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May 6, 2021

Will Lightbourne, Director
Jacey Cooper, Chief Deputy Director & State Medicaid Director
California Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

SUBJECT: CalAIM 1115 Demonstration and 1915(b) Waiver Renewals

Dear Directors Lightbourne and Cooper:

Gold Coast Health Plan (GCHP) serves approximately 220,000 Medi-Cal beneficiaries in Ventura County. Our mission is to ensure the health of our members through the provision of high-quality care and services. We thank you for the opportunity to provide public comment regarding the 1115 demonstration and 1915(b) waiver renewals.

GCHP strongly supports DHCS' commitment to improve and transform the Medi-Cal delivery system in order to meet the physical, behavioral, developmental, long-term services and supports, oral health, and health-related social needs of all Medi-Cal members in an integrated, patient-centered, whole person fashion.

GCHP is supportive of the Enhanced Care Management (ECM) and In Lieu of Services (ILOS) components of the 1915(b) waiver renewal. In Ventura County, the Whole Person Care (WPC) Pilot Program has become the cornerstone of redefining how to provide care to the most vulnerable Medi-Cal members in our county. These members include homeless individuals, high utilizers, and those suffering from severe mental illness and/or substance abuse.

From the outset of the WPC Pilot Program, GCHP has worked collaboratively with the County of Ventura, the lead entity, to coordinate care. Over the pilot's course, we have continued our close collaboration with the county to care for this population successfully. We have found that local control and flexibility have been key to creating a successful program. Thus, we are looking forward to working collaboratively with the county as we transition the populations of focus into ECM. We believe we are well positioned to engage with our county partners on a robust readiness review to ensure successful implementation of ECM and ILOS by January 1, 2022.

The 1115 waiver also seeks authority for federal matching funds for the PATH program, which would support infrastructure, capacity building, and IT systems for ECM and ILOS providers. Given the significant investment needed to successfully implement ECM and ILOS, GCHP is supportive of this proposal, which we believe will complement the proposed

managed care incentive program. Nevertheless, managed care plans would benefit from greater detail about the PATH program, including the proposed funding amount and the specific activities or infrastructure that will be supported by the program. This information will be critical as we work with our county partner to transition the WPC program into ECM and implement ILOS for the additional populations of focus in the coming years.

Additionally, GCHP expresses support for DHCS in continuing the Low-Income Pregnant Women program, under the 1115 waiver, which provides coverage for women with incomes that fall within 109-138% of the federal poverty level (FPL). According to the Medicaid and CHIP Payment and Access Commission (MACPAC), Medicaid's Role in Maternal Health Report, approximately 700 women die annually because of pregnancy or related complications, with such deaths occurring over the course of pregnancy and in the postpartum period. Women of color are also at greater risk of maternal morbidity and giving birth to a preterm or low-birthweight infant. These poor outcomes and disparities may be exacerbated by the current COVID-19 pandemic. Poor outcomes for many women and infants could be addressed through Medicaid policy. Medicaid has long played a key role in providing maternity-related services for pregnant women, financing more than two out of every five births in the U.S. in 2018.

At GCHP, over 60% of our members are families and children, and approximately 40% of our top inpatient diagnoses are related to pregnancy and childbirth. Moreover, GCHP ranked in the 90th percentile for the Postpartum Care measure, under the Medi-Cal Managed Care Accountability Set (MCAS). Therefore, we believe the continuation of this program is crucial as it allows for Medi-Cal coverage to be extended to women during a critical time in their child's development and contributes to the mother's overall health.

Thank you for your leadership in proposing these historic and ambitious federal waivers. GCHP looks forward to continuing to work together to ensure the success of ECM, ILOS, and the other transformative proposals in the 1115 demonstration and 1915(b) waivers.

Sincerely,



Marlen Torres
Executive Director, Strategy and External Affairs
CC: Margaret Tatar, Chief Executive Officer



To: California Department of Health Care Services

From: Barbara Masters, Director
California Accountable Communities for Health Initiative (CACHI)

Date: May 3, 2021

Re: Comments on Medicaid Section 1115 Demonstration Five-Year Renewal and Amendment
Request: CalAIM Demonstration

On behalf of 13 Accountable Communities for Health (ACHs) located throughout California, we applaud DHCS for the vision reflected in the revised CalAIM proposal, the commitment to maintain and scale programs and policies that are working, and the focus on improving outcomes for systemically marginalized communities and individuals. The [California Accountable Communities for Health Initiative](#) shares DHCS's goals of moving toward a prevention-oriented system, integrating and coordinating care and services for physical and behavioral health and health-related social needs, and genuinely engaging community members. We particularly appreciate your recognition of needed investments in building capacity to promote the connection between service providers and programs inside and outside of the health care system.

In addition to our [prior comments on earlier versions of CalAIM](#) that still hold, we have two suggestions for further strengthening relevant provisions of the revised proposal to ensure success of these goals. We recommend that you explicitly designate funding/language in both the Providing Access and Transforming Health (PATH) Supports and GPP Equity Sub-Pool sections for the following:

- I. Acknowledge and designate funding for the convening and coordinating work necessary to formally connect the health care sector to other sectors and *community* resources to: a) improve health equity and b) improve individual and community health. Achieving CalAIM's goals is going to require trusting, functional relationships between a wide range of stakeholders. Health plans are being asked to lead, but they can't do it alone. Intermediary collaboratives such as ACHs possess the capacity, trust, convening expertise, relationship with communities, and track record in multiple counties across the state to partner with health plans.
- II. Provide funding for partnerships to better measure disparities and implement community-wide disparity reduction plans. Health equity is critical as a matter of social justice and of safety net performance. It is not achievable solely by delivering services to people who are already sick or injured. Achieving equity requires understanding patterns of health within a community, developing targeted efforts to address underlying drivers of inequities, and creating accountability for results. Plans need a local partner that has experience building trusting relationships with stakeholders and developing strategies and interventions to address disparities and equity.

We stand ready to work with you on the implementation of these ground-breaking efforts.

These policy recommendations are solely the product of CACHI and do not necessarily reflect the views of CACHI funders or partners.

May 6, 2021

To Director Will Lightbourne and the broader DHCS,

I write to you as a concerned citizen

mental health care is vital for everyone - children included.

