HEALTH CENTER PARTNERS
of Southern California

May 6, 2021

Will Lightbourne, Director
Department of Health Care Services
Attn: Angeli Lee and Amanda Font
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413
Submitted via email to CalAIMWaiver@dhcs.ca.gov

RE: Public Comments on CalAIM Section 1115 & 1915(b) Waivers

Dear Director Lightbourne:

On behalf of Health Center Partners of Southern California, representing 17 member organizations, including 12 Federally Qualified Health Centers, 4 Indian Health Centers, and Planned Parenthood of the Pacific Southwest, I would like to thank you for the opportunity to offer comment on the CalAIM Section 1115 & 1915(b) Waiver documents released by DHCS on April 6, 2021. Members of this regional primary care association operate over 160 practice sites across five counties, serve 917,000 patients with 3.9 million patient visits annually, and generate $2.2 billion in economic impact to the region and $1.4 billion in savings to Medicaid.

I appreciate the hard work and vision you have expressed for Medi-Cal in California through the California Advancing and Innovating Medi-Cal (CalAIM) initiative as well as your diligence and attention to ensure that stakeholder engagement remains a key part of that process. I look forward to continuing to work with you to support and implement a reformed health delivery system that addresses social determinants of health among our most vulnerable populations and returns all to equity in health, with a focus on whole person care.

Overall Comments on CalAIM Section 1115 & 1915(b) Waivers

I commend the administration's commitment to implementing CalAIM, an initiative that will lead to broad delivery system, program, and payment reforms across Medi-Cal. I see many positive changes in the proposal. **However, I do have concerns and recommendations, and I would like to share them below for your review and consideration. Specifically, in the paragraphs below, I detail the following:**

- DHCS must continue to delay the transition of pharmacy benefits into FFS and consider removing the pharmacy transition from its waiver proposal.
- DHCS needs to clarify how medically necessary services can be provided and billed prior to a complete SMH/SUD assessment.
- DHCS must apply network adequacy, quality and access, and clinical performance standards to county behavioral health plans.
- DHCS must ensure community providers, including community health centers and FQHCs, are eligible for support under Providing Access and Transforming Health (PATH).
- DHCS must ensure the public has adequate opportunity to review and comment on all policy changes.
- DHCS must continue to pursue and provide data sharing and integration across all sectors of care including the social services.

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I applaud DHCS for detailing a vision for large-scale transformation of the Medi-Cal delivery system. However, I am concerned the scale of transformation, and the ambitious timeline, may pose challenges in practice. I am concerned small community-based Drug Medi-Cal providers may not have the data sharing and claim processing infrastructure to transition to an integrated and more aligned Medi-Cal Managed Care (MCMC) system.

In addition, the CalAIM Waiver proposals outline significant integration and alignment of Medi-Cal services for beneficiaries through Medi-Cal Managed Care (MCMC) plans. The increased responsibility placed on MCMC plans will require a heightened level of oversight and accountability. **I encourage DHCS to share information with stakeholders on how it will increase oversight and transparency during and beyond the implementation of these Waivers.**

I thank you for your continued work on this important initiative and look forward to working with the Department on CalAIM implementation.

Comments

DHCS must continue to delay the transition of pharmacy benefits into FFS and consider removing the pharmacy transition from its waiver proposal.

- I am aware of the time and investment the state committed to the design and vision of Medi-Cal Rx. However, providers and health plans have systems in place today to ensure pharmacy access for Medi-Cal beneficiaries. Delaying the transition at the last minute, as was done in December 2020 and again in April 2021, will undermine an already strained delivery systems and further confuse and worry Medi-Cal beneficiaries.
- **I ask DHCS to continue to delay the pharmacy transition to ensure no disruption in pharmaceutical access and guarantee patient access to their current pharmacy through the COVID-19 pandemic.**
- Eliminating 340B savings would jeopardize patient access to critical supports like oral health, optometry, behavioral health, transportation services, health education, and cause in-house pharmacies to close. Taken collectively, such eliminations would raise costs. From the inception of Governor Newsom's Medi-Cal Rx program in 2019, Health Center Partners joined with community health centers across California to voice considerable concern with the proposed transition. At a time when access is needed most and when community health centers are stretched from a year of new financial burdens and operational challenges, community health centers need a guarantee that Medi-Cal Rx transition will not undermine their financial stability.
- **I recommend the department delay the pharmacy transition and consider removing the transition from its waiver proposal.**

DHCS needs to clarify how medically necessary services can be provided and billed prior to a complete SMH/SUD assessment.

