



Transforming Medi-Cal Managed Care Through Statewide Procurement

On February 9, 2022, the Department of Health Care Services (DHCS or the Department) released a Request for Proposal (RFP) to commercial Medi-Cal managed care plan contractors. Through this process, based on a restructured and more robust contract, the state is embarking on new relationships with managed care plans. The goal is to enhance how care is delivered to Medi-Cal members by advancing health equity, quality, access, accountability, and transparency of the health care delivery system.

One in three Californians and more than half of school-age children are enrolled in Medi-Cal. Additionally, half of California births and more than two in three long-term care patient days in California are covered by Medi-Cal. With approximately 99 percent of Medi-Cal beneficiaries expected to enroll in a managed care plan by 2024, Medi-Cal can set the pace for transforming the state's entire health care system.

California relies on its Medi-Cal managed care plans (referred to as "MCPs" and "plan partners" in this brief) to provide health care services to more than 12 million enrolled Californians. While this procurement is for commercial MCPs, DHCS will implement the new MCP contract across all plan model types, including County Organized Health Systems, Local Initiative Plans, and the new Single Plan Model Type Plan. In parallel with the commercial plan procurement, DHCS has provided [conditional approval](#) to 17 counties to change the type of managed care model in which they participate and proposed a direct contract with Kaiser in 32 counties, subject to state and federal approval. County-level model changes, direct contract with Kaiser and plan changes resulting from the procurement will provide a different mix of MCPs available to beneficiaries across California in 2024. All MCPs will go through a rigorous readiness review period in 2022–2023 to demonstrate their ability to comply with the new MCP contract provisions. DHCS and its plan partners will provide substantial outreach to members to advise them of these changes in advance of the transition.

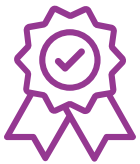
The recently released RFP is issued as part of California's first statewide procurement, signaling a shift in how the Medi-Cal managed care delivery system is administered. By rebidding commercial Medi-Cal managed care contracts and putting in place a new contract with all managed care plan partners across model types, California seeks to ensure that plans are committed to, capable of, and accountable for meeting the state's goal of achieving a Healthier California for All.

New Requirements of Managed Care Plan Partners

Through this bidding process, DHCS will select managed care plan partners that demonstrate their commitment and ability to meet the following new and enhanced contract requirements:



Transparency. Plan partners will now be required to routinely and publicly report on access, quality improvement, and health equity activities, including their fully delegated subcontractors' performance and consumer satisfaction. These reports will be posted publicly by DHCS to help members choose their plan. MCPs will also be required to post their financial performance information and Memoranda of Understanding with third parties.



High-Quality Care. Plan partners will be expected to exceed quality improvement benchmarks and create a culture of continuous quality improvement with a focus on primary care, physical and behavioral health, access to and engagement of providers, and continuity and coordination across settings and all levels of care. MCPs will be held accountable for their own quality as well as that of their subcontractors. MCPs failing to achieve quality benchmarks will face sanctions and potentially be required to surrender a portion of their net income. MCPs will be newly required to review utilization reports to identify members not using primary care, and to address those members' needs and health disparities. Plan payment will be linked to quality and equity, and MCPs will be required to comply with new provider shared risk/savings and incentive arrangements. MCPs and their subcontracted plans are expected to achieve National Committee for Quality Assurance (NCQA) Health Plan Accreditation by 2026.



Access to Care. Plan partners will be required to meet more robust expectations in assisting members and their families with navigating delivery systems and care management services. MCPs will maintain comprehensive networks that provide all members timely access to care that is appropriate, culturally and linguistically competent, high quality, and within geographic access standards, and that include timely access to interpreter services, auxiliary aids and services, and appropriate telehealth modalities.



Increased Health Equity and Reduced Health Disparities. Plan partners will meet new requirements related to reducing health disparities among specific populations and measures identified by DHCS. MCPs will be required to identify physical and behavioral health disparities and inequities in access, utilization, and outcomes by race, ethnicity, language (including limited English proficiency), and sexual orientation, and to have focused efforts to improve health outcomes within the most impacted groups and communities. For the first time, plans will be required to have a Chief Health

Equity Officer. Furthermore, both the MCPs and their subcontracted health plans will be mandated to achieve NCQA Health Equity Accreditation, a new standards program focused on advancing the delivery of more equitable and culturally and linguistically appropriate services across member populations.



Continuum of Care. Plan partners will help members manage their health over time through a comprehensive array of person-centered health care and social services spanning all levels of care, from birth to dignified end of life. Plan partners will be obligated to strengthen their coordination and continuity of care for out-of-network providers and to educate members on, for example, what an advance directive is and their right to have one.



