State of California—Health and Human Services Agency
Department of Health Care Services

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**DATE:** October 18, 2021

ALL PLAN LETTER 21-015

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS

**SUBJECT:** BENEFIT STANDARDIZATION AND MANDATORY MANAGED CARE ENROLLMENT PROVISIONS OF THE CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL INITIATIVE

**PURPOSE:**
The purpose of this All Plan Letter (APL) is to provide guidance to all Medi-Cal managed care health plans (MCPs) on the Benefit Standardization and Mandatory Managed Care Enrollment (MMCE) provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative.[1]

**BACKGROUND:**
CalAIM seeks to move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility through Mandatory Managed Care Enrollment and Benefit Standardization.

The Medi-Cal program provides benefits through both a fee-for-service (FFS) and managed care delivery system. Enrollment into FFS or managed care is based upon specific geographic areas, the managed care model type, and/or the Medi-Cal eligibility aid code assigned to a beneficiary. Currently, enrollment in managed care is voluntary for some beneficiaries while others are excluded from managed care altogether. In an effort to enhance coordination of care, increase standardization, and reduce complexity across the Medi-Cal program, the Department of Health Care Services (DHCS) is standardizing managed care and FFS enrollment statewide. Standardizing enrollment processes will help ensure populations moving between counties are subject to the same enrollment requirements, thereby eliminating variances in benefits according to aid code, population, and geographic location.

While Medi-Cal managed care is available statewide, the benefits vary among counties depending on the managed care plan model. Variations in benefits include the following:

- Only County Organized Health System (COHS) MCPs currently cover the Major Organ Transplant (MOT) benefit.

[1] The CalAIM proposal can be found on DHCS' website at the following link: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-03-23-2021.pdf

- Only COHS MCPs, as well as the MCPs and Cal MediConnect Medicare-Medicaid Plans (MMPs) operating in the seven Coordinated Care Initiative (CCI) counties, currently cover institutional Long Term Care (LTC) services.[2]
- Kaiser Foundation Health Plan covers Specialty Mental Health Services (SMHS) in Solano and Sacramento Counties.[3,4]

To further CalAIM's goals to standardize and reduce complexity across the state and reduce county-to-county differences, DHCS will implement Benefit Standardization across MCPs statewide. Benefit Standardization will help ensure consistency in what benefits are delivered by managed care and FFS statewide and allow for transition of specific populations into managed care through MMCE.[5]

Effective no sooner than January 1, 2022, DHCS will:

- Require the non-dual population in voluntary or excluded aid code groups (detailed in Attachment 1 of this APL) to enroll in an MCP.[6]
- Transition the populations outlined in Attachment 1 of this APL from the Medi-Cal managed care delivery system into the Medi-Cal FFS delivery system.

Effective no sooner than January 1, 2023, DHCS will:

- Require the dual populations outlined in Attachment 1 of this APL in non-COHS and non-CCI counties (except those with a Share of Cost (SOC) or restricted scope Medi-Cal) to enroll in an MCP.[7]
- Require all non-dual and dual LTC beneficiaries (including SOC LTC) to enroll in an MCP.

DHCS will ensure MCP readiness before the transition of these populations into managed care, including but not limited to, requiring MCPs to submit data and information to DHCS to confirm there is an adequate network in place to meet anticipated utilization for their members.

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[2] The seven CCI Counties are: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
[3] Solano is a COHS model county and Sacramento is a Geographic Managed Care model county.
[4] Kaiser is a Subcontractor of Partnership Health Plan of California in Solano County.
[5] See Attachment 1 for more detailed information on MMCE
[6] Non-dual beneficiaries are defined as Medi-Cal beneficiaries only or Medi-Cal only beneficiaries with Medicare Part A **or** Part B only.
[7] Dual beneficiaries are defined as Medi-Cal beneficiaries with Medicare Part A **and** Part B or Medicare Part A, B, and D.