- The CalAIM proposal will ensure beneficiaries receive the care they need no matter how they enter the system or where they are in the system. Currently, treatment services are not available until a patient completes an assessment, which can often be counterproductive to patient engagement, especially for patients in crisis or in substance withdrawal. I applaud the administration's proposal regarding allowing treatment during the assessment period and the "no wrong door" proposal, which will ensure providers' ability to render necessary medical

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services to patients. However, questions remain as to how providers can comply with and bill for these services if they are not contracted with a county specialty mental health (SMH) and substance use disorder (SUD) health plan.

- **I ask DHCS to provide clarification on how non-contracted providers can provide medically necessary services prior to an assessment.**

DHCS must apply network adequacy, quality and access, and clinical performance standards to county behavioral health plans.

- The CalAIM proposal will integrate county mental health plans and Drug Medi-Cal Organized Delivery Systems into a single behavioral health plan. Although I recognize a statewide need to enhance access to both sets of services in a coordinated manner, I see several issues that need to be addressed to ensure counties are prepared to adequately meet the demand for services and so patients and families may be assured they are receiving the highest quality of care.
- **I am concerned with how the state will hold county behavioral health plans accountable for performance with managed care responsibilities, especially when the administration of two discrete programs is consolidated**. Recent statewide audits of SMH plans found that counties were deficient in meeting quality and timely access goals. In fact, the Medi-Cal Managed Care External Quality Review Technical Report, dated July 1, 2017–June 30, 2018, indicated several SMH plans did not have performance improvement plans, functioning quality improvement committees, and failed to meet culture-specific and community defined best practices for communities, perpetuating ongoing disparities in access and care.
- **While I agree the integration of SMH/SUD into specialty behavioral health is necessary, there must be necessary safeguards to ensure oversight, transparency, adequacy, and access to timely and quality SMH/SUD services**.

DHCS must ensure community providers, including community health centers and FQHCs, are eligible for support under Providing Access and Transforming Health (PATH).

- I am pleased to see the inclusion of Enhanced Care Management (ECM) and In-Lieu-of-Services (ILOS) in the CalAIM proposal as well as the administration's commitment to ensure adequate funding be allocated for the development of these services in this year's budget. Providing Access and Transforming Health (PATH) funding will help provide the necessary support to transition from county-based Whole Person Care services to ECM ILOS. This support is also needed to guarantee data exchange, establish payment relationships, measure value and outcomes, and ensure that beneficiaries remain at the center of care, and allow ECM and ILOS providers to continue to move toward delivery system reform, addressing inequities by race and ethnicity for patients who are historically underserved and experience poor health outcomes.
- **To ensure successful implementation of these elements, it is important community-based organizations, including community health centers, have the tools and resources needed to work together and build capacity, including payments for new staffing and infrastructure.**

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DHCS must ensure the public has adequate opportunity to review and comment on all policy changes.

- While I appreciate the opportunities to comment on the 1115 and 1915(b) waivers and expect DHCS will release other policy changes for public comment in the future, I would like to underscore the importance of gathering and incorporating stakeholder input into all final policies. This includes an opportunity to provide input on any assessment tools that will be selected for use. Assessment tools must be rapidly deployed in the care setting and integrated into provider electronic health record systems.
- California needs to get this right to build effective workflows between primary care and specialty providers, including specialty mental health. This is important because the responsibility exists at the local level to best serve the needs of beneficiaries. Too much can be left to interpretation, especially when one partner or system of care is under stress due to capacity or other constraints.
- **A thoughtful approach will require input from all stakeholders. I encourage DHCS to work with stakeholders to design clear guidance in implementing these assessment and referral processes. Specifically, I request extensive public comment and engagement on the following items noted in the proposal:**
    - The new Individual Risk Assessment (IRA) tool which DHCS plans to implement, in an adult and a pediatric version, for risk stratification - replacing several existing tools including the Staying Healthy Assessment (SHA) tool where providers were previously afforded the opportunity to contribute input.
    - A standardized screening tool for county mental health plans (MHPs) and Medi-Cal managed care (MCMC) plans to use to guide beneficiaries toward the delivery system that is most likely to meet their needs.
    - A standardized transition tool for MHPs and MCMC plans to use when a beneficiary's condition changes, and therefore as a result better served in another delivery system.
    - A process for facilitated referral and linkage from county correctional institution release to county MHPs, Drug Medi-Cal, DMC-ODS, and MCMC plans when the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

