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March 25, 2015

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Via e-mail to Jennifer.kent@dhcs.ca.gov

RE: General Comments on Medi-Cal 2020 Waiver Renewal Concept Paper

Dear Director Kent:

Health Access California, the statewide health care consumer advocacy coalition, offers the following comments on the Medi-Cal 2020 Waiver Renewal Concept Paper (March 16, 2015 release). We served on three different Medi-Cal waiver renewal stakeholder advisory committees, and we are pleased to see some of that input reflected in the state's March 16 draft.

The story that California is telling in its waiver renewal application should include more of what we have heard from Secretary Diana Dooley, you, and others in these meetings: the compelling, "big picture" visions for what needs to happen in Medi-Cal to make the program more responsive to the health care needs of beneficiaries and be more financially sustainable. For example, at the most recent DHCS quarterly stakeholder meeting you suggested California could be more innovative in the way we deliver care or pay for care more efficiently by reaching across the silos within government or between clinics and community. In several venues Secretary Diana Dooley, too, has described her own robust vision: that what we do in the Medi-Cal waiver will or should have implications for the state's health care system as a whole—if not the nation's.

The waiver application would benefit from a more clear articulation of the state's vision—and our comments provide examples of how that vision could help bring the somewhat disconnected waiver initiatives together into a coherent whole.

The rest of our comments are organized in four sections:

1. Framing the waiver's vision
2. Financing the safety net
3. The disposition of health equity in the waiver initiatives
4. Miscellaneous issues

1) Detailed Suggestions on Framing and Vision

The Context of the State's Success on the ACA. The concept paper does a good job framing the waiver renewal in terms of the state's success with ACA implementation—but how the waiver provisions build on that success is not clear. One suggestion would be to show how

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the safety net financing pieces help to position the state for universal coverage and comprehensive care—and from there to be able to demonstrate both the impacts to health care system and the economic impacts of covering most residents in a given state.

The Context of the Medi-Cal Population is Part of the Story. The state's waiver "story" should be structured around the people with the most to gain from the proposed Medi-Cal transformation: the eminently diverse populations that are enrolled in the program. Right now people of color comprise 75-80% of Medi-Cal beneficiaries. This and related facts provide the justification to articulate waiver goals in terms of a "quadruple aim," with health equity as a fourth goal woven through the next waiver's triple aim initiatives.

Lessons from Bridge to Reform 2010-2015: Among the many positive lessons from Bridge to Reform is the success on streamlining or fast tracking enrollment, for example through the LIHPs. To build on this more directly, the waiver renewal could emphasize the county's role in renewal of coverage and on connecting patients with care (or monitoring access difficulties and supporting a feedback loop back to policy work on access).

From what we understand, CMS does not want a basic continuation of previous waiver concepts. Moreover, there were hard and important lessons—not just successes to trumpet—from the current waiver (in particular the troubled transition to managed care for the SPDs and the duals). We observe learning on the part of DHCS as it deals with each of these transitions to managed care: the lessons learned are a part of the picture that should help frame the fresh ideas.

Overall Health Goals: The paper lists the various delivery system efforts through multiple vehicles: managed care, fee-for-service, the public safety-net, county pilots on whole person care, etc. This appropriately acknowledges the complexity of California's health system, and how different these reforms will have to be implemented in different venues. That said, much of this discussion is around process and systems rather than about outcomes. It would be useful to have a handful of outcomes that the state of California is seeking system-wide, regardless of whether the patient is in Medi-Cal managed care, Medi-Cal fee-for-service, or remaining uninsured getting safety-net care. This could be outcomes related to a specific diseases or treatments or conditions (perhaps pulled from the Let's Get Healthy California Task Force report), such as an overall reduction in obesity, or even a lower incidence of ER visits for childhood asthma. Such overall goals should show the impact of the delivery system reform: for example, that all Californians seeking care are assigned a medical home if they don't have one—at least for their follow up visit if not long-term. Such overall goals would help tie some disparate elements together and show how reforms in different systems actually work together.

2) Financing the Health Care Safety Net

a) The Role of the Counties

The role of the counties in funding the non-federal share of the Medicaid program, and most particularly the safety net also deserves more attention. We think of Medicaid as a federal-

state partnership but this waiver is also about a federal-state-*county* partnership. The counties have been the state's partner in the waiver efforts and this paper should reflect that. This distinguishes California from other states, an important consideration, and helps to paint a fuller picture of the non-federal share.