While the initial CalAIM proposal offered ambitious, tangible, and critically needed changes for specialty mental health care for children and their families, language in the 1915(b) Waiver appears to overturn key aspects of these advancements. I assert that these erosions of the original CalAIM proposal will lead to the perpetuation of a broken system of services for vulnerable families in our state. The science of healthy early childhood development and the services that promote it clearly demonstrate that behavioral health is *vital* for healthy development, not a response to pathology. To address these concerns and promote lasting family wellness, I urge timely revision of the proposal in the following manners:

1. Resist pathologizing adversity—as evidenced by proposed tools to "screen in for a high-risk score" for ongoing services. We must honor the wisdom and intelligence of low-income communities to determine their own definition of medical necessity. Any request for support from a beneficiary, regardless of screening score, should qualify a child for services and support.
1. Fully honor the commitment to "no wrong door" by removing the future creation of a level of care tool and plan – or if such a tool is to be used it must only be used during the course of treatment, and treatment cannot be stopped or interrupted until or if there is a transition in care.
1. Provide the public with answers to questions about the potential risks related to moving county mental health plans from a Certified Public Expenditure (CPE) methodology to Intergovernmental Transfer (IGT).

Thank you for reading this letter and considering these revisions. As adults, we are responsible for leaving this world better than how we found it, which includes creating easily accessible mental healthcare services for those individuals and families for whom it was previously out of reach. I believe that with concerted effort, the CalAIM proposal will make significant strides to meet the mental health needs of California's children and families.

Sincerely,
Anjali A. Palazzotto



May 6, 2021

Via electronic submission to CalAIMWaiver@dhcs.ca.gov

Jacey Cooper, State Medicaid Director and Chief Deputy Director of Health Care
Will Lightbourne, Director
California Department of Health Care Services
1501 Capitol Avenue
P.O. Box 997413
Sacramento, California 95899

Re.: Comments on CalAIM Section 1915(b) Waiver Proposal

Dear Ms. Cooper and Mr. Lightbourne:

Thank you for the opportunity to comment on the California Department of Health Care Services (DHCS) proposed Section 1915(b) waiver amendment and renewal (“the DHCS proposal”). The National Center for Youth Law (NCYL) is a nonprofit organization that has worked for over four decades to improve the lives of disadvantaged children and youth. We appreciate the steps the state is taking to improve and expand access to mental health care for California children and families. Below we offer comments on some specific aspects of the DHCS proposal impacting access to care for Medi-Cal beneficiaries under age 21 that we believe should be strengthened or clarified.

Medical necessity for Specialty Mental Health Services (SMHS) for beneficiaries under age 21 (DHCS proposal p. 8 and attachment 2, pp. 24-26)

Children and youth enrolled in Medi-Cal have a broad entitlement to mental health screening and care under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. This includes a right to all “necessary health care, diagnostic services, treatment, and other measures described in [42 U.S.C. § 1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.” 42 U.S.C. § 1396d(r). Historically, the state has limited access to SMHS in a way that is inconsistent with the EPSDT mandate and that has created barriers to children accessing the care that they need and are legally entitled to.

We appreciate the important steps that DHCS has taken to acknowledge and begin addressing this problem. We support DHCS’s proposal to open access to SMHS to children and youth who have conditions that put them at high risk for a mental health disorder due to experiencing trauma, including children with child welfare involvement and children who have experienced homelessness (Criteria 1). We believe this change will expand access to critical services for

many children and youth, and allow for earlier intervention to address the impact of trauma on their overall health and development.

We are concerned, however, that the specific wording of Criteria 1 will exclude some children who have experienced trauma and have a medical need for SMHS, but who may not fall into the specifically enumerated groups listed or receive a particular score on a DHCS-approved trauma screening tool. For example, we are concerned that the current language may not allow access to medically necessary SMHS for a child who has experienced the trauma and adversity of involvement in the juvenile justice system, a child who has experienced the trauma and adversity inherent in family separation due to immigration reasons (such as the deportation of a parent or caregiver), or a child who has experienced trauma and is *at risk* for child welfare involvement. If such children do not qualify under Criteria 1, their only avenue for qualifying for SMHS would be through Criteria 2, which includes the heightened requirement of having a diagnosed mental health disorder or a suspected mental health disorder.

To address this and to ensure that children receive all medically necessary mental health services, consistent with the EPSDT entitlement, we recommend editing the wording of Criteria 1 to clarify that a high-risk trauma screening score, child welfare system involvement, and experiencing homelessness are *examples* of, but not an exhaustive list of, evidence for meeting this criteria. One possible way to do so is as follows:

*“The beneficiary has a condition that puts the child or youth at high risk for a mental health disorder due to experiencing trauma, evidenced by, **for example**, any of the following: scoring in the high-risk range on a DHCS-approved trauma screening tool, or involvement in the child welfare system, or experience of homelessness, **or other finding of trauma by a qualified provider.**”*

In addition, we recommend providing more clarity on the intended meaning of the phrase “scoring in the high-risk range on a DHCS-approved trauma screening tool.” For example, it would be helpful to specify what tool or tools this refers to (e.g. Pediatric ACEs and Related Life-events Screener (PEARLS)) and to specify what is considered “high-risk” under the relevant tool or tools.

We also recommend providing clarification regarding what responsibilities Managed Care Plans (MCPs) have for serving children who are impacted by trauma, in addition to the responsibilities of County Mental Health Plans (MHPs). For example, the proposal could specify that even when a child enters through Criteria 1 and receives medically necessary SMHS from an MHP, the MCP remains responsible for providing any medically necessary non-SMHS in addition to holding important case management and coordination responsibilities.

With respect to Criteria 2, in part (A)(IV) (“A less than significant impairment but requires mental health services that are not included within the mental health benefits that managed care plans are required to provide.”), we recommend providing clarification around the intended meaning of “A less than significant impairment” to specify whether it refers to a low impairment or to a low or no impairment. Alternatively, the language “A less than significant impairment,

but” could be deleted such that 2(A)(IV) would state, “Requires mental health services that are not included within the mental health benefits that managed care plans are required to provide.”

Also with respect to Criteria 2 (and similar to our note above regarding Criteria 1), it would be helpful to specify that if a child enters through Criteria 2 and receives medically necessary SMHS from an MHP, the MCP remains responsible for providing any medically necessary non-SMHS in addition to holding important case management and coordination responsibilities.