DHCS must continue to pursue and provide data sharing and integration across all systems of care including social services.

- A major component of new success in Medi-Cal will stem from everyone's ability to capture and share data across systems. I am very excited to see DHCS' plan in the **CalAIM Data Exchange Roadmap,** with identification of data use cases, that define information system requirements and data sharing activities necessary to enable ECM and ILOS and facilitate care coordination between physical, behavioral, and social service providers.
- Tackling legal, regulatory, infrastructure, and care coordination issues that have plagued the industry for years and prevented real care coordination is now being addressed substantially. A heavy lift: but you should be commended for the move in this direction. I look forward to active participation in this process and finding resolution strategies that work for all providers and beneficiaries.
- I realize the Cal AIM Data Exchange Roadmap does not need CMS approval, and therefore is not included in the waiver, but it is an important component toward future success, so it is worth mentioning in this comment letter. This is an ambitious approach to driving data exchange at every level of the delivery system.

- My only concern is this work will take years, and providers will not have the support and infrastructure necessary as the state rolls out major CalAIM and related initiatives. Most struggle with the systems they have in place today, lacking the underlying infrastructure to support expanded work and effort, which will diminish the possibility of success.
- **I recommend DHCS keep CalAIM Data Exchange Roadmap efforts at the forefront of their efforts and as a top priority with stakeholder engagement.**

Additional Comments on the CalAIM 1115 & 1915(b) Waivers

Section 3.4 - Low Income Pregnant Women

- I would like to thank the state in continuing full scope Medi-Cal coverage to pregnant women with incomes from 109 percent up to and including 138 percent of the Federal Poverty Level (FPL) so community health centers may continue to reach and serve this population and help curb infant mortality rates among poor and minority populations. This aligns with the new federal initiative focused on Black maternal and infant mortality disparities.

Section 4 – Initiatives Being Discontinued or Transitioned Under CalAIM

Medi-Cal Managed Care

- **Population Health Management**
  - DHCS has indicated plans will be required to implement a needs assessment based on NCQA standards. In this approach, each health plan may design its own algorithm to determine population health stratification based on such an assessment. This could prove to be challenging for regions with multiple plans. As a stakeholder representing at-risk entities, I would like to be included in the development of any algorithms not only for development of a standard but to be sure delegated entities align.
  - **I request DHCS allow stakeholder input on selection of the population health tool and requisite data capture, and I recommend DHCS set a standard for all plans to use in stratification of patients based on use of the selected tool.**
- **Payments and Incentives**
  - I commend DHCS for recognizing the importance of structuring payments and aligning incentives to achieve the goals of CalAIM, that support whole person care approaches, address social determinants of health and equity, to improve outcomes and drive delivery system transformation. The waiver proposes that managed care plans will be incentivized to support outreach and provide the infrastructure necessary for ECM and ILOS. However, such incentives do not always make it down to the provider level, where engagement of hard -to-reach populations occurs. Additionally, today providers receive the same reimbursement for all Health Homes Program enrollees (per managed care payer) regardless of enrollees' needs and the amount of time and effort expended outreaching to and working with enrollees on their care plans.
  - **I recommend DHCS specifically include a commitment that CalAIM incentives will make it down to the provider level, and providers be afforded the opportunity to receive managed care plan shared savings. I recommend DHCS build-in risk stratification, even within the most complex populations.**

