Request for Information

Introduction

The California Department of Health Care Services (DHCS) is releasing this Request for Information (RFI) to provide information and solicit input from Interested Parties regarding: 1) goals for the Medi-Cal managed care delivery system to be achieved through the upcoming Medi-Cal Managed Care Plan (MCP) Request for Proposal (RFP) process; and 2) updates proposed to be included in contracts awarded through the RFP process. Please note that DHCS intends to use the updated MCP Contract as the boilerplate for all Medi-Cal MCPs, including non-commercial Local Initiative and County Organized Health System plans, concurrent with implementation of the new contracts for commercial plans through the RFP process. Interested Parties for this RFI may include, but are not limited to, Health Plans, counties, providers, advocates, or other stakeholders.

The RFI includes the following sections:

- Purpose/Background
- Major Policy Changes Affecting Medi-Cal Managed Care
- MCP Contract – High-level overview of planned updates
- MCP Contract – Samples of specific planned updates

DHCS may use information from the RFI responses in the development of the RFP. The RFP will be used to procure commercial health plans in the following Plan Model types:

- Two-Plan Model
- Geographic Managed Care (GMC)
- Regional Model
- Imperial Model
- San Benito Model

The RFP will not be used to procure the County Operated Health Systems (COHS) Plans, or Local Initiative Plans in the Non-COHS plan model types.

DHCS intends to release a draft RFP for stakeholder feedback in early 2021.

More information is available in the RFP schedule (2/27/2020):
https://www.dhcs.ca.gov/provgovpart/rfa_rfp/Documents/MCOD_RFP_Schedule_v20200227.pdf

Purpose/Background

DHCS is the single State Medicaid agency responsible for administering Medi-Cal, California's Medicaid program. The mission of DHCS is to provide Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services and long-term care. Our vision is to preserve and improve the overall health and well-being of all Californians and particularly, to address the needs of populations experiencing disparities in health outcomes.

DHCS oversees operational and program activities to meet the needs of providing health care to over 12 million Medi-Cal beneficiaries in all of California's 58 counties. Most Medi-Cal beneficiaries are enrolled in Medi-Cal MCPs, and receive all or most of their health care through MCP provider networks and organized systems of care. DHCS conducts contract management and oversight of the MCPs, so that beneficiaries receive high quality, accessible, and cost-effective health care.

In accordance with our mission and vision, DHCS has developed goals for the Medi-Cal managed care program. These goals will be used to develop the qualification requirements and evaluation criteria in the RFP for commercial plans, as well as to update the MCP contract.

DHCS is looking for Managed Care Plans that demonstrate their ability to provide:

1. **Quality** - Meet or exceed Minimum Performance Levels for quality, on the measures included in the Managed Care Accountability Set.
2. ***Access to care*** - Ensure comprehensive networks that provide all members timely access to appropriate, culturally competent, and high-quality care, within time and distance standards.
3. **Continuum of care** - Manage patients over time through a comprehensive array of person-centered health and social services spanning all levels of intensity of care, from birth to end of life.
4. **Children services** - Provide children's services, specifically preventive and early intervention services, maternal services and those that support social, emotional development and address adverse childhood experiences.
5. **Behavioral health services** - Expand access to evidence-based behavioral health services, focused on earlier identification and engagement in treatment for children, youth, and adults.
6. **Coordinated/integrated care** - Provide coordinated, integrated care for all members, particularly vulnerable populations with complex health care needs. This will include the strategies articulated in CalAIM https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx coordination with entities providing carved-out benefits and services, as well as other state and federal requirements.

7. **Reducing health disparities** - Identify health disparities and inequities in access, utilization, and outcomes among racial, ethnic, language, and LGBTQ groups and have focused efforts to improve health outcomes within the groups and communities most impacted by health disparities and inequities.
8. **Increased oversight of delegated entities** - Provide increased oversight of all delegated entities to ensure enrollees receive quality care and service in accordance with the MCPs contractual obligations to DHCS.
9. **Local presence and engagement** - Demonstrate a local presence and collaborate and engage with local community partners and resources to ensure community needs are met.
10. **Emergency preparedness and ensuring essential services** - Ensure continuity of its business operations, delivery of essential care and services to members, and to mitigate any potential harm caused by an Emergency, such as a natural or manmade hazard or disaster or health crises.