b) Payment Incentives

- **The points system in Public Safety Net Global Payment structures should risk adjust for socio-economic status.** For example, a sicker patient mix will need more specialized care in expensive settings—the points system should be flexible enough to reward plans/providers for progress relative to patients' starting point.
- **Tie Pay for Performance incentives directly to equity** (see SEIU, Health Access, CPEHN letter of February 5, 2015: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CPEHN_SEIU_HA_Letter.pdf) benchmarks, from data collection, better patient outcomes, to engagement in population health initiatives. The best hook for this is in p. 15 (Strategy 2). To flesh this out, Medi-Cal Waiver 2020 should explain what the plans have tried and what they've learned from any efforts to tie their own past or current P4P structures to equity-related goals, including disparities data collection and meaningful use of that data.
- **Payment incentives, including any shared savings strategies, should be tied to measurable results in addressing population health** (see Let's Get Healthy Task Force goals) goals anchored in a medical home approach to care. Here payment incentives might need to reward for efforts or use a point system (or offer a menu of possible initiatives, depending on local interests or capacities).
- **Payment incentives should test risk adjustment for socio-economic status.** For example, this calls for higher reimbursement to providers who see sicker or more at risk patient mix, as noted above. This is not spelled out in enough detail.

3) Health Equity

Just as our comments weave equity into all areas of concern, so should the waiver renewal application include more specificity on how goals related to improving health and health care for the supermajority-minority population served by Medi-Cal. In addition to the comments above, we find this area lacking in specificity and not as strongly threaded throughout as it should be. Health equity is mentioned here and there as a priority for Medi-Cal 2020 (though tellingly not in the executive summary), but without concrete details or mechanisms for addressing equity in ways that might be measured.

Given the inherent diversity of the Medi-Cal population, it would make sense to integrate equity goals and measures into all waiver initiatives. Please consider framing the waiver renewal in terms of a "quadruple aim."

4) Public Safety Net System Global Payment for the Remaining Uninsured

We appreciated participating in the Safety Net workgroup and are supportive of the proposal in the paper on several fronts:

- We appreciate the continued focus on the remaining uninsured. The paper could do more to spell out the significant need that will remain in California even after full implementation of the ACA, both in terms of the scale of people projected to be uninsured, for a variety of reasons, and underinsured for a range of needed services.
- Because of this ongoing need that may be greater in California than elsewhere, we strongly support the need to continue the Safety Net Care Pool, which could be stated more forthrightly.
- We support the proposal's intent to get more flexibility from both Safety Net Care Pool and DSH funds to meet the ongoing needs in California in the most appropriate way possible. While we appreciate the desire to give counties discretion, we think some direction and standard is appropriate, and it might be useful to give concrete examples of what some counties are starting to do to adapt their safety-nets to a post-ACA world, and how such a new methodology would give them both the budget security and incentive to have many ore counties move in that direction.

5) Miscellaneous Issues

- Whole Person Care
  We are excited by the Whole Person Care elements of the proposal. While it makes sense to start with pilots, these pilots should target the most vulnerable, highest risk groups, and others most likely to benefit. Consider distributing the pilots across different segments of the population, geographies, disease categories, etc. Governance around Whole Person Care Pilots needs to include consumer groups representing patient target populations (or patients/families for some if possible). Closely related to governance is the need for transparency and "community dashboarding" on the achievement of whole person pilots over time.

- Work across silos of government for all waiver initiatives—and demonstrate how this can happen in practical terms.
  - If Medi-Cal 2020 is about reaching across silos to housing, corrections, county mental health: these agency and/or community partner perspectives should be reflected in the application or concept paper.
  - The counties, too, should be prepared to demonstrate how they will work across their local silos for these programs. And how those results will be measured and reported out.

- Medical Home: An effective medical home stretches outside the clinical settings of care to the community supports needed to help patients benefit from care or improve their overall health. How will community health workers, for example, help patients connect with affordable local options for healthy food? Consider the Prevention Institute's population health approach to medical homes.

- Palliative Care: We commend the emphasis on training, but this training and education should include patients and families. And the training itself needs cultural competency built in.

Thank you for the opportunity to comment and for considering our comments. Please find additional details on our concerns and overall priorities in our recent report, "Medi-Cal Reform 2.0: Health Access Priorities for California's Next Medicaid Waiver." http://health-access.org/images/pdfs/Medi-CalWaiverIssueBrief_DiscussionDraft1-12-15FinalPublish.pdf.

We could offer more comments, but wanted to get the Department some initial comments quickly given the timeframes. It will be important to get initial input from CMS as soon as possible so we know where the state stands on key waiver provisions. .

Health Access appreciates the Department's dedication to a thoughtful stakeholder process. We commend this Administration both for involving the consumer advocacy community at all stages of the waiver renewal process. We look forward to continuing to work with the Department as the waiver renewal process moves on to the critical negotiation stage.

Sincerely,

Anthony Wright
Executive Director

Cc:
Judi Hilman & Beth Capell, Health Access California
Mari Cantwell, Medicaid Director, Department of Health Care Services
Secretary Diana Dooley, Health and Human Services Agency