



**CALIFORNIA
HOSPITAL
ASSOCIATION**

*Providing Leadership in
Health Policy and Advocacy*

December 19, 2019

Richard Figueroa
Acting Director
California Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

SUBJECT: California Advancing and Innovating Medi-Cal (CalAIM) Initiative Proposal

Via e-mail: Richard.Figueroa@dhcs.ca.gov

Dear Acting Director Figueroa:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to provide recommendations to the California Department of Health Care Services (DHCS) on the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the state's multi-year initiative to redesign the Medi-Cal delivery system. We look forward to participating in the ongoing stakeholder engagement effort, and we offer the comments below to be incorporated into the CalAIM work group discussions.

Hospitals appreciate your leadership in developing a comprehensive proposal that includes an array of services designed to meet the behavioral, developmental, physical, and oral health needs of Medi-Cal members in an integrated, patient-centered, whole person fashion. The proposal represents a significant step forward in reforming a fractured delivery system, building on the both lessons learned from numerous managed care transitions over the years as well as successful programs like the Whole Person Care pilots and Health Homes Program.

CHA also appreciates DHCS' acknowledgement of the need to integrate physical and behavioral health with access to long-term services and supports, and the critical need for care coordination to ensure timely access and cost-effective delivery of care. In addition, DHCS' recognition of the need to provide for non-clinical interventions that address social determinants of health and reduce health disparities and inequities is of great importance. This focus will have a significant impact on Medi-Cal members' overall health and quality of life, help drive delivery system transformation that focuses on value and outcomes, and — if implemented successfully — will considerably slow the growth of the cost of care for Medi-Cal members.

Critical to CalAIM's success will be:

- 1) **Increased Oversight and Accountability:** DHCS' increased oversight and accountability of Medi-Cal managed care plan and county mental health plan performance is critical, as is the development of transparent mechanisms to ensure that these plans are held accountable for

existing and new standards outlined within the proposal. As numerous California State Auditor reports have found over the years, DHCS has had difficulties providing appropriate oversight of these plans, resulting in challenges for Medi-Cal enrollees to access the care to which they are entitled. This has also made it difficult for providers, including California's hospitals, to care for them. CHA looks forward to partnering with DHCS on CalAIM's implementation efforts to ensure that these plans fulfill their obligation to ensure care for Medi-Cal members.

- 2) **Transparency:** Transparency regarding all aspects of CalAIM implementation will help ensure that DHCS, managed care plans, mental health plans, providers, and community partners have shared accountability for the care provided to Medi-Cal members. Successful CalAIM implementation will require an "all hands on deck" approach where there are clearly defined roles and responsibilities, measures that can be used for accountability, and commitment to an ongoing assessment throughout the implementation process.
- 3) **Meaningful Stakeholder Engagement:** We appreciate DHCS' acknowledgement that the CalAIM reforms are interdependent; without one, the others are neither possible nor as powerful. We also understand that the timeline to implement the numerous proposals within CalAIM is ambitious. CHA urges DHCS to implement CalAIM in a thoughtful manner, recognizing that if additional time is needed to refine a proposal, that DHCS and stakeholders do so in a way that ensures Medi-Cal members do not experience any unintended consequences.

Comments below — informed by the experience of California's hospitals and post-acute care providers under the current system — are organized within two of CalAIM's primary goals: 1) to identify and manage member risk and need through whole person care approaches and address social determinants of health; and 2) to move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility. CHA urges DHCS to consider the significant opportunity to further develop and refine its proposal with stakeholders through the work group process.

IDENTIFY AND MANAGE MEMBER RISK AND NEED THROUGH WHOLE PERSON CARE APPROACHES AND ADDRESS SOCIAL DETERMINANTS OF HEALTH

The CalAIM proposal acknowledges the need to focus on a whole-person care approach that addresses the overall needs of Medi-Cal members – targeting physical and behavioral health, as well as the social determinants of health. Paramount to this goal is the need for significant improvements to case management and care coordination at all levels of care and role clarity to ensure accountability for access to and provision of care and services to Medi-Cal members.

Integral to this process will be:

- Identification of clear and meaningful indicators of care coordination, including outcome measures
- Greater transparency into the managed care plan provider network to assist with better coordination
- The opportunity for Medi-Cal members and providers to escalate issues and concerns to DHCS when appropriate care is not being provided.

1) Population Health Management Program

DHCS proposes requiring managed care plans to develop and maintain a beneficiary-centered population health management program, in accordance with National Committee for Quality Assurance and DHCS requirements, and to require the plans to describe how they will manage member safety and outcomes during transitions, across delivery systems or settings, through the use of effective care coordination. CHA appreciates DHCS' recognition of the critical role care coordination, including care transitions, plays in developing a population health management program. Appropriate departmental oversight is critical to ensure the plans are actually managing the health of Medi-Cal members, as envisioned under the proposal.

CHA urges DHCS to make the population health management plans publicly available on the DHCS website in a timely manner so that Medi-Cal members, providers, and other partners have a clear understanding of roles and responsibilities in serving Medi-Cal enrollees. It is only through transparency that managed care plans and others can be held accountable for the care provided to Medi-Cal members.

Finally (detailed below), CHA encourages DHCS to consider requiring standardization of managed care plans' population health management programs to ensure accountability and limit administrative burden and costs for providers and DHCS. While we appreciate that the plans will need flexibility in designing population health management program in accordance with the National Committee's framework, the standardization of key elements will limit variation in care delivery and enable the agency to track uniform metrics to ensure quality and efficiency.

Initial Risk Assessment

DHCS proposes to require managed care plans to conduct an initial assessment of each new member's risk and need, including emerging risk, by assessing behavioral, developmental, physical, and oral health status, as well as social determinants of health within 90 days of the effective date of plan enrollment. CHA urges DHCS to require the plans to share the member's level of risk (low, medium, high) with all network providers identified on the plan's monthly 274 file, as well as the plan to link the member with appropriate services – including but not limited to wellness and prevention, general case management, complex case management, enhanced care management, external entity coordination, and transition coordination. In addition, CHA recommends DHCS require the plans include providers when conducting a risk assessment.

Under California's Coordinated Care Initiative, hospitals in the seven participating counties reported routinely not being included when health plans conducted health risk assessments and/or developed interdisciplinary care teams and individual care plans. For Medi-Cal members with complex medical needs and chronic conditions, many hospitals and their affiliated post-acute care providers serve as the primary care provider. Including a provider-based case manager or other clinician to provide meaningful input on a patient's clinical and functional status would enhance the overall care planning process and improve provider-plan communication for more effective implementation.

Reassessment

DHCS proposes that, at a minimum, managed care plans be required to reassess members' risk and need — including emerging risk —annually through an approved data-driven risk stratification process. DHCS indicates members' risk and need *may* need to be reevaluated throughout the year based on a change in condition or level of care. This requirements reads as optional for health plans and is insufficient to accurately capture an individual's health and well-being at any given point. CHA urges that DHCS require the plans to reevaluate member risk throughout the year based on any change in condition or level of care, such as an inpatient admission or new diagnosis, the availability of new data, or a case management interaction. In addition, CHA requests that DHCS standardize the reevaluation process among the plans to alleviate administrative burden and improve care coordination.

Provider Referrals

DHCS proposes to require managed care plans to establish a process by which providers may make referrals for members to receive case management. DHCS has indicated that referrals for case management should lead to a reassessment of risk and need. CHA strongly supports this proposal and suggests that plans be required to provide quarterly reports to DHCS on the case management referral process — including volume and types of requests, and follow-up actions (both case-specific and system improvement). Moreover, CHA recommends the information be made publicly available in a timely manner.

Actions to Address Risk and Need

General Requirements and Services

DHCS proposes to require managed care plans to provide a toll-free line for primary care providers and specialists who seek technical and referral assistance when any physical or behavioral condition requires further evaluation or treatment. The plans would be required to provide the following information: assistance in arranging for referrals, including mental health and substance use disorder treatment referrals; developmental services referrals; dental referrals; and referrals to long-term services and supports.

CHA requests that DHCS clarify and ensure this resource is available to hospitals, skilled-nursing personnel, and non-physician practitioners, as well as to physicians (regardless of network status), 24 hours a day, seven days a week. In order for the toll-free line to be successful, the managed care plan should be required to provide real-time information to assist a provider in the highest quality care transition. In addition, the plans should be required to report on performance metrics.

Hospitals' experience under Cal MediConnect was that some of the Cal MediConnect plans provided hospitals with a list of vendors, facilities, etc., and the hospital case manager was expected to coordinate a Coordinated Care Initiative member's discharge planning — including contact with multiple suppliers — with the plan effectively transferring contractual care coordination activities to the hospital. Hospitals reported that they often received little to no information or support regarding community services, or in developing alternatives to skilled-nursing facility placement. CHA urges DHCS to provide clear guidance to clarify that care coordination is a plan responsibility. Additionally, CHA requests clarification on how

the plans will integrate with county mental health plans and regional centers, and how the needs of individuals with developmental disabilities will be addressed.

DHCS proposes to require managed care plans to develop or provide access to a current and updated community resource directory for case managers and contracted providers. CHA requests that DHCS include links to this information on the DHCS website for ease of access and that DHCS require the plans to update the information on a quarterly basis.

