DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
February 12, 2020

MEETING SUMMARY

Members Attending: Bill Barcellona, America's Physician Groups; Doreen Bradshaw, Health Alliance of Northern California; Michelle Cabrera, County Behavioral Health Directors Association; Paul Curtis, CA Council of Community Behavioral Health Agencies; Lisa Davies, Chapa-De Indian Health Program; MJ Diaz, SEIU; Anne Donnelly, San Francisco AIDS Foundation; Michelle Gibbons, County Health Executives Association of CA; Kristen Golden Testa, The Children's Partnership/100% Campaign; Carrie Gordon, CA Dental Association; Barsam Kasravi, Anthem Blue Cross; Anna Leach-Proffer, Disability Rights CA; Kim Lewis, National Health Law Program; Farrah McDaid Ting, California State Association of Counties; Erica Murray, CA Association of Public Hospitals and Health Systems; Linda Nguy, Western Center on Law and Poverty; Gary Passmore, CA Congress of Seniors; Andie Patterson, California Primary Care Association; Chris Perrone, California HealthCare Foundation; Cathy Senderling, County Welfare Directors Association; Al Senella, CA Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Stephanie Sonnenshine, Central California Alliance for Health; Bill Walker, MD, Contra Costa Health Services; Ryan Witz, California Hospital Association; Anthony Wright, Health Access CA.

Members Attending by Phone: Maya Altman, Health Plan of San Mateo.

Members Not Attending: Richard Chinnock, MD, Children's Specialty Care Coalition; Michael Humphrey, Sonoma County IHSS Public Authority; Sherreta Lane, District Hospital Leadership Forum; Kiran Savage-Sangwan, CA Pan-Ethnic Health Network; Jessica Rubenstein, CA Medical Association; Jonathan Sherin, LA Department of Mental Health; Stephanie Welch, Department of Corrections and Rehabilitation.

DHCS Attending: Richard Figueroa, Jacey Cooper, Anastasia Dodson, Jennifer Lopez, Lindy Harrington, Erica Bonnifield, Norman Williams, Morgan Clair.

Public in Attendance: 39 members of the public attended in person and 282 participated by phone.

Welcome, Introductions and Opening Comments
Richard Figueroa, Acting Director, DHCS

Acting Director Richard Figueroa opened the meeting and welcomed SAC members. He welcomed three new members: Andie Patterson, California Primary Care Association; Doreen Bradshaw, Health Alliance of Northern California; and Ryan Witz, California Hospital Association. He also announced that the new DHCS Director will be Dr. Bradley Gilbert. Dr. Gilbert participated in SAC as a member during his tenure as CEO of Inland Empire Health Plan and will join DHCS in February. This is the last SAC meeting for Acting Director Figueroa as he is returning to the Governor's Office. He also announced that Jacey Cooper is the newly appointed Chief Deputy Director for Health Care Programs

and the State Medicaid Director.

In opening comments, Acting Director Figueroa spoke to the newly released public charge implementation date (February 24, 2020) and federal instructions. The Administration is reviewing the information and working through the implications for state programs. For individuals or groups trying to understand how this will impact California, the California Health and Human Services Agency (CHHS) website information is being updated and is serving as the main referral for information and resources (https://www.chhs.ca.gov/blog/2020/02/24/update-chhs-public-charge-guide-2/). We are reviewing to identify important information we need to clarify, however the implications are specific to each person and family and they will need to get legal help for individual questions.

Questions and Comments

Cathy Senderling, County Welfare Directors Association: Across all programs, eligibility workers expect to be swamped with questions. We appreciate CHHS working with us on an initial toolkit. We hope that DHCS will work with California Department of Social Services (CDSS) on messaging. We are working on Gabrielle Lessard at National Immigration Law Center to put together training and we want your review to ensure we are aligned.

Richard Figueroa, DHCS: Gina Da Silva is the point person in the Governor's Office for all activity across DHCS, CDSS and other departments. We agree and appreciate the opportunity to be in sync.

Kim Lewis, National Health Law Program: We echo the concerns. We are working on resources for health advocates since they are the front lines and will also receive questions. It will be important to have some resources, so there is information advocates can rely on.

Richard Figueroa, DHCS: Thanks, we have noted some misinformation in the press. We are trying to offer information, so everyone knows what this means. We are also being careful because it is a fine line to offer information and not venture into legal guidance.

Linda Nguy, Western Center on Law and Poverty: There is a pressing need to get this information out quickly. I appreciate county and state staff can't offer legal advice, but want to make sure that resources like the Health Consumer Alliance are listed.

Richard Figueroa, DHCS: There is a list of resources on the CHHS website. Please let us know if there is something missing from that list.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Last year when the rule was first announced, there was a press conference about pro-active steps California would take in response along with messages that California is a safe place for immigrants. Are you thinking through policy to counter the chilling effect of these policies? We have some ideas on this.

Richard Figueroa, DHCS: Gina Da Silva could speak to that. I will take the comment back to

her about the broader message of inclusion. I don't know if there is any campaign anticipated.

