

Revolutionizing Medi-Cal: The Potential Impact of California's CalAIM Initiative

California's Medi-Cal program is the largest Medicaid program in the country. It is tasked with providing care for approximately [15 million enrollees](#), or one third of California's population. To ensure affordability while maintaining quality and improving health care outcomes, CalAIM was created as California's newest approach to reform Medi-Cal, including changes to managed care plans and reimbursement of behavioral health plans. Although many of these objectives under CalAIM are still in the initial implementation stages, the potential ramifications of this multi-year, billion-dollar investment in changing how millions of people receive health care state-wide is evident. This post explores some of the reform initiatives under CalAIM that aim to improve the access, quality, and affordability of health care for Medi-Cal managed care patients.

What is CalAIM?

Established in 2021 by [AB 133](#), the California Advancing and Innovating Medi-Cal (CalAIM) Initiative is an innovative, multi-year program designed to improve the state's Medicaid health insurance system. While state and federal policymakers debate various ways to address health care spending, CalAIM is designed to address a specific problem: 5% of enrollees account for over 50% of Medi-Cal spending. This overrepresentation is due to a variety of factors including Medi-Cal enrollees typically having complex medical conditions that require several delivery systems to administer care. They also frequently utilize emergency rooms, one of the most expensive health care services. CalAIM hopes to help patients access care that is less costly earlier in the process, as a means to decrease overall health care spending.

Given that California spends a staggering [\\$139 billion on Medi-Cal](#) with less than

optimal results, Governor Gavin Newsom has committed to increasing access and improving outcomes for those most affected by the rising cost of healthcare by committing a roughly \$12 billion investment in CalAIM over five years. The first part of the program was launched in January 2022 with successive reforms planned until 2027.

Operated by the Department of Health Care Services (DHCS), CalAIM has [three goals](#):

- identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

Much work has been done in advancing the first goal with the creation of the Providing Access and Transforming Health (PATH) program, which funds projects related to justice-involved capacity building and reproductive health services. However, this piece will focus on the second and third goals, which are still in the initial implementation phases. To achieve those goals, CalAIM focuses on reforming the managed care delivery systems using a data driven approach that relies on accurate reporting from managed care plans (MCPs). It also considers the need for changes to the reimbursement structure to incentivize more effective cost planning.

Reforming California's Managed Care Delivery Systems

One of the ways California attempts to reduce cost while maintaining quality and improving health care outcomes is the creation of managed care systems, including Medi-Cal Managed Care (MCMC), Dental Managed Care, Medi-Cal Specialty Mental Health Services (SMHS), and Drug Medi-Cal Organized Delivery System (DMC-ODS). Previously, the systems operated independently of each other, creating a complex, and often confusing, system for enrollees. Patients were often enrolled in multiple MCPs with differing guidelines, paperwork, and benefits, causing many

people to delay care until their health worsened. The creation of CalAIM aims to create a single, coordinated system that will ensure network adequacy of the plans and is easy to access.

Creating a Unified System

In December 2021, the Centers for Medicare & Medicaid Services (CMS) approved the CalAIM Section 1915(b) waiver authorizing MCMC, Dental MC, SMHS and DMC-ODS plans under a single waiver. DHCS will continue to oversee these programs; however, there will now be standardized enrollment, benefits, and payment based on a Medi-Cal enrollee's eligibility category and county of residence. This waiver is effective through December 31, 2026, so researchers have ample time to assess whether these standardizations have truly increased patients' access to care.

As health care system plans become increasingly complicated, DHCS also recognizes the need to analyze the complex sub-delegated arrangements of some health plans. For example, a Medi-Cal managed plan may subcontract to an independent physician association who handles billing and claims through an external company. Starting with MCMC plans in June 2023, and expanding to the other plans by June 2025, DHCS will stratify the MCP results for the Timely Access Survey (and its accompanying Timely Access Data Tool) by subcontractor. As a result, patient outcomes and costs can be more closely tracked by direct access to subcontractor care, instead of from the aggregated data of the larger MCP. These new guidelines will further ensure that the originating MCP is responsible for ensuring access to all members, regardless of its subcontractor assignments.

Quality Measurement Through Increased Data Collection

An important part of creating an accessible, affordable, and equitable health care system is having enough data to meaningfully understand where, and who, the system is failing. CalAIM requires the state to collect new data elements on beneficiary, capacity and availability, service utilization, realized access and member experience. Through tracking these categories of data across the initial five year period, DHCS can compare network performance and reveal deficiencies across the various delivery systems. These identified deficiencies could then be addressed to improve patient experience and access to care.