- **Accountability and Oversight**
    - DHCS has taken steps to increase managed care oversight and accountability, but it is unclear how DHCS will expand this with so many CalAIM initiatives being implemented. Does DHCS have the bandwidth or necessary funding to deploy staff and resources in this regard? Further, accountability and oversight run downstream to delegated providers and groups, who will also need support. Guidelines, forms, and policy must be standardized and implemented at every level. Has this been fully accounted for or captured in DHCS' budget and expenditures?
    - **I recommend DHCS include detailed information about how accountability and oversight factor into the budget as part of the CalAIM 1115 & 1915(b) Waivers.**

Whole Person Care (WPC) and Health Homes Program (HHP)

- I support DHCS in transitioning key services from the WPC and HHP into the managed care delivery system through Enhanced Care Management and In Lieu of Services benefits**. However, I have concerns there is not sufficient time to move these services**.
- DHCS is not expected to begin negotiations with managed care plans until the summer of 2021. Normal negotiations can take more than 1-2 years with payers. This work, including establishing new contracts with downstream providers, some of which will be completely new relationships, will need to be done in less than six months to meet the current timeline.
- Also, one could draw the conclusion, based on the state's recent request (mid-April 2021) to plans and providers for ILOS data, that the state may not have all the pricing information necessary to support the full range of services that will be required when ILOS moves to managed care. To ensure sustainable program costs and a smooth transition of these services,
    - **I suggest DHCS consider delaying the implementation of ECM/ILOS to allow sufficient time for the state, payers, and providers to adequately prepare to deliver these new benefits under Medi-Cal.**
- While I appreciate the state has doubled the budget as WPC and HHP transition into managed care as ECM/ILOS under CalAIM, I am concerned this will not be enough to meet the need of an expanded population under Medi-Cal. It is a heavy lift. ECM and ILOS are ambitious reforms that will take time and support to implement, at the same time as we will be trying to recover from the COVID-19 public health emergency.
    - **I recommend the state allow for a phased-in approach for targeted populations and allow managed care plans to select only 1-2 ILOS services to initially implement, rather than try to implement a broad array of ILOS services.**

Coordinated Care Initiative (CCI)

- I appreciate DHCS' intent to better align care coordination of dual-eligibles by contracting only with Dual Special Needs Plans (D-SNPs) where Medicare and Medi-Cal are administered by the same company. **However, I am concerned in the transition of components of CCI into a statewide aligned enrollment structure, that narrows networks in the special needs plans (D-SNP) to reduce potential risk exposure, one result would be limited access and provider participation.**
- This could result in disrupted care for this vulnerable population. This concern is only heightened if plans are not selected to continue serving the Medi-Cal Managed Care System as part of the open procurement process. In the Waiver, DHCS indicates an intention to selectively

contract with Dual Special Needs Plans (D-SNPs), but there is no indication as to the criteria they will use for this selection process.

- Limiting health plan choice from the beneficiary perspective will be problematic, and networks could be affected impacting access and adequacy.
    - **I request a transparent process in development of the criteria that will be used to select D-SNPs and to request that DHCS commit to seeking open input from local stakeholders to help inform this process.**

Oral Health Services

- I applaud DHCS for establishing a new, statewide dental benefit for children and certain adults and expanding pay-for-performance initiatives under the state plan. This builds upon what was learned through key initiatives that worked well in the Dental Transformation Initiative (DTI) program. The DTI initiative improved statewide access to dental preventive services for children and high-risk adults.
    - **I recommend DHCS structure the program in a meaningful way so FQHCs may continue to participate by receiving the incentive outside of their PPS rate, as was the case in the DTI program.**

Finally, as providers continue to support the administration in the COVID-19 vaccination effort, the January 1, 2022 implementation date is ambitious and requires careful planning to ensure successful implementation while avoiding disruption to current operations.

Again, I appreciate this opportunity to submit comments on the waiver proposal. I look forward to working with you to implement these major changes. If you have any questions, please contact me directly.

Sincerely,

Henry N. Tuttle
President and Chief Executive Officer

CC: California Primary Care Association (CPCA)

Health Center Partners of Southern California, a family of companies, includes a 17-membership organization of federally qualified health centers, Indian Health Services Organizations, both urban and sovereign, and Planned Parenthood of the Pacific Southwest, collectively serving 917,000 patients each year, for 3.9 million patient visits each year, at 160 practice sites across San Diego, Riverside and Imperial counties, and is the seventh largest provider group in the region. Read our latest Impact Report.

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