

The 2021-22 Budget: CalAIM: New Directions for Services for Seniors and Persons With Disabilities

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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 fourth in a series assessing different aspects of the Governor’s proposal—analyzes CalAIM proposals targeted at seniors and persons with disabilities (SPDs), including new benefits and structure changes to how long-term services

and supports (LTSS) are administered. (LTSS include, among other supports and services, institutional care in nursing homes and home- and community-based services [HCBS] such as home care and personal care services.) Previous posts in this series provided an [overview of CalAIM](#), considered [CalAIM financing issues](#), and examined [equity considerations](#) related to the CalAIM proposal.

Background

THE GROWING POPULATION OF SPDS

Senior Population Expected to Grow Faster Than State’s Population as a Whole.

The Department of Finance estimates that the state’s senior population (aged 65 and older) will increase from 6 million in 2019 to 11 million in 2060 (83 percent). The estimated growth rate of the senior population is higher than the estimated growth rate of the state’s total population (13 percent) over the same period.

Senior Population With Disabilities Expected to Grow at a Higher Rate Than Overall Senior Population. In our 2016 report, [A Long-Term Outlook: Disability Among California’s Seniors](#), we projected that the number of seniors in California with disabilities (as defined by limitations in routine activities of daily living, such as dressing or bathing) will increase by 135 percent, from 1.2 million in 2019 to 2.7 million in 2060, which is greater than the projected growth of the overall senior population (83 percent) over the same period. The faster growth of the senior population with disabilities is partially driven by long-term increases

in average life expectancy, as seniors over the age of 85 are more likely to have developed disabilities late in life. Another driver of growth in the senior population with disabilities is the increasing racial diversity of the senior population, as seniors of color make up a disproportionate share of seniors with disabilities. As the share of seniors of color increases, a higher proportion of the senior population will likely have disabilities.

PUBLIC SERVICES FOR SPDS ARE HIGHLY FRAGMENTED, RAISING ACCESS AND OTHER ISSUES

Evidence of Fragmentation

Large Share of SPD Population Must Access Two Different Insurance Programs. Among the 2.1 million SPDs enrolled in Medi-Cal, about 1.4 million are eligible for and enrolled in both Medicare and Medi-Cal. For these dually eligible beneficiaries, Medicare is the primary payer for the services that it covers (such as hospitalization and doctor visits), while Medi-Cal covers services that are not covered by Medicare, including most LTSS.

Figure 1 summarizes the services dual eligibles receive from Medi-Cal and Medicare.

Medi-Cal LTSS Infrastructure Encompasses Multiple Programs With Overlapping

Beneficiaries. California’s Medi-Cal LTSS infrastructure is made up of several programs—with different access points, delivery systems, and eligibility assessment processes—that may serve the same or similar beneficiaries while operating independently. For example, a single Medi-Cal SPD simultaneously may receive case management through the Multipurpose Senior Services Program (MSSP), personal and home care services through In-Home Supportive Services (IHSS), and care in a congregate setting through Community-Based Adult Services (CBAS). This individual likely would receive these services through three different providers, after establishing eligibility separately for each program. Many LTSS programs—such as MSSP, Programs of All-Inclusive Care for the Elderly, Assisted Living Waiver, and CBAS—also have a limited number of slots or limited capacity, such that many individuals who are eligible for these programs may not be able to receive services from them due to supply constraints. **Figure 2** shows the various aspects of this fragmentation that make Medi-Cal LTSS challenging to navigate for SPDs. Additionally, dually eligible SPDs must

navigate both the Medicare and Medi-Cal delivery systems.

Implications of Fragmentation

Fragmentation Creates Service Coordination and Access Issues for SPD Beneficiaries.

If individuals were able to access all Medi-Cal LTSS programs, they could be able to receive a comprehensive suite of LTSS benefits. However, individual programs’ services vary, as do their availability geographically. As a result, ensuring that Medi-Cal beneficiaries are receiving all the services they require, or that beneficiaries’ care is being effectively coordinated between the various programs they have accessed, without duplication or gaps in services is difficult. (Some beneficiaries

Figure 1

Medi-Cal and Medicare Services for the Dual-Eligible Population

Medi-Cal	Medicare
<ul style="list-style-type: none"> • Long-term nursing facility stays • Home and community-based care 	<ul style="list-style-type: none"> • Hospital care^a • Short-term nursing facility stays • Pharmacy • Physician/clinic

^a Medi-Cal provides “wrap-around” payments for these services.

