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 introduced, 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 give preference to contracting with community providers, as defined, whenever those providers are available in the respective county and have experience in providing the applicable ECM or community support.

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.

This bill would expressly include providers of ECM or community supports within the consultation process and would additionally require the department to develop standardized and streamlined templates to be used by managed care plans, as specified, and to develop guidance to allow community providers to subcontract with other community providers.

The bill would require the department to annually update rate guidance as a benchmark for managed care plans to use to reimburse for ECM or community supports, 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 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 managed care plan shall, for purposes of covering the ECM benefit pursuant to this section, give preference to contracting with community providers whenever those providers

are available in the respective county and have experience in providing the applicable ECM.

~~(g)~~

(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.

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

(1) A monitoring plan and reporting template for the implementation of ECM pursuant to this section. The department shall annually publish a public report on reported ECM utilization data, populations served, and demographic data, stratified by age, sex, race, ethnicity, and languages spoken, to the extent *that* statistically reliant data ~~is~~ *are* available.

(2) Standardized and streamlined templates to be used by managed care plans for contracting with providers of ECM for the purpose of facilitating inclusion of community providers with limited prior experience in contracting with Medi-Cal managed care plans.

(3) Guidance to allow community providers to subcontract with other community providers.

(i) The department shall annually update rate guidance as a benchmark for managed care plans to use to reimburse for ECM. The rate guidance shall be based on the provision of the actual cost of service in the state and by community providers. Rates shall include, but not be limited to, all related administrative expenses required for service approval and billing, such as outreach for referrals, gathering relevant medical data to support treatment authorization request (TAR) approvals, TAR management and claims billing, travel, and documentation time.

(j) For purposes of this section, "community provider" means a locally governed, community-led nonprofit organization that has direct experience with the Medi-Cal populations being served and is generally embedded in the health care and social services ecosystem in the provider's county. 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.

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) 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, give preference to contracting with community providers whenever those providers are available in the respective county and have experience in providing the applicable community support.

~~(d)~~

(e) 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.

~~(e)~~

(f) 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.

~~(f)~~

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

(1) A monitoring plan and reporting template for the implementation of community supports pursuant to this section. The department shall annually publish a public report on reported community supports 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.

(2) Standardized and streamlined templates to be used by managed care plans for contracting with providers of community supports for the purpose of facilitating inclusion of community

providers with limited prior experience in contracting with Medi-Cal managed care plans.

(3) Guidance to allow community providers to subcontract with other community providers.

~~(g)~~

(h) 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.

~~(h)~~

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

(j) The department shall annually update rate guidance as a benchmark for managed care plans to use to reimburse for community supports. The rate guidance shall be based on the provision of the actual cost of service in the state and by community providers. Rates shall include, but not be limited to, all related administrative expenses required for service approval and billing, such as outreach for referrals, gathering relevant medical data to support treatment authorization request (TAR) approvals, TAR management and claims billing, travel, and documentation time.

~~(i)~~

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

(1) "Community provider" means a locally governed, community-led nonprofit organization that has direct experience with the Medi-Cal populations being served and is generally embedded in the health care and social services ecosystem in the provider's county. 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.

~~(1)~~

(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.

~~(2)~~

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

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