Andie Patterson, California Primary Care Association: We appreciate you doing two jobs for these past months.

State HHS Budget Update: Current and Proposed
Jacey Cooper, DHCS

Jacey Cooper reviewed the highlights of the budget and there is information posted on DHCS website (https://www.dhcs.ca.gov/Documents/Budget_Highlights/DHCS-FY-2020-21-Governor%27s-Budget-Highlights.pdf). For 2020-21, the Administration proposed a $107.4 billion budget with notable $695 million budget for California Advancing and Innovating Medi-Cal (CalAIM) from the General Fund to Medi-Cal and annually $1.4 billion thereafter.

The budget includes the following proposed General Fund expenditures:

- $450 million for Enhanced Care Management (ECM) services for high risk individuals.
- $115 million for In Lieu Of Services (ILOS) for housing and wraparound services.
- $600 million for incentive payments to expand ECM and ILOS statewide.
- $225 million for transition of the Dental Transformation Initiative to statewide.
- $45 million for Behavioral Health Quality Improvement Program for counties to make system changes, including payment reform.
- Full scope expansion for undocumented adults aged 65+.
- Updated Medi-Cal Rx savings. There is trailer bill language to remove the six prescription limit and eliminate the $1 copay.
- $105 million supplemental pool for non-hospital 340B clinic pharmacy claims.
- There is trailer bill language to create flexibility to negotiate pharmacy rebates for Medi-Cal and savings for non-Medi-Cal state-only programs through other pharmacy rebates.
- Transition out of Dental Managed Care into fee-for-service (FFS) statewide.
- Nursing facility financing reform through value based purchasing and quality reforms.
- Additions to cover all Medication Assistance Treatment (MAT) services to expand access.
- $10 million for hearing aid and related services for non-Medi-Cal children under 600% of poverty.

Questions and Comments

Barsam Kasravi, Anthem Blue Cross: Is there coordination or overlap between the Behavioral Health Quality Improvement item you mentioned and the Behavioral Health Integration grant funding running through managed care plans? We have lots of interest in the grants – over 40 applications.

Jacey Cooper, DHCS: They are two very different initiatives with similar names. The Behavioral Health Integration is through Prop. 56 and focuses on integration at the provider level. The budget figure I referenced for the Behavioral Health Quality Improvement

Program is funding directly to counties to update systems and processes for delivery system and payment reform.

Anthony Wright, Health Access CA: We are excited about the expansion of Medi-Cal regardless of immigration status. Since this is related to the previous conversation about public charge, what is your thinking on the implications and how to be welcoming? What are you observing about enrollment for the youth expansion in Medi-Cal?

Jacey Cooper, DHCS: I can get back to you on the young adults. We want to make Medi-Cal as welcoming as possible while disclosing the information individuals need during the application process.

Anthony Wright, Health Access CA: What is the timetable for the Medi-Cal Rx initiatives? How do the various proposals on pharmacy such as generic manufacturing interact with Medi-Cal?

Jacey Cooper, DHCS: The Governor is approaching pharmacy from several angles. Medi-Cal is one-third of the state population and has a large impact. We will work closely with the CHHS and Department of Finance on the interactions going forward or federal waivers that we would need.

Richard Figueroa, DHCS: There are phases that are important here. There are some items that are state-only changes and do not involve federal approval. Other proposals, like creating our own pharmacy label, would require federal approval. Some aspects of the overall policy approach are short-term; others are long-term, like Golden State and generic manufacturing. DHCS analysis of the executive order has given us some ideas about what we can do shorter term to realize state savings in the Medi-Cal program while we work on the longer term. We don't want to forestall any current-year budget savings while we address longer term changes.

Anthony Wright, Health Access CA: Is there a timeline for the various proposals?

Jacey Cooper, DHCS: For example, if Medi-Cal "best price" goes into effect through the budget, we could use that immediately. On rebates for non-Medi-Cal populations, we are discussing this with CMS about a variety of issues, including what guardrails we need to consider. There is no specific timeline in place.

Richard Figueroa, DHCS: No state has taken CMS up on this option before so there is a lot of discussion and learning to work through.

Anthony Wright, Health Access CA: Can you provide an update on the Managed Care Organization (MCO) tax?

Jacey Cooper, DHCS: The original MCO tax submission was denied on January 30 by CMS. We explored options, including legal options, and this week submitted a modified MCO tax proposal to CMS (https://www.dhcs.ca.gov/services/Documents/CA-MCO-Tax-Modified-Model-2-10-2020.pdf). We believe it addresses the CMS concerns.

Kristen Golden Testa, The Children's Partnership/100% Campaign: We are thrilled about the further expansion of coverage for adults and the children's hearing aid services. We have concern and disappointment that CalAIM didn't include promotion of preventive care utilization for children, especially given the audit report last year on the data. Is there a DHCS estimate about whether there will be an uptick in utilization results? If not, are there things that can be done to improve this?

