LAO

The 2021-22 Budget:
Analysis of CalAIM Financing Issues

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The California Advancing and Innovating Medi-Cal (CalAIM) proposal is a far-reaching set of reforms to expand, transform, and streamline Medi-Cal service delivery and financing. This post—the second in a series assessing different aspects of the Governor's proposal—analyzes CalAIM financing issues, including both the Governor's funding plan for CalAIM as well as CalAIM's policy changes related to Medi-Cal financing. The first post in this series provides an overview of CalAIM, including the key changes from last year's withdrawn proposal, and analyzes overarching issues related to the proposal. Subsequent posts in this series will assess how CalAIM could affect the care provided to Medi-Cal's senior and disabled populations and health equity.

Background

Medi-Cal and the State's Expiring 1115 Waiver. Medi-Cal is the state's Medicaid program. As a joint state-federal program, Medi-Cal costs generally are shared between the federal, state, and local governments. Federal Medicaid rules outline what health care services and populations are eligible to receive federal Medicaid funding. Through a federal waiver opportunity for states known as the 1115 waiver, states can receive federal funding for experimental, innovative programs whose rules do not strictly conform to federal Medicaid rules. California has used this authority for many years. Under the state's current 1115 waiver—that is set to expire at the end of 2021—the state operates a variety of innovative programs. The following bullets summarize several of the state's current 1115 waiver programs:

- The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, which provides incentive payments tied to the state's public hospitals meeting certain quality and efficiency targets.
- The Global Payment Program, which repurposes federal funding for uncompensated care at public hospitals into an incentive-based structure that encourages hospitals to provide preventive care in order to avoid the need for acute care.
- The Dental Transformation Initiative, under which dental providers receive payments for meeting performance benchmarks related to the provision of preventive dental care and continuity of coverage.
- The Whole Person Care program, which allows participating counties to receive funding to coordinate and provide health, behavioral health, and social services for Medi-Cal high-risk, high-need beneficiaries.
- The Drug Medi-Cal Organized Delivery System program, which expands the array of substance use disorder services available within participating counties.

Governor Proposed CalAIM as Part of the January 2020-21 Budget Before Withdrawing the Proposal in May. CalAIM is a large package of reforms aimed at (1) reducing health disparities by focusing attention and resources on Medi-Cal's high risk, high-need populations; (2) rethinking behavioral health service delivery and financing; (3) transforming and streamlining managed care; and (4) extending federal funding opportunities currently available under the state's

soon-to-expire 1115 waiver. Originally proposed in January 2020 as part of the 2020-21 budget, CalAIM was withdrawn at the May Revision due to the coronavirus disease 2019 and the estimated effects the pandemic was having on the state's fiscal situation. Prior to its withdrawal, the Governor proposed to fund CalAIM with $348 million General Fund ($695 million total funds) in 2020-21 and $395 million General Fund ($790 million total funds) annually on an ongoing basis. The non-General Fund portion of these proposed expenditures comprised federal Medicaid funds.

Governor's Proposal

The Governor's 2021-22 budget reintroduces CalAIM in a highly similar form to last year's proposal. **Figure 1** summarizes the major policy reforms included under the CalAIM proposal, the vast majority of which are essentially unchanged from last year's proposal except as relates to their proposed implementation time line. The Governor is seeking significant state statutory changes related to CalAIM, which are needed to authorize many components of the reform package.

Proposed Policy Changes Affecting Funding Needs

Many, if not most, of the reforms under CalAIM have significant potential to result in new costs and/or savings in Medi-Cal. The rest of this section highlights several proposed CalAIM reforms that could have significant fiscal impacts in Medi-Cal.

Improved Coordination and New Services for High-Risk, High-Need Populations. The CalAIM proposal includes new care coordination provisions

Figure 1

Major Policy Reforms Under CalAIM Proposal

Increasing the Focus on High-Risk, High-Cost Populations
Create new enhanced care management benefit.
Ensure enrollment assistance for individuals transitioning from incarceration.
Reimburse managed care plans to provide nonmedical "in lieu of services."
Require managed care plans to develop population health management programs.
Convene foster care workgroup.
Transforming and Streamlining Managed Care
Transition certain benefits and enrollee populations from fee-for-service to managed care and vice versa.
Modify approach to coordinating care of beneficiaries eligible for both Medi-Cal and Medicare.
Set capitated rates on a regional rather than county basis.
Require NCQA accreditation of Medi-Cal managed care plans; deem as meeting most federal and state standards.
Consider creation of a full-integration pilot.
Rethinking Behavioral Health Service Delivery and Financing
Streamline behavioral health financing.
Seek new federal funding opportunity for residential mental health services.
Change medical necessity criteria for beneficiaries to access services.
Implement "no wrong door" approach for children obtaining mental health services.
Integrate county administration of specialty mental health and substance use disorder services.
Extending Components of the Current 1115 Waiver
Continue public hospital funding under other programs.
Maintain expansion of substance use disorder services begun under DMC-ODS.
Extend certain components of the Dental Transformation Initiative and provide a new covered benefit, silver diamine floride.

