APRIL 2021

CHCF Issue Brief

Meeting the Moment:
Strengthening Managed Care's Capacity to Serve California's Seniors and Persons with Disabilities

Introduction

Like their counterparts across the country, California's Seniors and Persons with Disabilities (SPDs) face serious obstacles and challenges navigating fragmented systems of medical and long-term services and supports to get the care they need.[1] Yet, through the reform elements proposed in its California Advancing and Innovating Medi-Cal (CalAIM) initiative, the state has the potential to increase system integration and coordination of care for the approximately two million SPDs — including those with Medi-Cal only and those enrolled in both Medicare and Medi-Cal (dually eligible enrollees).[2]

The state's commitment to improving how the Medi-Cal program works for SPDs is underscored by the 2021–22 budget proposal of California Governor Gavin Newsom, which allocates significant funding for CalAIM and integration efforts, and the Governor's recently released Master Plan for Aging, which includes recommendations for improvements and innovation in care delivery for SPDs.[3,4] In addition, the California Department of Health Care Services continues to solicit input and feedback from relevant stakeholders — including Medi-Cal managed care plans, long-term services and supports providers, and SPDs and their families — that can inform CalAIM implementation.

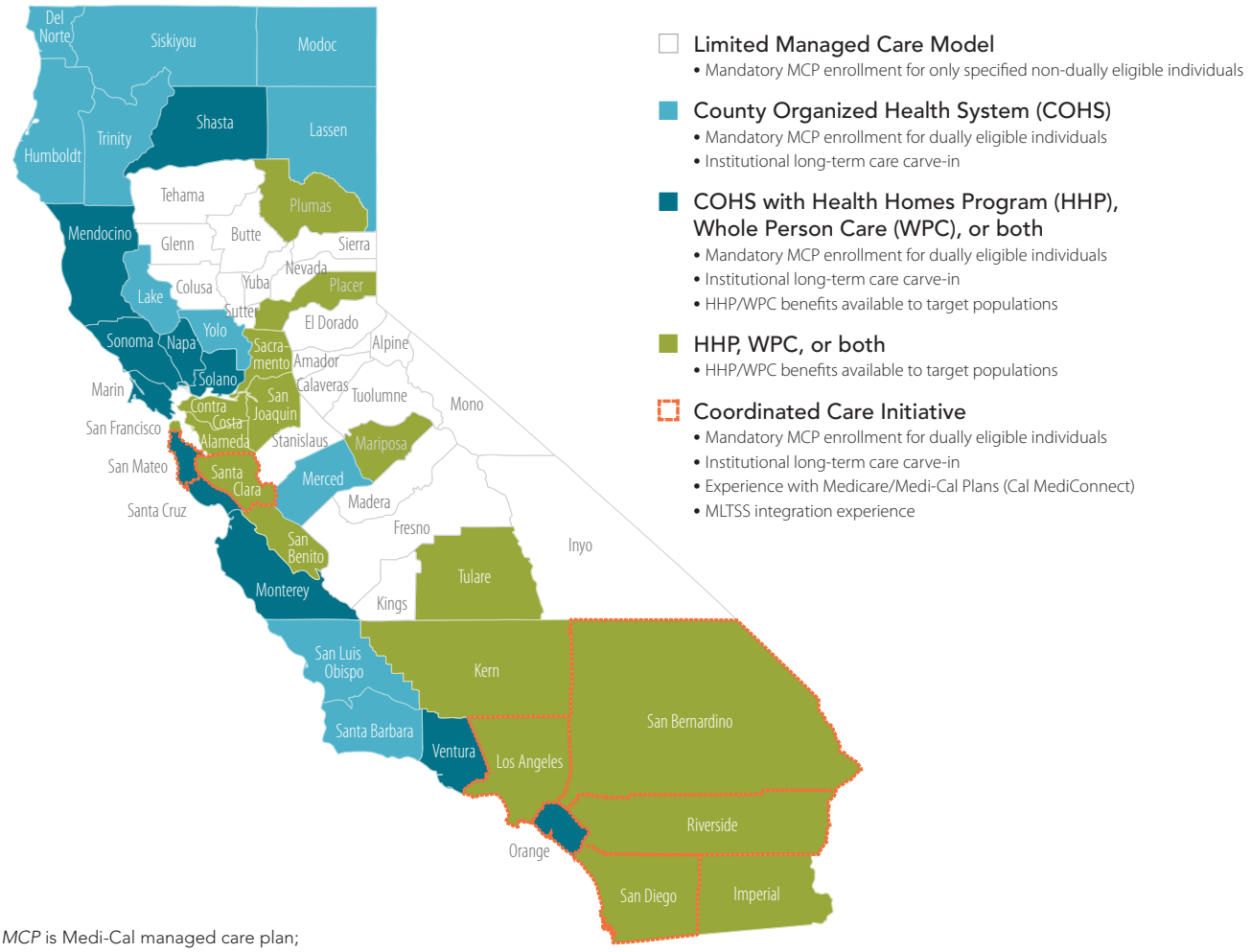
To support stakeholders in preparing for these changes, this issue brief reviews foundational challenges that the state, its Medi-Cal managed care partners, and other stakeholders face in implementing proposed reforms; highlights key success factors for the innovation and integration of care from the perspective of representatives from Medi-Cal managed care plans interviewed by the authors; and describes opportunities to advance capacity to develop an integrated system of medical and long-term services and supports for all SPDs.[5]