Reflecting on the proposed SMHS criteria as a whole, we urge DHCS to be mindful of the challenges of applying complex criteria in practice and to make the language as clear and straightforward as possible. We also urge DHCS to provide clear, comprehensive guidance regarding application of these criteria, if approved. If the criteria are ambiguous and subject to multiple interpretations, this could lead to different application in different locations, exacerbating existing inequities in access to care. Vulnerable children and families must not be made to bear the burden of the state’s complex children’s mental health delivery system and access criteria.

“No Wrong Door” Policy (p.8, attachment 2, pp. 27-28)

We support the concept of implementing a “no wrong door” policy, and DHCS’s stated commitment to ensuring “beneficiaries receive the care they need, no matter how they enter the system” (p. 27). When children and families navigate mental health challenges and take the brave step of seeking help, they must be able to access the care they need, without delay, regardless of which entry point they use. If they face closed doors or are bounced back and forth between delivery systems, it adds to their burden and may discourage them from seeking care in the future. In addition, we appreciate DHCS confirming the importance of beneficiaries being able to receive coordinated, non-duplicative services in multiple delivery systems simultaneously.

However, we believe this component of the proposal needs more detail and clarification as to how this will be successfully implemented. DHCS should also make clear its commitment to continuity of care rules and to ensuring that beneficiaries will not be required to change providers and/or delivery systems. Moreover, DHCS should ensure that when there is a true need for a child to transition from one system to another, the system in which care originated is responsible for closely monitoring the transition and ensuring the child does in fact receives the care in the other system. The responsibility of coordinating between systems should not be left to the child and family.

Standardized statewide screening and transition tools (p.9, attachment 2, p.28)

The DHCS proposal describes a “standardized statewide screening tool” (including one specific to beneficiaries under age 21) to “determine the appropriate delivery system for mental health services for beneficiaries seeking services for the first time.” (p. 28) We support the use of universal screening and assessment tools to help determine the mental health needs of Medi-Cal-enrolled children and youth, and to ensure consistent, equitable access to care. However, we are uncertain if that is what is being proposed here. We would like clarification as to what tool will

be used, what it will screen for, who will administer it, when it will be administered, and how it will interact with other screening tools. It is critical that the tool not be used to limit access to either system, to redefine medical necessity criteria in any way that would conflict with the EPSDT entitlement, or to replace the mental health screenings required under EPSDT. It is also important the tool not simply add a new layer of administrative burden, potentially delaying access to care.

The DHCS proposal also describes a “standardized statewide transition tool” (including one specific to beneficiaries under age 21) “to facilitate coordination of care between MHP and MCP delivery systems.” (p.28) We support the goal of ensuring that when a transition needs to occur, the process be coordinated and thoughtful to minimize any negative impact on children and families. However, we would like to reiterate the importance of continuity of care, and the negative impact that transitions between multiple providers and systems can have on children and family. Transitions should only be required when a child needs a new service that is not available in the system in which they are already receiving care, and if the new service is needed in addition to the existing service, the child should be served in both systems, not transitioned from one to the other. Moreover, any tools used to assist with transition planning should emphasize the importance of approaching the transition in a supportive, therapeutic way. We recommend that DHCS provide further information about these proposed tools and how they would be implemented so that stakeholders can better understand how they would result in increased access to services for children and families.

Thank you for your time and your consideration of these comments, and for your commitment to improving access to mental health care for California children and youth.

Sincerely,



Jesse Hahnel, Executive Director
National Center for Youth Law



Submitted via electronic mail: CalAIM@dhcs.ca.gov

May 6, 2021

Department of Health Care Services
Director's Office
Attn: Angeli Lee and Amanda Font
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Re: Comment on California Advancing & Innovating Medi-Cal (CalAIM) Proposal

Dear DHCS Director Lightbourne, Ms. Lee, and Ms. Font:

We are writing in support of the proposed CalAIM Section 1115 demonstration application and Section 1915(b) waiver, and to encourage DHCS to ensure a smooth transition from Whole Person Care to CalAIM, and continued funding for medical-legal partnerships (MLPs) to provide access to free civil legal services related to addressing the social determinants of health.

As sub-contractors for the Whole Person Care pilots in Contra Costa County and Alameda County, we are closely following the developments in the Whole Person Care/Health Homes Program Transition Plan component of CalAIM. I am writing on behalf of Bay Area Legal Aid to urge DHCS to expand investment in addressing social determinants of health by ensuring that there is a clear funding pathway to build on the medical-legal partnerships that have served so many members of our communities as part of the Whole Person Care and Health Homes Program Pilots.

Bay Area Legal Aid ("BayLegal") is the largest provider of free civil legal services in the Bay Area. We provide critical legal services to marginalized communities in the areas of housing, public benefits, health access, consumer, youth, veterans, reentry, immigration, family law and domestic violence prevention. Many of our clients are Medi-Cal recipients or eligible for Medi-Cal. Among our core priorities, BayLegal provides free wrap-around civil legal services to patients of our Medical-Legal Partnership healthcare partner sites, homeless and at-risk youth, formerly incarcerated persons, and veterans. Each year, we serve approximately 10,000 low-income individuals in seven of the nine Bay Area counties. Our mission is to ensure that our clients and potential clients obtain equal access to justice regardless of their income, race, primary language, national origin, ethnic background, gender identity, sexual orientation, or disability.

Legal aid is a non-clinical intervention that helps to mitigate social determinants of health and reduce health disparities and inequities in low-income communities.