Jacey Cooper, DHCS: CalAIM includes population health management that requires plans to move forward on preventive services for children and adults. We are also moving ahead on a media and outreach approach for beneficiaries to know their rights about what preventive services are available. Given that DHCS is moving this strategy, we did not propose a specific child program. We are interested in your input about how to strengthen the population health management specifics for children. There is a focus through ECM on children with complex needs. Also, we will announce a foster care workgroup in March.

Kristen Golden Testa, The Children's Partnership/100% Campaign: On the campaign, will that contract go through public review?

Jacey Cooper, DHCS: Yes, it will go through public review. We look forward to working with all of you on that campaign in 2020.

Anne Donnelly, San Francisco AIDS Foundation: On the Medi-Cal Rx, where will the details come out? I have questions about using international reference pricing because there are only a small number of drugs included and it is usually coupled with strict utilization management to get those prices. How does the rebate fit with reducing best price because usually when we see best price, we see a decrease in rebates?

Jacey Cooper, DHCS: Medi-Cal RX is about carving out pharmacy from managed care plans to FFS. This will be discussed in Medi-Cal Rx Advisory Group. The issues of rebates or best price will not be discussed there. We can get back to you about the interactions when we have done some analyses. Anytime we do get a supplemental rebate, it does usually come with a utilization contract related to prior authorization. I can connect you to our pharmacy experts to discuss this further.

Anne Donnelly, San Francisco AIDS Foundation: I appreciate there is a prevention and wellness focus on population health management, and also think there should be deeper dive and accountability on quality of services. For example, the uptake on pre-exposure prophylaxis for HIV has been slow and we would want to see more accountability on that.

Farrah McDaid Ting, California State Association of Counties: Thanks to the administration for including the Behavioral Health Quality funding and look forward to working with you on this.

Kim Lewis, National Health Law Program: In moving away from dental managed care and moving to include dental in the full integration plans, can you offer thoughts about the policy direction? Leaving people to find dentists on their own is not working and I am not sure this

is solving anything. How is DHCS working to improve access?

Jacey Cooper, DHCS: Historically, there is even lower utilization on managed care than FFS and it costs more. We acknowledge we need to improve statewide utilization for dental, especially for children. We will continue to advance dental through CalAIM, encourage the Dental Home and ensure access. We look forward to seeing the San Mateo pilot to carve dental into managed care as we continue to develop policy for full-integration plans.

Linda Nguy, Western Center on Law and Poverty: On dental, specific to silver diamine fluoride, the budget says it's for children only?

Jacey Cooper, DHCS: It covers children 0-6, SNF and disability population as outlined in CalAIM.

Linda Nguy, Western Center on Law and Poverty: On DTI expansion to adults, is there an impact on Prop. 56? Will there be the same requirements for providers related to prevention?

Jacey Cooper, DHCS: There will be a transition in DTI to a statewide program. We are still evaluating the impact on Prop. 56, so more on this to come later.

Maya Altman, Health Plan of San Mateo: How will the SNF financing reform to move revenues toward quality and the requirements for managed care plans to cover long term care interact?

Jacey Cooper, DHCS: We will change the rate year for SNF reform to align with managed care rate years so it can be incorporated into managed care rates. We will require both plans and facilities to continue to take the FFS rate. This does not preclude a mutual agreement between a plan and a SNF on other arrangements if they wish.

Carrie Gordon, CA Dental Association: On behalf of the California Dental Association, we are committed to exploring options around full integration. While we thought Dental Managed Care just needed more structure and attention, we have learned that they have not met the FFS levels and the goal was more than FFS. We agree with ending this program and direct attention to other promising approaches, like San Mateo.

CMS Draft Guidance on Medicaid Fiscal Accountability Regulation (MFAR) and DHCS Response
Jacey Cooper and Lindy Harrington, DHCS

Lindy Harrington provided a high level overview of CMS draft guidance on MFAR. CMS released the notice of proposed rule-making in November 2019 on a wide range of Medicaid financing and reporting requirements. DHCS submitted a comprehensive response letter in January 2020. CMS said the draft guidance provides accountability and transparency and clarifies existing policy. Our position is that this goes far beyond existing policy and current practice, especially related to sources of non-federal share and supplemental payments. We are requesting adjustments in four major areas:

1. Sources of Non-Federal Share: CMS proposes to restrict non-federal share to state and local taxes, which is problematic for California. This would prohibit using fees from Intergovernmental Transfers being collected from the state and restricts permissible state share to General Fund, which excludes special funds. Finally, it imposes a two-year reconciliation timeline of certified public expenditure (CPE) payments. We asked they revert to the existing public funds language or add substantial clarification to recognize the legitimacy of patient revenue, other sources of state and local funds, special funds and acknowledge other state agency appropriations.
2. Provider Tax Waiver: CMS broadened its discretion to evaluate whether a waiver for a provider tax complies with requirements. This discretion is in addition to the statistical standard used today and renders the current test useless by allowing CMS other discretion to deny a waiver. We asked they rescind the undue burden test proposed or at a minimum allow a safe harbor of 3:1 allowable magnitude of activities to remove some CMS discretion.
3. Additional Discretion on Supplemental Payments: There is additional scrutiny on the purpose and criteria of payments. There is a three-year time frame for supplemental payments and limits the total payment to be calculated by individual providers. We asked for additional clarification, an extended timeline and staggered phase-in for implementation.
4. Reporting Requirements: This requires annual reporting of any non-state source and payments to providers by 60 days after the end of a fiscal year. There are new, significant reporting requirements by provider and the proposal gives CMS the authority to withhold FFP payments for non-reporting.