Figure 2

Various Aspects to Fragmentation of Medi-Cal LTSS Infrastructure

Delivery System	SPDs may access LTSS through a number of different delivery systems, including Medi-Cal managed care and Medi-Cal fee-for-service.
Administrator	Various state and local offices are responsible for administering LTSS programs, including the Department of Health Care Services, the Department of Social Services, the Department of Aging, and the Department of Developmental Services. Various LTSS programs provide different services and levels of care. In order to receive comprehensive care, many SPDs may need to utilize several LTSS programs simultaneously.
Service Area	Few LTSS services are accessible statewide. Some (such as the Program of All-Inclusive Care for the Elderly) are available only in a handful of counties.
Service Provider	LTSS is provided through thousands of private and nonprofit providers. These providers are of varying quality, capacity, and cost.
Program Capacity	Several LTSS programs (such as the Assisted Living Waiver and Multipurpose Senior Services Program) have a limited enrollment capacity due to facility constraints or state enrollment caps.
Eligibility Criteria and Assessment	While many LTSS programs use similar eligibility criteria, some programs target individuals with higher levels of need. Applicants generally go through a separate eligibility assessment for each LTSS program despite the overlap in eligibility criteria.

SPDs = seniors and persons with disabilities and LTSS = long-term services and supports.

may even receive case management services from multiple programs, with no guarantee their case managers are coordinating effectively with one another.) For dual eligibles, similar coordination problems can exist between their Medi-Cal and Medicare plans.

LTSS fragmentation also can create access problems for many beneficiaries. Beneficiaries may have trouble navigating multiple access points and sets of eligibility requirements in order to receive care from multiple programs. They also may find that some LTSS programs they are attempting to access are not available in their regions, or have a limited number of slots available.

Fragmentation Erodes Financial Incentives to Provide More Cost-Effective Care. In addition to contributing to a lack of service coordination for SPDs, the current system can create an incentive for each program to “cost shift.” Cost shifting occurs when one entity or program takes actions that have fiscal impacts on a separate entity or program. Because the impacts are not borne by the entity taking action, that entity has limited financial incentive to limit overall costs or maximize overall benefits for a particular total level of expenditure. For example, under the current fragmented structure, while Medi-Cal pays for the majority of LTSS costs for dual eligibles, it pays for only a relatively small portion of the costs of hospitalizations, which are paid primarily by the federal government under Medicare. In such circumstances, the state has limited financial incentive to provide additional LTSS that potentially would reduce hospital utilization for dual eligibles, since the savings resulting from avoided hospitalizations largely would accrue to the federal government instead of the state.

RECENT AND ONGOING STATE EFFORTS TO ADDRESS FRAGMENTATION

Coordinated Care Initiative (CCI)

In 2012, the state undertook a major demonstration project called CCI to improve care coordination for individuals with both Medi-Cal and Medicare coverage. CCI, which is scheduled

to be in effect until the end of 2022, includes the following major components:

- **Cal MediConnect.** In seven participating counties under CCI’s Cal MediConnect program, dually eligible beneficiaries may receive their Medicare benefits and Medi-Cal benefits through the same managed care plans known as Cal MediConnect managed care plans.
- **Mandatory Enrollment of Dual Eligibles in Medi-Cal Managed Care.** CCI requires most dual eligibles in the seven demonstration counties to enroll in managed care plans to access their Medi-Cal benefits, including their LTSS benefits.
- **Integration of LTSS Under Medi-Cal Managed Care.** CCI shifted funding for nursing home, IHSS, CBAS, and MSSP benefits from Medi-Cal fee for service to Medi-Cal managed care for most SPDs in the demonstration counties. Budget-related legislation in 2017-18 later removed integration of managed care and IHSS.