Managing Members with Emerging Risks

Under DHCS' proposal, a managed care plan's Population Health Management program shall ensure members receive appropriate follow-up for behavioral, developmental, physical, and oral health needs — including preventive care — care for chronic conditions, and referrals to long-term services and supports, social services and community-based organizations, as appropriate; as well as refer members identified as needing care coordination to the member's case manager for follow-up care and needed services within 30 calendar days. CHA encourages DHCS' efforts to ensure that clinical practices and assessments are evidence-based, including the use of predictive analytics. However, in that context, we encourage DHCS to implement the use of data with close oversight and ongoing assessment to avoid confirming/continuing past utilization patterns that may not be optimal. In addition, CHA requests that DHCS track and publicly report on plan performance in this area to ensure the plans are appropriately managing Medi-Cal members' health.

Case Management

DHCS proposes that case management services include documentation of the individual care plan and assigned case manager in an electronic format, as well as support from an inter-professional team with one primary point of contact. CHA recommends that the plans be required to share with Medi-Cal members and all providers (regardless of network status) the name and contact information of the member's assigned case manager. This information should be readily available to providers in a manner and mechanism that will allow for 24-hour access, seven days a week.

DHCS proposes that if a Medi-Cal managed care plan assigns a case manager outside the plan, the plan will be required to develop a written agreement that defines the responsibility of each party in meeting the requirements to ensure compliance and non-duplication of services. If situations arise where a member may be receiving care coordination from multiple entities, the plans would be required to identify a lead care coordinator. CHA requests that this information be made available to Medi-Cal members and all providers. CHA also requests that DHCS implement processes for network providers to report, and for DHCS to track, when plans have shifted their administrative responsibilities to providers, as the absorption of such responsibilities by network providers should be acknowledged through increased provider rates.

DHCS proposes that if a member changes enrollment to another plan, the old plan shall coordinate transition of the member to the new plan's case management system to ensure services do not lapse and are not duplicated in the transition. CHA recommends that DHCS require the new plan to connect with Medi-Cal members within 10 days of enrollment to ensure proper coordination of services.

DHCS indicates that managed care plans are required to incorporate performance measurement and quality feedback from the member and caregivers. CHA requests that DHCS require the plans include providers and other key stakeholders in this process, as well include in their population health management program the process used to solicit feedback, the feedback provided, and how the feedback will be addressed.

Coordination Between Medi-Cal Managed Care Plans and External Entities

DHCS proposes to require the plans to explain in the population health management program description how they will coordinate with, and refer members to, health care and social services/programs including behavioral health services, dental, and home- and community-based services. CHA requests that this information be made publicly available in a timely manner to Medi-Cal members and providers in a standardized manner to promote accountability.

Transitional Services

DHCS proposes that the plans ensure transitional services are provided to all members transferring from one setting, or level of care, to another. CHA strongly supports DHCS' inclusion of transitional services. Coordination of hospital discharges has been an increasing challenge in recent years, and many CHA members report significant problems in accessing necessary post-hospital care, including problems with timely communication from their plan, as well as issues with network adequacy, which often lead to delays in discharge and lack of timely access to medically necessary care. The current proposal provides a critical opportunity to address these issues.

Under DHCS' proposal, plans will be required to establish operational agreements or incorporate transitional language into existing subcontracts with contracted hospitals, residential treatment facilities, and long-term care facilities to ensure smooth transitions. CHA strongly supports DHCS' proposal to require plans to develop discharge planning policies and procedures in collaboration with all hospitals, and to prevent delayed discharges. As noted previously, plan-hospital communication for hospital discharges has been particularly challenging, as there is confusion about roles and responsibilities. A requirement to develop standardized and transparent policies and procedures in collaboration will be essential in assisting DHCS with plan oversight.

Skilled-Nursing Facility Coordination

DHCS proposes to require that plans coordinate with hospital or other acute care facility discharge planners, and nursing facility case managers or social workers to ensure a smooth transition to or from a skilled-nursing facility or nursing facility. Today, many plans that have the division of financial responsibility for long-term care services for a Medi-Cal beneficiary do not reimburse for hospital services considered to be an administrative day (level 1). Plans knowingly choose to leave Medi-Cal members not requiring an acute level of hospital care in a hospital setting, while awaiting placement into a nursing home or post-acute care setting. DHCS proposes to require plans coordinate with the facility to provide case management and transitional care services, as well as ensure coverage of all medically necessary services not included in the negotiated daily rate. This includes, but is not limited to, prescription medications, durable medical equipment, intravenous medications, and other medically necessary services or products.

CHA commends DHCS' discussion of care coordination for members residing in skilled nursing facilities, including requiring the plan to ensure coverage of all medically necessary services not included in the negotiated daily rate. Specifically, CHA requests that "rehabilitative services, including physical and occupational therapy and speech/language pathology" be added to the description of such services, and that plans work with nursing facilities to ensure that medically necessary therapy services are provided in the facility. Under traditional fee-for-service (FFS) Medi-Cal, many nursing facilities do not provide therapy services, due to billing and reimbursement issues. CalAIM represents an important opportunity to address this issue and to ensure access to these important services, which are critical to beneficiaries' ability to achieve maximum independence and return to their communities.

To ensure that plans are not taking advantage of an existing reimbursement loophole, CHA urges DHCS to require plans to reimburse hospitals at the FFS rate for eligible administrative days (level 1), with no limit on the administrative day reimbursement, when acute care is no longer medically necessary and the member awaits a transition to a post-acute setting. Such a requirement incentivizes the plan to work with providers to ensure timely discharge to the appropriate care setting. In addition, CHA urges DHCS to ensure plan billing guidelines are consistent with Medi-Cal billing guidelines.

Population Health Management Oversight

DHCS proposes that plans document quality assurance reviews of population health management activities on an annual basis, or upon DHCS' request, and submit them to DHCS for review. In addition, MCPs must submit a population health management oversight plan in accordance with National Committee for Quality Assurance requirements for any entities to which they delegate population health management functions. Such plans would be reviewed and approved by the state. CHA requests that the plans' population health management oversight plan be made publicly available in a timely manner on the DHCS website, to promote transparency and accountability.

DHCS acknowledges that plans are responsible for ensuring their delegates comply with all applicable state and federal regulations, as well as DHCS policies. As this proposal proceeds, it will be important to include a mechanism for Medi-Cal members and providers to identify and address concerns on a timely basis about the behavior of delegated entities. CHA encourages DHCS to develop processes and oversight mechanisms that address the unique opportunities and challenges of the delegated model to ensure consistency in application of policies across the plans and their delegated entities. Plans must be responsible for delegated entity failures to comply with payment practices and California law.

Health Information Technology to Support Integrated Care and Care Coordination

CHA shares the department's goals for improved interoperability of health information technology and improvements to the health information exchange infrastructure. In California, 97% of hospitals have adopted certified electronic health records. However, hospitals continue to find it challenging to electronically share health information with other community providers that have lower rates of electronic records adoption. In addition, the transfer of health information can be challenging between providers that have both adopted certified electronic records, even those that may have products from the same vendors. The federal government is in the process of updating regulations related to interoperability and information blocking that may significantly impact the framework under which health care providers, health insurance plans, and health information technology developers and vendors capture and exchange highly sensitive health information. CHA urges DHCS and plans to engage

stakeholders — including providers, health information technology developers and vendors, health information exchanges, federal policymakers, and others — to ensure interoperability policies and data exchange protocols do not increase the burden on providers or introduce additional confusion into an already complex regulatory framework.

Accountability and Oversight of Medi-Cal Managed Care Plans

DHCS proposes to increase oversight and assessment of plans, including changes to its audit procedures and imposition of corrective action plans and financial sanctions, when appropriate. CHA requests that DHCS publicly post this information on the DHCS website in real time, including sending notices to Medi-Cal members and the managed care plan's network providers when plans have been placed on a corrective plan and/or when DHCS has imposed financial sanctions. DHCS has not always made this information available to the public in a timely manner, with stakeholders having to request that DHCS post a corrective action plan to the DHCS website months after issuance.

To provide enhanced oversight of managed care plans, CHA recommends that the state reevaluate the county organized health system exemption from Knox-Keene licensure. Such consistency would support CalAIM's goal of reducing complexity within the Medi-Cal program, as well as ensure Medi-Cal enrollees have the same consumer protections across all counties in California. Unlike other managed care plans, county system plans are not required to obtain Knox-Keene licensure for their Medi-Cal lines of business, and unless they choose to obtain a Knox-Keene license, they are not regulated by the California Department of Managed Health Care. Consumer protections for county system plan enrollees incorporated by contract with DHCS may not ensure the same level of care quality and accessibility as provided by the Knox-Keene Act. This is particularly important given the number of consumers affected: 2.2 million Medi-Cal members are served by six county system plans in 22 counties.

As managed care plan networks grow increasingly complex with more delegation of risk, CHA urges DHCS to take a greater role in overseeing plans' entire networks, including ensuring delegated entities comply with the each plan's contractual requirements. In some California markets where the delegated model is more dominant, there are additional challenges. Specifically, it is a challenge for DHCS to receive accurate and timely encounter data to ensure plan contract compliance. There is also a lack of care coordination for members, creating greater risk of duplication and inefficiencies. CHA urges DHCS to evaluate the economy and efficiency of care networks and apply greater accountability to the primary plans that have chosen to enter into such arrangements. Far too often, hospitals hear from delegated entities they are not aware of contractual or significant policy changes (e.g., effectuating contractual changes to meet the network provider definition).

Future Policy Development and Technical Assistance

DHCS indicates it is committed to providing managed care plans with technical assistance on development of their population health management program. DHCS acknowledges that the best method to advance promising practices in these areas may be to allow best methods to emerge through a learning collaborative and assessment of outcomes. CHA requests that, in addition to its ongoing commitment with stakeholders, DHCS build in a formal mid-point assessment with stakeholders to document and assess what is working and can be improved. All stakeholders, including CHA, should be included in this process.