Through this RFI, DHCS is seeking input from Interested Parties on the goals above, as well as the contract updates described below. More specifically, DHCS seeks input on the following questions:

Q1. What MCP contract changes or actions do you recommend DHCS consider to address health disparities and inequities, as well as, identify and address social determinants of health?

Q2. What MCP contract changes or actions do you recommend DHCS consider to increase MCP's community engagement?

Q3. What MCP contract changes or actions do you recommend DHCS consider for emergency preparedness and response for disasters?

Q4. What MCP contract changes or actions do you recommend DHCS consider to achieve the other MCP goals listed?

Q5. What, if any, of the listed MCP goals provide significant challenges and what should be done to address those challenges?

Q6. What additional MCP goals should DHCS consider?

Q7. What additional changes or actions do you recommend DHCS consider for the planned *structural* updates to the MCP contract?

Q8. What additional changes or actions do you recommend DHCS consider for the planned *content* updates to the MCP contract?

Medi-Cal Managed Care Models

As of March 2020, approximately 11 million Medi-Cal Members in all fifty-eight (58) California counties receive their health care through the six models of managed care: Two-Plan, GMC, Regional Model, Imperial, San Benito, and COHS. Below is a brief description of each model type.

Two-plan:

- In a Two-Plan Model county, there is a county organized plan called the Local Initiative (a prepaid health plan) and a commercial plan. Both the Local Initiative plan and the commercial plan are required to be Knox-Keene Act licensed. The Local Initiative plan is a county sponsored managed care plan that serves one or more counties. DHCS contracts with both plans for the delivery of Medi-Cal managed care services in the county.

- As of March 2020, the Two-Plan Model operates in 14 counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, Santa Clara, San Francisco, San Joaquin, Stanislaus, and Tulare.

Geographic Managed Care:

- In a GMC Model county, DHCS contracts with multiple Knox-Keene Act licensed commercial health plans within the county. The GMC Model serves clearly defined geographic areas.

- As of March 2020, the GMC Model operates in two counties: Sacramento and San Diego.

Regional:

- In rural counties that have not elected to participate as a COHS model or as the Local Initiative of a Two-Plan model, DHCS contracts with two commercial health plans, through the Regional Model. Both commercial health plans are Knox-Keene Act licensed and serve two or more contiguous counties in the designated Rural Expansion Region.

- As of March 2020, the Regional Model operates in 18 counties: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba.

Imperial:

- The Imperial Model originated out of the Regional Model to serve rural expansion needs. Similarly, in the Imperial Model, there are two Knox-Keene Act licensed commercial plans that contract with DHCS to serve one county.

- As of March 2020, the Imperial Model operates in Imperial County only.

San Benito:

- The San Benito Model also originated out of the Regional Model to serve rural expansion needs. In the San Benito Model, there is one Knox-Keene Act licensed commercial plan that contracts with DHCS. Beneficiaries can choose to receive Medi-Cal services through the managed care plan or regular fee-for-service (FFS) Medi-Cal.

- As of March 2020, the San Benito Model operates in San Benito County only.

County Organized Health Systems:

- In a COHS Model county, there is only one managed care plan serving the Medi-Cal population and it is operated by the county. The county Board of Supervisors may establish, by ordinance, a commission. The commission negotiates a COHS contract with DHCS and serves as an independent oversight entity for the delivery of Medi-Cal managed care services in that county. The commission COHS contracts may be on a non-bid basis.

- As of March 2020, the COHS Model operates in 22 counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo.

The following links provide more information about the Medi-Cal managed care plan models: https://www.dhcs.ca.gov/services/Documents/MMCD/MMCDModelFactSheet.pdf and https://www.dhcs.ca.gov/services/Documents/MMCD_County_Map.pdf

The following link provides additional information regarding Medi-Cal managed care: https://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx

Major Policy Changes Affecting Medi-Cal Managed Care

The Medi-Cal program continues to evolve, respond and innovate to reflect health care delivery system changes, public health requirements, and beneficiaries' health care needs. Detailed below are major recent and anticipated Medi-Cal policy changes expected to affect the managed care program and be reflected in the updated contracts to be awarded through the RFP.