We believe these are significant changes and we requested states have at least five years after finalizations for changes to become effective, and limiting the new reporting to a single annual report due one year after the close of a fiscal year to make this administratively feasible.

Questions and Comments

Andie Patterson, California Primary Care Association: Are we working with other states that will also be burdened by this? I am concerned about the overall Medi-Cal program implications. As I recall, this represents billions of dollars of potential loss for California. I am concerned about the public hospital system and the Medi-Cal delivery system. Can you comment on the likelihood of implementation? Also, can you comment on the relationship between this and the released block grant guidance?

Jacey Cooper, DHCS: We are working with other states and have had multiple calls with other Medicaid directors about the rules, as well as partners within the state. There is no question that, if implemented as written, it would have a serious impact on California. We took a detailed approach in our comment letter. There is a lengthy process that requires CMS to address each comment before finalizing the rules. State Medicaid directors had a call with CMS about overarching concerns and lack of engagement with states prior to issuing the proposal. We are analyzing the block grant opportunity and will keep you

updated, although there are concerning elements.

Erica Murray, CA Association of Public Hospitals and Health Systems: The public health care systems would be decimated if finalized as written. We estimate it would reduce by 1 million patients in just two health systems and perhaps as many as five health systems would close. Local health systems have figured out how to supplement low Medi-Cal base rates to continue to serve, and if that is rolled back, it would be devastating. We appreciate the collaboration and support from the state and everyone here to ensure that the rule is not finalized as it stands. We are working with colleagues across the country to ensure this is not implemented. Supplemental payments going back years would be impacted as well as current. As we look at this Administration, we need to develop contingencies and begin to strategize about how this might play out. The way forward is not predictable, and the administration could finalize this through many pathways, finalize part of it, delay implementation, or other scenarios.

*Ryan W*itz*, California Hospital Association*: I appreciate the opportunity to review and submit comments. There are over 4,000 comments submitted to CMS on this rule. We are also wondering about any retroactive aspects of the proposal to the MCO tax?

Lindy Harrington, DHCS: The reason cited for MCO tax denial was our hold-harmless and structure we have in place. As stated, it was not a retroactive application of the proposed rule. It was related to having tiers for plans that they determined did not meet current requirements. We have modified this aspect of the proposal.

Carrie Gordon, CA Dental Association: Thanks to DHCS for getting this out quickly and it was helpful to other states as well as here in California.

Anthony Wright, Health Access CA: Who is the point person at DHCS?

Jacey Cooper, DHCS: Either Lindy or I are point for this.

Coverage Expansion to Undocumented Young Adults
Rene Mollow, DHCS

Erica Bonnifield, on behalf of Rene Mollow, offered an update on the coverage expansion [to cover otherwise eligible young adults regardless of documentation up to age 26]. The young adult expansion was implemented in January 2020. We worked with our county partners and others on beneficiary notices and FAQs and issued an All County Letter that are posted on the website. There was a batch process through the Statewide Automated Welfare Systems (SAWS) to transition those already enrolled in restricted scope Medi-Cal over to full scope. Approximately 80% of the estimated 67,000 eligible young adults were transitioned. We are working through cases that did not correctly transition to clean up. We are working on updated data sets that we will post next month showing data on those who transitioned (81%), those who remain in restricted scope (10%) or discontinued (9%).

Questions and Comments

Anthony Wright, Health Access CA: Over what time period were they in restricted scope? Is there a redetermination process?

Erica Bonnifield, DHCS: I can take that back to clarify but that is my understanding that there was point in time data used to identify the population for transition.

Anthony Wright, Health Access CA: Do we have any tracking of utilization of those who transitioned?

Erica Bonnifield, DHCS: I do not have that information ready available, but can check with the team to see if I can get that information for utilization post-transition.

Financing Medi-Cal Healthier California for All: Shared Savings and Incentives
Lindy Harrington, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/MC-FinancingConsiderations.pdf

Jennifer Lopez provided an update on the financing considerations of CalAIM, including Enhanced Care Management, In Lieu of Services, Seniors and Persons with Disabilities (SPD)/Long-Term Care (LTC) Blended Rate and Shared Risk/Savings and the Incentive Program.