2) Enhanced Care Management Benefit

CHA commends DHCS' inclusion of an Enhanced Care Management benefit designed to provide a whole-person approach that addresses clinical and non-clinical needs of high-cost and/or high-need Medi-Cal members. CHA appreciates DHCS' commitment to finding a suitable federal authority pathway to continue to build upon the success from the Whole Person Care pilots and Health Homes Program that operate within the Medi-Cal 2020 Waiver. CHA also supports DHCS' description of the role of care managers as Medi-Cal members' primary point of contact, responsible for ensuring that all physical, behavioral, long-term care, developmental, oral care, social, and psycho-social needs are met in the safest, least restrictive, and most cost-effective way. Care coordination is a central component of population health management. For DHCS to achieve the goals envisioned in CalAIM, oversight is critical to ensuring that plans are providing the care coordination required for Medi-Cal members to thrive.

In addition, there should be minimum statewide standards for enhanced care management services and eligibility criteria to ensure that Medi-Cal members receive care management benefits that do not vary based on county of residence or by plan. Standardization helps ensure consistency and equity in implementation of the enhanced care management benefit throughout the state, and this should be balanced with efforts to innovate care delivery methods. The Health Homes Program has a clearly defined service package and expectations, which offers a good starting place for consideration in building the enhanced management benefit requirements.

Program Administration

DHCS acknowledges that this benefit will be administered by the plans, which will have direct responsibility for establishing enhanced care management programs and criteria for their members, and for contracting with public and private providers to deliver such services. However, in the November 20 Enhanced Care Management & In Lieu of Services stakeholder meeting, the provider types discussed included only public hospitals and health systems, excluding many other types of hospitals ([slide 22 of presentation](#)). The target populations for this benefit – including but not limited to high utilizers with frequent hospital or emergency room visits/admissions, individuals at risk for institutionalization with serious mental illness or eligible for long-term care, individuals transitioning from incarceration, and individuals experiencing chronic homelessness – are those who seek shelter and care in *all* hospital emergency departments, so *all* hospitals should be viewed as critical partners in providing this benefit. CHA requests DHCS clarify that provider types include all hospitals, acute psychiatric hospitals among them. Hospitals not only provide quality direct care services for this target population, but are also critical in coordinating connections to needed community supports for other care needs.

CHA requests additional clarification about DHCS' proposal that for adults with a primary serious mental illness diagnosis, children with serious emotional disturbance, or individuals with substance use disorder, mental health plan staff should be considered to serve as the enhanced care management provider through a contractual relationship, so long as they agree to coordinate all the services (physical, developmental, oral, or long-term care) needed by those target populations, not just their behavioral health needs. While CHA supports the move toward integration of physical and behavioral health, we also note that the coordination of other aspects of care delivery — including medical, developmental, and long-term services and supports — has not been a responsibility of mental health plans. It will be critical to develop oversight mechanisms that ensure the competencies of all entities

seeking to provide enhanced care management services. CHA recommends that the plans be required to share with Medi-Cal members and all providers (regardless of network status) the name and contact information of the member's assigned case manager. This information should be readily available to providers in a manner and mechanism that will allow for 24-hour access, seven days a week. In addition, CHA requests that any memoranda of understanding related to such coordination be publicly available in a timely manner for Medi-Cal members and providers.

DHCS indicates that if a plan proposes to keep some level of enhanced care management in-house rather than contracting with direct providers, the plan will need to demonstrate to the state that its program is community-based, and programs would be submitted for both medical and financial audits. CHA requests that plans' enhanced care management programs be publicly available in a timely manner for Medi-Cal members and providers. For the benefit to provide comprehensive care for Medi-Cal members and to achieve better health outcomes, it will be incumbent on all parties — managed care plans, providers, community-based organizations — to be clear about roles and responsibilities, and to promote joint accountability.

In addition, it is essential that managed care plans and providers understand the amount of funding that the state is making available to provide this new benefit. Without this knowledge of enhanced care management as a clearly defined add-on to the plan rates, adequate payments might not be passed down to providers. Care management at this level is not simply an administrative task that providers can easily absorb. It requires dedicated staff and ongoing infrastructure investments that must be adequately funded. For example, time intensive, face-to-face outreach is often a prerequisite to engaging an individual in effective care management, and sometimes this needs to occur before a patient is enrolled in Medi-Cal, or before they are identified by the managed care plan as eligible for enhanced care management. Such activities should be paid for, but do not lend themselves to the traditional mechanisms available to plans for paying providers (e.g., billed claims, capitation for assigned lives, encounter data submission). To account for this disconnect and the importance of the work to the success of enhanced care management, we recommend that incentive payments recognize and incentivize outreach efforts.

CHA requests more detail about how this proposal would interact with the California Children's Services program, and how this will be done prior to January 1, 2021. There is concern about how this new benefit will be coordinated with the children's services program, which already provides its own form of care management to its enrollees. The children's services program is should be strengthened and improved, and this proposal might undermine the good work of the program. In addition, DHCS should fully understand how it will incorporate the role of schools and the educational system in the delivery of the enhanced care management benefit, recognizing the significant role both play in health care delivery for Medi-Cal children.

Transition Plan

DHCS indicates that managed care plans will be required to submit a transition plan to the state by July 1, 2020, demonstrating how the plans will transition such existing programs into their enhanced care management and in lieu of services programs; and demonstrate a good faith effort to agree on and contract for enhanced care management and in lieu of services with Health Homes Program providers,

Whole Person Care entities, and local governmental agencies already providing such services. Additionally, if the plan and existing provider cannot come to agreement, the plan will be required to provide DHCS information about why they were not able to come to agreement. CHA requests that DHCS urge plans to work closely with community-based medical and behavioral health facilities and providers in the development of their network of programs and services, to assess needs and address operational issues. CHA requests that transition plans be made publicly available in a timely manner so providers have a common understanding of the changes and of the rationale the plans are providing DHCS for not being able to come into agreement with existing providers.

Implementation

DHCS acknowledges in its proposal the significant coordination required to operationalize this benefit. CHA requests that plans be required to convene formal quarterly regional advisory councils composed of all providers (hospitals, skilled nursing facilities, community health centers, etc.) and community partners to foster communication and transparency, and to ensure all parties are clear about all aspects of CalAIM implementation. For the meetings to be inclusive, they should be open to the public, and DHCS should maintain on its website links with information about each meeting. Plans should be required to report to DHCS on the feedback provided at each meeting and how they plan to address the feedback. This information should be made publicly available in a timely manner.

Mandated County Inmate Pre-Release Application Process

CHA applauds DHCS for proposing to mandate all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2022, including juvenile facilities. CHA also applauds the proposal to mandate all counties implement warm handoffs from county jails to county behavioral health departments, for inmates who were receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community. The transition of individuals from incarceration brings additional unique challenges, particularly when there is a need for ongoing residential care. CHA supports DHCS' attention to this complex issue and the proposed standardization of pre-release Medi-Cal application policy and process; it is long overdue.

3) In Lieu of Services

As illustrated in the successful Whole Person Care pilots and Health Homes Program, investing in an integrated and flexible approach to coordinating medical care, behavioral health, and social services has directly improved health outcomes for many Medi-Cal members. Rather than continue individual local or county-driven solutions, DHCS has proposed to cover 13 distinct services as "in lieu of services" critical to address combined medical and social determinants of health needs and to reduce the need for higher levels of care. These services are intended to be provided as a substitute or to reduce utilization of other services, such as hospital or nursing facility admissions, discharge delays, or emergency department use.

This proposal presents an incredible opportunity to enhance health outcomes and independence and reduce unnecessary medical care utilization and costs. Hospitals support building on the infrastructure of the Health Homes Program, the Whole Person Care pilots, and targeted case management, with the goal of enhancing consistency in services provided throughout the state.

In the CalAIM proposal, DHCS acknowledges that current Medi-Cal strategies to address members' social determinants of health vary across the state, depending on the initiatives underway in different regions. One of CalAIM's core goals is to standardize and reduce complexity by implementing administrative and financial efficiencies, and encouraging delivery systems that provide more predictability and reduce county-to-county differences. CHA appreciates DHCS' willingness to include a standardized list of 13 services even though they are considered optional services in the managed care plan contracts.

CHA acknowledges that the "menu" of proposed services is extensive and will require significant financial resources. The development and implementation of the current proposal and its associated financing mechanism(s) must recognize this. Additionally, it is important that the realization of cost avoidance may be difficult to ascertain in the short term. For example, the provision of in-home personal care may represent an increased cost for a specific individual's care, but will reduce the likelihood of a hospitalization or institutional admission at a later date. It will be critical that any evaluation of the effectiveness of the in lieu of services option be done on a long-term basis to account for the full array of cost avoidance factors rather than focusing only on short-term savings.

Similarly, care must be taken to ensure that the provision of these services does not impact the availability of reimbursement for medically necessary care. Rather, the goal should be to reduce *unnecessary and avoidable* medical care utilization and costs.

CHA requests that DHCS remove barriers related to the proposed payer of last resort clause. To be eligible for in lieu of services programs, "Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding." Given the complexity of funding streams at the federal, state, and local levels related to housing and homelessness, there will be a significant burden on plans and contracted providers to ensure compliance with this requirement. There are a dizzying array of funding streams and programs, and this clause could be a major barrier to these services being delivered if it is not clarified. The existence of other related programs in no way suggests adequate supply; these services will be important to address significant unmet need.