**POLICY:**

## I. MANDATORY MANAGED CARE ENROLLMENT:

Starting January 1, 2022, beneficiaries in certain voluntary or excluded aid codes that are currently enrolled in Medi-Cal FFS will be transitioned to Medi-Cal managed care and will be required to enroll in an MCP. These beneficiaries will not be permitted to remain in Medi-Cal FFS except for individuals eligible for disenrollment or exemption from mandatory enrollment. Beneficiaries will be defaulted into an MCP if they do not make a plan choice. DHCS will implement MMCE in two phases:

1) In 2022, non-dual (Medi-Cal only) and some dual eligible populations.

   The following populations will transition from FFS to Medi-Cal managed care no sooner than January 1, 2022:

   - Trafficking and Crime Victims Assistance Program, except share of cost (non-dual and dual)
   - Individuals participating in accelerated enrollment (non-dual and dual)
   - Breast and Cervical Cancer Treatment Program (BCCTP) (non-dual)
   - Beneficiaries with other health coverage (non-dual)
   - Beneficiaries living in rural ZIP codes[8] (non-dual)

   American Indian/Alaska Native beneficiaries have the option to opt in or opt out of managed care enrollment in Non-COHS counties only. In COHS counties, American Indian/Alaska Native beneficiaries do not have the option to opt out of mandatory managed care enrollment.

   In addition, DHCS will transition Omnibus Budget Reconciliations Act (OBRA) and SOC beneficiaries (except institutional long-term care SOC beneficiaries) that are currently enrolled in the Medi-Cal managed care delivery system into Medi-Cal FFS.

[8] Rural zip codes: 93558, 90704, 92225, 92226, 92239, 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 9359293555, 93556, 93560, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304,92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92358, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, 92398

2) In 2023, dually eligible Medicare and Medi-Cal beneficiaries and institutional long-term care populations will transition to managed care enrollment, except for individuals eligible for disenrollment or exemption from mandatory enrollment.

See Attachment 1 for more detailed information on MMCE.

## II. BENEFIT STANDARDIZATION:

**Major Organ Transplants**
Effective January 1, 2022, all MCPs are required to cover the Major Organ Transplant (MOT) benefit for adult and pediatric transplant recipients and donors, including related services such as organ procurement and living donor care.

MCPs must authorize, refer and coordinate the delivery of the MOT benefit and all medically necessary covered services associated with MOTs, including, but not limited to, pre-transplantation assessments and appointments, organ procurement costs, hospitalization, surgery, discharge planning, readmissions from complications, post-operative services, medications not otherwise covered by the MCP contract, and care coordination for transplants that the MCP is responsible for.[9,10,11] MCPs will not be required to pay for costs associated with transplants that qualify as a California Children's Services (CCS) condition if the MCP does not participate in the Whole Child Model (WCM) program. MCPs must also cover all medically necessary covered services for both living donors and cadaver organ transplants.[12] MCPs may authorize MOTs to be performed only in approved transplant programs located within a hospital that meets DHCS criteria.[13]

MCPs participating in the WCM program will continue to be responsible for covering the MOT benefit for its CCS-eligible beneficiaries. WCM MCPs must ensure that all MOT

[9] Billing Examples for Inpatient Services for transplants is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/transplantexip.pdf
[10] Further information about transplants is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/transplant.pdf
[11] Donor protocol for transplants is available here: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/transplantproto.pdf
[12] Title 42 of the Code of Federal Regulations (CFR) Section 482.94, 482.94(c)(ii). Part 482 of the CFR is searchable at: https://www.ecfr.gov/cgi-bin/text-idx?SID=4841e8fe7f6f3cef42c3c64e43ba6fc3&mc=true&node=pt42.5.482&rgn=div5.
[13] Criteria for approved transplant programs is detailed in Attachment 2.

surgeries are performed in CCS-approved Special Care Centers (SCCs). A list of the CCS-approved SCCs can be found on DHCS' website.[14]

MCPs that do not participate in the WCM program will be required to refer pediatric beneficiaries that are identified as MOT candidates by their Primary Care Provider or specialist to the CCS County program to determine the beneficiary's eligibility for the CCS program. If the CCS County program determines that the beneficiary is CCS-eligible, the CCS County program will be required to refer the beneficiary to the appropriate CCS-approved SCC. The DHCS Integrated Systems of Care Division will be responsible for determination of medical necessity and adjudication of the request for the MOT upon the SCC's confirmation that the beneficiary is a suitable candidate for the MOT.