CalAIM = California Advancing and Innovating Medi-Cal; NCQA = National Committee on Quality Assurance; and DMC-ODS = Drug Medi-Cal Organized Delivery System.

and services that could result in new gross costs but also could lead to some offsetting savings in the long run. For example, CalAIM proposes to create a new statewide managed care benefit, Enhanced Care Management (ECM), to provide intensive case management and care coordination for Medi-Cal's most high-risk and high-need beneficiaries (provided they are enrolled in managed care). The objective is for ECM to play an important role in connecting high-risk, high-need members to the appropriate services to improve health outcomes. The CalAIM proposal also allows plans to be reimbursed for "in lieu of services" (ILOS), nonmedical services such as personal care and housing navigation that managed care plans could provide (at their option) in place of more expensive standard Medicaid benefits. Today, managed care plans may offer such services but would not be reimbursed for the associated costs. As one final example, CalAIM would require that all counties implement pre-release Medi-Cal application processes for inmates. This proposal is intended to ensure that soon-to-be released inmates who are eligible for Medi-Cal receive timely access to physical and behavioral health services that could prevent the need for costlier interventions in the future.

Transforming and Streamlining Managed Care. CalAIM's proposed changes to transform and streamline Medi-Cal managed care include a number of reforms that could affect the funding needs of Medi-Cal, particularly in the long term. These include, for example, (1) the various proposed transitions of benefits and populations between Medi-Cal's two major delivery systems, fee for service (FFS) and managed care; (2) the setting of capitated payment rates on a regional basis rather than by county and by plan, as today; (3) requirements that managed care plans obtain National Committee on Quality Assurance (NCQA) accreditation; and (4) changes to managed care financing methodologies to allow managed care plans to retain at least a portion of the savings they generate through improving the delivery of cost-effective care (and also to share additional risk with plans to incentivize more cost-effective care). These various proposed changes could result in new costs and/or savings, particularly in the long term.

Changes to Behavioral Health Service Delivery and Financing. Three significant changes to behavioral health services and financing could affect overall state and local costs for these services. Whether the net impact of these changes will increase or decrease costs is unknown. The three changes are:

- ***Additional Federal Funding for Residential Behavioral Health.*** Historically, federal rules have prohibited Medicaid from funding residential behavioral health—including substance use disorder, Severe Mental Illness (SMI), and Severe Emotional Disturbance (SED)—services in facilities with more than 16 beds. Updated federal guidance in the last several years has relaxed this prohibition, providing new opportunities for state Medicaid programs to access federal Medicaid funding for residential behavioral services in large facilities. CalAIM commits to pursuing one of these opportunities—known as the SMI/SED demonstration opportunity—to obtain federal funding for residential mental health services in large facilities. (The state already accesses federal funding for residential substance use disorder services in large facilities through the Drug Medi-Cal Organized Delivery System program.) Obtaining this federal funding could result in savings to the county behavioral health delivery system, which could free up county funds to be invested in providing additional behavioral health services.
- ***Proposed Revisions to Medical Necessity Criteria.*** Currently, beneficiaries are generally required to have a covered diagnosis to be eligible for county behavioral health services. However, individuals often exhibit symptoms of behavioral health needs before an accurate diagnosis of their condition can be provided. CalAIM proposes to reform medical necessity criteria for county behavioral health services to focus more on level of impairment rather than specific diagnoses. This proposed change could have a fiscal impact, but the direction of the impact is uncertain. State or county costs could increase if the change leads to an increase in services provided, while savings could result if the new rules lead to obtaining

federal funding for services that are already being provided, but currently are paid only with state and local funds.

- ***Implementation of "No Wrong Door" Policy.*** Current law and policy is somewhat ambiguous regarding the delivery system through which beneficiaries under the age of 21 are to receive certain mental health services—that is, whether this should be through a Medi-Cal managed care plan or in the county behavioral health system. Under CalAIM, beneficiaries under age 21 would be able to access mental health services no matter which delivery system they initially seek care from. These new rules could lead to changes in which delivery system beneficiaries under age 21 receive certain services from. (For example, under the new rules a beneficiary may access care through their managed care plan rather than their county.) Accordingly, this policy could change which costs are borne by the state and counties, to an uncertain degree.