For five of the proposed services, we offer the following feedback:

- **Recuperative Care (medical respite):** CHA strongly believes that clarification is needed on the role of recuperative care and medical respite with behavioral health clients, as the terms are not well-defined or understood. Medical respite care is acute and post-acute care for people experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets, but are not ill enough to be in a hospital. Unlike "respite" for caregivers, "medical respite" is short-term residential care that allows individuals experiencing homelessness the opportunity to rest in a safe environment while accessing medical care and other supportive services. This care is offered in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing.

DHCS notes recuperative care would be ideal for people experiencing homelessness exiting a hospital who are recovering from either a physical or *behavioral health* illness. However, patients exiting acute inpatient psychiatric facilities need to be placed in behavioral health step-

down facilities or programs that have strict licensing and regulations, and not in an unlicensed and unregulated environment such as a recuperative care facility. While people with complex health conditions often have co-existing behavioral health needs, counties still have a responsibility as the managed care plan to provide appropriate levels of care for Medi-Cal recipients with serious mental illness and/or substance use disorder in recovery-oriented environments specializing in behavioral health. Counties are responsible for ensuring or working toward establishing a robust continuum of care for behavioral health, which includes step-down facilities after acute inpatient psychiatric hospitalization. Additionally, it would be important that such services are not being provided when skilled nursing services are warranted.

DHCS notes that examples of eligible providers include interim housing facilities with additional on-site support, shelter beds with additional on-site support, or converted homes with additional on-site support, and county operated or contracted recuperative care facilities. CHA requests clarification about how/who would provide the necessary medical care, and the requirements they would need to meet regarding licensing and care delivery standards.

- **Short-Term Post-Hospitalization Housing:** DHCS notes that short-term post-hospitalization housing would provide “supports necessary for recuperation such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric substance use disorder care and case management...” As noted above, it will be important that such services are not being provided when skilled nursing services are warranted. Eligible providers are noted as “supportive housing providers.” Again, CHA requests clarification about how/who would be providing the necessary medical care and how the provider would be reimbursed for the care provided.
- **Sobering Centers:** DHCS states that sobering centers are alternative destinations for individuals found to be publicly intoxicated who would otherwise be transported to an emergency department or jail. CHA recognizes the value of sobering centers in appropriately diverting people to support avoiding overcrowded emergency departments. However, CHA notes that community paramedicine, including the ability for paramedics to route patients to sobering centers, remains an issue that needs to be addressed for this to reduce emergency department utilization.
- **Housing Deposits:** CHA requests that DHCS remove the proposed once-in-a-lifetime restriction that would unnecessarily limit access to in lieu of services for Medi-Cal’s most vulnerable. Unfortunately, homelessness is often linked to one or more chronic conditions, with cycles of stabilization and relapse over time. Restricting receipt of the housing-related services to once in an individual’s lifetime ignores this reality and would not support housing providers in the work they do to meet client needs. We are unclear as to why this restriction is necessary given that each authorization of a service is determined to be a less costly alternative to a State Plan service. CHA requests that DHCS allow housing supports for those at-risk of homelessness, in addition to those who are already facing homelessness. Where capacity exists, housing supports should be considered a required part of care management for individuals who are homeless or

at-risk of homelessness, rather than a separate, optional in lieu of services plan offering, as proposed.

- **Housing Tenancy and Sustaining Services:** As proposed, this in lieu of service focuses on the next phase of support that a homeless individual would need upon being housed. It is not clear that the criteria would allow service to be provided to an individual if the plan or in lieu of service provider first encounters a patient when they are technically housed, but unstably so or are at risk of becoming homeless. We do not support a ‘fail-first’ approach to rationing services. From a financial stewardship perspective, it can be even more cost-effective to help someone stay housed as opposed to getting housing in the first place. High-risk patients who are unstably housed or at risk of homelessness should also be eligible for housing sustaining services.

4) Shared Risk, Shared Savings, and Incentive Payments

DHCS notes that the combination of carving-in statewide long-term care, enhanced care management, and in lieu of services allows for a number of opportunities, including an incentive to build an integrated, managed long-term services and supports program by 2026 and the necessary clinically linked housing continuum for California’s homeless population. The CalAIM proposal outlines a series of incentives through a multi-pronged risk strategy:

Blended capitation rate for seniors, persons with disabilities and long-term care members

Before DHCS moves forward with another blended capitation rate structure similar to the Coordinated Care Initiative program, which specifically blends managed care plans’ risk of members residing in a long-term care setting with those who live in other settings, CHA urges DHCS to consider a sustainable structure that considers the interaction and dependency of in lieu of service, incentive payments, and more impactful quality measures.

Throughout the Coordinated Care Initiative demonstration, hospitals observed several challenges with the managed care plans’ ability to effectively and timely institute clinically appropriate discharge planning, including significant delays with members transitioning from a hospital back into a community. Even though the proposed initiative rate structure was to incentivize plans to effectively reduce a member’s acuity level in a timely manner (i.e. from an institutional setting transitioned back into the community, from home and community-based services (HCBS) High to HCBS Low acuities), without the ability of in lieu of service or other non-traditional benefit structures, plans didn’t have the full array of tools to be successful. CHA urges DHCS to consider instituting a sustainable blended capitation structure that includes the in lieu of service and incentive payment arrangements, but also includes a much larger quality component (either a withhold or incentive payment) that takes into account the plans’ ability to provide the appropriate level of care for members in appropriate settings. CHA suggests including metrics that focus on a plan’s rehospitalization rate, reinstitutionalization rate, and discharge to community rates (or delays in discharges rates), to generate more care coordination accountability.

Time-limited, tiered, and retrospective shared savings/risk financial calculation performed by DHCS (2021-2023)

CHA recommends that the time-limited, tiered, and retrospective shared savings/risk financial calculations performed by DHCS also factor in utilization reported by the managed care plan through the encounter submission process. Accurate and timely reporting of encounters is a contractual

requirement for plans, and their shared savings/risk calculations should be based on encounters — not just independent financial and utilization files that are used to support the initial rate development.

Prospective shared savings/risk model incorporated via capitation rate development (2024/2025)

CHA recommends that any prospective model of shared savings/risk financial calculations performed by DHCS factor in utilization reported by the managed care plan through the encounter submission process. CHA also recommends that DHCS consider shared savings arrangements that do not negatively impact future base years of cost and utilization data used in rate development for the plans. Assuming plans become more innovative during the time period estimated for the prospective model, CHA recommends DHCS avoid designing a shared savings/risk model that penalizes plans by the mere update of a base year being used with rate development.

Plan incentives linked to delivery system reform through investment in enhanced care management and in lieu of service infrastructure

CHA recommends that investments in enhanced care management and in lieu of service infrastructure be temporarily omitted from any retrospective shared savings/risk financial calculation. Additionally, DHCS should require that incentive payments linked to delivery system reform should be focused on providers that are considered a network provider, as indicated on the plan's monthly 274 file, and that plans be held accountable for the payments actually made to providers. CHA urges DHCS to monitor these arrangements and utilize meaningful metrics to ensure the incentive payments were implemented as intended.

CHA supports financing mechanisms or incentive payments that support delivery system reform — especially when incentive payments are directed to the local or provider level. Additionally, CHA encourages the funding of services that facilitate transition to community care and recognize that overall cost savings benefit from a long-term perspective. CHA appreciates that this proposal seeks to address the current lack of certain critical services — including housing, long-term residential care, and home and community-based services — to support maximum independence and care in the least restrictive setting. The lack of these important services is due, to a large degree, to inadequate reimbursement.

5) Institutions for Mental Disease; Serious Mental Illness/Serious Emotional Disturbance Section 1115 Expenditure Waiver

DHCS seeks stakeholder input on whether California should pursue a serious mental illness/serious emotional disturbance Section 1115 demonstration waiver to receive federal financial participation for services provided to Medi-Cal members in an institution for mental disease. DHCS indicates it is engaging stakeholders to assess interest in pursuing the demonstration and to determine if participation is feasible for California given the rigorous implementation, data, and monitoring requirements. CHA strongly urges DHCS to pursue this waiver, either through a statewide approach or through a pilot approach in select counties. We appreciate being able to participate in the CalAIM Behavioral Health Stakeholder Workgroup that is evaluating this waiver option. Provider perspectives — specifically that of psychiatric hospitals' and chemical dependency recovery hospitals— are integral to understand the impact of federal funding for hospital services provided to individuals with serious mental illness / serious emotional disturbance.

Hospitals' experience with the Medicaid Emergency Psychiatric Services Demonstration was that federal funding for inpatient psychiatric stabilization services helped improve access to and quality of care for Medi-Cal members. Absent the demonstration, California's counties inconsistently pay the full cost of inpatient mental health services for Medi-Cal members in these settings, with no direct enforcement by the state for the counties to reimburse providers for services provided.

CHA requests additional information about the average length of stay under this waiver. DHCS indicates that CMS is developing guidance on calculations of average length of stay, and this will be an important consideration for implementation of the waiver. Due to the challenges hospitals have discharging patients from these settings to appropriate care settings, administrative days will need to be factored into this discussion.

In addition, CHA strongly believes DHCS should analyze utilization of institutions for mental disease – specifically hospital-based institutions – under the current Drug Medi-Cal Organized Delivery System waiver to identify any barriers to providing services in institutions under the current waiver. For example, it would be important to know if the population under the current waiver is accessing care through residential treatment facilities, but not hospitals. One question that should be answered is: With the serious mental illness / serious emotional disturbance population, would the state expect increased utilization for psychiatric hospitals? CHA requests that DHCS share this data at a future Behavioral Health Stakeholder Workgroup discussion.