The Whole Person Care Pilots and the Medi-Cal Healthier California for All Proposal already recognize that improving population health for low-income communities is complex and requires cross-sector collaboration. Nationally, 71% of low-income households experienced at least one civil

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legal problem, including domestic violence, unhealthy or dangerous housing conditions, eviction, public benefits denial or termination, disability access, and access to health care.¹ These civil legal problems often tie directly into a persons' health: eviction resulting in homelessness, lack of food due to CalFresh denial or termination, unhealthy living conditions flaring up chronic diseases, physical and mental health concerns due to domestic violence, poverty, or debt. While health systems can address acute medical needs, there is much that happens in a patient's life that impacts patient health about which, without bringing in other partners, the health system cannot address. Nonetheless, as trusted professionals, clinicians often end up as a primary source of nonlegal help for problems related to rental housing, income maintenance, health, and safety.²

Over the last twenty-five years, MLPs have emerged as an intervention to address social determinants of health by identifying legal needs within the healthcare setting and providing a connection to legal services.³ This connection is vital because the majority of Californians do not seek legal help for legal issues because of a gap in knowledge about the civil legal system.⁴ MLPs frequently operate on a warm-handoff referral model—the healthcare provider sends the referral to the legal aid partner after receiving authorization from the patient, and the legal aid partner initiates contact with the referred patient in order to assess what level of legal help to provide. If the legal aid partner is unable to establish contact, they can contact the referring provider again to strategize on how to connect the patient with legal help. By shifting the onus of initiating contact with legal services from the patient to the legal staff, MLPs remove barriers to access for people in need of assistance who may struggle with a legal services organization's regular intake protocols such as navigating through a call-in line during the hours of operation. This model also shifts the investment of time to initiate the relationship from the patient to the legal staff, with legal staff setting aside time for call-backs and partnering with the referring individual or agency to conduct the most effective outreach possible. BayLegal's MLPs have found that even when patients receive information from their healthcare providers on how to contact legal help, they frequently are not able to be proactive about making the call for various reasons, including anxiety about calling a lawyer or being turned away from services.

Patients given access to legal assistance have shown reduced stress and decreases in readmission rates, inpatient stays, and emergency department visits.⁵ Clients in Alameda County's SSI Disability Advocacy MLP, for example, have shown increased housing stability, and reduced usage of psychiatric emergency services, hospitalization, and recidivism.⁶ Thus, MLPs have proven to align with the guiding principles and key goals of CalAIM, including to improve the member experience, deliver person-centered care, identify and mitigate social determinants of health and reduce

¹ "The Justice Gap: Measuring the Unmet Civil Legal Needs of Low-Income Americans," 2017, available at <https://lsc-live.app.box.com/s/vvg3z2a0ze7444jgge49v7y530q3ykkx>.

² The State Bar of California, California Justice Gap Study, revised Feb. 2, 2019, available at <https://www.calbar.ca.gov/Portals/0/documents/accessJustice/Justice-Gap-Study-Executive-Summary.pdf>

³ Heather A McCabe and Eleanor D Kinney, "Medical Legal Partnerships: A Key Strategy for Addressing Social Determinants of Health," *J Gen Intern Med* 25, no. 2 (2010): 200–201, <https://doi.org/10.1007/s11606-010-1298-9>.

⁴ The State Bar of California, California Justice Gap Study, revised Feb. 2, 2019, available at <https://www.calbar.ca.gov/Portals/0/documents/accessJustice/Justice-Gap-Study-Executive-Summary.pdf>

⁵ Marsha Regenstien et al., "Addressing Social Determinants Of Health Through Medical-Legal Partnerships," *Health Affairs* 37, no. 3 (March 5, 2018): 378–85, available at <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.1264>.

⁶ http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_2_22_21/PUBLIC%20ASSISTANCE/Regular%20Calendar/Item_2_General_Assistance_SSI_2_22_21.pdf

disparities and inequities in access to healthcare, and to improve quality outcomes, and reduce health disparities.

Medical Legal Partnership services should be clearly enumerated as a covered service within the CalAIM In Lieu of Services framework.

Legal services providers and MLPs are aligned with the proposed target populations for Enhanced Care Management (“ECM”), including services for children and youth with disabilities, individuals experiencing homelessness, high utilizers of emergency services, individuals at risk of institutionalization, and individuals transitioning from incarceration. Likewise, MLPs are consistent with the proposed implementation of In Lieu of Services (“ILOS”) and provision of flexible wrap-around services, including by being able to help individuals to maintain housing, e.g., by preventing eviction, preventing housing discrimination, ensuring habitability, protecting personal safety of interpersonal violence survivors, increasing access to public benefits, or maintaining eligibility for In-Home Support Services. Housing transition navigation services, rental assistance, and tenancy supports are effective tools for preventing and ending homelessness⁷, but can be more effective when supported by legal services. We hope that you will consider explicitly enumerating legal services in the list of ILOS covered services, and that managed care plans will be reminded to include existing MLPs in their Transition & Coordination Plan.

Ongoing funding is needed to ensure access, coordination and continuity of services.

Funding for civil legal services does not adequately meet the needs of low-income Californians. The State Bar of California estimates that given the state’s poverty rate, an additional 8,961 full-time attorneys would be needed to address all the civil legal problems experienced each year by low-income Californians.⁸ Whole Person Care (“WPC”) has helped increase the number of full-time attorneys in the counties that have chosen to include legal services as part of their pilots. WPC added two full-time BayLegal attorneys to operate an MLP with Contra Costa Health Services (“CCHS”), and thus has added significant attorney capacity in Contra Costa County.⁹ These attorneys are able to provide full scope representation to Contra Costa County residents, and provide regular trainings and technical assistance to case workers throughout the county. Alameda County’s WPC pilot added 5.5 attorneys to provide legal representation for housing issues, operate a countywide Tenant’s Rights Line, and develop and deliver housing legal workshops.¹⁰ Los Angeles County has also added a significant number of attorneys through their WPC model. These programs have established relationships between medical and legal service providers, and have ongoing caseloads, funding for which should be maintained through the transition from Whole Person Care to CalAIM. We urge

⁷ Medicaid Waivers and Tenancy Supports for Individuals Experiencing Homelessness: Implementation Challenges in Four States, April 27, 2021, <https://onlinelibrary.wiley.com/doi/full/10.1111/1468-0009.12514>

⁸ The State Bar of California, California Justice Gap Study, revised Feb. 2, 2019, available at <https://www.calbar.ca.gov/Portals/0/documents/accessJustice/Justice-Gap-Study-Executive-Summary.pdf>

⁹ In December 2012, Stanford Law School published the study “A Snapshot of Legal Services in Seven Bay Area Counties.” We inquired with Stanford Law School on whether they plan to update the study and unfortunately, they have no immediate plans to do so. As of that time, Contra Costa had the highest ratio of families in poverty per attorney/advocate: 14,274:1. See [https://law.stanford.edu/wp-content/uploads/sites/default/files/publication/920332/doc/slspublic/A%20Snapshot%20of%20Civil%20Legal%20Services%20in%20Seven%20San%20Francisco%20Bay%20Area%20Counties%20\(2012\).pdf](https://law.stanford.edu/wp-content/uploads/sites/default/files/publication/920332/doc/slspublic/A%20Snapshot%20of%20Civil%20Legal%20Services%20in%20Seven%20San%20Francisco%20Bay%20Area%20Counties%20(2012).pdf)

¹⁰ See id, As of that time Alameda County’s ratio of families in poverty per attorney/advocate was 6,843:1.