California Advancing and Innovating Medi-Cal (CalAIM): CalAIM is a multi-year initiative by DHCS to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing broad delivery system, program and payment reform across the Medi-Cal program. The major components of CalAIM build upon the successful outcomes of various pilots from the previous federal 1115 waivers and will target better health outcomes for Medi-Cal beneficiaries as well as long-term cost savings/avoidance.

The following link provides more information about CalAIM and its impacts in managed care: https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

Medi-Cal Rx: On January 7, 2019, Governor Newsom released Executive Order N-01-19 (EO-N-01-19), which directed DHCS, in part, to transition pharmacy benefits and services from Medi-Cal managed care to the Medi-Cal FFS delivery system by January 1, 2021. The EO-N-01-19 transition is called Medi-Cal Rx, and includes Medi-Cal pharmacy benefits and services for most Medi-Cal managed care members.

The following link provides more information about Medi-Cal Rx and its impacts in managed care. https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx

MCP Contract – High-Level Overview of Planned Updates

The most current boilerplate Contract is available online at

https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

This section includes a high-level overview of planned updates to the boilerplate MCP Contract that will be included in the RFP and will be used for all Medi-Cal managed care plans. This is neither a final nor an all-inclusive list.

Updates identified in this section have been grouped into two categories:

Planned structural updates	High-level updates identified in this section are specific to the organization of the contract; for example, sections that will be moved, added, deleted or reviewed for applicability.
Planned content updates	High-level updates in this section identify examples of planned requirement and textual changes in the identified attachment. Note: The updates in this section are listed in the order and identified by the attachment name in the current two-plan CCI boilerplate contract.

Planned Structural Updates

1. **Definitions** will be moved to front of contract – Currently in Exhibit E, Attachment 1.
2. A new section, "**Acronyms"** will be added after the Definitions Section.
3. **Implementation Plan and Deliverables** contract requirements will be moved to the front of the MCP Contract. These requirements are associated with MCP's demonstrating Operational Readiness. Currently this is in Exhibit A, Attachment 18.
4. **Exhibit A (Scope of Work) will be reordered** into more logical groups to improve readability.
5. **Existing language will be reviewed, moved, or consolidated** into other sections of the MCP Contract as appropriate. See Planned Content updates below.
6. **DGS and DHCS-standard Exhibits** (C – General Terms and Conditions, D(f) – Special Terms and Conditions) will be reviewed for applicability to the MCP Contract updates, updated or removed as appropriate.
7. A new section, "**Emergency Preparedness and Response**" will identify related requirements to ensure continuity of services and appropriate communication between DHCS, MCPs, Providers, and Members.

Planned Content Updates

1. **CalAIM policy updates** will be incorporated into the MCP Contract as appropriate.
2. **Budget-related policy updates identified through release of the RFP** will be incorporated into the MCP Contract as appropriate. For example, budget changes adopted between the release of the RFP in 2021 and go live of the Plans in January 2024 will be incorporated into the final contract as appropriate.
3. **Any new State and Federal statutes and regulations** applicable to the MCP Contract will be incorporated as appropriate.
4. **Existing language referencing State and Federal statutes and regulations** will be reviewed and updated as appropriate.
5. **California State Auditor (CSA) report recommendations** will be reviewed for inclusion into Contract language where appropriate. For example, some recommendations from CSA Reports 2018-111 and 2019-105, regarding preventative health services and blood lead level screenings for children will be incorporated into the contract.
6. **Medical Audit findings** will be reviewed to determine if clarifying language is needed for inclusion into Contract language where appropriate. For example, if due to an audit finding, a timeline or policy and procedure requirement in the contract needs further detail, contract language will be updated as needed.
7. **Published All Plan Letters (APLs)** will be reviewed for possible inclusion into Contract language where appropriate. Inclusion of APL language into the contract will not replace or make APL's obsolete, but will allow for the contract language to be aligned with APL's as needed. (A complete list of APLs is available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx)
8. **Terminology updates** will be reviewed and updated as appropriate throughout the MCP Contract. For example, "Program Fraud and Abuse" will be updated to "Program Integrity."
9. **Outdated Contract language** will be removed.
10. **Duplicative and Conflicting Contract language** will be assessed and resolved.
11. Contract will be reviewed and updated to ensure **consistency across Contract citations, acronyms, and terminology** where appropriate.
12. **HIPAA Business Associates Agreement (BAA) will be updated** based on current State and Federal requirements.