Proposed Reforms to Improve Care Integration and Delivery for Dually Eligible Enrollees and Other SPDs

Most SPDs in California must navigate a fragmented and uncoordinated network of services to access the full range of Medi-Cal benefits, including long-term services and supports (LTSS). Most Medi-Cal-only SPDs and some dually eligible individuals are required to enroll in a Medi-Cal managed care plan (MCP), yet many LTSS are administered outside the managed care delivery system, through fee-for-service Medi-Cal, counties, or waiver agencies. For dually eligible enrollees in particular, the administration and delivery of Medi-Cal benefits vary significantly statewide (Figure 1 on page 2).

Of California's 58 counties, only 27 have mandatory enrollment into Medi-Cal managed care for dually eligible enrollees — those that are part of the Coordinated Care Initiative (CCI) or have a County Organized Health System (COHS) Medi-Cal managed care model (see boxed text on page 2).[6] Dually eligible enrollees in the remaining 31 counties currently have the option of enrolling in an MCP or receiving their Medi-Cal benefits through fee-for-service, and most choose the latter.[7] This complexity has motivated the state to test policy and financing options that increase coordination across systems with the goal of reduced fragmentation and improved care delivery. However, existing initiatives have not been implemented statewide, and several rely on time-limited federal funding for demonstrations or pilot programs. California now has the opportunity, as part of the CalAIM initiative, to take lessons learned across the various models and pilots to develop a statewide approach to the delivery of care for SPDs.

Figure 1. Current Landscape of Medi-Cal Managed Care Enrollment, Long-Term Care Benefit Integration, and Pilot Programs Impacting Seniors and Persons with Disabilities



Notes: *MCP* is Medi-Cal managed care plan; *MLTSS* is managed long-term services and supports.

Source: Author analysis based on California Department of Health Care Services sources.

Background on Select Medi-Cal Managed Care Models

The **Coordinated Care Initiative (CCI)** was implemented in California in 2014 with the goal of improving the integration and coordination of medical benefits and long-term services and supports (LTSS) for dually eligible enrollees and other Medi-Cal Seniors and Persons with Disabilities (SPDs) through mandatory enrollment in managed care, broader integration of LTSS, and development of Cal MediConnect (CMC). CMC is California's capitated model demonstration under the Financial Alignment Initiative, which is operated in partnership with the Centers for Medicare & Medicaid Services. This demonstration coordinates the service delivery of both Medicare and Medi-Cal benefits — including limited LTSS and carved-out benefits — under one plan for full-benefit dually eligible enrollees. Seven counties participate in CCI (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara). CMC is currently set to expire December 31, 2022.

In the **County Organized Health System (COHS) model**, a single managed care plan (MCP) is operated by the county and is the sole plan serving the Medi-Cal population in that county. Dually eligible enrollees are required to enroll in a Medi-Cal plan in all 22 COHS counties, and under this model, institutional long-term care benefits are carved into MCP contracts. (Note: Two COHS counties, Orange and San Mateo, also participate in CCI.)