DHCS to clearly enumerate legal services as a covered service under CalAIM. Alternatively, plans opting to incorporate other ILOS services should also be required to contract with legal services providers and offer this benefit to members. ILOS without a legal services component will offer an incomplete and suboptimal service to patients.

Expanded funding for the Global Payment Program, eligibility for a fee-for-service option, and Enhanced Care Management will help to ensure access to legal services.

We support DHCS' commitment to the Global Payment Program (GPP) as a way to increase engagement with vulnerable populations who are either uninsured or on restricted-scope Medi-Cal, and encourage DHCS to include a fee-for-service option to allow individuals to access legal services through CalAIM even when a health plan has not included ILOS. Furthermore, the focus on vulnerable target populations for Enhanced Care Management will help to identify individuals with civil legal needs and direct them for appropriate legal services, including access to public benefits, including disability benefits.

Continued support for legal services will further DHCS' goals of improving patient outcomes and reducing health disparities by helping to reduce homelessness, increase housing stability, increase household income, and reduce reliance on emergency and inpatient services.

Thank you for your consideration of these comments. I can be reached at sweiss@baylegal.org or by phone at (510) 663-4744 x5206.

Sincerely,



Steven M. Weiss

Regional Managing Attorney

Bay Area Legal Aid





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May 6, 2021

Will Lightbourne, Director
California Department of Health Care Services
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Sacramento, CA 95814

RE: Public Comments on California 1115 & 1915(b) Waiver Proposal

Dear Director Lightbourne,

Venice Family Clinic appreciates the opportunity to comment on the proposed CalAIM Section 1115 and Section 1915(b) Waiver Amendment and Renewal Applications.

Venice Family Clinic commends the Administration’s commitment to implement CalAIM, an initiative that will lead to broad delivery system, program, and payment reforms across Medi-Cal. We see many positive changes in the proposal. However, we do have concerns and recommendations, and would like to share them below for your review and consideration. Specifically, In the paragraphs below, we detail the following:

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



important initiative and look forward to working with the Department on CalAIM implementation.

Comments

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

We are aware of the time and investment the state committed to the design and vision of Medi-Cal Rx. However, providers and health plans have systems in place today that ensure pharmacy access for Medi-Cal beneficiaries.

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Delaying the transition at the last minute, as was done in December 2020 and again in April 2021, will undermine already strained delivery systems and further confuse and worry Medi-Cal beneficiaries. To that end, we ask DHCS to continue to delay the pharmacy transition to ensure no disruption in pharmaceutical access and guarantee patient access to their current pharmacy through the COVID-19 pandemic. We have already upended typical operations to ensure safety during the past calendar year. We canceled group programming; limited in-person visits and expanded telemedicine infrastructure (shifting non-urgent medical, behavioral, and dental visits to phone or video); redesigned workflows; developed infection control protocols; altered common clinic areas for physical distancing; and began COVID testing and vaccination. With this onslaught of changes, we have not been able to adequately prepare for the pharmacy transition. Recognizing the rapidly evolving pandemic response, as well as the current challenges and unknown resolution to conflict concerns with the project's contractor vendor, we recommend the department delay the pharmacy transition and consider removing the transition from its waiver proposal.

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

The CalAIM proposal will ensure that beneficiaries receive the care they need no matter how they enter the system and where they are in the system. Currently, treatment services are not available until a patient completes an assessment, which often can be counterproductive to patient engagement, especially for patients in crisis or in substance withdrawal. For that reason, we applaud the Administration proposal regarding allowing treatment during the assessment period and the “no wrong door” proposal that will ensure provider’s ability to render necessary medical services to patients. However, questions remain as to how providers can comply with, and bill for, those services if they are not contracted with a county specialty mental health plan. Health centers often are contracted providers and that arrangement often leaves health centers in a financially disadvantaged position where they must provide needed services under federal law but cannot bill for those services. Venice Family Clinic is not currently contracted with the county and for that reason, we ask DHCS to provide clarification on how non-contracted providers can provide medically necessary services prior to an assessment.

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

The Cal AIM proposal will integrate county mental health plans and Drug Medi-Cal Organized Delivery Systems into a single behavioral health plan. Although we recognize a statewide need to enhance access to both sets of services in a

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coordinated manner, we see several issues that need to be addressed in order to ensure that counties are prepared to adequately meet the demand for services and patients/families can be assured they are receiving the highest quality of care. Most notably, we are concerned with how the state will hold county behavioral health plans accountable for performance with managed care responsibilities, especially when the administration of two discrete programs are consolidated. Recent statewide audits of SMH plans found that counties were deficient in meeting quality and timely access goals. In fact, 2017/18 External Quality Review Organization (EQRO) reported that several SMH plans did not have performance improvement plans, functioning quality improvement committees, and failed to meet culture-specific and community defined best practices for communities, perpetuating ongoing disparities in access and care. Thus, while Venice Family Clinic agrees that the integration of SMH/SUD into specialty behavioral health is necessary, there must be necessary safeguards to ensure access to timely and quality SMH/SUD services.

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

Venice Family Clinic is pleased to see the inclusion of Enhanced Care Management and In-lieu-of Services in the Cal AIM proposal as well as the Administration’s commitment to ensure adequate funding is allocated for these services in this year’s budget. However, to ensure successful implementation of these elements, it is important that community-based organizations, including health centers, have the tools and resources needed to work together. We are encouraged by the inclusion of the Providing Access and Transforming Health Supports, which is necessary to transition existing services and build up capacity, including payments for new staffing and infrastructure. Supports are also needed to guarantee data exchange, establish payment relationships, measure value and outcomes, and ensure that beneficiaries



elements that might impact their current operation and infrastructure, namely implementation of a new care management system and process, new care referral process or new claim submission process, new patient assignment process and other. Yet more is needed. Therefore, we respectfully ask DHCS to ensure ample resources and support available to ECM and ILOS providers.

