AMENDED IN ASSEMBLY JUNE 18, 2025

AMENDED IN SENATE APRIL 7, 2025

AMENDED IN SENATE MARCH 24, 2025

SENATE BILL No. 324

Introduced by Senator Menjivar
(Principal coauthor: Senator McGuire)

February 11, 2025

An act to amend Sections 14184.205 and 14184.206 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 324, as amended, Menjivar. Medi-Cal: enhanced care management and community supports.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, requires the department to implement an enhanced care management (ECM) benefit designed to address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Under existing law, target populations include, among others, high utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits, and individuals experiencing homelessness.

Existing law, subject to CalAIM implementation, authorizes a Medi-Cal managed care plan to elect to cover community supports, as specified. Under existing law, community supports that the department is authorized to approve include, among others, housing transition navigation services and medically supportive food and nutrition services.

This bill would require a Medi-Cal managed care plan, for purposes of covering the ECM benefit, or if it elects to cover a community support, to contract with community providers, ~~as defined, whenever~~ *as defined. In determining which community providers to contract with, the bill would authorize Medi-Cal managed care plans to take into consideration whether* those providers are available in the respective ~~county and~~ *county,* have experience in providing the applicable ECM or community support, and can demonstrate that they are capable of providing access and meeting quality requirements in accordance with Medi-Cal guidelines. *The bill would require the department, in enforcing these provisions, to require Medi-Cal managed care plans to set goals every other year to increase the contracting and utilization of community providers and local entities, as defined. The bill would require these goals to be set in consultation with the department, as specified.*

The bill would require a *Medi-Cal* managed care plan to honor member preference with regard to the applicable ECM or community support by authorizing ~~service delivery to~~ the contracted provider who ~~is submitting a~~ *submits the* request for approval of services to ~~the managed care plan.~~ *deliver the requested services if that provider is capable of providing those services.*

Existing law requires the department to develop, in consultation with Medi-Cal managed care plans and other appropriate stakeholders, a monitoring plan and reporting template for the implementation of ECM or community supports. Existing law requires the department to annually publish a public report on reported ECM or community support utilization data, populations served, and demographic data, stratified by age, sex, race, ethnicity, and languages spoken, to the extent that statistically reliant data are available.

This bill would expressly include providers of ECM or community supports within the consultation process. The bill would require the department to publish the public report on a quarterly basis instead and would require additional demographic data.

The bill would also require the department to develop standardized and streamlined templates to be used by *Medi-Cal* managed care plans or their contracted providers, as specified, and to develop guidance to

allow community providers to act as a primary subcontractor with *Medi-Cal* managed care plans and to subcontract with other community providers as a 3rd-tier subcontractor, as specified.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 14184.205 of the Welfare and Institutions Code is amended to read:

14184.205. (a) Subject to subdivision (f) of Section 14184.102, the department shall implement an enhanced care management (ECM) benefit designed to address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans, in accordance with this section and the CalAIM Terms and Conditions.

(b) (1) Subject to the effective dates listed in subdivision (c), the ECM benefit shall be available on a statewide basis to an eligible Medi-Cal beneficiary who is enrolled in an applicable Medi-Cal managed care plan and who meets the criteria in the CalAIM Terms and Conditions for one or more target populations, as determined by the department. A Medi-Cal beneficiary is excluded from ECM while enrolled in a 1915(c) waiver or the Family Mosaic Project, or while receiving California Community Transitions (CCT) Money Follows the Person (MFTP) services. ECM shall be available to a qualifying dual eligible beneficiary, as described under Section 14184.200, except for a dual eligible beneficiary enrolled in a fully integrated program for members who are dually eligible for Medicare and Medicaid, including Cal MediConnect during the duration of the demonstration authorized in former Section 14132.275, Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), and the Programs of All-Inclusive Care for the Elderly (PACE).

(2) ECM only shall be available as a covered Medi-Cal benefit under a comprehensive risk contract with a Medi-Cal managed care plan. A Medi-Cal beneficiary who is eligible for ECM shall enroll in a Medi-Cal managed care plan in order to receive those services.