Proposed Funding

Governor Proposes General Fund Spending of $532 Million in 2021-22 and $423 Million Ongoing on CalAIM. The Governor released a multiyear funding plan for CalAIM. In 2021-22, the Governor proposes spending $532 million General Fund ($1.1 billion total funds) on CalAIM. Costs in 2021-22 represent a half-year of ongoing CalAIM proposals and certain one-time costs. In 2022-23, funding would ramp up to $745 million General Fund ($1.5 billion total funds) to reflect a full year of implementation. CalAIM funding would remain at a similar level as 2023-24. Beginning in 2024-25, funding would be reduced to its ongoing level of $423 million General Fund ($846 million total funds). This reduction reflects the expiration of certain limited-term spending components, namely, the managed care plan incentive payments related to ECM and ILOS. Figure 2 summarizes the Governor's proposed CalAIM funding plan.

Figure 2

Proposed CalAIM Funding—Governor's 2021-22 Budget

(In Millions)

	2021-22		2023-23		2023-24		2024-25 and Ongoing	
	Total Funds	General Fund	Total Funds	General Fund	Total Funds	General Fund	Total Funds	General Fund
Plan incentives[a]	$300	$150	$600	$300	$600	$300	—	—
Enhanced care management	188	94	467	233	490	245	$490	$245
In lieu of services	48	24	115	58	115	58	115	58
Dental services	113	57	227	114	227	114	227	114
Behavioral health QIP	22	22	32	32	32	32	—	—
Benefit and population delivery system transitions[b]	403	175	-10	-5	-10	-5	-10	-5
Local Assistance Subtotal	($1,074)	($521)	($1,431)	($732)	($1,454)	($744)	($822)	($415)
DHCS state operations	$24	$11	$28	$13	$25	$12	$24[c]	$11[c]
Grand Totals	**$1,098**	**$532**	**$1,459**	**$745**	**$1,479**	**$756**	**$846**	**$423**

[a] To assist with the establishment of enhanced care management and in lieu of services.

[b] Not included in last year's proposal.

[c] While the 2024-25 costs are as listed, ongoing costs are proposed to be $20 million total funds, $10 million General Fund.

Note: Totals may not add due to rounding.

QIP = Quality Incentive Payments and DHCS = Department of Health Care Services.

Assessment

Estimated Costs

While Similar to Last Year's Proposal, Updated CalAIM Funding Plan Includes New One-Time Components. As with last year's proposal, the Governor's budget provides upfront funding for ECM, ILOS, and incentive payments to help managed care plans build the necessary infrastructure to be able to deliver these new benefits. Additionally, consistent with last year's proposal, the administration proposes funding the continuation of certain dental components from the expiring Dental Transformation Initiative and a new dental benefit, silver diamine fluoride. Not part of last year's budget proposal, the updated 2021-22 funding plan includes one-time costs related to the transition of certain benefits and populations into and out of managed care. (CalAIM proposes various benefit and enrollee population transitions, in both directions, between managed care and FFS.) These transitions create additional costs that require funding because, with Medi-Cal budgeted on a cash basis, the timing of when services are reimbursed often differs between the managed care and FFS delivery systems.

First-year CalAIM spending under last year's proposal was $368 million General Fund, whereas in 2021-22 it is proposed at $532 million General Fund. The new one-time components related to transitions between managed care and FFS explain virtually the entire difference in cost between the two proposals. As for ongoing funding beginning in year four of CalAIM implementation, the *2020-21 Governor's Budget* proposed annual General Fund spending of $415 million while the 2021-22 budget proposes annual General Fund spending of $423 million. The difference in proposed ongoing General Fund spending is largely related to a relatively minor increase in the projected ongoing cost of ECM.

Changes in Service Delivery and Financing

Many CalAIM Components Would Build Upon or Replace Existing Innovative Programs. Many of the benefit expansions and other components proposed under CalAIM are not entirely new. Rather, many CalAIM components are intended to build upon or replace innovative programs that debuted within the last several years and offer them within managed care. For example, ECM is intended to replace Health Homes and the case management functions of the Whole Person Care pilots. ILOS is intended to build upon and replace the components of Whole Person Care focused on the provision of nonmedical benefits such as housing navigation and transition services. Even the incentive payments to help managed care plans build the infrastructure necessary to successfully deliver ECM and ILOS build upon and/or replace existing infrastructure funding that currently primarily goes to counties under Whole Person Care. The dental and public hospital financing components of CalAIM similarly build upon or replace existing programs.