Enhanced Care Management (ECM): This is a new State Plan benefit that will replace the current Health Homes Program (HHP) and elements of the Whole Person Care (WPC) pilots to provide a whole-person approach to care for high cost and/or high-need members. The benefit is for intense and targeted case management outside the four walls to address clinical and non-clinical needs. By January 2021, counties with WPC or HHP will implement ECM and by July 2021, all counties will go live. This has rate implications. The assumption is that 1% of members will be served through ECM and the funding for these services will be included in the managed care plan base capitation rate. This is different than previous payment methods for HHP that were based on actual utilization via a supplemental payment. The rate considerations will include outreach and engagement because plans and providers may need to reach out to an estimated 2-3% of members to engage the targeted 1%. The assumption will differ for non-HHP/non-WPC counties because they are in different starting places. DHCS will use the HHP rate as a starting point for rates. We have heard from plans about the importance of having rates well ahead of implementation to set up contracts and be ready to implement. We plan to provide rates five months ahead.

In Lieu of Services (ILOS): This is not a benefit but a cost-effective alternative to benefits that are voluntary for the plan and for the member. There are 13 ILOS proposed in CalAIM, such as housing navigation, nursing facility transition and sobering centers. These are the only ILOS which plans may propose for funding in rates. There are federal requirements for ILOS that must be met. The major change is that we are able to include the expenses for ILOS into rates. Rate considerations will include looking at WPC pilot data to crosswalk

services provided to the list of ILOS to translate to rate development. ILOS will not be a new rating category. For example, recuperative care ILOS will replace inpatient days.

Seniors and Persons with Disabilities (SPD)/Long-Term Care (LTC) Blended Rate (SPD/LTC): DHCS will utilize a blended SPD/LTC rate-payment structure to incentivize the use of home- and community-based alternatives to long-term institutional care. Both SPD and LTC populations are acute populations. There will be variation on which and when plans receive this blended rate. For example, CCI counties already have a form of blended rate and will not implement this until 2023 when CCI ends. For non COHS/non-CCI counties, a risk provision will be implemented to control for projected member mix vs. actual member mix differences. The blended rate is based on projected member mix, but we recognize we may not be perfect in these projections for each individual plan. We will true-up the projected assumptions through actual member mix. After the rating period, we will do a post period rate of expenses and revenue through tiered risk sharing. There will be a time delay in when data is collected and when it applies to the rates so that beginning in calendar year (CY) 2024, ILOS utilization in CY 2021 will be considered in rate development.

Incentive Program: Incentive payments do not need to be included in approved rates if they are less than 5%. The incentives are for public and private plans; they are time-limited and linked to performance during the rating period; and they are for performance measures tied to the State's quality strategy. The Governor’s budget includes incentive payments to reward plan investment in ECM and ILOS implementation. It will reward plans that meet milestones. There will be a public process to determine what should be incentivized and we are requesting feedback from plans and providers by February 29.

Questions and Comments

Erica Murray, CA Association of Public Hospitals and Health Systems: We appreciate the open process. It is clear DHCS is open to ideas and input. Public health systems are central providers in WPC and we approach the new proposals from the point of view of ensuring successful transition of WPC. I commend you on hearing our concerns about rates. It makes sense to base these on HHP and plans have spoken to the difficulty in planning without knowing rates. You said ECM is not based on utilization; how will this work?

Jennifer Lopez, DHCS: There is a trigger in the current HHP of actual inpatient utilization to release payments. We are targeting 1% using this method and incorporating assumptions about outreach. The actual numbers may differ plan to plan.

Michelle Gibbons, County Health Executives Association of CA: The target population description is broad. How did you come up with the 1% projection? Also, can you speak to how you will hold plans accountable on the outreach? You mentioned the 13 ILOS options. Are you considering additional ILOS, particularly for asthma mitigations?

Jacey Cooper, DHCS: We have worked with Mercer Government Human Services Consulting (Mercer) to inform the definitions and rates. In regard to ILOS, it is currently the 13, but we are still reviewing the asthma in-home proposal. We may roll out the 13 as we continue to review.

Jennifer Lopez, DHCS: The 1% is a projection. We think the 1% is achievable but it could change over time. Some members may remain on ECM; others may graduate so the rate will have some churn in and out. Future rates will be tied to both ILOS and ECM utilization and the Managed Care Quality and Monitoring Division will ensure that activities occur. We are still refining this through stakeholder input and once the policy becomes set and is rolled out, the rates will become more definitive.

Jacey Cooper, DHCS: The 1% refers to the entire population in managed care. This is different than how WPC and HHP were calculated. Plans suggested an outreach target of 3% and that is under review by Mercer. We are hesitant to be too prescriptive on the number of outreach and engagement activities because this population is difficult to engage, especially the homeless. We don't want to put an unrealistic number forward. We are thinking through how to establish parameters for this.

Michelle Gibbons, County Health Executives Association of CA: Is outreach only for their members?

Jacey Cooper, DHCS: Yes, we can only hold plans accountable for members.

Chris Perrone, California HealthCare Foundation: What is the public stakeholder process mentioned on the slide?

Jacey Cooper, DHCS: These are the ongoing CalAIM stakeholder workgroups and this topic is scheduled for the CalAIM stakeholder meeting next week.

Chris Perrone, California HealthCare Foundation: On your focus of ECM incentives to the 1%, Kristen raised the issue of preventive services and the quality strategy is broader than the 1%. I'm wondering why this is focused on 1%.