(c) (1) A Medi-Cal managed care plan operating in counties in which either the Whole Person Care pilot program, pursuant to Section 14184.60, or the Health Home Program, pursuant to former Article 3.9 (commencing with Section 14127), or both, were implemented, as determined by the department, shall be required to cover ECM under its comprehensive risk contract as follows:

(A) Commencing January 1, 2022, a Medi-Cal managed care plan described in this paragraph shall be required to cover ECM for existing target populations under either the Whole Person Care pilot program or the Health Home Program, or both, as identified by the department.

(B) (i) Commencing January 1, 2023, a Medi-Cal managed care plan described in this paragraph shall be required to cover ECM for other select target populations described in subdivision (d), as identified by the department and in accordance with the CalAIM Terms and Conditions.

(ii) Commencing July 1, 2023, a Medi-Cal managed care plan described in this paragraph shall be required to cover ECM for all target populations described in subdivision (d) and in accordance with the CalAIM Terms and Conditions.

(2) A Medi-Cal managed care plan operating in counties in which neither the Whole Person Care pilot program, pursuant to Section 14184.60, or the Health Home Program, pursuant to former Article 3.9 (commencing with Section 14127), was implemented, as determined by the department, shall be required to cover select ECM target populations, as identified by the department, under its comprehensive risk contract, commencing July 1, 2022. All other target populations, including the target population described in paragraph (7) of subdivision (d), shall be covered commencing January 1, 2023, or July 1, 2023, in accordance with the CalAIM Terms and Conditions.

(d) Target populations shall include the following, consistent with the department's eligibility criteria, and to the extent approved in the CalAIM Terms and Conditions:

(1) Children or youth with complex physical, behavioral, developmental, or oral health needs, including, but not limited to, those eligible for California Children's Services, those involved or with a history of involvement in child welfare or the juvenile justice system, or youth with clinical high-risk syndrome or a first episode of psychosis.

(2) Individuals experiencing homelessness.

(3) High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.

(4) Individuals at risk for institutionalization and eligible for long-term care services.

(5) Nursing facility residents who want to transition to the community.

(6) Individuals with serious mental illness (SMI), and children with serious emotional disturbance (SED) or substance use disorder (SUD).

(7) Individuals transitioning from incarceration requiring immediate transition of services to the community.

(e) Notwithstanding any other law, for any time period in which a Medi-Cal beneficiary is eligible to receive ECM services through enrollment in their Medi-Cal managed care plan, the beneficiary shall not receive duplicative targeted case management services as described in Section 14132.44 or otherwise authorized in the Medi-Cal State Plan, as determined by the department.

(f) Medi-Cal managed *care* plans shall consult and collaborate with Medi-Cal behavioral health delivery systems for the delivery of ECM for beneficiaries with an SMI, SED, or SUD.

(g) (1) ~~A~~ *(A) A Medi-Cal* managed care plan shall, for purposes of covering the ECM benefit pursuant to this section, contract, directly or indirectly, with community ~~providers whenever those providers~~ *providers.*

(B) In determining which community providers to contract with, a Medi-Cal managed care plan may, in addition to considering its own network needs, take into consideration whether community providers are available in the respective ~~county and~~ *county,* have experience in providing the applicable ECM, and can demonstrate that they are capable of providing access and meeting quality requirements in accordance with Medi-Cal guidelines. ~~This~~

(C) This requirement shall not limit a *Medi-Cal* managed care plan's ability to contract with other nonprofit, for-profit, or ~~local~~ governmental providers for the same ECM population of ~~focus.~~ *focus, particularly local entities that provide services to Medi-Cal beneficiaries.*

(2) If a Medi-Cal managed care plan proposes to keep some level of ECM in house instead of contracting with direct providers, the Medi-Cal managed care plan shall demonstrate to the state that

its ECM benefit is appropriately community based and shall provide a rationale for not contracting with existing providers.

~~(3) A Medi-Cal managed care plan shall honor member preference with regard to ECM by authorizing service delivery to the contracted provider who is submitting a request for approval of services to the managed care plan.~~

(3) A Medi-Cal managed care plan shall honor member preference with regard to ECM by authorizing the contracted community provider who submits the request for approval of services to deliver the requested services if that provider is capable of providing those services.

(h) For purposes of enforcing paragraph (1) of subdivision (g), the department shall require Medi-Cal managed care plans to set goals every other year to increase the contracting and utilization of community providers and local entities. The goals shall be established in consultation with the department and based on the information obtained by the department pursuant to subdivision (i).