Proposal Shifts Funding to Managed Care Plans. While certain components of CalAIM largely are akin to an extension of existing programs, some of the largest and costliest components of CalAIM represent a significant change in approach. Counties typically served as the lead entity and recipient of funding under Whole Person Care (though managed care plans generally were involved as partners). Under CalAIM, the funding that would support similar activities to Whole Person Care—ECM, ILOS, and the related incentive payments—would instead flow to managed care plans. While the administration has expressed a goal for managed care plans to continue to work with existing community-based providers, including those currently providing Whole Person Care and Health Homes services, the extent to which managed care plans will bring certain services in-house or forge new community partnerships is unclear. Overall, CalAIM would represent a shift in responsibility and funding for the delivery of ECM and new nonmedical benefits.

As a Result, State Would Take on New Funding Responsibilities. CalAIM would spend similar amounts on the programs—like Whole Person Care and Health Homes—ECM and other nonmedical benefits would replace. The proposed funding

sources under CalAIM, however, are different than those of existing programs. Namely, General Fund would replace the local funding that currently serves as the nonfederal share of cost for Whole Person Care. CalAIM's dental components also would be funded using General Fund for the state's share of cost. Currently, similar dental initiatives under the Dental Transformation Initiative effectively are entirely federally funded—an option that is no longer available due to federal rule changes. (Other CalAIM components that reflect extensions of existing programs, even if in modified form, do not feature a change in the nonfederal fund source.) Combining the new costs to build upon and replace Whole Person Care and the Dental Transformation Initiative, the funding plan would replace what are currently hundreds of millions of dollars of non-General Fund expenditures with around $400 million of General Fund expenditures on an ongoing basis.

Using State General Fund Resources Is Reasonable. Using General Fund is a reasonable approach to replacing other state and local sources of nonfederal funding that currently support the expiring, but potentially promising, services CalAIM seeks to build upon or replace. First, Whole Person Care currently is an *optional* pilot program operating in 24 counties and one city and funded with a mix of federal and local funds. CalAIM would end these pilots, expand certain service components of Whole Person Care statewide, and transfer management over many of the activities included under Whole Person Care generally from counties to managed care plans. In moving these services statewide, making certain services mandatory, and shifting control away from counties, the justification for using local funds diminishes. (Traditionally, *mandatory*, statewide programs have usually used state funds to cover the nonfederal share.) Second, regarding the dental service components of CalAIM, recent federal rule changes prohibit the state from using the same fund source as the nonfederal share of cost as was used under the Dental Transformation Initiative. Accordingly, using another available state fund source such as General Fund to continue to fund similar services seems appropriate.

CalAIM Would Unlock Federal Medicaid Funding for Services Beyond Traditional Health Benefits and Settings. CalAIM would expand the state's ability to draw down federal Medicaid funding in several ways. First, CalAIM would replace certain existing programs—whose federal funding under the state's 1115 waiver is capped—with programs with no such federal funding limitations. Second, CalAIM would allow the state to start drawing down federal funding for services not previously covered by Medicaid. Third, CalAIM would expand statewide a variety of services that are only available in certain counties. The following bullets provide additional detail on two changes under CalAIM that would allow the state to draw down additional federal Medicaid funding for services not historically eligible for such funding:

- ***ILOS.*** Services such as housing navigation and transition (including funding to cover rental deposits), recuperative care, and home modifications such as ramp installations have not been broadly eligible for Medicaid funding. Instead, public funding for such services often has come from capped funding sources, rather than varying automatically with the level of need. By proposing to add the 14 optional nonmedical benefits through ILOS, CalAIM could expand the amount of federal (and state) funding that supports such services, which could both offset existing funding sources and expand the services' availability.
- ***Residential Mental Health Services Provided in Large Facilities.*** As discussed earlier, the state currently receives federal funding for residential substance use disorder services provided in large facilities (which were previously ineligible for Medicaid funding). Under CalAIM, the state would pursue federal funding for residential mental health services in large facilities, with the goals of (1) offsetting local funds used to fund these services today and (2) expanding the availability of residential mental health services as part of a more comprehensive continuum of mental health services.

CalAIM Would Expand the Resources Managed Care Plans Have to Address Their Members' Needs. CalAIM vests managed care plans with significant new responsibilities and opportunities, namely those related to ECM and

ILOS. To support managed care plan efforts to develop new capacities and provide new services under CalAIM, the funding plan would provide plans with significant new resources. Over four years, managed care plans would receive an additional $2.3 billion in total funds, half of which would be General Fund. During the first two full years of implementation, total annual funding for managed care plans would increase by around $1 billion, a roughly 2 percent increase over what plans currently receive for all services. The ongoing funding commitment to managed care plans under CalAIM would be substantially less at around $600 million annually in total funds. As we discuss later in this post, however, we have outstanding questions about the reasonableness of assuming such a significant scaling back of CalAIM expenditures within managed care by the fourth year of implementation.