Jacey Cooper, DHCS: It is focused on ILOS and ECM. We learned from WPC that there is a long timeline to build capacity and do workforce readiness for services. We know there are severe deserts for these services, and we want to use the incentive dollars upfront to help build statewide infrastructure in places where that doesn't exist. For example, recuperative beds do not exist in parts of the state. We can look at other things with incentive dollars and we are looking for proposals of metrics, capacity building, workforce or other things that improve success for ECM and ILOS.

Chris Perrone, California HealthCare Foundation: You provided examples for ILOS and how they affect rates. It suggested almost that rates might be reduced based on lower utilization. Can you play out an example?

Jennifer Lopez, DHCS: Looking at a non-WPC county, we will review historical outpatient, emergency, inpatient utilization and cost trends to project it forward. We will not reduce rates based on ILOS – we will add dollars based on the replacement services to be offered. For WPC counties, we look at what the expected cost would be if an ILOS went away, for

example if recuperative care beds went away, so we can build that into the rates. In the early years, there will be shared savings for plans and the state. For the out years, we will have to learn and discuss with CMS how to incorporate savings and increased ILOS utilization into rates for 2024. Our intention is not to cut rates. It is very complex, and we will continue to have discussion of the actuarial soundness.

Doreen Bradshaw, Health Alliance of Northern California: Some providers manage multiple complex patient programs. I want to stress the importance of moving to universal criteria and a simpler reimbursement method to reduce the complexity of managing this at the provider level. For those providers and counties not in WPC, is there training envisioned? How will this intersect with Targeted Case Management (TCM)?

Jacey Cooper, DHCS: DHCS is working on a technical assistance (TA) toolkit for areas transitioning WPC and those without WPC or HHP for plans and providers. In January, we announced a phased approach for ECM to allow more time. The original proposal said no TCM for managed care members; however, we have revised the proposal to say if beneficiaries are getting ECM, the member would not receive any TCM. This is based on CMS guidance during WPC to ensure no duplication between WPC and TCM. We don't know if CMS will accept this middle ground, but that is what we will propose.

Andie Patterson, California Primary Care Association: Given that ECM is based on HHP, did we save money? Did we learn from that program? On rates, is there a method to evaluate whether rates are sufficient? If this is not captured in a rate cell, is there a way to evaluate this? Clinics appreciate the proposals here, but we have concern about the capacity of health plans to accomplish the work. Where are discussions happening about plan capacity?

Jacey Cooper, DHCS: We have not completed the evaluation of HHP, and it is not a straight comparison to ECM. We do continue to learn from both HHP and WPC. This week we held a discussion with plans and are developing a TA plan and a team to support health plans with their challenges. The waiver ends in 2020 so there are few options related to timelines for existing WPC counties. It is complex because WPC differs in each county. We are continuing to work with plans and are pushing some components of CalAIM to later on the timeline to make sure there is not too much pressure in one year. We will continue to assess this over time.

Jennifer Lopez, DHCS: On evaluating the rate setting, we will collect encounters and actual costs of ILOS. For example, we would expect inpatient days to go down where recuperative beds are used. The population is not static so we will look at this through the annual rate setting. We are requiring both ILOS and ECM services to be submitted through the claims process so we can query utilization.

Kim Lewis, National Health Law Program: The populations going live through ECM and ILOS are varied and complex, such as kids with special needs and seniors. It is unclear how expectations will be decided on milestones and metrics, as well as what they will submit to you to serve those disparate populations. There is impact from other agencies such as CCS. How will this boil down to a rate? What kind of plan will they prepare?

Jacey Cooper, DHCS: In WPC and HHP, not all populations are served in a single way. We are asking counties to do mapping, what is transitioning and where are there gaps. We are sending out information on the ECM "model of care" for what plans will need to submit to demonstrate they are ready for ECM. There will be a narrative, with some specifics for each population on the policies/procedures, network and other core components. We are working with CMS on this. We want plans to contract with experts doing housing services, not become housing experts. We have received comments suggesting that some populations should go live on different dates.

Kim Lewis, National Health Law Program: Could a plan contract with a mental health plan to do comprehensive coordination?

Jacey Cooper, DHCS: Yes, plans should be talking to counties about the SMI populations, assuming they want to take responsibility for ECM. We want to ensure plans do not keep all services in-house. We have asked they report on conversations the plan is having with partners and counties.

Kim Lewis, National Health Law Program: On ILOS, the 13 are voluntary. How will people know?

Jacey Cooper, DHCS: The plans will let us know by a date what ILOS they will provide and then it will function like a benefit, although it is not technically a benefit. They can't pick certain individuals to receive services – they have to offer the service to all members. They may be able to stand up ILOS at different times in different counties as they build out the network and capacity. They must evaluate it is cost-effective and how they will deliver services. We will release a revised version for comment.

Carrie Gordon, CA Dental Association: Can DHCS let us know how the fiscal projections for dental were calculated? There are data-quality and utilization issues and a time lag for DTI. I want to emphasize that DHCS not go back to a lack of data from safety net clinics. We don't want to lose the progress that DTI payments have produced.