~~(h)~~

(i) The department shall develop, in consultation with Medi-Cal managed care plans, providers of ECM, and other appropriate stakeholders, all of the following:

(1) A monitoring plan and reporting template for the implementation of ECM pursuant to this section. The department shall quarterly publish a public report on reported ECM utilization data, populations served, and demographic data, stratified by county, age, sex, race, ethnicity, and languages spoken, with each of those demographic categories disaggregated by type of provider delivering the service, including, but not limited to, for-profit providers, local governments, and community providers, to the extent that statistically reliant data are available.

(2) Standardized and streamlined templates to be used by *Medi-Cal* managed care plans or their contracted providers to facilitate inclusion of community providers with limited prior experience in contracting with Medi-Cal managed care plans but who can demonstrate that they are capable of providing access and meeting quality requirements in accordance with Medi-Cal guidelines. The department shall consult with *Medi-Cal* managed care plans and providers in developing these templates.

(3) Guidance to allow community providers to act as a primary subcontractor with *Medi-Cal* managed care plans and to subcontract with other community providers as a third-tier subcontractor. Community providers acting as a primary subcontractor may provide administrative support to third-tier subcontractors, including billing, training, coordination, and other ancillary support, as necessary to meet the requirements of providing Medi-Cal services. The department shall address in its guidance how to resolve applicable concerns when using a primary subcontractor that contracts with third-tier subcontractors.

~~(i)~~

(j) For purposes of this section, ~~"community~~ *the following definitions shall apply:*

(1) "*Community* provider" means a locally available, community-based nonprofit organization that has direct experience with ~~the Medi-Cal populations being served and is generally embedded in the health care or social services ecosystem in the provider's county.~~ *providing services to Medi-Cal beneficiaries in the county in which the organization operates.* A community provider offers health-related social needs (HRSN) services that are covered under Medi-Cal, and is authorized, rather than required, to provide additional Medi-Cal services.

(2) "Local entity" means a locally available health, behavioral health, or human services entity, including, but not limited to, agencies, departments, or independent commissions, or a locally available designated public hospital and its affiliated entities, that has direct experience with providing services to Medi-Cal beneficiaries in the county in which the entity or hospital operates.

SEC. 2. Section 14184.206 of the Welfare and Institutions Code is amended to read:

14184.206. (a) Commencing January 1, 2022, and subject to subdivision (f) of Section 14184.102, a Medi-Cal managed care plan may elect to cover those community supports approved by the department as cost effective and medically appropriate in the comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services, in accordance with the CalAIM Terms and Conditions.

(b) (1) Approved community supports pursuant to this section shall be available only to beneficiaries enrolled in a Medi-Cal

managed care plan under a comprehensive risk contract, subject to paragraph (2).

(2) Approved community supports shall not supplant other covered Medi-Cal benefits that are not the responsibility of the Medi-Cal managed care plan under the comprehensive risk contract, including, but not limited to, in-home supportive services provided pursuant to Article 7 (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.

(3) An enrolled Medi-Cal beneficiary shall not be required by their Medi-Cal managed care plan to use the community support.

(c) Subject to subdivision (f) of Section 14184.102, community supports that the department may approve include, but need not be limited to, all of the following when authorized by the department in the comprehensive risk contract with each Medi-Cal managed care plan and to the extent the department determines that the community support is a cost-effective and medically appropriate substitute for the applicable covered Medi-Cal benefit under the comprehensive risk contract:

(1) Housing transition navigation services.

(2) Housing deposits.

(3) Housing tenancy and sustaining services.

(4) Short-term post-hospitalization housing.

(5) Recuperative care or medical respite.

(6) Respite.

(7) Day habilitation programs.

(8) Nursing facility transition or diversion to assisted living facilities, including, but not limited to, residential care facilities for the elderly or adult residential facilities.

(9) Nursing facility transition to a home.

(10) Personal care and homemaker services.

(11) Environmental accessibility adaptations or home modifications.

(12) Medically supportive food and nutrition services, including medically tailored meals.

(13) Sobering centers.

(14) Asthma remediation.