One of the reasons CalAIM prioritizes the collection of beneficiary data is to enable regional rate-setting across MCPs, while creating statewide standard benefits. Currently MCPs use a county-based model, but a move to a regional rate model would allow for a simpler presentation of rates to CMS with a more flexible rate model and allow for cost averaging across all MCPs. With a large basis for averaging than a singular county, MCPs will be incentivized to plan cost efficiencies and ultimately create a more sustainable system. This update may in turn give patients access to less costly medical services that reflect the needs of the region they live in.

DHCS has also proposed requiring MCPs to become accredited by the National Committee for Quality Assurance (NCQA) by 2026. Even without a formal requirement, as of 2022, 12 of the 26 MCPs were already accredited and reporting information to NCQA. Once MCPs are accredited, DHCS plans to use the reported data when certifying plans based on state and federal Medicaid requirements. This requirement would give MCPs a better framework for improving key impact areas like care coordination and availability of health resources to better patient health outcomes.

Ensuring Network Adequacy Within MCPs

The [CMS approval](#) of the CalAIM Section 1915(b) waiver specifically addresses the need for “increased accountability, improved data collection and analysis, and greater transparency into network adequacy and timely access.” Both DHCS and CMS are concerned with whether Medi-Cal plans have the capacity to meet necessary covered services based on the specific community needs. Through a combination of DHCS-conducted and independent assessments, Medi-Cal MCP’s network adequacy will be tracked alongside Medicare Advantage and private market plans.

Importantly, the CMS waiver lays out specific requirements for the state, including reporting of information on MCPs’ provider networks, medical loss ratios, and other measures of access and utilization. These oversight and monitoring functions must also include coordination with consumer advocates and community stakeholders on at least a quarterly basis. If an MCP was noncompliant and showing improvement in providing beneficiary access to services, then the state will identify any actions

taken, or planned to take, to ensure accountability. Central to this program is identifying when care is being underutilized and ensuring patients adequate access to care.

In December 2022, DHCS announced a new contract with five commercial MCPs to provide services in 21 counties starting in January 2024. The [new contract](#) has new standards of care and greater accountability, including required public reporting on “access, quality improvement, and health equity activities, including their fully delegated subcontractors’ performance and consumer satisfaction.” Both DHCS and CMS have stated a commitment to ensuring network adequacy, but it remains unclear what role CalAIM is playing, or will play in the future.

Provider Payment Reform

Global Payment Program for Reimbursement of Uninsured Services

CalAIM is an innovative program, but it also includes continuing previous programs, including the Global Payment Program (GPP). Originally part of the Medi-Cal 2020 waiver, GPP is a statewide fund for public hospitals that provide care for the remaining uninsured Californians. CalAIM expands upon the initial program by extending coverage and reimbursements to nontraditional services that address the social determinants of health. The ultimate goal is to reduce spending by providing preventative care that will ultimately decrease costly services, such as emergency room visits.

Behavioral Health Payment Reform

Behavioral health is a rising concern for many, but the current process for MCP reimbursement has made providers reticent to join certain Medi-Cal MCPs. Beginning July 1, 2023, CalAIM has three separate payment initiatives that will make it easier for physicians to be reimbursed. First, county behavioral health plans will be reimbursed on a fee-for-service instead of a cost-based reimbursement basis to simplify the payments and reduce administrative costs. County behavioral health plans will establish a plan fee schedule and negotiate payment terms and rates with

subcontracted providers without any additional settlement after a service is provided. Second, intergovernmental transfers will be utilized to cover the non-federal share of cost for Medi-Cal services instead of the more costly Certified Public Expenditure protocol. Third, behavioral health plans will align with other CMS requirements and use Current Procedural Terminology (CPT) for coding rather than the Health Care Common Procedure Coding System. CPT is more detailed and nationally standardized, which allows for disaggregating data and easier analysis of services.

In sum, these reforms will allow greater patient access to care while decreasing healthcare costs through reducing administrative fees. Although these changes are specific to behavioral health plans, the success of these changes may be a signal that similar changes will happen to other types of health plans.

Conclusion

CalAIM is the first-of-its-kind program in the United States that is still in its very early stages for many of its programs. Much of the attention and focus has been on more “immediate” needs including getting Medi-Cal enrollees access to care. Therefore, many of the other initiatives that are more evaluative and retrospective in nature are still being prepared or in the initial planning stages. With the Governor’s hefty investment, however, CalAIM has the opportunity to truly reform the Medi-Cal system to provide patients with greater access to affordable care through an accountable and unified managed care system that is more streamlined and efficient.