CalAIM is a comprehensive framework developed to build on several reforms authorized under the state's current federal 1115 Medicaid Waiver (Medi-Cal 2020), which is set to expire on December 31, 2021.[8] As proposed, CalAIM would address broad delivery system and payment reforms across the Medi-Cal program, while also advancing policy and program changes aimed at improving care integration and person-centered care delivery for Medi-Cal enrollees. Although the California Department of Health Care Services (DHCS) formally released the CalAIM proposal in October 2019, efforts were paused to focus on COVID-19 response efforts. A revised CalAIM proposal was released in early January 2021 with the core components of the original proposal intact. Targeted reforms that are expected to improve care for dually eligible enrollees and other SPDs are described below.[9] Figure 2 provides detail on the implementation timelines for each of these reforms (see page 4).

- **Statewide mandatory enrollment of dually eligible enrollees.** Dually eligible enrollees in all non-CCI and non-COHS counties will be mandatorily enrolled into Medi-Cal managed care by January 2023 as a key step toward expanding access to integrated care statewide.

- **Statewide institutional Long-Term Care (LTC) carve-in.** By January 2023, institutional LTC will become a statewide benefit under Medi-Cal managed care, expanding beyond the CCI and COHS counties that currently deliver this benefit. All MCPs will need contracting and oversight capacity for LTC facility benefits beyond the first two months, including skilled nursing facilities, intermediate care facilities, and subacute facility care. All MCPs will then bear risk as payment will transition from a distinct capitation rate for members in institutional LTC to a single blended capitation rate for all SPDs.

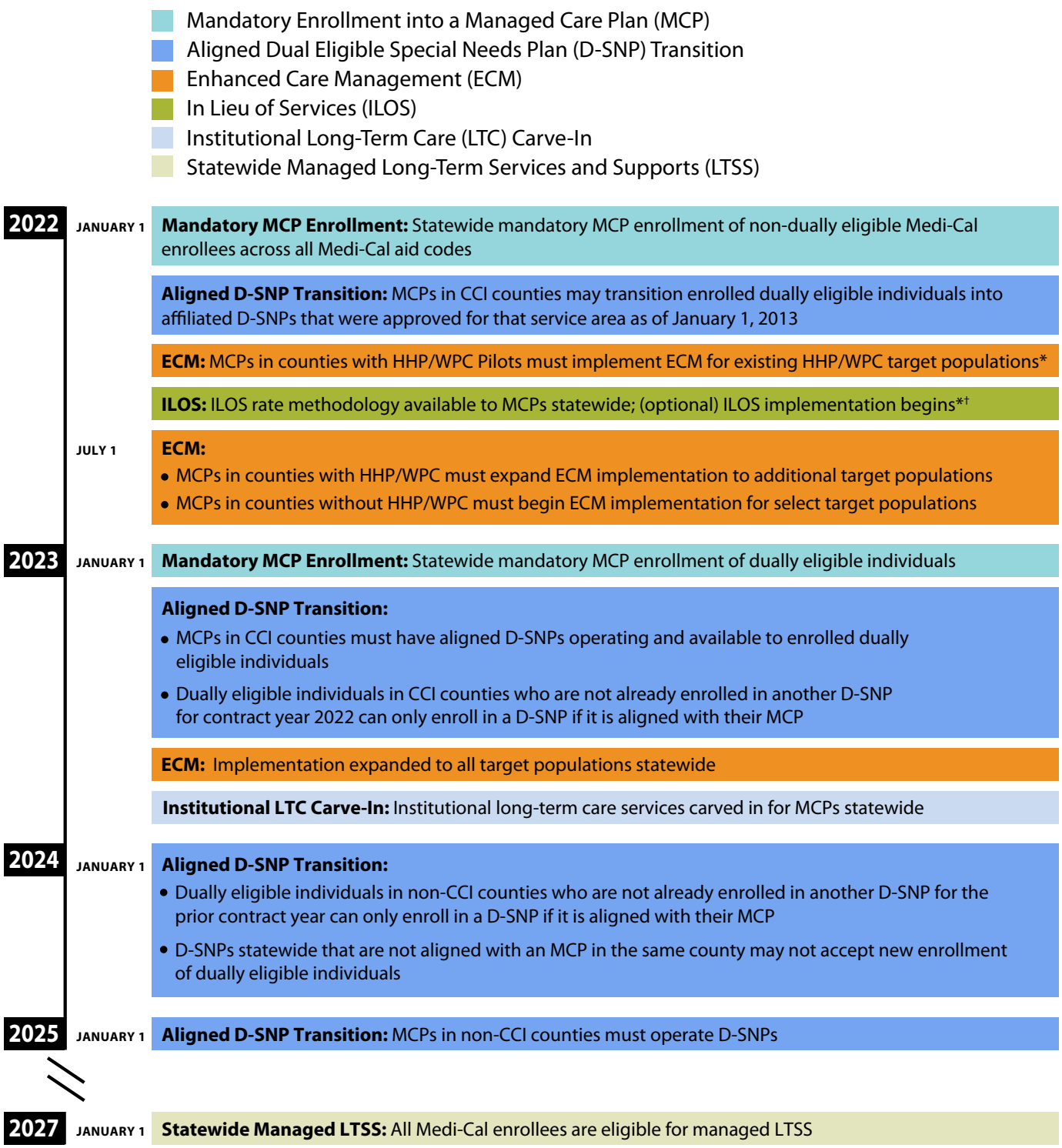
- **Transition to aligned Dual Eligible Special Needs Plans (D-SNPs) and MCPs.** To address the December 31, 2022, sunsetting of the Cal MediConnect (CMC) program, DHCS has proposed developing an aligned D-SNP and MCP model. MCPs in CCI counties would be required to operate a D-SNP by January 1, 2023, to ensure that current CMC enrollees have the option to enroll in a Medicare product that is aligned with their MCP. Under CalAIM as currently proposed, DHCS would require all MCPs to offer an aligned D-SNP by 2025.