MCP Contract – Samples of Specific Planned Updates

This section includes a list of specific planned updates to the sample Contract included in the RFP. This is neither a final nor an all-inclusive list. Attachments or Provisions identified in this table may have a different number or title within a specific MCP Contract.

Exhibit/Attachment/Title	Sample of Planned Update(s)
Exhibit A Attachment 1 Organization and Administration of the Plan	• Placeholders will be added for National Committee for Quality Assurance (NCQA) requirements.
Exhibit A Attachment 2 Financial Information	• Financial reporting requirements will be consolidated, streamlined, and updated to reflect federal audit requirements.
Exhibit A Attachment 3 Management Information System	• Language will be added to address plan consumption of data files shared for care coordination purposes. • Language will be added for 274 provider network data and also template data which is comparable to encounter data language. • Language will be added to account for potential requirement to report denied claims/encounters. • Financial reporting requirements will be consolidated, streamlined, and updated to reflect federal audit requirements.
Exhibit A Attachment 4 Quality Improvement System	• Language will be updated from External Accountability Set (EAS) to Managed Care Accountability Set (MCAS) based on Centers for Medicare & Medicaid Services (CMS) Core Set measures. • Language for the Minimum Performance Level (MPL) will be updated to align with language in the Quality Improvement All Plan Letter (QI APL). • Language around reducing health disparities will be strengthened.
Exhibit A Attachment 5 Utilization Management	• Contract language references to Pharmacy Prior Authorization will be removed – these are carved out effective January 1, 2021.

Exhibit A Attachment 6 Provider Network **Exhibit A Attachment 9** Access and Availability	• Attachments 6 and 9 will be updated and rearranged. DHCS intends to create one Contract section specific to requirements for Network Provider Agreements and Subcontractor Agreements and another specific to requirements for Access to Care and the Contractors' Network. • All provisions from APL 99-01 Community Advisory Committee will be added so the APL will no longer be needed. • Requirements for Network Provider/Subcontractor Agreements (previously Subcontracts) will be separated from Memorandum of Understanding (MOU) requirements. MOUs will be required when there is overlapping responsibility for care coordination between MCP and other party, but no reimbursement is made.
Exhibit A Attachment 7 Provider Relations	• Section titled "Provider Grievance" will be renamed "Provider Dispute Resolution Process" and updated appropriately. • Section titled "Non-Contracting, Non-Emergency Provider Communication" will be renamed "Out-of-Network Provider Relations" and updated appropriately. • Section titled "Contractor's Provider Manual" will be renamed "Contractor's Network Provider Manual" and updated appropriately.
Exhibit A Attachment 8 Provider Compensation Arrangements	• New section will be added as "Compliance with Directed Payment Initiatives and Related Reimbursement Requirements" to define Contractor requirements to reimburse for 42 CFR 438.6(c) directed payments and 42 CFR 438.6(d) pass-through payments. • Section titled "Physician Incentive Plan Requirements" will be renamed "Provider Financial Incentive Program Payments" and updated appropriately. • Language will be added regarding CSA Audit recommended reporting for all financial incentive programs related to this Contract.