CalAIM Would Reform Behavioral Health Payment Model in an Effort to Move Toward Value-Based Care in the Future. The CalAIM proposal would change how county behavioral health departments receive reimbursement for providing Medi-Cal-eligible services. Currently, counties pay for behavioral health services when they are administered. They then submit expenditure claims to the Department of Health Care Services (DHCS) in order to be reimbursed with federal funds that cover the federal government's share of cost. The state provides this reimbursement to counties on an interim basis until the completion of a multiyear cost reconciliation process. The current financing system is cost-based, which does not account for quality or outcomes in reimbursement amounts.

DHCS is proposing to transition behavioral health financing to a different system in which reimbursement would not be tied directly to cost, and would rather be based on predetermined per-service payment rates. Unlike today, as long as the payment rates are above counties' costs, counties would be able to retain payment amounts above their costs. This methodology also is expected to result in more timely payment and reduce counties' administrative burden and multiyear fiscal uncertainty. In addition, this framework would make transitioning to payment models that would incentivize the quality of care provided over the volume of services provided easier.

Changes to Managed Care Plan Finances and Fiscal Incentives

Managed care is Medi-Cal's largest delivery system, covering over 80 percent of enrollees. Over $50 billion in total Medi-Cal funding flows through managed care annually, reflecting about 50 percent of total Medi-Cal funding. Given the size of the managed care delivery system, how managed care plans are financed has major implications for Medi-Cal funding as a whole. Several CalAIM reforms would affect managed care financing. As described below, these reforms have the potential to significantly affect the long-term funding needs of Medi-Cal.

CalAIM Could Improve Managed Care Plan Fiscal Incentives to Deliver More Cost-Effective Care. Medi-Cal managed care plans receive a monthly payment, or "capitated rate," per member to cover the cost of the care they arrange and pay for on behalf of their members. Plans' capitated rates generally are set based on the costs they report on the eligible services utilized by their members (with a lag time of around three years). Capitated rates are set at different levels for different Medi-Cal enrollee populations—for example, a managed care plan might receive around $100 per child member per month and closer to $1,000 per senior member per month. As the following bullets describe, certain aspects of how capitated rates currently are set lead to distorted incentives at the managed care plan level around whether to make investments to provide more cost-effective care, which CalAIM seeks to improve upon.

- ***Reimbursable ILOS.*** Today, managed care plans can provide benefits not covered by Medi-Cal for their members, such as the services proposed under ILOS. However, plans currently cannot receive reimbursement through their capitated rates for the costs of any such services they provide, which reduces plans' incentives to offer such services, even if the services could improve health outcomes. Under CalAIM, the costs of ILOS would be reimbursable via plans' capitated rates, improving plans' incentives to provide these benefits.

- ***Shared Savings and Shared Risk.*** Because managed care plan funding is to a significant extent cost-based, investments made by plans that result in savings ultimately can result in reduced funding in the future. Accordingly, plans do not have a consistent incentive to reduce costs. Under the current model, there is even less motivation for plans to provide services such as ILOS since plans are not reimbursed for those services *and* any generated savings largely would accrue to the state and federal governments. This would change under CalAIM, as plans would be reimbursed for the ILOS they provide. Shared savings mechanisms are designed to mitigate these perverse incentives and instead allow plans to at least temporarily keep at least some of the savings they generate from new investments, such as better care coordination and the provision of ILOS or ILOS-like services. As we discuss below, while the shared savings *concept* has merit, almost no detail on this aspect of the CalAIM proposal currently is available, making determining whether the changes under CalAIM represent the best approach to improving plan incentives to provide more cost-effective care impossible. Beyond the blended capitated rates mechanism discussed below, how the administration intends to leverage the concept of shared risk is even less clear.
- ***Blended Capitated Rates.*** In areas of the state where institutional long-term care (LTC) is a managed care plan benefit, plans generally receive increased funding when their members enter an LTC facility and decreased funding when their members leave an LTC facility. This funding arrangement means plans do not have a consistent incentive to divert members from unnecessary institutional LTC stays. Under CalAIM, the state would pay managed care plans a blended capitated rate for LTC facility residents and seniors and persons with disabilities (SPDs) who live in the community. Since this blended capitated rate would essentially compensate plans for the combined, average costs of institutionalized and non-institutionalized SPDs, plans could receive and retain earnings if they are able to improve their capacities to reduce unnecessary LTC facility stays.
- ***Enrolling Dual Eligibles in a Single Plan.*** Medi-Cal pays for the majority of long-term services and supports (LTSS) costs for dual eligibles, but a relatively small portion of the costs of hospitalizations, which are paid primarily by Medicare. Therefore, Medi-Cal plans have limited financial incentive to provide additional LTSS that would potentially reduce hospital utilization for dual eligibles, since the savings resulting from avoided hospitalizations would largely accrue to Medicare. Under CalAIM, aligning Medicare and Medi-Cal enrollees within a single health plan could eliminate the incentive to shift costs between programs, because both potential costs to Medi-Cal and potential savings to Medicare would accrue to the same plan.