CCI Demonstration Has Shown Some Promise... Several evaluations of CCI have been carried out. These evaluations show promise on the part of the demonstration project in the areas of improved care coordination between Medi-Cal managed care plans and IHSS program administrators (in a small subset of counties), high satisfaction among Cal MediConnect participants, and potential reductions in hospital and nursing facility utilization.

...But Has Experienced a Number of Challenges. At the same time, the CCI demonstration experienced significant challenges. For example:

- **CCI Was Not Able to Fully Address Fiscal Misalignment.** CCI did not fully align fiscal incentives to provide more cost-effective care in at least two ways. First, for many SPDs, CCI maintained the state’s pre-CCI practice of directly paying managed care plans higher rates for plan enrollees residing in nursing homes. Because this leads to higher managed care plan payments to cover the cost of

individuals' placement in a nursing home, and lower payments when such individuals leave a nursing home, plans do not benefit financially when nursing facility care is avoided. As a result, they have limited fiscal incentive to avoid unnecessary and costly nursing home placements. Second, CCI explicitly authorized Cal MediConnect managed care plans to pay for nonmedical benefits (such as home modifications or medically tailored meals), but did not allow plans to be specifically reimbursed for the costs of these nonmedical benefits. This meant plans were not provided with a fiscal incentive to arrange and pay for such benefits even when doing so would have improved beneficiary outcomes and reduce the utilization of high-cost care.

- **Gaps in the Integration of LTSS and Managed Care.** One of CCI's primary goals was to better integrate some existing LTSS programs and Medi-Cal managed care. Ultimately, only CBAS was integrated with managed care. CCI initially routed IHSS funding through managed care while leaving IHSS program and managed care administration relatively unintegrated. Then, in 2017-18, IHSS funding was removed from managed care. MSSP generally never transitioned to becoming a managed care benefit.
- **Many Dually Eligible Beneficiaries Chose Not to Participate in Cal MediConnect.** In the years following initial implementation of CCI, many dually eligible beneficiaries living in participating CCI counties chose not to participate in Cal MediConnect, leaving enrollment below initial expectations. This led to various challenges including low participation on the part of health care providers and also limited revenues to Cal MediConnect plans to cover their costs of participating in the demonstration. As of September 2020, about 112,000 dually eligible beneficiaries were enrolled in Cal MediConnect, which represented as little as one-quarter of SPDs who were eligible to participate.

Master Plan for Aging

In June 2019, the Governor signed an [executive order](#) establishing a formal process for the creation of a Master Plan for Aging. The executive order required the creation of a stakeholder advisory committee, publication of a stakeholder report on LTSS, and publication of the administration's Master Plan for Aging.

Stakeholder's Master Plan for Aging Has Components Related to Integration of Health and LTSS Programs Relevant to SPDs. The stakeholder [report](#) on LTSS was released in May 2020 and made a number of recommendations related to Medi-Cal and Medicare integration efforts, including recommendations to:

- **Develop a Five-Year Plan for Integrating Services for SPDs Under Medi-Cal Managed Care.** Develop a five-year Medi-Cal/Medicare integration plan that commits the state to the highest level of integration possible. At a high level, the plan should (1) ensure people have access to certain highly integrated Medi-Cal/Medicare health plans, (2) incorporate best practices from past state integration efforts, (3) require strong consumer protections, (4) ensure dual eligibles are eligible for all CalAIM services, (5) implement a comprehensive set of Medi-Cal HCBS, (6) offer incentives to health plans to provide HCBS and contract with linguistically and culturally responsive local organizations, and (7) establish a policy and specific targets for reducing avoidable institutionalization. (Additional detail on the recommended plan can be found in the stakeholder report.)
- **Improve Coordination Between IHSS, Health, and Other LTSS Providers.** Improve care coordination between IHSS and other LTSS and health providers, including through formal authorization for secure information sharing with managed care providers of health and LTSS services. Additionally, require the state to collect data and report on beneficiary access to services, including data on referrals and receipt of services, transitions, and care coordination.