- **Enhanced Care Management (ECM).**[10] ECM is a proposed statewide Medi-Cal managed care benefit that would provide intensive, comprehensive care management and access to social services and supports for Medi-Cal members with the most complex needs. Implementation of this benefit is intended to replace the current Health Homes Program (HHP) and Whole Person Care (WPC) Pilot program. ECM will be implemented through a phased-in approach beginning with the transition of populations served under the HHP and WPC pilots in January 2022, with full statewide implementation for all target populations expected by January 2023. See the appendix for the mandatory ECM target populations.

- **In Lieu of Services (ILOS).**[11] Implementation of ILOS will enable MCPs to receive payment to provide flexible wraparound services that address medical and social determinants of health (SDOH) issues. Many of these services are currently provided via waivers but are not currently reimbursable for MCPs as Medi-Cal benefits. These services would function as a substitute for — or in lieu of — higher levels of care, including hospitalization or nursing facility care. Under ILOS, MCPs could choose to offer and be reimbursed for alternative supportive services that are likely to decrease costs over time. Plans may begin offering ILOS in 2022, but per federal regulation, ILOS is optional for both the MCP and for the enrollee, so these services may not be offered consistently statewide. See the appendix for the proposed menu of ILOS.

- **Statewide managed LTSS (MLTSS) benefit as a longer-range goal.** The above transitions and reforms are intended to serve as incremental steps toward establishing a statewide MLTSS model under the Medi-Cal program by 2027. This approach of phasing both Medi-Cal enrollees and benefits into managed care gives the delivery system time to develop the infrastructure needed to expand LTSS access and better coordinate its delivery. Over time, dually eligible enrollees and other SPDs would be able to access more LTSS services through their MCP.

Figure 2. Implementation Milestones for CalAIM Reforms Expected to Impact Seniors and Persons with Disabilities



*See appendix.

†ILOS are optional for both enrollees and MCPs, meaning that MCPs can choose which ILOS to offer, and enrollees can elect not to use an ILOS. If an MCP chooses to offer ILOS, the offered services must be made available to all of their enrollees.

Notes: *CCI* is Coordinated Care Initiative; *HHP* is Health Homes Program; *WPC* is Whole Person Care.