5. DHCS must ensure the public has opportunity to review and comment on many policy changes that are described in the waivers but are not included as part of the waiver proposal.

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While we appreciate the opportunities to comment on the 1115 and 1915(b) waivers and expect DHCS will release other policy changes for public comment in the future, we would like to underscore the importance of gathering and incorporating stakeholder input into final policies. Specifically, we request extensive public comment and engagement on the following items noted in the proposal:

- A standardized screening tool for county Behavioral Health plans and Medi-Cal managed care plans to use to guide beneficiaries toward the delivery system that is most likely to meet their needs.
- A standardized transition tool for MHPs and MCPs to use when a beneficiary's condition changes and they would be better served in the other delivery system.
- A process for facilitated referral and linkage from county correctional institution release to county specialty mental health, Drug Medi-Cal, DMC-ODS, and Medi-Cal MCPS when the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

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

Again, Venice Family Clinic appreciates this opportunity to submit comments on the waiver proposal. We look forward to working with you to implement these major changes. If you have any questions, please contact Elizabeth Benson Forer at EForer@mednet.ucla.edu.

Sincerely,



Elizabeth Benson Forer, MSW/MPH
Chief Executive Officer and Executive Director
Venice Family Clinic

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Providing quality primary health care to people in need



May 6, 2021

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

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

Dear Director Lightbourne:

On behalf of [San Diegans for Healthcare Coverage](#), representing a collaborative including healthcare providers, social service agencies and consumer advocacy organizations, I would like to thank you for the opportunity to offer comment on the CalAIM Section 1115 & 1915(b) Waiver documents released by DHCS on April 6, 2021, as well as many of the CalAIM documents and workgroup proceedings that further define DHCS plans.

These comments are limited primarily to plans related to Medicare and Medi-Cal beneficiaries. As a Cal Medi-Connect (CMC) county, we in San Diego have firsthand experience with the preferences of our dual eligible populations, with the majority opting out of CMC enrollment. What we understand from state documents and presentations is that:

- Medicare Advantage D-SNPs have not been approved for operation in CMC counties and will not be approved to operate in CMC counties until 2024:
- Medicare Advantage Look Alike plans will not be available to enroll dual eligible beneficiaries starting January 1, 2022 and those already enrolled will be transitioned at some point to D-SNP plans -- when and how that will occur is not at all clear:
- We have been told that the state is not limiting the right of dual eligible beneficiaries to enroll in Medicare Advantage Plans or to stay in Fee-for-Service Medicare; however, this is not a realistic option for low-income seniors when they face cost sharing unless they enroll and use the provider network of a Medi-Cal Managed Care plan:
- The plan presented at the April 29, 2021 Stakeholder Advisory Committee (SAC) indicates that the state wishes to contract with just two Medi-Cal Managed Care Plans in San Diego. This would mean there could be only two Medicare Advantage D-SNP plans approved for San Diego. Given provider affiliations, this will severely limit beneficiary provider options and access as the major medical groups in our region are affiliated with Advantage Plans but do not contract for full care with CMC plans; and,
- At today's MLTSS Workgroup, it was stated that these steps are to move to an integrated system for our vulnerable low-income seniors; however, the first section of the Draft D-SNP Scope of Work – Attachment 1 -- lists requirements to coordinate care with five other entities and agencies. This does not appear to integration so much as fragmentation.

The state plans for low-income duals is a poor reward for those who have worked many years to earn their Medicare eligibility and coverage. While we understand that CMS will not allow Medicare

Advantage Look Alike plans to enroll after January 1, 2022, we also know that it is through these plans that many seniors in our community are provided access to integrated health care and much greater access to specialty care in their own neighborhoods. Our community health centers are also part of these plans and work with the affiliated groups. Eliminating the Look Alike option without addressing the reasons most duals opt out of CMC plans is acknowledging that consumer access is not truly a priority.

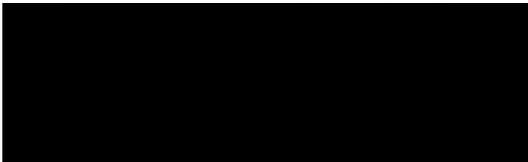
It is unconceivable that the state would limit “realistic” options for duals when there are alternatives that would provide health plan options and access to all healthcare systems in our region through true Medicare Advantage D-SNP plans. The Look Alike plans have demonstrated that this is possible.

We ask that the state focus on expanding the number of Medicare Advantage D-SNP Plans available effective January 1, 2022 while pursuing broader integration of LTSS and ILOS over the coming years. We further request that the State recognize that two plans for a county with our population, size, diversity and geography is simply not realistic, nor in the best interest of the beneficiaries.

We admire the goals of the CalAIM program but do believe the timing for implementation, in light of these and other factors, is simply too short and it is the beneficiaries who will suffer.

Again, I appreciate this opportunity to submit comments on the waiver proposal. I look forward to working with you to establish the best systems and options for low-income seniors possible. If you have any questions, please contact me directly.

Sincerely,



Jan C Spencley, Executive Director
San Diegans for Healthcare Coverage

cc: SDHCC Board of Directors



May 6, 2021

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

RE: CAPH Comments on California’s Medicaid Section 1115 Demonstration Five-Year Renewal and Amendment Request: CalAIM Demonstration & Related Efforts

Dear Director Lightbourne,

On behalf of California’s public health care systems, we appreciate the opportunity to provide comments on California’s Medicaid Section 1115 Demonstration Five-Year Renewal and Amendment Request. As you know, since 2005, California’s 21 public health care systems have partnered with the State and Federal Administrations to utilize Section 1115 Medi-Cal waivers to transform care delivery for the state’s most vulnerable patients. Public health care systems play a unique role in this regard, as they serve as both key safety net providers, and as a source of non-federal share to finance waiver and other supplemental payment programs.