- **Establish a Statewide Integration Oversight Council.** Establish a formal stakeholder council comprised of health plans, consumers, advocates, and healthcare providers on issues pertaining to integration of Medi-Cal/Medicare and Managed LTSS (MLTSS). The council should be charged with exploring and analyzing emerging implementation issues and challenges, and provide recommendations for systemwide improvements.
- **Create a Medi-Cal/Medicare Innovation and Coordination Office.** Establish an office to design and implement innovative strategies that are linguistically and culturally responsive to serve dual eligibles from diverse backgrounds, with a goal of improving how services are delivered at the local level across the health and LTSS systems. The office would explore (1) targeted demonstration programs intended to reach special populations with complex care needs and (2) new state and federal partnership models, while also overseeing implementation of related elements of CalAIM.

Administration's Master Plan for Aging Has Components Related to CalAIM. The administration released its Master Plan for Aging in January 2021. The Master Plan for Aging identifies

five goals and 23 strategies to help build what it describes as a “California for All Ages” by 2030. The plan includes the implementation of certain CalAIM components to support specific initiatives, which we discuss below.

- **Increase Access to LTSS.** Expand access to HCBS for people receiving Medi-Cal via CalAIM by implementing “in lieu of services” (ILOS) and enhanced case management (ECM). We define ECM and ILOS and describe them in detail later in the post.
- **Integrate Health Care for Dual-Eligible Population.** Plan and develop innovative models to increase access to LTSS and integrated health care for dual eligibles by implementing statewide MLTSS and a Dual Eligible Special Needs Plan (D-SNP) structure, in partnership with stakeholders. We describe MLTSS and define D-SNPs later in the report.
- **Consider Home and Community Alternatives to Short-Term Nursing Home Stays.** Consider home and community alternatives to short-term nursing home stays for participants in Medi-Cal managed care through utilization of a combination of the home health benefit; ILOS; and proposed expanded telehealth benefit, including remote patient monitoring.

CalAIM: SPD-Related Components

CalAIM Includes Several Proposals With Significant Implications for SPDs. SPDs are a key target population for CalAIM. Elements of the CalAIM proposal that would directly affect care for Medi-Cal SPDs through the provision of new benefits and programmatic strategies include the following:

- **ECM.** CalAIM proposes to create a new statewide managed care benefit, 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 intent is for ECM to provide much more high-touch,

community-centered care coordination services than generally are available to the targeted populations, which include, for example, high utilizers of emergency departments and beneficiaries with unstable housing. The intent is for ECM to connect high-risk, high-need beneficiaries to the appropriate preventive services (both medical and non-medical) necessary for the improvement of health outcomes. ECM target populations include the following groups in which SPDs are heavily represented: high health care utilizers, individuals at risk of institutionalization in nursing homes, and

individuals who are transitioning from a nursing home to the community.

- **New Population Health Management Strategies.** Population health management programs represent a bundle of administrative activities—typically performed by managed care plans—that aim to (1) identify beneficiaries’ medical and nonmedical risks and needs and (2) facilitate care coordination and referrals. Managed care plans would be required to collect and analyze information on their members’ health status, service utilization history, and social needs. While existing data sources would form the basis of some of this information, a new standardized, statewide Individual Risk Assessment tool would be developed by the Department of Health Care Services to ensure consistent information collection across managed care plans. With this information, managed care plans would assign their members into one of four risk categories, including “low risk,” “medium and rising risk,” “high risk,” and “unknown risk.” While plans would remain responsible for connecting low-risk members to preventive and wellness services, they would be responsible for providing increasing levels of care coordination and service linkages to their higher-risk members.
- **ILOS.** The CalAIM proposal allows managed care plans to be reimbursed for ILOS, defined as 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. Many of the services that could be offered as ILOS benefits currently are provided through existing LTSS programs, including personal care and home care services, medically tailored meals, and home modifications such as wheelchair accessible ramps.