Source: Author analysis of *California Advancing & Innovating Medi-Cal (CalAIM) Proposal* (PDF), California Department of Health Care Services, January 2021.

In parallel to CalAIM development and implementation, a re-procurement process for commercial MCPs is slated to occur. A request for proposal (RFP) for this MCP procurement process is expected to be released in late 2021, with planned implementation of new MCP contracts in 2024. While re-procurement is distinct from the broader CalAIM initiative, the process should serve as an opportunity to incorporate CalAIM policy elements, including efforts to integrate care, into all MCP contracts.

Core Elements of an Integrated System of Care for Dually Eligible Enrollees and Other SPDs

Foundational Elements — Addressing Current Challenges

California's proposed reforms have significant potential to improve care delivery for dually eligible enrollees and other SPDs, building on the current LTSS and Medi-Cal managed care systems while expanding access to integrated care. As policymakers, MCPs, and key partners work together to advance these important reforms, fundamental challenges in the current California landscape should be considered.

- **Consolidating accountability across the continuum of care.** Having a single accountable entity that can effectively integrate care and manage benefits and costs across the care continuum is expected to result in better outcomes and reduced costs over time — although California's experiences with such efforts (e.g., through CCI, CMC, HHP, and WPC) have varied. Fully understanding and applying the lessons from these demonstrations and pilots would, however, provide a strong foundation for the development of statewide integrated care models. Additionally, with the responsibility for financing and delivery of services — physical health, dental, behavioral health, and LTSS for SPDs — being shared across a wide array of programs and providers, meeting the challenge of coordinating the full continuum of care will not be easy. MCPs will benefit from sharing replicable best practices that are focused on assuming greater accountability for both delivery and coordination of these benefits.

- **Ensuring statewide access to high-quality Medi-Cal home- and community-based services (HCBS).** As California aims to increase access to community-based care as an alternative to institutional care, significant disparities in the availability of HCBS — including variation in the breadth and depth of HCBS coverage and provider experience — present challenges. Some aspects impacting statewide access include:
  - Unequal availability of HCBS options due to the current Medi-Cal benefit structure, where HCBS waiver services are only offered in certain service areas or counties and often with limited capacity;[12]
  - Low Medi-Cal reimbursement rates and the negative impact this has on HCBS provider network development and direct care workforce capacity necessary to meet demand;
  - Inadequacy of home and community placement options due in large part to the limited supply of sustainable supportive housing and tenancy supports for SPDs; and
  - Reliance on the presence of informal (unpaid) caregivers in discharge planning and determining whether home-based care is offered, given the critical role caregivers play in HCBS settings.

- **Streamlining coordination and strengthening data-sharing capacity.** Considerable investment will be needed at the state, county, MCP, and provider levels to develop the capacity to collect, share, and analyze data that would support care coordination and integration across the delivery system. This will be needed most when a single point of accountability for an enrollee is not feasible given various Medi-Cal managed care benefit carve-outs, which will require solutions that help coordinate with services excluded from capitated MCP reimbursement.[13] In addition, clear expectations and requirements for information sharing could create access to real-time data to inform policy and financing changes and, over the longer term, would support development of evidence-based care approaches. Specific challenges that would need to be overcome include:

- Limited platforms and capacity for robust data sharing across MCPs, network providers, community-based organizations, and partially integrated behavioral health and LTSS providers;
- Gaps in the ability to collect and effectively use LTSS needs assessment data to connect Medi-Cal enrollees with social services and supports in the community; and
- Lack of standardized data-sharing agreements and a need for consistent interpretation of state and federal law regarding permissible data sharing between entities and across the delivery system.

Key Success Factors for Medi-Cal Managed Care to Achieve Integrated Care

Many of the state's proposed reforms seek to leverage managed care as an avenue for achieving more coordinated and integrated care for dually eligible enrollees and other SPDs.[14] In interviews with MCPs and stakeholders about the reforms, several themes emerged regarding key success factors that would help advance these changes.

