CHCF Fact Sheet

CalAIM FAQ for Assisted Living Community Operators

California's residential care facilities for the elderly and adult residential facilities are partnering with Medi-Cal managed care plans under CalAIM (California Advancing and Innovating Medi-Cal) to improve access to assisted living. The program lets operators access Medi-Cal reimbursement through an Enhanced Care Management benefit and optional Community Supports services. While these are exciting opportunities, operators must navigate new requirements and challenges when contracting with managed care plans. CalAIM offers opportunities for increased access and financial stability but requires due diligence and adaptation to new practices.

This Frequently Asked Questions document is a companion to *CalAIM Explained for Assisted Living Community Operators*. It provides general information and resources for operators interested in learning more about CalAIM and how its Community Supports program may support the populations they serve. The questions were compiled through a survey sent to a diverse group of operators and the Q&A part of an educational webinar offered in June 2023.

Does the assisted living or adult residential operator contract directly with the Managed Care Plan?

To bill for Community Supports, a licensed operator first needs to contract with a Medi-Cal managed care plan (MCP). MCP administrative requirements include contracting, data, and quality reporting. MCPs also require invoicing or billing processes, which may require new workflows for operators. The operator may choose to negotiate a direct contract or work with a management services organization (MSO) that would contract with the MCP. An MSO would provide administrative support such as financial management, coding and billing services, and compliance oversight, among other services.

Operators should conduct an internal operational capacity assessment to determine the most viable and sustainable path to working with MCPs before engaging in contractual discussions. The *Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide* (PDF) of July 2023 details the requirements that Community Supports providers must meet and can be used as the basis for the capacity assessment.[1]

Is CalAIM part of the Assisted Living Waiver program?

No, they are separate programs. CalAIM is a statewide reform of the Medi-Cal program and expands access to assisted living and adult residential care through MCPs.[2] The MCPs administer optional services known as Community Supports and a benefit called Enhanced Care Management. The Assisted Living Waiver is a distinct waiver program with limited capacity and geographic coverage and remains outside of managed care.[3] Residents can be enrolled in either program, but not in both.

How does an assisted living or adult residential operator find MCPs operating in its service area?

Please see CHCF's short guide that includes both a list of current MCPs by county and the MCPs that will operate in each county starting January 1, 2024.[4] Operators should note that the MCP changes by county starting January 1 will be stable for several years. Operators should consider if an MCP will enter or leave a service area in 2024 when assessing the potential opportunities for partnerships and contracting.

Must operators have a National Provider Identifier and be enrolled as a Medi-Cal provider to contract with an MCP?

Yes, operators will need a National Provider Identifier but they do not currently need to enroll as a Medi-Cal provider because there is not a pathway for enrollment

through the Provider Application and Validation for Enrollment (PAVE) portal. Instead, the MCP is responsible for ensuring licensing and credentialing. MCPs may also set up individual letters of agreement as a temporary solution, but the goal is for MCPs to build contracted networks rather than one-off arrangements.

How does an assisted living or adult residential operator contracted with an MCP get paid? How long is the typical turnaround for payment?

MCPs are required by state and federal law to meet certain claims payment requirements, including paying 90% of clean claims (meaning those with no errors or omissions) within 30 days of receipt and 99% of all clean claims within 90 days. Operators may also be able to negotiate for prospective per member per month payment accompanied by retroactive submission of encounter data to show services rendered.

Who signs the Residency Agreement? Who has financial responsibility?

The resident, or responsible person if the resident lacks capacity, should sign the residency agreement because it includes contractual agreements beyond financial responsibilities. Generally, the contract with the MCP outlines the financial obligations to the operator. Operators should consult with their legal or regulatory counsel to determine what changes need to be made to the residency agreements, schedule of fees, and house rules if contemplating a Medi-Cal MCP contract.

Since Community Supports are optional benefits, is there a risk that a resident or managed care plan would opt out?

Per federal law Community Supports are optional for the MCP to offer and for the member to accept. So Community Supports are not available statewide, as MCPs have made different elections by county. These elections can change every six months; check the most recent list (PDF).[5] If an MCP enrollee is receiving a Community Support and switches to a new MCP that does not offer that service, or if the MCP stops offering one of the Community Supports, there are specific continuity of care requirements that the MCP must adhere to. These requirements are outlined in the Community Supports Policy Guide.[6]

If a resident receives Supplemental Security Income (SSI), is the licensed operator required to continue to provide all services for the SSI rate if the resident is disenrolled in the plan?

There are regulatory requirements and interpretations for residential care facilities for the elderly specific to accepting and retaining residents receiving SSI that should be reviewed with regulatory counsel. The residency agreements and house rules that address the admission and retention criteria should clearly outline financial responsibility if a resident is disenrolled for any reason.

What happens if an MCP will leave the service area in 2024?

A handful of MCPs are exiting current service areas at the end of 2023, as part of a recontracting between California's Department of Health Care Services (DHCS) and Medi-Cal managed care plans. In these cases, there are specific transition requirements. DHCS has developed the 2024 MCP Transition Policy Guide (PDF) that outlines MCP requirements related to the transition of MCP members, including these:[7]

- Member enrollment and noticing
- Continuity of care requirements
- Enhanced Care Management and Community Supports transition requirements

DHCS's companion All Plan Letter (APL) 23-018 (PDF) establishes the binding nature of the policy guide, which will be updated throughout calendar year 2023 with new and developing guidance.[8]

Do Medi-Cal MCPs have to conduct eligibility assessments for enrollees to access Community Supports? Will an MCP accept care levels and assessments completed by an assisted living or adult residential operator for services?

MCPs are required to conduct initial health risk assessments to identify the needs of enrollees. Additionally, each Community Support has specific individualized assessment requirements that are outlined in the Community Supports Policy Guide.[9]

Each MCP will have to work internally, and with its providers, to complete these assessments for eligibility to receive covered Community Supports. If an additional assessment conducted by an operator points to the need for additional or new services, the operator would have to work with its contracted MCP to request authorization and reimbursement for any additional Medi-Cal covered services. The operator would want to review its contractual arrangement with the MCP to determine how best to use its proprietary assessment as part of the overall care management strategy for a Medi-Cal enrollee.

Most MCPs allow for additional fees to be billed if the scope of additional services falls under acceptable Medi-Cal reimbursable services and the fee schedule is negotiated and agreed upon.

About the Authors

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About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system. For more information, visit www.chcf.org.

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.

Endnotes

1. *Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide* (PDF), California Dept. of Health Care Services (DHCS), July 2023.
2. "Medi-Cal Transformation," DHCS, last modified August 10, 2023.
3. "Assisted Living Waiver," DHCS, August 14, 2023.
4. Ralph Silber, *Medi-Cal Explained: 2024 Medi-Cal Managed Care Plans by County*, California Health Care Foundation, June 2023.
5. *CalAIM Community Supports - Managed Care Plan Elections* (PDF), DHCS, updated June 2023.
6. *Medi-Cal Community Supports*, DHCS.
7. *2024 Medi-Cal Managed Care Plan Transition Policy Guide* (PDF), DHCS, August 7, 2023
8. Dana Durham (chief, Managed Care Quality and Monitoring Div., DHCS) to all Medi-Cal managed care health plans, "Managed Care Health Plan Transition Policy Guide" (PDF), All Plan Letter 23-018, June 23, 2023.
9. *Medi-Cal Community Supports*, DHCS.