Jacey Cooper, DHCS: We can connect you with Rene to get those fiscals.

Linda Nguy, Western Center on Law and Poverty: We question the 1% target number given that the homeless population is greater than 1% of Medi-Cal. We understand you don't want to be prescriptive, but the type of outreach is important based on lessons learned in WPC. For example, in person outreach is more effective with homeless. Plans often do telephonic outreach services. On ILOS, what is DHCS doing to ensure take up by the plans?

Jacey Cooper, DHCS: We have made it clear to plans that outreach and services should be in person. They are already paid for complex case management and this is beyond that. We will survey the plans to gather information on their interest in ILOS. It may change later but we are working to get upfront information to inform planning.

Barsam Kasravi, Anthem Blue Cross: CalAIM has been very collaborative. Anthem is in six HHP and nine WPC counties and we are doing in person outreach. We have done analysis

that shows a positive impact from WPC and we are happy to share our lessons. It will be important for primary care capacity to be a focus. As plans have to improve, providers have to improve and their capacity is critical to success.

Al Senella, CA Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers: Will there be standardization from DHCS for plans on what they will look for related to outreach? It sounds like services will be plan-specific. We have been talking about standardizing and equity across the system. It sounds like we are not adopting that lesson. A beneficiary should get the same service wherever they live but it doesn't sound like that will happen in this. Using utilization to set rates is concerning and I hope there are additional factors. All of the patients are complex, and outreach will be difficult, even dangerous. Patients will take many engagements to be ready to access services. It seems as if rates will be reduced if there is not utilization for members who are not ready to engage, in spite of the outreach. I understand the issue of duplicative payments on TCM. However, if we pull out TCM, how does the case management get addressed? Finally, on those previously incarcerated, it is not isolated – it is threaded through these lives we are discussing today.

Jacey Cooper, DHCS: On standardization, there are two ways we are approaching this. There will the standardized target populations across the state. There will be an ECM contract template to outline what engagement is required, with additional flexibility to add other elements. On ILOS, unfortunately, we don't have enough infrastructure to make this a statewide benefit. It is a federal requirement that ILOS remain voluntary. Over time, we can use the opportunity to build infrastructure and move toward a statewide benefit. We can move a benefit into managed care sooner if we see infrastructure is getting built for a particular service. On the utilization piece, we get data from a combination of sources and all of that data is being used by Mercer and state staff. Some is historical; some is assumption-driven. The 1% are those who get services, not those who are eligible for services. There will be those who are eligible, those engaged, and services to individuals. On TCM, we are not talking about Mental Health/Substance Use TCM. There would be impact if a mental health provider wanted to do ECM. On incarceration, our bundle is focused on those transitioning out of incarceration, but I understand the point about past incarceration.

Kristen Golden Testa, The Children's Partnership/100% Campaign: On ECM, how many of the 1% are children? My understanding is this is not a new benefit, given this is an EPSDT benefit. Do you have data on those costs for what is already being provided? On ILOS, you will look at utilization of the service the plan is replacing; if that utilization does not happen, how will you monitor the ILOS?

Jacey Cooper, DHCS: Children have access to EPSDT protections. We don't have an answer to your exact question because of the way it is billed and capitated. Today children have access to complex case management. We want to develop a new ECM model that incorporates in-home, whole family services and takes existing services to a new level. How do we create a model to address social needs? We will issue codes for what is provided in ECM and ILOS and will put those codes out for feedback. There are two prongs on assumptions of utilization. If we have opened 200 recuperative beds and we stop providing recuperative beds available through WPC, we will see a spike in inpatient and emergency care. We are calculating that into the rates

Kristen Golden Testa, The Children's Partnership/100% Campaign: I appreciate the openness for comment on incentives,. For example on prevention, looking at those with emerging risk would be beneficial to reduce the pipeline of high risk. In all due respect to the population health management proposal, what we saw in the audits is that what was currently required for plans was not bringing desired results.

MJ Diaz, SEIU: We appreciate the openness. Can DHCS do a crosswalk of changes from the original CalAIM proposal? How will the ECM/ILOS contract template and plan-county partnerships become public? What is the mandate for the plans to contract out services?

Jacey Cooper, DHCS: The only mandate we are considering relates to WPC and HHP providers. There are no mandates related to counties, other than the WPC counties. We will use the transition plans to encourage those conversations. We have added a request to plans that they report how they are engaging tribal partners. There will be mandated contract elements related to WPC and HHP and we will post the contract template when it is available.

MJ Diaz, SEIU: Will the discussion be monitored through transition plans, not contracts?

Jacey Cooper, DHCS: We will use transition plans to monitor plans' discussions with counties and tribal partners. There are a number of requirements that will be monitored through contracts for ECM and ILOS.

Anne Donnelly, San Francisco AIDS Foundation: I want to underscore consideration of including outcomes in the rates as Kristen observed. There are many organizations doing this work effectively and it would be helpful to have both increased oversight and support on who plans engage with. For example, we have Low Threshold Harm Reduction programs and Ryan White care systems where we see better outcomes.