6) Full Integration Plans

DHCS proposes to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. Multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, substance use disorder managed care, and dental) would be consolidated under one contract with DHCS. DHCS solicits feedback on the challenges in implementing a plan that provides medical, dental, specialty mental and substance use disorder services. Hospitals will need assurances that same-day billing prohibitions won't impede providers' ability to seek reimbursement for multiple services rendered to a Medi-Cal beneficiary on the same day.

The full integration plan proposal holds great opportunity to improve care provided to Medi-Cal members. CHA urges DHCS to reevaluate parity compliance once the full integration plans are operational, to ensure that the complex parity requirements are met.

CHA recommends that DHCS ensure the medical outpatient services offered by a hospital (e.g. post-hospitalization and intensive outpatient programs) be incorporated into the available continuum of care for Medi-Cal members. Currently, counties do not avail themselves of the opportunity to contract with these providers. Access to these services helps improve access to care, improve outcomes, and avoid rehospitalization.

CHA requests confirmation that the full integration plans will be DMHC-licensed for the specialty mental health and dental components they are adding. In preparation for full integration plans, CHA notes that county mental health plans should be required to be DMHC-licensed. This will better position them for full integration by ensuring they are prepared to meet the DMHC licensure requirements for specialty mental health.

Last, CHA urges DHCS to make any associated plan-specific memoranda of understanding available on the DHCS website so that Medi-Cal members, providers, and other partners have a clear understanding of their roles and responsibilities in serving Medi-Cal members. It is only through transparency that managed care plans and others may be held accountable for the care provided to Medi-Cal members.

7) Long-Term Plan for Foster Care

DHCS proposes to convene a work group in 2020 of interested stakeholders to consider whether the department should develop a different model of care for children and youth in foster care, including the former foster youth program and transitions out of foster programs and services at age 26. CHA requests to be included in this process, as hospitals are acutely aware of the challenges these children and youth encounter in navigating multiple systems of care. Hospitals have a unique perspective on obstacles to provide care to this vulnerable population. In addition, CHA requests that DHCS include the Department of Developmental Services in its stakeholder process.

MOVING MEDI-CAL TO A MORE CONSISTENT AND SEAMLESS SYSTEM BY REDUCING COMPLEXITY AND INCREASING FLEXIBILITY

DHCS has included in the CalAIM proposal numerous initiatives aimed at standardizing the Medi-Cal program and reducing complexity across all delivery systems, so that Medi-Cal members can receive the right care, in the right place, at the right time. CHA appreciates that the proposals seek to address many concerns raised over the years related to network adequacy/access, care coordination, and opportunities for plan/provider education. We look forward to working with DHCS to implement the proposal so that patients receive the care to which they are entitled.

Hospitals have been concerned about whether DHCS has adequate tools in place to oversee the compliance of managed care plans and mental health plans. The changes DHCS proposes under CalAIM rely more on MCPs and MHPs, without any specific improvements to state oversight and compliance. CHA views this as a potential vulnerability. DHCS should create a more robust and structured process to ensure proposed compliance by both types of plans, and any delegates within their networks.

1) Managed Care

Managed Care Benefit Standardization

DHCS proposes to standardize the benefits provided through Medi-Cal managed care plans statewide, including all institutional long-term care services and major organ transplants. Benefit standardization is a step in the right direction to ensure that the Medi-Cal program is as seamless as possible for patients to navigate. The current system has been challenging for patients to navigate, and it has been increasingly difficult to hold managed care plans accountable in such a complex system. Carving-in the long-term institutional care benefit should come with access and adequate pricing for providers for a robust network. CHA urges DHCS to effectuate these changes to the plan contracts through a full contract amendment process subject to review and approval by the Centers for Medicare & Medicaid Services — avoiding the traditional pathway of an All Plan Letter. These changes should also be a requirement of the plans' delegated network, and CHA urges DHCS to include the requirement to reimburse hospital providers for the administrative days (level 1) that are currently reimbursed in the Medi-Cal fee-for-service (FFS) delivery system, but not in Medi-Cal managed care delivery system.

Under this proposal, DHCS proposes to also include the governor's executive order to carve-out all prescription drugs and/or pharmacy services billed on a pharmacy claim, referred to as Medi-Cal Rx. CHA appreciates DHCS' selection of the association and several hospital members to serve on the Medi-Cal Rx Stakeholder Advisory Group set to begin in January. CHA supports the governor's vision to reform the health care delivery system, expand affordable coverage, increase access, and lower total health care costs — but concerns remain that the Medi-Cal Rx proposal to carve out pharmacy services in Medi-Cal managed care could erode access and quality of care for Medi-Cal members. We look forward to partnering with DHCS to help ensure the Medi-Cal Rx implementation efforts proceed smoothly, while also considering potential solutions to mitigate the indirect impacts to safety-net providers as result of this policy change.

Mandatory Managed Care Enrollment

DHCS proposes to standardize the Medi-Cal categories of aid that will require mandatory managed care enrollment versus mandatory fee-for-service enrollment on a statewide basis. DHCS proposes a two-phased approach to coincide with the discontinuation of the Coordinated Care Initiative program and the transition to a future statewide managed long-term services and support structure: transitioning all **non-dual** eligible populations in 2021 and **dual** eligible populations in 2023. CHA supports this approach, as it seeks to reduce the complexity of the varying models of care delivery in California, which has been a challenge for patients and providers. However, with the increased responsibilities of managed care plans, DHCS must increase oversight of the plans and their delegated entities to ensure that not only are current requirements being met but that the additional layers of benefits and requirements contained in CalAIM are being achieved.

To enhance the real-time assistance for consumers and providers when managed care plans are not meeting their contractual obligations or not providing the necessary case and care management, CHA recommends that DHCS revisit its ombudsman program and create a single point of entry for patients and providers who have concerns with their health plan so that DHCS can track trends regarding patient and provider complaints, to inform systemic improvements. Currently, DHCS maintains a Medi-Cal Managed Care and Mental Health Office of the Ombudsman to answer consumer questions and to resolve complaints. In addition, there is an Independent Ombudsman, a program funded by a federal grant, which offers services to Cal MediConnect members for individuals enrolled in Medicare and Medi-Cal. There is also an independent Long-Term Care Ombudsman program to help patients in nursing and other health facilities and in residential care facilities. Patients and providers need a single point of contact — a “no wrong door” approach — to receive real-time assistance with their health care coverage and to hold plans accountable.

Transition to Statewide Long-Term Services and Supports, Long-Term Care & Duals-Special Needs Plans

DHCS proposes to discontinue the Coordinated Care Initiative Program and begin a transition to a statewide managed long-term services and supports and Dual Eligible Special Needs Plan structure. CHA supports the move to standardize policies and procedures addressing long-term services and supports, long-term care, and Dual Eligible Special Needs Plans throughout the state and agrees that these changes will support streamlined plan oversight, as well as greater consistency in care services.

As DHCS notes in the proposal, the Coordinated Care Initiative provided valuable lessons about the challenges of coordinating between Medicare covered services and Medi-Cal services for dually eligible

individuals. With the transition to CalAIM, it will be important for DHCS to proactively address the issues identified in the Coordinated Care Initiative, including but not limited to enrollment, access to services, prior authorization and appeals, and care coordination between medical care and long-term services and support services. It will be important to clarify plan responsibilities for all dually eligible members, including those enrolled in traditional Medicare FFS, as well as those enrolled in Medicare Advantage or Dual Eligible Special Needs Plan plans.

CHA urges DHCS to develop and implement timely, accessible and clear appeal procedures, especially regarding access to Medicare benefits and the coordination with delegated entities. This is particularly important in the context of prior authorizations and timely access to medically necessary care post-acute hospitalization. This process must include the ability for providers to pursue appeals on behalf of Medi-Cal members, ensure that decisions are made on a real-time basis to allow for care planning, and that managed care plans remain responsible for reimbursement of care during the appeal time frame.

A major concern in the Coordinated Care Initiative was the ability to access post-acute hospital services, in particular skilled-nursing care and medically necessary post-acute care services such as inpatient rehabilitation and long-term hospital services. Plan networks were often inadequate and even inaccurate, in that contracted facilities declined to admit plan members based on clinical or financial concerns. CHA strongly recommends that DHCS consider requiring the following of managed care plans:

- Demonstrate network adequacy based on actual care transitions, rather than a list of “available” beds or facilities.
- Provide reimbursement to hospitals for care that extends beyond the patient’s need for acute medical care while awaiting an appropriate post-hospital in-network care setting.

CHA also seeks additional clarification on how plans will address the needs of dually eligible members, including traditional Medicare FFS members, as well as those enrolled in Medicare Advantage plans. As evidenced by the Coordinated Care Initiative, the issues of enrollment, access to services, prior authorization, and appeals, as well as care coordination between medical care and long-term services and support services, can be particularly challenging for dually-eligible members, and the current proposal provides an opportunity to address these concerns.