- **Supporting tailored approaches to care management.** Incentives and pathways to offer more tailored strategies for care management would give MCPs the flexibility to respond to individual needs and provide more effective care. The proposed transition to the aligned D-SNP/MCP platform will require MCPs to respond to a higher threshold of collaborative and interdisciplinary care management requirements that promote integration across medical and nonmedical services and aim to close gaps in care across Medicare and Medi-Cal service delivery. Additionally, the proposed ECM benefit will expand the responsibility of MCPs to identify needs and coordinate care to holistically address medical, social, and LTSS needs. To do this successfully, plans would value having flexibility to create individualized approaches to care that reflect the heterogeneity of SPDs and the diversity of their needs.

- **Leveraging flexible capitated financing to align incentives and address social needs across the continuum of care.** When MCPs have financial risk in a person-centered model that integrates benefits and financing across the continuum of care, there can be: (a) an increased ability to meet enrollee preferences for care in community settings, (b) funding to help build adequate LTSS and social services provider networks, and (c) increased accountability and oversight by a single responsible entity. The statewide carve-in of institutional LTC benefits alongside flexible ILOS would position MCPs and provider partners to build a more integrated system of medical, LTSS, and social services. ILOS, as proposed, also creates incentives for MCPs statewide to offer new flexible services that can address social determinants of health (SDOH) needs. Together with the proposed ECM benefit, reimbursement for ILOS under capitated MCP payments will be central to the ability of MCPs to build or expand networks and infrastructure that can meet the diverse and often complex needs of SPDs.

- **Building capacity to prevent avoidable stays in institutional settings.** Increasing access to HCBS as an alternative to institutionalization is a central focus of proposed reforms, particularly salient given the disproportionate impact of COVID-19 on LTC facilities. The proposed ECM benefit and ILOS flexibility offers opportunities to better support SPDs eligible for institutional care in the setting of their choice — which can benefit Medi-Cal enrollees, MCPs, and the state. In addition, the statewide carve-in of institutional LTC benefits will further focus MCPs' attention on managing care transitions to prevent unnecessary use of institutional care. To achieve this, MCPs, particularly those newly at risk for institutional LTC benefits, will need to develop a thorough understanding of the institutional and home- and community-based care continuum. They also will need to establish or expand programs aimed at diversion from institutional LTC settings and transition from institutions to community-based services. Insights from MCPs and provider partners that have developed successful models in this area would provide helpful guidance to all parties newly working to manage these transitions.

- **Addressing health disparities.** Addressing health disparities, especially racial inequities in access to services and health outcomes, will be an essential component for achieving effective person-centered care for dually eligible enrollees and other SPDs.

Understanding and addressing the mechanisms contributing to these inequities would help MCPs and providers more readily respond to consumer needs and develop targeted outreach strategies. Although ECM and ILOS may offer increased opportunities to support member needs and could serve as tools to help address health disparities, DHCS could bolster these efforts with clear expectations for MCPs regarding equitable approaches to care delivery and service coverage. Additionally, the aligned D-SNP/MCP platform and the eventual goal of statewide MLTSS also could expand opportunities to address inequities, including supporting comprehensive data collection and reporting across entities on service use by race and ethnicity.

Opportunities to Advance Managed Care's Capacity to Serve California's Dually Eligible Enrollees and Other SPDs

California's MCPs have varying levels of experience with building LTSS networks, integrating Medicare and Medicaid benefits and financing, and coordinating the full continuum of care for SPDs with complex needs. Therefore, implementation of the reforms highlighted in this issue brief will require different MCP capacity-building activities based on plan experience with existing Medi-Cal demonstration or pilot programs, delivery of institutional LTC, and operation of Medicare products, including D-SNPs. While significant opportunities exist for federal, state, local, and philanthropic partners to help identify lessons and replicable best practices that can contribute to the success of proposed reforms, MCPs will need to: (1) identify their own capabilities and gaps, (2) devise internal capacity-building strategies, and (3) support provider partners to ensure the capability of their networks. The following are suggested areas for MCPs to focus on, with the goal of increasing their potential for success as they work with provider partners and other key stakeholders.

- **Integrated care operations and workflows.** Truly integrating medical, LTSS, and social services requires that MCPs and providers build system capacities that include, but are not limited to: (a) conducting comprehensive needs assessments, (b) developing interdisciplinary care management teams across settings and providers, (c) engaging in data collection and sharing, and (d) implementing robust quality reporting between MCPs, providers, and any delegated care managers. MCPs will need to identify and work with a broad array of provider contractors to develop needed skills and capacity to provide services to SPDs while working toward higher standards for care coordination and data sharing to enhance members' experience of care.