Exhibit A Attachment 10 Scope of Services	• Will remove language, as appropriate, around specific preventative services above the American Academy of Pediatrics (AAP) and United States Preventive Services Task Force (USPSTF) recommendation. • Language will be added to reflect certain components of CalAIM.
Exhibit A Attachment 11 Case Management and Coordination of Care	• This section will be renamed and reorganized, with additional language to reflect certain components of CalAIM. Language will also reflect coordination responsibilities with entities providing non-contracted services.
Exhibit A Attachment 12 Local Health Department Coordination	• This section will be updated and renamed to include requirements for MOUs and Agreements with Third-Party entities including, but not limited to, County Programs and Local Government Agencies. For example: 1) County California Children's Services programs 2) Maternal and Child Health 3) Local Health Departments for Tuberculosis Direct Observed Therapy 4) Women Infants and Children Supplemental Nutrition Program 5) County substance use disorder treatment services 6) Regional Centers for persons with developmental disabilities 7) Local Governmental Agencies for Targeted Case Management services 8) County Mental Health Plans 9) Local Educational Agencies • The list of third party entities/county programs will be modified to identify which requirements apply for having an MOU or a Subcontractor/Network Provider Agreement. • Standard components will be identified that must be included in all MOUs, in addition to additional components for specified third party entities/county programs. • Additional requirement will be added for review/renewal of MOU every three years.

	• New language around requirements for Health Plans to have robust local engagement including but not limited to participation in Medi-Cal oversight committees or other local commissions.
Exhibit A Attachment 13 Member Services	• Non-Discrimination requirements will be updated to comply with new Regulations and APLs.
Exhibit A Attachment 14 Member Grievance and Appeals System	• Contract language within this section related to Discrimination Grievances will be updated to align with current regulations. • A separate provision specifically related to continuation of services until appeal and State Fair hearing rights are exhausted will be added.
Exhibit A Attachment 15 Marketing	• Updated requirements to obtain DHCS approval for all advertisements will be added. • Language around outreach to reduce health disparities.
Exhibit A Attachment 16 Enrollments and Disenrollments	• Contract language related to anti-discrimination will be reviewed and updated.
Exhibit A Attachment 17 Reporting Requirements	• This section will be expanded to include a comprehensive list of Deliverables and Submissions.
Exhibit A Attachment 18 Implementation Plan and Deliverables	• Contract language will be updated to reflect related changed from in the other Contract sections.
Exhibit A Attachment 19 Community Based Adult Services (CBAS)	• Contract language will be updated based on any changes to CBAS-related policy. Selected requirements will be assessed for possible integration into the Scope of Services or other appropriate Contract sections.
Exhibit A Attachment 20 Mental Health and Substance Use Disorder (MHSUD) Benefits	• Contract language will be updated based on changes to MHSUD-related policy. Selected requirements will be assessed for possible integration into the Scope of Services or other appropriate Contract sections.

Exhibit A Attachment 21 Managed Long-term Services and Supports (MLTSS)	• Attachment 21 currently is only included in contracts where Plans operate in a Coordinated Care Initiative (CCI) County. Relevant portions of this attachment will be incorporated into other Attachments, and modified in accordance with CalAIM provisions, including the carve-in of long-term care in all MCPs, and the requirement to operate a Dual Eligible Special Needs Plan (D-SNP) by a specific date.
Exhibit B Budget Detail and Payment Provisions	• Plan reimbursement provisions related to capitation payments, supplemental payments, and additional payments will be clarified and streamlined.
Exhibit E Attachment 1 Definitions	• Definitions such as "Network Provider" and "Subcontractor" will be aligned with the Federal definitions (42 CFR § 438.2). • Definitions section will be reviewed in its entirety and updated as appropriate. Terms and phrases will be added based on Contract content updates.
Exhibit E Attachment 2 Program Terms and Conditions	• DHCS' APL authority will be strengthened and clarified. • Phaseout requirements, including an increase in DHCS' retention of Capitation Payment to ensure accountability of the MCP during the Phaseout Period, will be strengthened. • Contract language identifying DHCS' sanction authority will be clarified. • Program integrity provisions, including additional fraud, waste, and abuse reporting requirements and provisions requiring MCPs to assist Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA) in their program integrity efforts, will be strengthened. • Provision 28 (Fraud and Abuse Reporting) will be renamed Program Integrity and moved out of Exhibit E - Additional Provisions into Exhibit A - Scope of Work.
Exhibit E Attachment 3 Duties of the State	• Duties of the State will be eliminated as a standalone Attachment and relevant state duties will be incorporated into applicable sections of the Contract.