Annual Medi-Cal Managed Care Plan Open Enrollment

DHCS proposes to establish an annual Medi-Cal managed care plan open enrollment process for all enrollees in counties where two or more Medi-Cal managed care plans operate. DHCS highlights the annual enrollment period as being consistent with health care industry practices and aligning with best practices for quality health care delivery. CHA agrees with DHCS that the proposal has the potential to enhance managed care plans’ ability to provide appropriate care coordination to Medi-Cal members; however, the Medi-Cal population is a particularly vulnerable and mobile population, unlike populations with employer-sponsored coverage. We urge DHCS to proceed with caution and commit to work with stakeholders to assess implementation of this proposal to ensure there are no unintended consequences and that Medi-Cal members do not experience any undue hardship or disruptions in care.

NCQA Accreditation of Medi-Cal Managed Care Plans

DHCS proposes requiring all Medi-Cal managed care plans to be National Committee for Quality Assurance-accredited by 2025 with the intent of streamlining plan oversight and increasing

standardization across plans. DHCS seeks feedback on requiring accreditation to include the Long Term Services and Supports Distinction Survey, the addition of the Medicaid module, as well as requiring accreditation of plan subcontractors. This proposal holds great promise for meeting CalAIM's overarching goals, including reducing complexity and improving quality outcomes. Given that plans will be significantly expanding enrollment and responsibility under the CalAIM proposal, it is critical to ensure they provide enrollees with quality and timely access to needed services.

Under DHCS' proposal, routine National Committee for Quality Assurance accreditation, in addition to use of the Medicaid module, could constitute the committee's assurance review of plans. It would be useful to fully understand what both routine accreditation and the Medicaid module entail, such as required standards and how they compare to DHCS' current review of Medi-Cal managed care plans.

The ability of the committee to assess how plans perform on its Healthcare Effectiveness Data and Information Set measures, as part of its review, has the potential to drive improved quality in the Medi-Cal program.

These measures could provide invaluable insight into enrollees' health outcomes. Greater specificity on how the committee uses these measures in its review would be appreciated. While DHCS currently includes the scores in its quarterly Managed Care Performance Monitoring Dashboard report, CHA requests that DHCS develop a scorecard specifically for Medi-Cal members' use. With annual open enrollment for Medi-Cal enrollees under the CalAIM proposal, such transparency could support consumers in making informed plan selections and further drive quality in the Medi-Cal program if enrollees can "vote with their feet."

CHA requests clarification on the roles and responsibilities that the committee and DHCS would have under this proposal. Specifically, this proposal states that DHCS would use committee findings to *certify or deem* that Medi-Cal managed care plans meet certain state and federal Medicaid requirements. In the area of health care providers, CMS approves accreditation organizations, whose accreditation of a health care provider then deems that the provider has met Medicare Conditions of Participation. However, if there is a complaint that a provider has violated the Conditions of Participation, CMS, through its regional offices and state survey agencies (for California, the California Department of Public Health) investigates the complaint. Questions that need clarification include:

- Would DHCS similarly consider NCQA accreditation to mean a plan has fully met its requirements for participation in the Medi-Cal program?
- Or, would DHCS have additional oversight?
- How would enrollees and providers file a complaint if the plan is not meeting its obligations?

CHA appreciates that DHCS is considering requiring committee accreditation of managed care plan subcontractors. CHA agrees this is worthy of further discussion, as enrollees deserve the same access to quality services, regardless of whether a plan has retained or delegated risk for an enrollee's care. Delegated entities, specifically independent practice associations and large physician groups, raise a number of challenges, including timely prior authorization, timely access to medically necessary care, and not always displaying a clear knowledge of and compliance with relevant state and federal regulations. This lack of compliance suggests that increased oversight is needed for increased accountability. CHA recommends that DHCS establish a stakeholder work group to discuss the

longstanding care coordination issues inherent in the delegated model to inform steps DHCS should take to address this issue prior to determining if delegated entities should be required to obtain committee accreditation.

CHA requests clarification regarding the interaction that DHCS and the committee will have with DMHC in the development and implementation of this proposal. California is unique both in its broad use of managed care and extensive body of law in the form of the Knox-Keene Act. Questions that need clarification include:

- Will DMHC participate in the CalAIM NCQA Accreditation Workgroup?
- How would DHCS and the committee coordinate with DMHC to refer any violations of the Knox-Keene Act to DMHC?
- Conversely, how would DMHC refer any issues it identifies to DHCS and the committee?

Last, CHA agrees that requiring the Long-Term Services and Supports Distinction is important given the increased responsibility for this care that managed care plans would take on under CalAIM. Greater information about what standards the committee uses in this program and whether there would be transparency around plan performance on these surveys would be helpful.

Regional Managed Care Capitation Rates

DHCS notes in the CalAIM proposal the process by which DHCS and its contracted actuaries develop distinct rates for each contracted managed care plan by county/region, and population group. Specifically, DHCS notes that it calculates multiple rating components for each rate, for over 4,000 annual rating components. As DHCS plans to standardize Medi-Cal managed care benefits and populations, the possibility of reducing administrative burdens by simplifying the rate development work is an attractive option for DHCS, hospitals, and all providers looking to secure quicker CMS approvals. CHA appreciates the two-phased approach proposed in CalAIM. While DHCS proposes only to implement Phase 1 for calendar years 2021 and 2022, CHA urges DHCS to utilize the following key principles as it looks to finalize the policy:

- Consider the provider networks for the existing plans prior to making any changes. While county lines may have historically been the arbitrary divide for setting risk for Medi-Cal managed care, provider networks over the years have adapted to these unique variances and should be considered when looking to create rating regions.
- In creating new rating regions where existing managed care plans that operate in a county organized health system managed care model are “averaged” with plans from another managed care model (Two-Plan Model, Geographic Managed Care Model), the current “county averaging” process should remain to be budget neutral. In an attempt to avoid potential rate shock, any rating region averaging should take place over several years so that providers and plans can adapt to the rate development methodology.
- Changing the rating regions should not impact members’ access to services or provider networks, or create unintended unfair market dynamics with the newly restructured markets. Prior to the finalization of Phase I and Phase II, CHA urges DHCS to conduct an independent evaluation to determine whether the proposed rating regions have any negative effects on these factors.

2) Behavioral Health

CHA applauds DHCS for including several behavioral health proposals with CalAIM, specifically highlighting many of the core issues that impact Medi-Cal members and the providers that serve them today. The current structure for mental health and substance use disorder services is fragmented, misaligned, and many commonly refer to the system as being “broken.” As the California Health Care Foundation reported in 2018, nearly one in six California adults experiences a mental illness of some kind; one in 24 has a serious mental illness that makes it difficult to carry out major life activities; and one in 13 children has an emotional disturbance that limits participation in daily activities. Simply translated —too many Californians need behavioral health services and are at significant risk of having an unmet need.

These Medi-Cal members generally fall into categories where their behavioral health and physical health illnesses are linked, contributing to overall poor health. While CalAIM is an ambitious framework that may provide many solutions, its scope will not address every challenge that exists today, and CHA urges that any measurement of improvement with structural changes be done on an incremental basis with a firm understanding that change will require an ongoing commitment from DHCS, the plans, and the providers that serve these members.

Behavioral Health Payment Reform

Within CalAIM, DHCS acknowledges that transformation of the behavioral health system requires a multi-faceted approach. CHA appreciates the commitment of DHCS, the California Health and Human Services Agency, and the Governor’s Office in making behavioral health a critical priority. An essential first step toward true progress at payment reform is conducting a thorough analysis of the existing financing structure for behavioral health services. When comparing the basic structure for Medi-Cal specialty mental health and substance use disorder services to the physical health delivery system, it quickly becomes obvious that behavioral health systems are significantly behind the payment reform curve compared to other delivery systems.

Payment reform happens almost continuously in the physical health delivery system, especially as providers and payers are willing to move away from cost-based and volume-driven structures to those that incentivize outcomes and quality and population-based accountability. CHA appreciates DHCS’ willingness to transform the reimbursement for these services from a cost-based structure into one that focuses on incentivizing value-based arrangements. It is our understanding that DHCS is considering this initially in two-phases. Below are recommendations to help inform the decision-making process.

- **Transitioning specialty mental health and substance use disorder services from existing Healthcare Common Procedure Coding System Level II to Level I coding (no sooner than January 2021):** CHA appreciates DHCS recognition that the implementation of the Healthcare Common Procedure Coding System Level I coding should begin no sooner than January 1, 2021. CHA urges DHCS to develop an implementation plan — similar to the CalHEERS 24-Month Roadmap — that is made publicly available and includes milestones and opportunities for provider feedback and technical assistance. Even though the Healthcare Common Procedure Coding System Level I coding is an industry standard composed of Current Procedural Terminology, the requirement to bill for more granular services will take time for mental health plans and providers to implement — not only for new billing technology (updating billing

systems), but also the administrative requirements to establish policies/procedures for appropriate oversight and opportunities for adequate provider education.

Hospitals believe it is important for DHCS to ensure that mental health plans have the resources available to implement the new requirements, there is adequate oversight of the implementation efforts (including provider training for the three common classes of providers – independent, group, and hospital), and that mental health plans implement the new requirements in a consistent manner. Last, before DHCS implements the new requirements, CHA urges DHCS to provide insight into how the annual updates to the Healthcare Common Procedure Coding System process impact counties and providers, and develop or share information regarding the ongoing Healthcare Common Procedure Coding System billing expectations.

- **DHCS proposes to establish reimbursement rates and the ongoing rate methodology, and utilize intergovernmental transfers instead of the traditional cost-based certified public expenditure reimbursement methodology (implementation TBD):** CHA appreciates the focus of reducing administrative complexities for the mental health plans, providers, and the state. Reducing the administrative burden that comes with cost-based certified public expenditure reimbursement — the labor-intensive cost-reconciliation and audit process — will provide mental health plans with timely reimbursement, greater flexibility of administrative resources, and the ability to improve services and coordination for Medi-Cal members seeking assistance.