CalAIM Also Would Make Several Structural Changes to SPD Care. In addition to creating new benefits for Medi-Cal SPDs, CalAIM would

make several changes to how SPD care—and in particular, LTSS—is administered. Those proposed changes are as follows:

- **Expanded Role of Managed Care in Nursing Home Care.** Under CalAIM, institutional long-term care services (including in nursing homes) would be shifted into managed care by January 2023. Currently, nursing home care is a managed care benefit in more than half of counties, but a fee-for-service benefit in the remaining counties.
- **Longer-Term Vision for MLTSS.** The administration proposes to transition from CCI to standardized mandatory enrollment of dual eligibles into managed care by January 2023. By January 2027, the intention is to make LTSS accessible directly through managed care plans, rather than through the variety of programs which currently comprise the state’s Medi-Cal LTSS infrastructure. LTSS provided through managed care would be available statewide and not subject to a capped number of slots for any service. (IHSS is not intended to be a part of the future statewide MLTSS at this time and would remain a separate fee-for-service benefit.)
- **D-SNPs.** Under CalAIM, the state would require all Medi-Cal managed care plan contractors to establish specialized plans, known as D-SNPs, which are designed to provide managed Medicare benefits to individuals who also are eligible for Medi-Cal. Under this framework, Medi-Cal beneficiaries could, but would not necessarily be required to, receive their Medicare benefits through a D-SNP that is operated by the same contracted managed care plan that provides their Medi-Cal benefit. Qualifying D-SNP plans would not include so-called D-SNP “look-alikes,” which are Medicare plans that are designed to attract dual eligibles but do not offer coordination with Medi-Cal or other benefits targeted to the dual-eligible population, such as risk assessments or care plans. (The federal Centers for Medicare and Medicaid Services have proposed that it will no longer enter into or renew contracts with

such look-alikes beginning in 2022. In the meantime, under CalAIM, the state would permit plans in CCI counties to transition beneficiaries enrolled in D-SNP look-alikes to existing D-SNPs.) Additionally, D-SNPs that

are not affiliated with Medi-Cal managed care plans (“non-aligned” D-SNPs) would no longer be able to accept new enrollees, although current enrollees could remain in those D-SNPs if they chose to do so.

Assessment and Issues for Legislative Consideration

Proposal Could Bring Benefits to SPDs.

CalAIM has the potential to improve care for Medi-Cal SPDs in the following ways:

- ***ECM and ILOS Proposals Could Improve Incentives for Plans to Offer Supportive Services and Coordinate Care for SPDs.*** Both the ECM and ILOS proposals would expand the services potentially available to Medi-Cal SPDs—ILOS by reimbursing plans for some nonmedical supportive services, and ECM by providing care management that could connect high-risk beneficiaries to preventive services they might not otherwise receive. In addition to providing a greater range of services for beneficiaries, these proposals potentially could reduce costs for plans over the long run because high-risk beneficiaries who receive relatively low-cost preventive supports and services may avoid the need for higher-cost interventions in the future. This could incentivize plans to provide high-risk beneficiaries with additional preventive supports and services. As mentioned above, this incentive does not exist under CCI, because CCI maintained the state’s practice of directly paying managed care plans higher rates for certain beneficiaries residing in nursing homes.
- ***Institutional Long-Term Care Carve-In to Managed Care Could Create Incentive to Emphasize Less Costly Alternatives to Nursing Home Care.*** Moving institutional long-term care into managed care statewide also could strengthen plan incentives to provide effective, less-costly care for those potentially needing nursing home services. Under CalAIM, plans would not immediately receive a higher rate when beneficiaries move

into nursing homes (or a lower rate when beneficiaries move out of such facilities). As a result, plans might opt to provide care in less-costly settings where feasible. There is general agreement that some nursing home residents could be safely cared for in more community-based settings and would prefer to do so if alternative services were available. The process of providing alternative services would be facilitated by allowing ILOS benefits.

- ***D-SNP Model Would Make Coordinated Care More Broadly Available.*** The proposal to require all Medi-Cal managed care plans to offer a D-SNP for their Medi-Cal beneficiaries would expand opportunities for at least some level of integration and coordination between Medi-Cal and Medicare more widely than it is available today. However, the level of integration available through D-SNPs potentially could vary between plans, since the CalAIM proposal does not specify a minimum standard of integration and coordination for D-SNPs.
- ***Difficult to Evaluate Governor’s MLTSS Plan Due to Lack of Detail.*** As previously discussed, the Governor’s CalAIM proposal includes a long-term goal of moving toward statewide MLTSS beginning in 2027 (the year by which the state would reevaluate and potentially extend, sunset, or modify major components of CalAIM generally). To lay the groundwork for MLTSS, CalAIM would take a number of incremental steps toward better coordination and integration of managed care and LTSS, including through the carve in of long-term care facilities, the inclusion of LTSS among optional ILOS, and the requirements around greater alignment of Medicare and