As each waiver expires, public health care systems reflect on the successes achieved, and the opportunities for further improvement that could be catalyzed through performance-based incentives. Beginning with the 2007 Coverage Expansion effort, 1115 waivers have accelerated coverage expansion and delivery system transformation for public health care systems and their patients. For example, the 2010 *Bridge to Reform* strengthened the groundwork for coverage and primary care efficiencies that were needed to prepare for Medi-Cal expansion through the Affordable Care Act. *Medi-Cal 2020*, renewed for an additional year through 2021, has continued the upward improvement trajectory for public health care systems with challenging performance metrics that have improved health outcomes through more patient-centered care.

With CalAIM, California, the Federal government, public health care systems, and other stakeholders again have an opportunity to build on key successes and further transform care. We recognize and appreciate the tremendous work by the Department of Health Care Services in developing CalAIM, and we thank you for your partnership and thoughtful policy considerations.

CAPH supports the CalAIM proposal as a comprehensive package of 1115 and related programs and policies, each essential to supporting and stabilizing the public health care safety net and catalyzing improvements in care delivery. We believe that this package must include the following elements:

- A successful transition of Whole Person Care to Enhanced Care Management, In-Lieu of Services, and PATH payments;
- Renewal of the Global Payment Program with Medicaid DSH and Safety Net Care Pool, as well as an Equity Pool;
- Services for Justice-Involved Populations 30 Days Pre-Release; and



- Transitioning the PRIME Program into the Quality Incentive Pool.

Whole Person Care's (WPC) Transition to CalAIM

The concept of Whole Person Care (WPC) is premised on the recognition that the best way to care for people requiring complex care is to consider their full spectrum of needs – medical, behavioral, socio-economic and beyond. For people in low-income communities, medical problems can be caused and exacerbated by factors related to poverty that include poor nutrition, lack of safe and stable housing, incarceration, unemployment, and the chronic anxiety of income insecurity. While services may be available to help alleviate some of these stresses and inequities, they are often delivered in a siloed fashion. Different types of service providers do not regularly communicate or coordinate care, even though they may be serving the same individuals and families.

By receiving tailored support and coordinated services, patients can ultimately enjoy healthier lives. The improved efficiencies associated with care coordination also enables safety net providers to maximize and stretch their limited resources, in order to reach more people and improve health outcomes across a wider swath of the community.

Whole Person Care pilots have clearly demonstrated the positive impact of integrated, patient-centered care. The WPC mid-term evaluation found improvements in:

- *Care coordination infrastructure*: Pilots implemented data sharing infrastructure, such as care management platforms and health information exchanges, which allow for real-time communication between providers and documentation of patients' holistic health and social needs. Pilots designed global payment bundles (per-member-per-month) for care coordination that afforded flexibility in how, when, and where staff coordinated services so they could be most responsive to patients' needs. Additionally, pilots established new, multidisciplinary care teams with representation across partnering organizations, many including peer support staff who draw on their personal lived experience and empathy to engage clients.
- *Better care processes*: WPC pilots use the Plan-Do-Study-Act (PDSA) methodology to continually test and improve their care processes, with demonstrable results. For example, in the first year of implementation, many pilots adapted their enrollment processes to expand provider referrals and rely more heavily on in-person outreach to engage difficult-to-reach clients, resulting in steady increases in enrollment in Year 2. Pilots are required to report PDSA improvements, as well as metrics that capture changes in care processes. An assessment of process metrics in the evaluation found that, compared to pre-enrollment, WPC clients had: (1) higher rates of follow-up after hospitalization for mental illness; (2) improved initiation and engagement in treatment for alcohol and other drug dependence; and (3) more timely provision of care plans. For several process measures, improvements were greater for justice-involved clients.

The findings suggest better coordination between physical health, behavioral health, and the criminal justice system, and point to the value of WPC's high-touch, intensive case management model. Additionally, the report showed that WPC clients received statistically significant better care in follow-up after hospitalization for mental illness, as well as initiation and engagement in



treatment for alcohol and other drug dependence, when compared to a control group of Medi-Cal enrollees with similar demographic, health, and service utilization patterns.

- *Better health outcomes:* The evaluation shows a complicated yet optimistic picture of health outcomes as a result of WPC. Compared to a control group, WPC clients had significantly greater reductions in Emergency Department (ED) use (19% vs. 8%) and all-cause readmissions (16% vs. 2%) between their first and second years of enrollment. ED use and all-cause readmissions increased immediately after enrollment in the program, likely because pilots identified clients based on high rates of utilization, and those high rates continued to trend upward until the program had time to take effect. While hospitalization rates decreased more in the control group, WPC clients were less likely to ever experience an ED visit or hospitalization during enrollment in the program. Of the six pilots that tracked self-reported health, the percent of beneficiaries reporting “Excellent” or “Very Good” increased for emotional health (15% to 22%) and almost threefold for overall health (8% to 22%). Finally, pilots reported improved rates of control in blood pressure and HbA1c for WPC clients.

Shifting Whole Person Care from an 1115 pilot program to a Medi-Cal managed care structure offers opportunities and potential challenges. The draft proposal notes that the State “seeks to transition Whole Person Care to seamlessly transition beneficiaries served by [Whole Person Care and Health Homes] to ECM and targeted ILOS.” While many of the elements to achieve this goal transcend the State’s 1115 CalAIM proposal, we believe that the transition can only succeed if the following objectives are met:

1. Counties’ and Public Health Care Systems’ Infrastructure and Expertise Are Leveraged and Reflected in the New Structure.

Having achieved the successes listed above, Whole Person Care pilots now run the risk of withering on the vine if their infrastructure and expertise are not fully leveraged. Managed care plans must contract with counties, organize the plans’ ECM and ILOS offerings around existing WPC pilot infrastructure, and share incentives payments with providers in order to ensure a seamless transition from one structure to another.

2. Providers Receive Adequate Funding For Services to Complex, Hard-to-Reach Patients.

The success of the future of Whole Person Care hinges on a successful transition and on the adequacy of payments for the services provided. We commend the State for making significant investments of State General Fund to ensure programmatic success, and hope that those investments will grow over time to meet the needs of this complex patient population. In particular, public health care system providers, who have and will continue to make their own investments to serve targeted populations, must share in the State-funded incentives and IGT-funded PATH payments, in order to support their efforts.