As DHCS evaluates the rate-setting process, specifically the idea of peer grouping mental health plans, CHA urges DHCS to learn from other static peer grouping arrangements that are implemented in the Medi-Cal program. Additionally, while DHCS has indicated it intends to develop peer groupings that would be made up of mental health plans with similar cost structures, CHA urges DHCS to consider the totality of circumstances before finalizing any groupings. In addition to existing cost structure, DHCS should also fully evaluate its provider networks, beneficiary utilization patterns and access to services, and whether the county has a history of fully expending its allocated Proposition 63—Mental Health Services Act funds.

As a fundamental principle with these proposed changes, CHA urges DHCS to implement the proposed changes in a way that ensures the change from certified public expenditures to peer-grouped reimbursement rates will be budget neutral or even result in greater investment in this important area over time. The overall behavioral health system is critically underfunded, and CHA hopes the change from a cost-based arrangement to an intergovernmental transfer system will alleviate any limitations on capping reimbursement to cost.

CHA urges DHCS to conduct more robust oversight of mental health plans before implementing any changes to an intergovernmental transfer methodology. Specifically, DHCS should follow the recommendations of the California State Auditor (CSA; 2017-117) report and implement a process of overseeing the sufficiency of local mental health agencies' Mental Health Services Act fund reserves.

Additionally, in the development of the peer-grouped rates, DHCS should include reimbursement for services provided to the estimated 1 million individuals seeking emergency

psychiatric care in hospital emergency departments across the state. DHCS should also closely scrutinize all mental health plans when it comes to their commitment to incentivizing additional investment in the behavioral health delivery system and address the growing issue of plans excessively issuing administrative denials to hospitals (on average 30 percent of psychiatric inpatient hospitalization claims that are not eligible for an appeal option). Creating a more robust oversight function will demonstrate to providers throughout the state that the CalAIM behavioral health payment reform proposal is here to stay, that DHCS is committed to seeing this through, and that DHCS will provide the necessary and required leadership to ensure the behavioral health delivery system advances with the rest of the Medi-Cal program.

Medical Necessity Criteria for Specialty Mental Health Services and Substance Use Disorder Services
DHCS proposes to modify the existing criteria for both outpatient and inpatient specialty mental health services, as well as substance use disorder services, to align with state and federal requirements and more clearly delineate and standardize the benefit statewide. CHA supports the proposed changes to improve beneficiary experience, increase efficiencies, and ensure cost-effectiveness. CHA is pleased that DHCS is proposing development of new statewide, standardized level-of-care assessment tools. CHA would like to work with DHCS and other stakeholders to identify the appropriate tools. Using a universal assessment tool will help ensure patients have access to the level of care they need and will decrease the inappropriately high denial rates by counties for the critical care that hospitals provide to patients. Hospitals have extensive experience working with clinical decision-making tools with other payers and can bring expertise to this important discussion.

The assessment tool should not be limited to outpatient levels of care and must include the full continuum of outpatient and inpatient care. CHA requests that DHCS clarify which providers will be using the assessment tool and whether the department has contemplated the tool's use to manage the significant influx of Medi-Cal patients served in hospital emergency departments. Given the enhanced care management benefit and in lieu of services proposals, it would be helpful to understand how this assessment tool fits with serving high utilizers with frequent hospital or emergency room visits/admissions. Given DHCS' proposal that the assessment tool be used by counties, managed care plans, and providers, DHCS must contemplate use of the assessment tool in emergency departments. CHA would like assurances that there will be infrastructure in place to support a patient's level of care, as well as incentives for infrastructure development.

Any tool must be accompanied by clear guidance that complies with federal Early and Periodic Screening, Diagnostic and Treatment requirements as they apply to children's behavioral health services. Medical necessity criteria for children's behavioral health services in Medi-Cal are poorly understood and frequently misunderstood, even by state and local health officials. Medical necessity criteria for children are codified in federal law and are broader than the standards that apply to adults, yet the bifurcation created by the realignment of Early and Periodic Screening, Diagnostic and Treatment specialty mental health has created profound confusion for providers and counties, and even the state.

State officials sometimes note the increasing number of children who are being served by Medi-Cal managed care plans because their behavioral health needs are "mild to moderate." Yet, the distinction between "mild to moderate" and "moderate to severe" is one that only applies to adults, not children.

Rather, the responsibility for providing behavioral health services for children in Medi-Cal is governed by Title 9, Section 183205 and 183210, which, in essence, requires county behavioral health agencies to cover services for common behavioral health diagnoses if “the services are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening” (Title 22, Section 51340(e)(3)).

Clear state guidance in this area has been lacking and, as a result, many children struggle to obtain the services they need, while counties refuse to contract with providers for needed services like intensive outpatient and partial hospitalization programs, even in circumstances when such services would obviously be appropriate. The CalAIM process should provide clearer guidance to counties that conforms with the law and hold counties to those standards. Along these lines, we note that the CalAIM proposal to focus on level of impairment may, if not carefully implemented, simply reinforce the current confusion about when counties are responsible for serving children with behavioral health conditions under Early and Periodic Screening, Diagnostic and Treatment.

DHCS proposes to align with federal requirements by allowing physician certification/recertification to document a member’s need for acute psychiatric services. CHA supports aligning with federal requirements. The therapeutic relationship between the treating physician and the patient is the most reliable determinant of a patient’s level of care needs.

DHCS proposes that eligibility criteria, largely driven by level of impairment as well as diagnosis or a set of factors across the bio-psycho-social continuum, should be the driving factor for determining the delivery system in which an individual receives services. With the high prevalence of co-occurring substance use and mental health conditions, CHA recommends that the assessment tool be designed for use across the entire behavioral health care delivery system. Substance use disorder services should not be excluded.

DHCS proposes a no-wrong-door approach for children under the age of 21. DHCS acknowledges that, whether a child presents in the Medi-Cal managed care plan or the mental health plan, each system is responsible for providing services and would be reimbursed for all medically necessary services, even if the child ultimately moves to another delivery system. This no-wrong-door approach for children under the age of 21 should be extended to all eligible Medi-Cal members.

Inpatient Specialty Mental Health Services for Adults and Children/Youth

DHCS indicates it is interested in the concept of providing counties with guidance to address inconsistencies in the mechanisms for authorization and reauthorization of inpatient mental health services, with the goal of establishing a consistent approach that is amenable to the state, counties, and hospitals as the statewide policy regarding implementation of concurrent review (i.e. authorization) of inpatient psychiatric hospital services. CHA looks forward to continuing our discussions with the department and counties related to concurrent review.

We’d like to reinforce our previous request that DHCS include a process for notification of emergency admissions, in addition to authorization and reauthorization for inpatient services, to reduce inappropriate denials and the significant administrative burdens inherent in the current system. As we have previously discussed, DHCS indicates it does not track a significant number of non-medically necessity denials (i.e., administrative denials/non-payment of claims). CHA requests that all county

payment denials for any reason be reported to DHCS and included in the Statewide Aggregate Specialty Mental Health Services Performance Dashboard, by county, and in the aggregate statewide.

Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

CHA appreciates that DHCS proposes the administrative integration of specialty mental health and substance use disorder services into one behavioral health managed care program. Such administrative integration has the potential to improve outcomes for Medi-Cal members through coordinated treatment across the continuum of care, and to reduce administrative and fiscal burdens for counties, providers, and the state. As DHCS pursues this proposal, a thorough assessment of current barriers to administrative integration will be required. CHA urges DHCS to provide stakeholders with transparent information as it identifies these barriers and looks for solutions.

For example, DHCS identifies federal patient privacy regulations as a barrier to the integration of certain administrative and clinical records. Specifically, the regulations at § 42 C.F.R. Part 2 – which govern the confidentiality of substance use disorder patient records – have long been a barrier to integrated, whole-person care for patients receiving services from substance use disorder programs. Notably, and acknowledged by DHCS, the regulations require providers to segregate substance use disorder records from other clinical records in separate electronic health records. This is not only administratively burdensome, but is counter to the goals of coordinated treatment across the continuum of care.

CHA has long advocated for statutory changes that would amend § 42 C.F.R. Part 2 to align with health information privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of treatment, payment, and health care operations. HIPAA regulations were designed thoughtfully, with considerable public input over several years, to carefully and appropriately balance the privacy rights of patients with the important goal of sharing necessary information to provide optimal patient care. HIPAA regulations apply to protect all types of health information that patients may feel is especially sensitive, including mental health, abortion, cancer, HIV, and other sexually transmitted disease records. It is time to stop stigmatizing patients with substance use disorder and treat them similarly to all other patients. CHA looks forward to partnering with DHCS in addressing this and other barriers to integration of specialty mental health and substance use disorder services.

Administrative Integration

Network Adequacy

DHCS proposes to certify one network for specialty mental health and substance use disorder managed care services for each county, instead of certifying two networks as currently required. CHA supports this proposal and requests that network adequacy be considered for the entire behavioral health delivery system inclusive of inpatient care. DHCS' omission of this level of care in DHCS' current network adequacy requirements fails to meet the network adequacy requirements under the Medicaid Managed Care Final Rule and fails to assure access to lifesaving behavioral health treatment provided by hospitals.

Further, CHA recommends that mental health plans and county substance use disorder departments, either individually or together, be required to hold a Knox-Keene license through DMHC. This will prepare them for participating in Full Integration Plans. It will also ensure that Medi-Cal members have the same protections that those in commercial health plans have when it comes to behavioral health.