California Advancing and Innovating Medi-Cal (CalAIM) Initiatives. Plan partners will implement and support [CalAIM](#) initiatives to improve the quality of life and health outcomes of member populations by establishing broad delivery system, program, and payment reform across Medi-Cal.



Coordinated/Integrated Care. Plan partners must ensure the needs of their entire member population are met across the continuum of care. MCPs will systematically coordinate services and comprehensive care management with a whole-person, interdisciplinary approach for populations with complex health care needs. This includes coordination with services provided by local health departments, county behavioral health plans, schools, justice systems, and community-based organizations. Plan partners will be required to facilitate warm hand-offs and closed-loop referrals of members to community resources and follow-up to ensure services are rendered.



Addressing Social Drivers of Health (SDOH). Plan partners will be expected to implement new population health management and care management strategies to address the unmet social needs of members, such as food security and housing, and document members' SDOH needs and services.



Local Presence and Engagement. MCPs will partner with local agencies (e.g., local health departments, county behavioral health plans, continuums of care, community-based organizations) to ensure that they understand and meet community needs. These relationships will help plans and providers go beyond the walls of a clinical office to address SDOH. MCPs and their fully delegated subcontractors with positive net income will also be required to allocate 5 to 7.5 percent of these profits (depending on the level of their profit) to local community activities that develop community infrastructure to support Medi-Cal members.



Children's Services. MCPs will take on new contract obligations for children with special health care needs that require them to implement methods for ensuring care management and care coordination with appropriate programs. Plans will be newly required to provide medically necessary health and behavioral health services in schools and other settings (i.e., at home and in the community) and implement interventions by school-affiliated providers that increase access to preventive, early intervention, and behavioral health services. For the first time, plans will be required to train providers on Early and Periodic Screening, Diagnostic, and Treatment Services. MCPs will be expected to ensure that their Community Advisory Committee membership reflects that of the health plan and the county being served, including children (or parents/caregivers of children) and adolescents.



Behavioral Health Services. Plan partners will expand access to evidence-based behavioral health services focused on earlier identification and engagement in treatment for children, youth, and adults and integrated with physical health care, including establishment of No Wrong Door policies to support access to diagnoses and treatment. Services will align with state-required interventions that increase access to providers within transitional kindergarten through grade 12 publicly funded schools. The contract clarifies substance use disorder coverage – including alcohol and drug screening, brief intervention, and referral to treatment – and medication-assisted treatment services across settings.



Accountability and Commitment to Compliance, Including Monitoring and Oversight of Delegated Entities. Plan partners must demonstrate robust accountability, compliance, monitoring, and oversight programs, including for all delegated entities, to ensure members receive quality care and have access to services. Managed care plans will be held accountable for the quality of care at all levels of delegation. This will include justification for the use of delegated entities and subcontractors to ensure that members' experiences and outcomes are drivers of these decisions. Additionally, for the first time, the contract mandates that MCPs report information on delegated functions.



Emergency Preparedness and Essential Services. During and after emergencies – such as a natural or man-made disaster or health crisis – plan partners will ensure delivery of essential care and services (including telehealth) to members and continuity of business operations.



Value-Based Payment. Plan partners will be mandated to link provider payments to value in the form of higher quality of care, better health care outcomes, and lower cost of care. Building on proposed changes for 2023 to base capitation payment rates on

performance on certain high-priority quality and health equity outcome measures, such arrangements include incentive payment arrangements that reward providers for high or improved performance on selected measures or benchmarks. Plan partners will report on what proportion of their spending is on primary and integrated care and tied to alternative primary care payment models.



Administrative Efficiency. Plan partners will reduce administrative waste and enhance efficiency.

Impact on Medi-Cal Members' Experience

With a focus on equity, quality, access, accountability, and transparency, the state's transformation of the Medi-Cal managed care delivery system will result in members receiving more holistic health care that takes into account social drivers of health, cultural and linguistic differences, and physical and behavioral needs throughout a member's life span. Medi-Cal members can expect:

- More information and insight to inform their choice of plan.
- A comprehensive array of person-centered health and social services from birth to dignified end of life.
- Better access to expanded preventive and early intervention services for children and services that support physical, social, and emotional development and address adverse childhood experiences.
- Care that is appropriate, high quality, and timely, including access to appointments, interpreter services, auxiliary aids and services, and appropriate telehealth modalities.