Medi-Cal services. However, what exactly the Governor’s vision is for MLTSS is unclear. Major outstanding questions on what this vision entails include which LTSS programs would be carved into managed care, how services would be coordinated for any LTSS not carved into managed care, and what kind of fiscal resources would be needed to expand MLTSS statewide.

Major Other Questions Remain. Figure 3 lists our major outstanding questions about CalAIM as the proposal pertains to SPDs. As the Legislature evaluates CalAIM’s impact on the SPD population, we suggest focusing on resolving these key questions.

ISSUES FOR LEGISLATIVE CONSIDERATION

In its evaluation of CalAIM’s effect on SPDs, the Legislature may wish to consider the following issues.

Ensuring CalAIM Proposal Ultimately Achieves Legislature’s LTSS Objectives. The CalAIM proposal is closely aligned with the LTSS objectives the administration laid out in its Master Plan for Aging. The Legislature may wish to consider whether the administration’s Master Plan for Aging aligns with its own objectives. If the Legislature disagrees with some of the administration’s LTSS objectives, the Legislature could articulate its own set of objectives, and then monitor CalAIM to ensure that it aligns with

Figure 3

SPD-Related CalAIM Questions for Legislative Focus

Overall Strategy for LTSS

- How will the administration include the Legislature in selecting and designing the LTSS benefits that will be provided statewide through MLTSS?
- How will the state measure progress and assess whether it is on track to implement MLTSS by 2027?
- What steps could the state take to strengthen coordination or integration between managed care and LTSS programs carved-out of MLTSS (IHSS and MSSP)?

Changes to Medi-Cal Managed Care

- How would the administration track the cost and utilization of ILOS and the services they replace to ensure cost-effectiveness and how would this information be made available to the Legislature?
- What would be the fiscal impact of transitioning SNFs to managed care statewide, including both increased costs associated with newly paying for managed care plan overhead and earnings, as well as potential savings from reduced SNF utilization?
- What steps would the state take to ensure a smooth transition of the SNF benefit into managed care statewide?
- To what extent could the transition of the SNF benefit into managed care statewide be delayed if plan readiness is not achieved by the proposed transition date of January 2021?
- Given the differences between ICFs and SNFs, how would the statewide transition of ICFs into managed care create benefits like those envisioned for SNFs?
- To what extent will ILOS and ECM strengthen or duplicate existing LTSS programs?

Discontinuing CMC in Favor of Statewide D-SNP Model

- How would integration of Medi-Cal and Medicare benefits for dually eligible beneficiaries differ between the current CMC structure and the proposed new D-SNP structure?
- What factors may contribute to, or hinder, the viability of D-SNPs in various parts of the state, particularly in instances where Medi-Cal managed care organizations have not offered them previously? What can the state do to address potential challenges?
- What additional requirements should the state impose on D-SNPs to ensure they provide an adequate level of integration between Medi-Cal and Medicare?

Evaluating CalAIM’s Impacts

- What is the administration’s plan for ensuring that CalAIM proposals are evaluated robustly?

SPD = seniors and persons with disabilities; CalAIM = California Advancing and Innovating Medi-Cal; LTSS = long-term services and supports; MLTSS = managed long-term services and supports; IHSS = In-Home Supportive Services; MSSP = Multipurpose Senior Services Program; ILOS = in lieu of services; SNFs = skilled nursing facilities; ICFs = intermediate care facilities; ECM = Enhanced Care Management; CMC = Cal MediConnect; and D-SNP = Dual Eligible Special Needs Plan.

those objectives. For example, the Legislature may choose to consider whether the state should prioritize expanding existing LTSS programs or consolidating the state's various LTSS services into a new statewide, comprehensive program.