- **HCBS and Community-Based Organization (CBO) network development and oversight.** Expanding beyond the medical model will require new MCP network development strategies. Some MCPs will be navigating HCBS and social service systems for the first time, so they will need to build capacity to contract with and oversee HCBS providers and CBOs that can deliver ILOS and other services to their enrollees. Similarly, HCBS providers and CBOs will need to build or expand capacity and capabilities to collaborate with MCPs. Collaborative learning across MCPs, HCBS providers, and other social service providers around billing processes, assessment and care planning, data sharing, reporting capacity, and other managed care program elements will aid these efforts.

- **Oversight and value-based contracting for institutional LTC and HCBS.** The development of greater institutional LTC expertise — including renegotiating facility contracts and developing new relationships to support diversion and transition to community settings — will be particularly important for MCPs in the non-CCI and non-COHS counties whose responsibility for covering institutional LTC will expand. MCPs newly facing institutional care risk also will need to build oversight capacity across a broad range of LTSS to help identify individuals that could best be served in community settings and advance value-based contracting strategies to support high-quality HCBS and diversion and transition efforts.

- **Medicare operations and contracting expertise.** MCPs without prior experience operating D-SNPs will need to better understand Medicare coverage and rules, how to align the operation of disparate MCP

and D-SNP products, and how to establish Medicare Advantage provider networks as the state shifts to the aligned D-SNP/MCP platform. MCPs new to enrolling dually eligible enrollees will also have to establish processes to effectively coordinate care delivery across Medicare and Medicaid, despite benefit carve-outs and potential data-sharing hurdles. Building Medicare knowledge among MCPs and key partners by leveraging MCP experience under the CMC program would provide useful insights, particularly around coordinating care across the full spectrum of benefits and designing value-based contracting strategies to support this new aligned model.

Conclusion

Over the next few years, California is primed to advance several Medi-Cal reforms that hold significant promise to improve care for its dually eligible enrollees and other SPDs. With the reactivation of proposals under CalAIM and related steps to reinforce the initiative's goals, the state and its partners (federal agencies, MCPs, and providers) have numerous opportunities to advance more integrated and person-centered care delivery that can holistically address the needs of SPDs. With insights from the MCPs themselves, this issue brief highlights priorities for the state and its stakeholders to keep top of mind as this work unfolds over the next several years. Fortunately, DHCS is well positioned to address most of these priorities via ongoing and active engagement with stakeholders. As efforts to design and implement proposed reforms continue, it is vital that stakeholders support this momentum and elevate these and other priorities to help shape this new system of care for dually eligible enrollees and other SPDs.

About the Authors

Giselle Torralba, MPH, is a program associate and Alexandra Kruse, MS, MHA, is the associate director for integrated care, state programs at the **Center for Health Care Strategies**, a national nonprofit policy center dedicated to improving the health of low-income Americans, including those dually eligible for Medicare and Medicaid and in need of Medicaid long-term services and supports. Athena Chapman, MPP, is president and Elizabeth Evenson is policy director at **Chapman Consulting**, which provides strategic planning, meeting facilitation, organizational support, market research, and regulatory and statutory analysis to organizations in the health care field.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Appendix. Overview of Enhanced Care Management (ECM) Target Populations and Proposed In Lieu of Services (ILOS)

The California Department of Health Care Services (DHCS) has presented its vision for Enhanced Care Management (ECM) and In Lieu of Services (ILOS) in its California Advancing and Innovating Medi-Cal (CalAIM) proposal documents.[15] DHCS describes ECM as a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and nonclinical needs of high-cost, high-need managed care members through systematic coordination of services that is community-based, interdisciplinary, high-touch, and person-centered. Table A1 presents DHCS's proposed mandatory target populations for ECM. These are subject to further refinement by DHCS, and managed care plans (MCPs) may propose additional populations or propose expansions of criteria within populations to increase eligibility for ECM. It will be the responsibility of the MCPs to risk-stratify their members, assess their needs, apply criteria, determine eligibility, and oversee the delivery of the ECM benefit.