Jacey Cooper, DHCS: We are thinking through an HCBS cheat sheet for health plans on ILOS.

Expanding Access for Dual Eligible Beneficiaries for Long Term Care Services and Supports
Anastasia Dodson, DHCS

Anastasia Dodson provided a short overview of CalAIM changes and timelines related to Dual Eligible Beneficiaries and mentioned there will be a deeper discussion about this topic on February 24. Based on learnings from the Coordinated Care Initiative (CCI), DHCS will carve in dual-eligible beneficiaries in 2023 and long-term care and coverage of transplants to become the responsibility of Medi-Cal managed care health plans in 2021. DHCS will carve out Multi-purpose Senior Services Program (MSSP) from managed care in the seven CCI counties. In 2021, DHCS will plan for the transition of Cal MediConnect (CMC) and the CCI to statewide mandatory Medi-Cal managed care enrollment for dual eligible beneficiaries. Managed Care Plans will be required to become a Dual Eligible Special Needs

Plan (D-SNP) and CMC members will be cross-walked to a matching D-SNP so a single plan is offering all benefits. By 2026, we want a statewide, coordinated system for dual eligible and others.

Andie Patterson, California Primary Care Association: How does this tie into the Master Plan on Aging?

Anastasia Dodson, DHCS: We are working closely with the Department of Aging and the workgroup for the Master Plan. This is in line with those discussions. We will participate together on webinars and are working to move ahead hand in hand.

*Ryan W*itz, *California Hospital Association*: Will DHCS submit comments in relation to the D-SNP and look-alike policy? Similar to the MFAR process, can you share the comments ahead of time?

Jacey Cooper, DHCS: Yes, we will be submitting and will share once it is complete.

Public Comment

Deborah Kelch, Insure the Uninsured Project: I want to raise an issue for the future. Recuperative care is emerging organically around the state, especially in WPC counties. Up to now, it has grown out of community collaboration to serve those in need of these services. As a veteran of the residential care abuse scandals, when something moves from an informal system to a managed care benefit, having unlicensed facilities caring for such complex patients is a recipe for danger without oversight. As you pay for the service, the industry will shift and new providers will emerge to follow the financing.

Cary Sanders, California Pan-Ethnic Health Network: I serve on the Population Health Management Strategy Workgroup. It has been interesting to hear about the financing and incentives and how they fold into ECM and ILOS. I was struck that none of the incentives focus on the population health management and how it will reduce disparities for the entire Medi-Cal population. We have not had a presentation on the financial incentives in the population health workgroup. For plans to build the infrastructure to do this, we need to think about how this will be built into our rate structure. You mentioned that the ILOS could potentially reach a broader population than the targeted 1%. I would be interested to understand how you see the potential for incentives to broaden and flow down to basic preventive services and case management. I'm pleased to hear about the additional consideration of ILOS for asthma and want to raise the importance of additional mental health options based on community-defined practices. We have raised this in previous comment letters and have additional information to share.

Fred Main, CalPACE: Program of All-Inclusive Care for the Elderly (PACE) was the original integrated program for frail individuals. We understand that although PACE is not called out in the CalAIM proposal, it will be allowed to operate. We are concerned from lessons learned in CCI that PACE needs to be offered as an option when people are transitioning

based on age or risk. We want DHCS to consider how this will happen and consider a form of automatic referral for individuals who are PACE-eligible.

Sidney Jackson, Association of Regional Center Agencies: In the LTSS proposal, what will be the impact on intermediate care facilities?

Anastasia Dodson, DHCS: We will get back to you.

Jacey Cooper, DHCS: It is included in the Long Term Care carve in.

Amanda Dickey, California County Superintendent Educational Services Association: There are a growing number of children with complex health issues and county offices operate programs for those with complex needs. How will you coordinate CalAIM with county offices who are required to serve them to ensure that Individuals with Disabilities Education Act (IDEA) requirements are met?

Jacey Cooper, DHCS: We are looking at the interaction of CalAIM and education and don't have specific comment at this time.

Amanda Dickey, California County Superintendent Educational Services Association: Children are an underserved population in California and I understand today is not a conversation about children. When does the administration plan to lead a conversation specific to children's health care access?

Jacey Cooper, DHCS: We are having separate school-based services outside of CalAIM and I'm happy to engage with you.

Amanda Dickey, California County Superintendent Educational Services Association I encourage you to include the SB75 workgroup on school health be tied into the discussion.

Jacey Cooper, DHCS: We are working with internal staff to interweave comments from that workgroup.

Gary Passmore, CA Congress of Seniors: Special thanks to Director Figueroa for your efforts.

Next Steps and Final Comments; Adjourn
Richard Figueroa, DHCS

2020 SAC Meeting Dates:

- May 27, 2020 1:30 p.m. – 4:30 p.m.
- July 16, 2020 9:30 a.m. – 12:30 p.m.
- October 28, 2020 1:30 p.m. – 4:30 p.m.