child between birth and 36 months, terminal illness, and authorized surgery or procedures documented as part of treatment plan to occur within 180 days.
For purposes of the 2024 CoC Policy discussion, the reference to Knox Keene is synonymous with Health and Safety Code 1373.96.

Continuity of Care for Covered Services

The policy for continuing active courses of treatment outside of Knox Keene is new, as is the expectation for MCP outreach to providers treating Special Populations. The policy for continuing authorizations is not new.

» CoC Policy for Services for <u>all members</u> required to transition MCPs, including Special Populations

- Members keep their existing authorizations for Covered Services for six months following the member's Transition to the Receiving MCP from the Previous MCP.
- Members can continue their "active course of treatment" without authorization for six months. Any active course of treatment is expected to be documented prior to January 1, 2024.
- Active Course of Treatment defined as: a course of treatment in which a patient is actively seeing a provider and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition.

» Enhanced Protection for <u>Special Populations</u> *(inclusive of members receiving CBAS)*

- Following the Transition, members keep their existing authorizations for six months and until the Receiving Plan assesses clinical necessity for ongoing services.
- During the six-month CoC for Services period, the Receiving MCP must examine utilization data of Special Populations to identify any Active Course of Treatment that requires authorization and must contact those providers to establish any necessary Prior Authorizations.

» Enhanced Protection for <u>Special Population Members Accessing the Transplant Benefit</u>

- The Receiving MCP must start reassessments for clinical necessity no sooner than six months after the transition date (beginning July 1, 2024). The reassessment applies to adults, and children for transplants performed to treat conditions that are not medically eligible for the California Children's Services (CCS) Program.

Continuity of Care Coordination and Care Management Information

Care coordination and care management information will travel with Members to the Receiving MCP. This is not a current expectation under the 2023 CoC Policy.

- This proposed policy applies only to Special Populations.
- Proposed CoC Policy:
  - Previous MCP provides contact information for plan-level contact and care managers to Receiving MCP
  - If a Member changes care managers,[1] the Receiving MCP contacts the Member's Previous MCP and/or care manager to obtain supportive information including, but not limited to:
    - Results of member assessments, member care plans, and ad hoc communication and coordination between incoming and outgoing care managers.
  - Information transfer must be complete before January 1, 2024, or within 15 calendar days of the Member changing to a new Care Manager, whichever is later.

[1] MCPs serving Medi-Cal Members in 2024 and beyond are expected to contract with all Enhanced Care Management (ECM) Providers, and thus, Members enrolled in ECM are not expected to change their care manager.

Enhanced Care Management and Community Supports

Enhanced Care Management Transition Policy for the 2024 MCP Transition

DHCS is committed to ensuring that Medi-Cal Members are authorized to receive ECM and Community Supports do not experience disruptions to authorizations, provider relationships or services due to the MCP Transition on January 1, 2024.

Enhanced Care Management:

- The Transition Policy for ECM **builds on and is aligned with the ECM Policy Guide and the Continuity of Care provisions contained therein**, as well as the Continuity of Care section in this Policy Guide.
- Members authorized for ECM, regardless of whether they are actively receiving ECM, are considered a **Special Population**. As such, the Receiving MCP **must honor all of the Previous MCPs' authorizations for ECM.**
- To ensure no interruption for Transitioning Members receiving ECM, DHCS will **require mandatory overlap of the Previous MCP's and Receiving MCP's ECM Providers to the maximum extent possible.**

Community Supports Transition Policy for the 2024 MCP Transition

Community Supports:

- The Transition Policy for Community Supports **builds on and is aligned with the Medi-Cal Community Supports, or In Lieu of Services, Policy Guide and the Continuity of Care provisions contained therein**, as well as the Continuity of Care section in this Policy Guide
- When both MCPs **offer the same Community Support**, the Receiving MCP must **honor the Community Support that was authorized by the Previous MCP** in alignment with DHCS Community Supports Policy Guide. If the Previous MCPs authorization **exceeds the State-defined Community Support** (e.g., due to member need), the Receiving MCP is **strongly encouraged to honor the greater Community Support** which has already been authorized
- If the Receiving MCP **does not offer a Community Support offered by the Previous MCP**, DHCS **strongly encourages the Receiving MCP to honor the Previous MCP's authorization for the Community Support** for those members determined eligible at the time of the Transition. If the Receiving MCP does not continue the Previous MCP's authorization for a member's Community Support, the Receiving MCP must assess the member's needs that are addressed by the Community Support and coordinate care to the necessary services, including ECM, to ensure an appropriate transition of care and to prevent the need for higher acuity services.