Table A1. Mandatory Enhanced Care Management (ECM) Target Populations

- Children or youth with complex physical, behavioral, developmental and/or oral health needs (i.e., California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness, or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

DHCS describes ILOS as: (1) medically appropriate and cost-effective alternatives to services covered under the State Plan, and (2) optional services for Medi-Cal MCPs to provide and for enrollees to accept.[16] Table A2 presents DHCS's proposed ILOS offerings that MCPs can propose to offer to their members. These proposed services are subject to further refinement by DHCS, and additional ILOS can be proposed for DHCS approval beyond what is listed here. Starting in January 2022, DHCS will authorize 14 preapproved ILOS in its contracts with MCPs.

Table A2. Proposed Menu of In Lieu of Services (ILOS)

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Endnotes

1. Long-term services and supports (LTSS) available to Medi-Cal enrollees include care provided in both institutional and home- and community-based settings. Medi-Cal LTSS benefits include, but are not limited to, skilled nursing facility services, personal care services, self-directed personal assistance services, Community First Choice Option (In-Home Supportive Services), and Home and Community-Based Services. For additional detail, see: Athena Chapman and Elizabeth Evenson, *Medi-Cal Explained Fact Sheet: Long-Term Services and Supports in Medi-Cal* (PDF), California Health Care Foundation (CHCF), October 2020.
2. California Department of Health Care Services (DHCS), *Summary Table of Medi-Cal Certified Eligibles, Seniors and Persons with Disabilities, by County and Age Group, December 2016 Month of Enrollment* (PDF), California Health Care Foundation (CHCF), June 2017.
3. *California Budget, 2021–2022*, California Department of Finance, accessed March 22, 2021.
4. *Master Plan for Aging*, California Department of Aging, accessed March 22, 2021.
5. The themes explored in this issue brief emerged from a series of interviews that the Center for Health Care Strategies conducted with a diverse set of managed care plans (MCPs) and other stakeholders in 2020, with support from the California Health Care Foundation. In May 2020, the state released a Long-Term Care at Home (LTCAH) proposal in response to COVID-19 impacts; therefore, a significant focus of the interviews conducted in the summer of 2020 includes the LTCAH benefit, which was eventually withdrawn from further consideration by DHCS in August 2020. However, the themes of integrated care and the tools that are necessary to successfully implement Medi-Cal reforms remain consistent for the pending reforms.
6. Amber Christ and Georgia Burke, *A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care* (PDF), California Health Care Foundation (CHCF), September 2020.
7. Christ and Burke, *A Primer on Dual-Eligible Californians*, CHCF.
8. *California Advancing & Innovating Medi-Cal (CalAIM) Proposal* (PDF), California Department of Health Care Services (DHCS), January 2021.
9. *CalAIM Proposal*, DHCS.
10. *Enhanced Care Management and In Lieu of Services*, California Department of Health Care Services (DHCS), last updated March 11, 2021.
11. *Enhanced Care Management*, DHCS.
12. Chapman and Evenson, *Medi-Cal Explained Fact Sheet*, CHCF.
13. In-Home Supportive Services, dental, and specialty mental health for serious behavioral health conditions are three notable benefits carved out of Medi-Cal managed care in all counties. The long-term care benefit, which covers nursing home and other institutional care, is covered in the MCP benefit package in County Organized Health System (COHS) and Coordinated Care Initiative (CCI) counties, and only covered for one month after the month of admission to a nursing home or other institutional setting in the remaining counties (after which the enrollee receives all Medi-Cal benefits through fee-for-service). The Multipurpose Senior Services Program is currently covered by MCPs in CCI counties and fee-for-service in the rest of the state. For additional detail, see: Christ and Burke, *A Primer on Dual-Eligible Californians*, CHCF.
14. Michelle Herman Soper, Alexandra Kruse, and Camille Dobson, *The Value of Pursuing Medicare-Medicaid Integration for Medicaid Agencies* (PDF), ADvancing States and Center for Health Care Strategies, November 22, 2019.
15. *CalAIM Proposal*, DHCS.
16. *CalAIM Proposal*, DHCS.