(d) (1) *(A)* If a Medi-Cal managed care plan elects to cover a community support pursuant to subdivision (a), the managed care plan shall, for purposes of covering that community support,

contract, directly or indirectly, with community ~~providers whenever those providers~~ *providers.*

(B) In determining which community providers to contract with, a Medi-Cal managed care plan may, in addition to considering its own network needs, take into consideration whether community providers are available in the respective ~~county and~~ *county,* have experience in providing the applicable community support, and can demonstrate that they are capable of providing access and meeting quality requirements in accordance with Medi-Cal guidelines. ~~This~~

(C) This requirement shall not limit a *Medi-Cal* managed care plan's ability to contract with other nonprofit, for-profit, or ~~local~~ governmental providers for the same community ~~supports.~~ *supports, particularly local entities that provide services to Medi-Cal beneficiaries.*

~~(2) A Medi-Cal managed care plan shall honor member preference with regard to community supports by authorizing service delivery to the contracted provider who is submitting a request for approval of services to the managed care plan.~~

(2) A Medi-Cal managed care plan shall honor member preference with regard to community supports by authorizing the contracted community provider who submits the request for approval of services to deliver the requested services if that provider is capable of providing those services.

(e) For purposes of enforcing paragraph (1) of subdivision (d), the department shall require Medi-Cal managed care plans to set goals every other year to increase the contracting and utilization of community providers and local entities. The goals shall be established in consultation with the department and based on the information obtained by the department pursuant to subdivision (h).

~~(e)~~

(f) The department shall publicly post on its internet website a list of which community supports are offered to enrollees by each Medi-Cal managed care plan.

~~(f)~~

(g) A Medi-Cal managed care plan shall provide information on the available community supports in its member handbook and plan website, including any limitations on community supports on the plan website. The *Medi-Cal* managed care plan provider

directory shall highlight which entities are community providers, as defined in subdivision ~~(j)~~. *(k)*.

~~(g)~~

(h) The department shall develop, in consultation with Medi-Cal managed care plans, providers of community supports, and other appropriate stakeholders, all of the following:

(1) A monitoring plan and reporting template for the implementation of community supports pursuant to this section. The department shall quarterly publish a public report on reported community supports utilization data, populations served, and demographic data, stratified by county, age, sex, race, ethnicity, and languages spoken, with each of those demographic categories disaggregated by type of provider delivering the service, including, but not limited to, for-profit providers, local governments, and community providers, to the extent that statistically reliant data are available.

(2) Standardized and streamlined templates to be used by managed care plans or their contracted providers to facilitate inclusion of community providers with limited prior experience in contracting with Medi-Cal managed care plans but who can demonstrate that they are capable of providing access and meeting quality requirements in accordance with Medi-Cal guidelines. The department shall consult with *Medi-Cal* managed care plans and providers in developing these templates.

(3) Guidance to allow community providers to act as a primary subcontractor with *Medi-Cal* managed care plans and to subcontract with other community providers as a third-tier subcontractor. Community providers acting as a primary subcontractor may provide administrative support to third-tier subcontractors, including billing, training, coordination, and other ancillary support, as necessary to meet the requirements of providing Medi-Cal services. The department shall address in its guidance how to resolve applicable concerns when using a primary subcontractor that contracts with third-tier subcontractors.

~~(h)~~

(i) The department shall conduct an independent evaluation of the effectiveness of community supports in accordance with the parameters and timeframes specified in the CalAIM Terms and Conditions.

~~(i)~~

(j) The department shall take into account the utilization and actual cost of community supports in developing capitation rates.

~~(j)~~

(k) For purposes of this section, the following definitions apply:

(1) "Community provider" means a locally available, community-based nonprofit organization that has direct experience with ~~the Medi-Cal populations being served and is generally embedded in the health care or social services ecosystem in the provider's county.~~ *providing services to Medi-Cal beneficiaries in the county in which the organization operates.* A community provider offers health-related social needs (HRSN) services that are covered under Medi-Cal, and is authorized, rather than required, to provide additional Medi-Cal services.

(2) "Community supports" means those alternative services and settings approved in the CalAIM Terms and Conditions and administered according to paragraph (2) of subsection (e) of Section 438.3 of Title 42 of the Code of Federal Regulations.

(3) "Comprehensive risk contract" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(4) "Local entity" means a locally available health, behavioral health, or human services entity, including, but not limited to, agencies, departments, or independent commissions, or a locally available designated public hospital and its affiliated entities, that has direct experience with providing services to Medi-Cal beneficiaries in the county in which the entity or hospital operates.

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