Considering Ways to Further Reduce LTSS Fragmentation. Although CalAIM has the potential to significantly improve LTSS coordination of care, there are additional steps the Legislature could consider toward creating an integrated Medi-Cal LTSS system. For example, as previously mentioned, Medi-Cal SPDs currently are subject to a different assessment and referral process for each LTSS program they might utilize. This means, for example, that an individual who requires both IHSS and MSSP services would need to go through an entirely separate enrollment process for each program. The Legislature could consider creating a standard assessment and referral process for Medi-Cal LTSS programs to streamline the process of enrolling in multiple programs simultaneously.

Explore Opportunities to Further Strengthen Relationship Between Medi-Cal Managed Care and IHSS Program. CalAIM allows for greater service coordination between Medi-Cal managed care and IHSS by allowing managed care plans to provide eligible beneficiaries with personal care and home care services while they await IHSS approval and, if needed, provide services above and beyond authorized IHSS service levels. In deciding what services will be provided through MLTSS by 2027, the Legislature could consider the benefits and trade-offs of pursuing a higher level of coordination or integration between Medi-Cal managed care and IHSS. For example, the Legislature could replicate or scale up past coordination efforts, such as providing funding so that IHSS county social workers could participate in interdisciplinary care teams and collaborate with other care providers to address the social, medical, and behavioral needs of an IHSS recipient. Alternatively, the Legislature could consider testing a fuller integration of IHSS within managed care plans, such as allowing managed care to play some role in the administration of IHSS. Whatever the Legislature chooses, it should carefully consider funding needs and the benefits and trade-offs to legislative oversight; local control; and current IHSS program

features, such as consumers being responsible for choosing their provider.

Requiring an MLTSS Development Plan. The administration has not yet articulated a specific vision for how it would realize MLTSS. We suggest the Legislature require more information from the administration on how it plans to implement MLTSS, and what components would be included in the final MLTSS infrastructure. This information could include what type of LTSS benefits would be provided under MLTSS, what goals and milestones the state would use to assess MLTSS implementation progress, and how the state would assess whether beneficiaries have equal access to and receive the same quality of care under MLTSS.

Considering Putting a Process in Place for Legislative Oversight of CalAIM Implementation. CalAIM would make many major changes to Medi-Cal, with significant impacts on beneficiaries, all over a relatively short period of time. If approved, legislative oversight of CalAIM will be critical to ensuring smooth and successful implementation. Accordingly, prior to January 2022, the Legislature could consider requiring regular check-ins with, and reports from, the administration, managed care plans, and other partners to discuss readiness for implementation. After January 2022, the Legislature could expand the focus of the check-ins to include monitoring of the successes and challenges of CalAIM implementation.

Requiring a Comprehensive and Independent Evaluation of Any Major Reforms Ultimately Adopted. In order to understand the impacts of CalAIM, we recommend that the Legislature establish a framework for an independent and robust evaluation of whichever major components of the CalAIM proposal ultimately are adopted. Because ascertaining the true impacts of a reform effort this large would be a significant challenge, we recommend that the Legislature consider providing direction over the evaluation's design and reporting. Reports of the evaluation should be clear and accessible to policymakers and should focus on pre-identified measures of success. Ideally, the evaluation should be available, at least in a preliminary form, prior to any deadlines for deciding on whether to reauthorize any major components of CalAIM.

Adopting a D-SNP Model That Maximizes Integration Between Medi-Cal and Medicare. As previously mentioned, D-SNPs vary in the level of coordination and integration they provide between Medi-Cal and Medicare. Although the CalAIM proposal makes clear that D-SNP look-alikes would not meet the threshold that would be required of managed care plans, it does not specify a minimum

standard of integration and coordination for D-SNPs themselves. The Legislature could consider setting this minimum standard. Determining the appropriate minimum standard would require further analysis, as there may be some trade-offs between the level of integration a D-SNP model offers and the feasibility of implementing that model statewide.

LAO Publications

This report was prepared by Ned Resnikoff, Ben Johnson, and Jackie Barocio, and reviewed by Mark C. Newton and Carolyn Chu. The Legislative Analyst's Office (LAO) is a nonpartisan office that provides fiscal and policy information and advice to the Legislature.