Effects of Regional Rate Setting

Regional Rate Setting Would Reduce DHCS Administrative Burdens. Currently, capitated rates generally are set on a plan-by-plan and county-by-county basis. Because capitated rates differ by enrollee population, plan, and county, DHCS and its contracted actuary annually have to develop thousands of distinct capitated rates. Under regional rate setting, rather than developing distinct capitated rates for each plan in each county, DHCS instead would develop capitated rates on a regional basis. For example, DHCS could develop a single capitated rate for each unique enrollee population for all the plans operating in the Bay Area. This single set of regional rates for the Bay Area could replace the 11 different sets of rates that currently have to be set for the Bay Area counties individually. Regional rate setting would reduce administrative burdens at DHCS by reducing the number of capitated rates the department has to develop and receive approval for from the federal government.

Regional Rates Could Encourage More Managed Care Plans to Improve Efficiency... In counties with more than one plan, the state employs an adjustment to the capitated rates that averages a portion of each plan's individually established

capitated rates. As a result of this adjustment, known as "county averaging," the higher-cost plan(s) in a county are paid capitated rates that do not fully reflect their reported costs, while the lower-cost plan(s) in that same county are paid at capitated rates above their reported costs. This encourages plans operating within a single county to compete with each other to meet their responsibilities more efficiently.

Regional rate setting would encourage plans that currently do not face competition within their county to be more efficient. For example, if the Bay Area were set as a region, the capitated rates paid to San Mateo Health Plan—which is the only plan in the county—would no longer fully reflect San Mateo's reported costs, but instead would reflect the average reported costs of all the Medi-Cal managed care plans operating in Bay Area counties (potentially with certain adjustments to account for differences in health care needs in different counties). Therefore, by setting capitated rates regionally, the state could encourage managed care plans in all regions of the state to provide more efficient care since they would not be fully compensated if their costs exceed the average costs of plans operating in their region.

...But Also Would Produce Different Winners and Losers... Moving to regional rates very likely would result in different winners and losers than under today's system. Under the current system, plans can be penalized if their costs are higher than other plans operating within their *county*. Under CalAIM, each *region's* relatively high-cost plans likely would be losers since they would be reimbursed at below their reported costs, while each region's low-cost plans would be winners. For example, we have heard that a large higher-cost plan recently forwent over $100 million that it otherwise would have received through capitation, which instead went the lower-cost competitor plan due to county averaging. Extending a similar rate-setting process to plans in single-plan counties, which have not been subject to any competition for decades, could result in similar financial losses (though for an individual plan, they likely would be lower in magnitude).

...And Possibly Impact Access and Quality. Despite generating winners and losers, improving the efficiency of Medi-Cal managed care through regional rate setting generally would represent sound public policy provided that it did not generate unacceptable trade-offs, such as impairing access to quality services. However, today we understand that the state's higher-cost plans often perform better in terms of access and quality. This raises questions about whether the transition to regional rate setting would improve efficiency at the cost of reduced access and/or quality. To mitigate against this important potential drawback, the Legislature could consider ways to more closely tie managed care plan funding to their performance on access and quality standards.

Multiyear Costs May Be Underestimated

Despite being more encompassing than last year's funding plan, we have outstanding questions around whether certain potential CalAIM costs are adequately reflected in the Governor's funding plan, both in 2021-22 and beyond. This section summarizes the components where we have such outstanding questions. Beyond the components highlighted below, additional, unanticipated costs also could emerge given the complexity and scope of the CalAIM reform package.

Managed Care Plan Incentive Payments Could Lead to Higher Ongoing CalAIM Costs. As shown in Figure 2, the Governor proposes three-year, limited-term funding in the form of incentive payments for managed care plans to establish ECM and ILOS infrastructure, which over three years would total $750 million General Fund ($1.5 billion in total funds). We have questions about whether the assumed phasing out of this funding after three years is reasonable. For example, plans may be able to use this funding on covered, reimbursable services. To the extent that managed care plans are able to use this funding on such services, they could reflect the associated cost in their cost reports. After several years, these costs could then get reflected in the ongoing payments paid to managed care plans, thereby raising state costs. To the extent managed care plans are not able to use this funding on covered, reimbursable services and are unable to achieve significant offsetting savings (such as on institutional care) through better targeting and

delivery of preventive services, there could be pressure on the Legislature to provide additional funding to sustain the new managed care plan services created under CalAIM.