If the CCS County program determines that the beneficiary is not eligible for the CCS program, the non-WCM MCP will be responsible for referring the beneficiary to an appropriate transplant program that meets DHCS' criteria. The MCP will be responsible for authorizing the request and covering the transplant once the transplant program determines that the beneficiary is a suitable candidate for the MOT.

Prior to the carve-in of the MOT benefit statewide, each MCP, including COHS MCPs, will be required to submit its MOT network for DHCS to confirm there is an adequate MOT network.

Subject to all necessary federal approvals being obtained, MCPs shall pay providers of MOT services in accordance with Section 14184.201(c)(2) of the Welfare and Institutions Code.

See Attachment 2 for more detailed information on MOT.

**Specialty Mental Health Services**
Effective July 1, 2023, specialty mental health services (SMHS) will be carved-out (i.e. not covered) services for all MCPs, specifically Kaiser Foundation Health Plan, and will be covered by county Mental Health Plans. MCPs are contractually required to develop and implement policies and procedures (P&Ps) to ensure that beneficiaries who need SMHS are referred to and receive such services from an appropriate SMHS mental health provider.[15] MCPs must continue to cover and ensure that beneficiaries receive covered services, including primary care services and any mental health services that is

[14] CCS approved SCCs can be found at https://www.dhcs.ca.gov/services/ccs/scc
[15] SMHS are mental health services outside the scope of practice of Primary Care Providers (PCP)

not considered specialty mental health care. MCPs are required to coordinate and manage carved out services with the SMHS provider(s). For example, MCPs must make good faith efforts to confirm whether beneficiaries receive referred treatments and document when, where, and any next steps following treatment. If a beneficiary does not receive referred treatments, the MCP must follow up with the beneficiary to assist in planning next steps in care coordination understand barriers and make adjustments to the referrals if warranted. MCPs should also attempt to connect with the provider to whom the beneficiary was referred to and facilitate a warm hand off to necessary treatment.

**Institutional Long-Term Care Services**
Effective January 1, 2023, all MCPs will be required to authorize and cover institutional LTC services as required by state and federal law in an appropriate LTC facility.[16] LTC means care that is provided in a skilled nursing facility (SNF), intermediate care facility (ICF), or sub-acute facility. Those facilities include: SNF, ICF, Intermediate Care Facility for Developmentally Disabled (ICF/DD), Intermediate Care Facility for Developmentally Disabled with Habilitative (ICF/DDH), Intermediate Care Facility for Developmentally Disabled with Nursing (ICF/DDN), Subacute Facilities and Pediatric Subacute Facilities.

MCPs will be required to implement quality monitoring, assurance, and improvement efforts for LTC services at institutional settings.

DHCS will be issuing forthcoming guidance regarding institutional LTC.

**Additional MCP Requirements**
MCPs must update and submit their P&Ps to include all requirements in this APL to their Managed Care Operations Division (MCOD) Contract Manager. In addition, MCPs must submit any P&Ps required in any DHCS deliverables lists for MOT and MMCE to their MCOD Contract Manager. MCPs are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs. These requirements must be communicated by each MCP to all subcontractors and network providers.

[16] Title 22 California Code of Regulations (CCR) sections 51118, 51120, 51120.5, 51121, 51124.5, and 51124.6 and the criteria for admission as set forth in Title 22 CCR sections 51335, 51335.5, 51335.6, and 51334. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Michelle Retke

Michelle Retke, Chief
Managed Care Operations Division