Alignment with Broader Medi-Cal Vision

Partnering with managed care plans that exceed the new contract requirements will further amplify and strengthen the state's unprecedented, recent investments in Californians' health and well-being. These investments are centered on the Administration's and DHCS' vision for Medi-Cal, founded on equity, better health outcomes, greater accountability for results, capacity building, and overall advancement of opportunities for Californians. Investments include:

- **CalAIM.** CalAIM provides the framework, infrastructure, and tools to support and guide statewide improvements in health and well-being. CalAIM implements a whole-system, whole-person, population health approach to equitable health and social care. This is an integrated wellness system to support and anticipate health needs, prevent illness, and reduce the impact of poor health.
- **Medi-Cal Expansion to All Regardless of Immigration Status.** The expansion of Medi-Cal to income-eligible populations regardless of immigration status includes young adults and the forthcoming expansion to adults ages 50 and older in May 2022 as well as the Governor's recent proposal to expand to populations between the ages of 26 and 49.
- **Children and Youth Behavioral Health Initiative.** This \$4 billion investment over five years will transform California's behavioral health system for young people into an innovative and prevention-focused system in which all children and youth are routinely screened, supported, and treated for emerging and existing behavioral health needs regardless of payer.
- **Behavioral Health Continuum Infrastructure Program.** This \$2.2 billion investment in competitive grants enables qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources. It will strengthen mental health services for people living with serious mental illness and for children and youth living with serious emotional disturbance.
- **Home and Community-Based Services Spending Plan.** This \$4.6 billion plan will expand services for California's most at-risk residents through Medi-Cal. These investments build capacity and transform critical safety net programs, as well as promote economic mobility and social stability, while maintaining Californians in their communities.
- **New Benefits to Support Culturally Competent Services.** The addition of community health workers, doulas, and dyadic care as Medi-Cal benefits will enhance culturally competent access to care and address barriers to better health outcomes.
- **Comprehensive Quality Strategy and Equity Roadmap.** The 2022 DHCS roadmap is a broad strategy that encompasses all of the Department's quality activities and includes program-specific objectives and metrics demonstrating the state's commitment to quality and health equity in all program activities.

To achieve this vision and make good on these investments, the state must demand more from its managed care plan partners and our delivery system. Consequently, this new contract requires all plan partners to demonstrate their commitment and capacity to support and help DHCS implement these initiatives.

DHCS' Future Approach to Ensuring Managed Care Plan Partner Accountability

As part of the improved transparency expected of the MCPs, DHCS will regularly report to the federal government and on the DHCS website its progress related to monitoring and overseeing plan partners. The new model contract includes additional oversight and accountability requirements:

- Plan partners will submit their compliance plan and publicly post it on their website. In addition, partners will submit a delegation reporting and compliance plan with a full view of their delegation structure and explain how they will ensure that all subcontractors providing services to Medi-Cal members are in compliance.
- As a new enforcement tool, all prime MCPs will provide remittance if they do not meet the medical loss ratio (MLR) minimum of 85 percent by January 2024. (The MLR is a measure of plan spending on medical care and quality improvement activities.) All fully or partially delegated plans and subcontractors, as applicable, will provide remittance if they do not meet the MLR minimum by January 2025.
- DHCS will newly require MCPs to report primary care spending (as a percentage of total expenditures) to help ensure sufficient investment in upstream and preventive care.
- To encourage value-based payments and a focus on quality and outcomes at the provider level, DHCS will require plans to report the percentage of their payments to providers that are tied to alternative payment models. (These initiatives will build on proposed changes to MCPs' base capitation payment rates according to their performance on selected high-priority quality and health equity outcome measures, scheduled for 2023.)
- Plan partners will be held accountable for exceeding the minimum performance level (MPL) for a host of pediatric and maternal-specific metrics, such as rates of developmental screening in the first three years of life and the promptness of prenatal care. Plans and subcontractors will be expected to meet an MPL set at the 50th percentile and will face financial penalties if the target is not met. If the plan fails to meet the metrics, then it must submit a corrective action plan. DHCS will also require reporting on a number of additional child and maternal measures, allowing for the development



of enforceable minimum performance level standards in future years. DHCS will also create a subset of metrics by race and ethnicity to inform the establishment of future health disparity reduction targets.

- If quality metrics are not met, managed care plans with positive net income will be required to allocate an additional 7.5 percent of their net income to community infrastructure development, thereby safeguarding public resources for the good of Medi-Cal members and their communities. This will be in addition to the potential imposition of corrective actions, sanctions, and liquidated damages.

Complementing these efforts, the state is expanding its oversight responsibilities as part of its new federal 1915(b) waiver, including by publishing an independent access assessment that contains a comparison of network adequacy compliance across different lines of business, including Medi-Cal managed care, Medicare Advantage, and the private market.

Looking Ahead

The RFP was released on February 9, and proposals from managed care plans are due April 11, 2022. The state is expected to issue notices of intent to award in August 2022, and all MCP contracts will become effective on January 1, 2024. The contract is a point-in-time document and will be updated before final execution as policies are refined.

Additional information about the procurement can be found [here](#).