New Managed Care Plan Administrative Requirements Could Increase Costs. CalAIM includes a number of new administrative requirements on managed care plans that do not appear to be directly funded under the Governor's plan. These include, but are not limited to, CalAIM's requirements that each plan establish a population health management program, obtain NCQA accreditation, and set up a Medicare Advantage special needs plan for their dual eligible beneficiaries. Each of these new requirements on plans is likely to result in new costs for managed care plans, though these costs would vary significantly among plans since many plans already at least partially comply with some of CalAIM's new standards. Although no direct funding for these new managed care plan requirements is provided under the funding plan, in the long run at least, some of these costs could get built into the payments the state makes to managed care plans, which are set in part based on plans' reported costs.

Behavioral Health Reforms Could Increase Counties'—and the State's—Costs. As part of an agreement in which the state realigned responsibility for certain programs and services to counties (including behavioral health services), the state is responsible for funding additional costs as a result of new state mandates placed on counties. As discussed previously, the proposed medical necessity revisions for receiving behavioral health services could result in additional costs that are not budgeted in the administration's multiyear funding plan, to the extent that they result in increased utilization of behavioral health services and do not result in offsetting savings from counties receiving increased federal funding. In addition, the transfer of responsibility for covering specialty mental health services to the county from a Medi-Cal managed care plan (Kaiser) in two counties could lead to a significant increase in costs in those counties. Whether the state would be required to fund the additional costs counties may bear for these reforms is unclear.

County Inmate Eligibility Processes Could Increase Medi-Cal Caseload and Represent a Reimbursable County Mandate. By requiring that each county implement a pre-release Medi-Cal enrollment process for inmates, CalAIM could significantly increase the number of inmates who enroll in Medi-Cal following their release. This could raise Medi-Cal caseload and thus increase Medi-Cal costs that are not budgeted under the CalAIM proposal. Additionally, requiring counties to establish new eligibility processes for counties may constitute a new state mandate, for which the state may need to reimburse county governments.

Many Key Programmatic Details Are Lacking

How Would the Cost-Effectiveness of ILOS Be Overseen by the State and Managed Care Plans? ILOS are intended to be cost-effective alternatives to standard Medi-Cal benefits. For example, home modifications such as ramp installations are intended to deter placement in nursing facilities, recuperative care is intended to reduce hospitals stays, and temporary housing assistance is intended to prevent emergency room visits for conditions that might develop during periods of homelessness. By replacing such costly services as nursing home stays, hospital admissions, and emergency room visits with less costly ILOS, the goal is for ILOS to ultimately offset other costs in Medi-Cal (and potentially other public programs). The extent to which ILOS ultimately will offset other Medi-Cal costs is uncertain. Recent research on such benefit expansions shows that, in many cases, new preventive and care coordination services often supplement rather than substitute for more costly services like hospital admissions and nursing home stays. How the state and managed care plans would oversee and evaluate whether ILOS are proving to be cost-effective alternatives to standard Medi-Cal benefits is unknown at this time. Moreover, an evaluation of ILOS benefits could help to inform future state decisions on what ILOS to extend and/or expand into statewide, mandatory covered benefits.

Would the State Meet the Requirements for Additional Federal Funding for Residential Mental Health Services? Historically, the state has favored placement in community settings for mental health treatment over placement in institutional settings, in keeping with the principle of providing mental health care in the least restrictive setting possible. One of the requirements for the state to obtain approval for the CalAIM SMI/SED waiver opportunity would be to demonstrate to the federal government that it is committed to maintaining support for and potentially enhancing community behavioral health treatment options. This is meant to ensure that additional federal funding provided for mental health services rendered in institutional settings does not incentivize institutional placement beyond what is absolutely necessary. While there is an accompanying budget proposal that may be seen as complementary to this effort, the CalAIM proposal does not provide details on the state strategy to meet this federal requirement.

What Performance Benchmarks Related to ECM and ILOS Would Trigger a Managed Care Plan Incentive Payment? The Governor's proposal to spend $750 million General Fund over three years on incentive payments for managed care plans lacks detail. What performance benchmarks would be used and how much plans would receive for achieving each benchmark are unclear. Additionally, the administration intends for this funding to be shared with on-the-ground providers but the administration provides no detailed plan for how this would be encouraged. Health Homes and Whole Person Care providers likely would need to receive some of this funding in order to sustain their relatively new services and infrastructure. Whether and how the performance benchmarks would reflect (1) the intent for the funding to flow to providers and (2) the goal of sustaining Health Homes and Whole Person Care services and infrastructure is unclear.