Behavioral Health Regional Contracting

In recognition that some counties have resource limitations, DHCS proposes to encourage counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal members. As options for how to implement this, DHCS identifies that counties could form a Joint Powers Authority or contract with a third-party administrator, such as the County Medical Services Program. DHCS indicates that small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. In addition, DHCS indicates it is interested in discussing how counties not currently seeking substance use disorder managed care participation may be more interested in doing so through a regional approach and/or how services provided under substance use disorder FFS might also be provided through a regional approach. Finally, DHCS notes that it is committed to working with counties to offer technical assistance and support to develop regional contracts and establish innovative partnerships.

CHA appreciates that DHCS is exploring ways in which regional contracts would allow counties to pool resources to improve access to services for Medi-Cal members in their region, as well as allow for increased county administrative efficiencies and improved compliance with state and federal laws. In particular, CHA appreciates that this could support the expansion of substance use disorder managed care statewide, extending these benefits and coordination to the 7 percent of the Medi-Cal population in counties not currently participating in substance use managed care. However, this proposal does not yet contain any specifics for how DHCS would promote county adoption of these regional approaches (counties can already act jointly today). CHA recommends DHCS provide clarification on what form its technical assistance and support would take.

Given the range of governance forms regional contracting could take, including a third-party administrator that is a private entity, as well as transparency and local stakeholder engagement, will be critical. CHA requests that counties electing this option be required to convene formal quarterly regional advisory councils composed of all providers (hospitals, skilled-nursing facilities, community health centers, etc.) and community partners to foster communication, transparency, and to ensure all parties are clear about all aspects of CalAIM implementation. For the meetings to be inclusive, they should be open to the public, and DHCS should maintain on its website links with information about each meeting. Counties should be required to report to DHCS on the feedback provided at each meeting and how the mental health plan will address the feedback. This information should be made publicly available in a timely manner. Additionally, as described in greater depth in the behavioral health payment reform portion of this letter, CHA requests that DHCS monitor counties' contracting practices and provide more robust oversight to ensure they are contracting with available providers and expending the funds available for services.

Substance Use Disorder Managed Care Program (Drug Medi-Cal) Renewal and Policy Improvements

DHCS proposes to incorporate the Drug Medi-Cal Organized Delivery System into a comprehensive Section 1915(b) waiver that would include the Medi-Cal managed care plans, mental health managed care plans, and substance use disorder managed care plans. DHCS indicates there are currently 30 counties participating in the substance use disorder managed care demonstration, providing access to treatment services for 93% of the Medi-Cal population. With escalating suicide rates and opioid deaths, CHA recommends that every county be required to provide substance use disorder managed care

services. Given that Proposition 30 requires the state to cover the costs of any new local mandate, we recognize the fiscal challenges with this proposal. However, efforts must continue to ensure all Medi-Cal members gain access to these benefits. The only proposal in CalAIM that would specifically support expanding substance use disorder managed care statewide is regional contracting. However, as CHA notes earlier in this letter, that is an option *already* available to counties. CHA requests DHCS provide greater clarification on how it will increase access to this program statewide.

DHCS proposes that the definition of residential treatment be updated to remove the adolescent length-of-stay limitations, and to add mandatory provisions for referral to medication assisted treatment. CHA additionally recommends that DHCS require that county substance use disorder departments participating in substance use managed care provide medication assisted treatment for substance use disorders in emergency departments. Through the Bridge Program, emergency departments are providing a key intervention for individuals with opioid use disorders who overdose by providing them with medication assisted treatment and linking them to services. To scale up the Bridge Program and ensure its continued sustainability, county substance use disorder services ought to begin funding these services in emergency departments and be required to include emergency departments in their networks. In addition, CHA recommends that DHCS revisit the current voluntary inpatient detox benefit policy under the current Drug Medi-Cal Organized Delivery System waiver. CHA requests that DHCS revisit the medical necessity criteria to clarify and ensure that patients can voluntarily access the benefit prior to exhibiting withdrawal symptoms. In addition, CHA requests that DHCS convene stakeholders to discuss additional improvements that can be made to the voluntary inpatient detox benefit to promote and enhance access.

3) Dental

New Dental Benefits and Pay for Performance

DHCS proposes the following reforms for Medi-Cal dental be made statewide in order to progress toward its goal of achieving at least a 60 percent dental utilization rate for eligible Medi-Cal children: 1) adding new dental benefits, based on the successes of the Dental Transformation Initiative, that will provide better care and align with national dental care standards, and 2) continue and expand pay-for-performance Initiatives that reward increasing the use of preventive services and establishing/maintaining continuity of care through a dental home for enrollees statewide. CHA appreciates DHCS' focus on addressing the whole person and its recognition that oral conditions have an impact on overall health — a policy consistent with the restoration of the optional benefits included in this year's final budget.

4) County Partners

Enhancing County Eligibility Oversight and Monitoring

DHCS proposes a phased-in approach to working with counties to increase program integrity with respect to eligibility and enrollment. Ensuring Medi-Cal eligibility services are provided in a standardized and consistent manner statewide is a crucial step toward achieving DHCS' larger vision for CalAIM. CHA appreciates DHCS' increased oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment. CHA also appreciates the activities of DHCS' contracted partners and the steps DHCS is taking to implement the recommendations of the California State Auditor's Office to ensure that eligible individuals do not encounter unnecessary hardship and are not inappropriately denied services due to discrepancies between the state and county eligibility systems.

Enhancing County Monitoring and Oversight: California Children's Services and Child Health and Disability Prevention

DHCS proposes to provide enhanced monitoring and oversight of all 58 counties to ensure California that the care provided to children served by the California Children's Services program and Child Health and Disability Prevention program is delivered in a standardized and consistent manner. DHCS indicates it will develop initial auditing tools to assess current county operations and compliance and will then evaluate and analyze the findings gathered during audits to identify gaps and vulnerabilities across counties within the programs. CHA appreciates DHCS' commitment to eliminate disparities in care provided to California's most vulnerable children by addressing county variance in program operations and compliance with federal and state laws. CHA requests that DHCS include stakeholders in the development of the memoranda of understanding between the state and counties, which will be developed to ensure these programs are being managed appropriately and that targeted interventions identified through DHCS' development of a strategic compliance program are implemented.

Improving Beneficiary Contact and Demographic Information

DHCS proposes to convene a work group of interested stakeholders to provide feedback and recommendations on ways in which contact and demographic information can be updated by other entities, as well as how to accomplish this while maintaining compliance with state and federal privacy laws. CHA appreciates DHCS' recognition that, as DHCS makes improvements in its approach to population-based health care, it is critical that Medi-Cal providers, managed care plans, county partners, and others have access to accurate, up-to-date contact and demographic information for Medi-Cal members.

CHA requests to be included in DHCS' stakeholder engagement process as the department develops recommendations for implementing improvements in how contact and demographic information can be updated by entities other than county eligibility staff. Hospitals are experienced in providing culturally and linguistically competent outreach, education, and eligibility and enrollment assistance — helping Californians enroll, and stay enrolled, in health coverage.

Last, CHA understands the CalAIM framework focuses on a broader delivery system, as well as on program and payment reform across the Medi-Cal program. CHA urges DHCS to continue its strong efforts to address the looming workforce crisis. As DHCS considers the future of the Medi-Cal program, it is important to also consider the growing gaps in the health care workforce. In February 2019, the California Future Health Workforce Commission issued a report that identified a strategy to help strengthen the state's health workforce by 2030. Given one of three Californians is enrolled in Medi-Cal, the sustainability of the health workforce in the future will have direct implications on the Medi-Cal program.

Of the 10 priorities identified by the commission, CHA recommends DHCS support the expansion of primary care physician and psychiatry residency programs, and recruit and train students from rural areas to practice in their home regions. As evidenced by the success of the Proposition 56 Loan Repayment Program, the need for resources to address the growing workforce challenges cannot be should be prioritized. CHA urges DHCS to consider making the existing time-limited loan repayment programs more permanent commitments and expand graduate medical education programs — including a particular focus on mental health providers — throughout the state.

CHA appreciates the opportunity to provide these initial recommendations on the CalAIM proposal. Comments were prepared in an effort to meet DHCS' compressed timeframe to review and provide feedback. Should we identify other areas of concern, we will submit our comments to DHCS in an expeditious manner. In the future, we would appreciate a standard 30-day comment period on every written document that DHCS releases for stakeholder input. We would also appreciate if the department would make publicly available a summary of all comments received and the reasons the department may or may not proceed in the direction stakeholders have recommended.

We look forward to participating in the stakeholder engagement effort and in the discussions that will occur over the next several months to inform the final approach to each element of the CalAIM initiative prior to submission for CMS approval. In addition, we look forward to partnering with DHCS on provider education as the CalAIM initiative is implemented.

If you have any questions, please contact me at (916) 552-7543 or akemp@calhospital.org, or my colleague, Ryan Witz, at (916) 552-7642 or rwitz@calhospital.org.

Sincerely,



Amber Kemp
Vice President, Health Care Coverage



Ryan Witz
Vice President, Health Care Financing

cc:

Dr. Mark Ghaly, Secretary, California Health and Human Services Agency
Ms. Mari Cantwell, Chief Deputy Director, Health Care Programs
Ms. Jacey Cooper, Senior Advisor, Health Care Programs
Ms. Sarah Brooks, Deputy Director, Health Care Delivery Systems