How Would Managed Care Shared Savings and Risk Be Structured? Although the concept of introducing shared savings and shared risk within the capitated rate-setting process is promising, information on how the administration intends to structure this component of CalAIM generally is not available (with the exception of the proposal to blend capitated rates for institutional LTC residents and non-institutionalized SPDs). We have outstanding questions about how savings would be determined under the shared savings calculation, how any determined savings would be shared between plans and the state and federal governments, and what the shared *risk* components of this proposal are.

Which Regions and What Adjustments Would Be Used Under Regional Rate Setting? Which counties would be grouped together regionally under the new rate-setting process is unclear and likely remains under development. In addition, whether DHCS would employ county-by-county or plan-by-plan adjustments to the regional capitated rates to account for local differences in population health and the health care market conditions is unclear. Such adjustments could be important for protecting against disruptions in Medi-Cal managed care if the new regional capitated rates do not adequately reimburse plans based on the underlying health of their members and the prices charged by local service providers.

Ensuring Transparency Around CalAIM Costs and Savings

Tracking CalAIM's Costs and Savings Could Prove Challenging Without New Reporting and Evaluation Requirements. Standard Medi-Cal budget documents are not organized in such a way or sufficiently detailed to allow analysts to closely track the myriad fiscal impacts an initiative like CalAIM is having in the program. Depending on decisions made by DHCS, supplementary budget documents such as managed care plans' cost reports similarly may not contain sufficient detail for identifying the costs and savings of the components of CalAIM that affect managed care. Accordingly, without new reporting and evaluation requirements, the costs and savings of the various reforms of CalAIM would be challenging to track. This raises issues since many CalAIM reforms are intended to be cost-effective and ultimately to reduce program spending in the long run. Without being able to identify the reform's fiscal impact, the Legislature would not be able to know whether the reforms are achieving their fiscal goals. The administration has yet to release a plan for how the fiscal impacts of CalAIM would be reported and evaluated.

Issues for Legislative Consideration

Despite Multiyear Budget Problem, CalAIM Merits Consideration Since Relatively New but Existing Programs Otherwise Would Expire. Under the Governor's budget proposal, the state would spend hundreds of millions of dollars of General Fund on an ongoing basis to implement CalAIM. Unlike when CalAIM was proposed in January 2020, the 2021-22 proposal comes in the context of a projected multiyear budget deficit. In this context, major program expansions or embarking on untested new ways of delivering services, with significant accompanying fiscal risks, may not be advisable. However, while much of CalAIM represents novel changes to how Medi-Cal services are delivered and financed, much of the proposed new General Fund spending reflects a change in how the state would fund fairly new but *existing* services. Should the Legislature choose not to fund at least certain components of CalAIM, certain programs that the state has been testing over the last several years would expire. That said, the Legislature could ask the administration whether an additional, temporary extension of the state's existing 1115 waiver is possible. This would allow existing programs to continue to operate at less cost to the state General Fund, though at higher cost to local governments.

CalAIM Brings Significant Fiscal Risks in Addition to Many Potential Programmatic Benefits. CalAIM has potential to transform Medi-Cal for the better by focusing attention on high-risk, high-need beneficiaries, streamlining care delivery and financing, and modernizing behavioral health services. However, CalAIM also brings significant fiscal risks due to its scope, complexity, and the experimental nature of many of the reforms. Unforeseen administrative costs could emerge as program administrators gradually realize all the various systems changes that would be needed to allow CalAIM's reforms to be effective. Savings might not materialize as expected from the creation of improved care coordination and a variety of new nonmedical benefits should the expanded access to preventive medical and nonmedical benefits prove to supplement rather than substitute for more costly services. Considering the fiscal risks of CalAIM, particularly over the longer term, is important as the Legislature deliberates over which CalAIM reforms to adopt.

Recommend the Enactment of Strong Oversight and Evaluation of the Fiscal, as Well as Programmatic, Components of CalAIM. The administration has yet to release a detailed plan for how CalAIM would be overseen and evaluated. Standard budget documents and other reports routinely released publicly by the administration are not suited to identifying CalAIM's fiscal impacts. We recommend that the Legislature establish a framework for overseeing and evaluating the fiscal impacts of CalAIM. Such a framework could include regular reports from the administration that track the direct costs of each of CalAIM's major reforms, as well as any direct or indirect savings that are generated from service and delivery system improvements. We recommend this be part of a larger oversight and evaluation framework established by the Legislature, as discussed in our post on CalAIM's overarching issues.

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