3. Enrollment and Care are Delivered in the Most Patient-Centered Way Possible

Commented [ABO1]:



Transitioning a program from a pilot structure to Medi-Cal managed care requires creative problem-solving around existing processes and potential hurdles for patients. For example, WPC patients are often identified through proactive outreach to homeless camps, shelters, and other locations. The provision of outreach, the processes for enrollment in managed care, and ongoing communication with the patient, must be structured to reflect their particular needs and situations.

4. Plans and Providers Develop Effective Mechanisms and Structures Together to Share Data.

The collaboration between pilots and plans in transitioning Whole Person Care to CalAIM must include clear guidance and policies regarding data sharing, which is the lynchpin for truly integrated care, especially when connecting a wide array of service providers to each other and to local managed care plans.

PATH Payments

We applaud the inclusion of PATH payments as an important mechanism to ensure a successful transition from Whole Person Care to a managed care structure. PATH payments must be adequately funded in order to support public health care system providers and their efforts to maintain and expand the services to targeted populations. Moreover, we believe the State should consider expanding PATH funding further, in order to stabilize and support public health care systems, which have, and would need to continue to, play a critical role in the state's pandemic response.

Commented [ABO2]:

Services for Justice-Involved Populations 30 Days Pre-Release

CAPH strongly supports the State's request for Medi-Cal matching funds for services for incarcerated individuals 30 days prior to release. Such in-reach has the potential to improve care for a patient population that often has mental health, substance abuse challenges, as well as barriers to services such as housing, food and other social supports. We believe that the State's proposal should cover a more comprehensive set of services to ensure a smooth transition from incarceration to Medi-Cal, reduce recidivism and unnecessary emergency room utilization, and help improve health outcomes.

Commented [ABO3]:

Global Payment Program (GPP)

In 2015, California restructured two funding streams to encourage county public health care systems to shift the preponderance of care provided to the remaining uninsured from emergency and inpatient settings to primary and preventive services. The Safety Net Care Pool and the county public health care system's allocation of Medi-Cal DSH payments were combined into a new program called the Global Payment Program that assigned points for care, with relatively higher values for primary and outpatient care versus emergency and inpatient services.



An independent evaluation of the current GPP found that it has been successful in rewarding cost-effective care, rather than volume of services. For example, GPP reported an increase in outpatient services and a decrease in inpatient and emergency services. Other key findings include a 42% increase in the use of non-traditional outpatient services, including services such as telehealth, e-consults, and health coaching, and an overall increase of 6% in the number of uninsured patients served over the first three years of the program.

These achievements, while significant, also reveal more work to do to ensure that uninsured patients receive care in the most appropriate setting. An additional five years of the GPP is intended to result in a further decline in the utilization of emergency and inpatient care by those who remain uninsured, as they develop and deepen their connections to primary care health care teams and succeed in adopting preventive strategies.

With ongoing uncompensated costs incurred for serving the remaining uninsured, the next five years of the GPP must include Safety Net Care Pool funding. These funds have proven to be critical in helping public health care systems provide services to the remaining uninsured during the first five years of the GPP. The COVID-19 pandemic has only increased the number of uninsured in California; public health care systems simply cannot afford to maintain their existing levels of service to the uninsured without ongoing SNCP funding as part of the GPP.

Moreover, we believe that beyond another 5 years of the GPP, the program could be even stronger with a sharper focus on opportunities to provide more equitable care for communities of color. Most Californians who remain uninsured are African American or Latinx. Public health care systems believe that uninsured patients should receive the same comprehensive range of services – physical, behavioral, and social – as those in Medi-Cal have received through Whole Person Care and now CalAIM. To achieve this programmatic equity, and to make meaningful strides in providing equitable care for communities of color, an Equity Pool would catalyze comprehensive and coordinated services for the uninsured. This Equity Pool would create the opportunity for the remaining uninsured to experience the benefits of care coordination, patient-centered care, and resulting improved health outcomes.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME) and the Quality Incentive Pool (QIP)

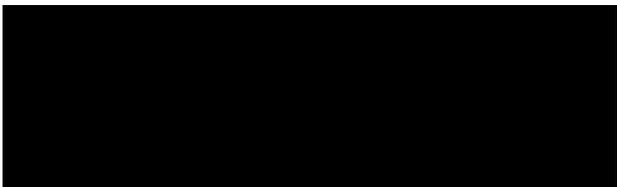
Through Medi-Cal 2020, public health care systems met hundreds of performance milestones in PRIME, which led to significant gains in the quality of care provided by public health care systems. For example, mid-year DY 15 data showed that between 2015 and 2019, an additional 17,800 patients achieved blood pressure control, which reduces the risk of other costly health outcomes. More than 100,000 patients received tobacco screening and counseling, and an additional 262,600 patients were screened for depression. These preventive health services can have a dramatic impact on the overall health of communities, especially in low-income and minority areas.

The expiration of PRIME in June 2020 provided the opportunity to evolve the program into an existing, and more challenging, performance-based program: the Quality Incentive Pool (QIP). Under the expanded QIP, public health care systems must report on 40 measures, including 20 required [measures](#) and 20 elective measures. By design, the selected measures align closely with State and Medi-Cal managed care plan priorities. The program also includes a required measure focused on improving health equity, which integrates stratified race and ethnicity data reporting into several multiple



measures. This stratification will inform and lay the groundwork for future expansion of health disparity reduction efforts in QIP. Although not part of the state's waiver proposal, the QIP provides an example of the success performance-based supplemental payment programs can have on Medi-Cal beneficiaries and public health care systems. We believe the proposals outlined in the state's waiver proposal demonstrate this same promise.

Again, thank you for the opportunity to provide comments. Please know that CAPH and our member systems appreciate your leadership and partnership as we pursue a new agreement with the Federal Administration that ensures higher quality and more equitable care for the state's most vulnerable, through a strong and vibrant public health care system.



Erica Murray
President & CEO
CAPH

cc: Dr. Mark Ghaly, Secretary, California Health and Human Services Agency
Jacey Cooper, State Medicaid Director & Chief Deputy Director, DHCS

May 6, 2021

Dear Director Lightbourne--

Young Minds Advocacy submits the following comments on the CalAIM 1915(b) Waiver Overview dated April 2021 (hereinafter “Waiver Proposal”). Young Minds Advocacy, founded in 2012, is a 501(c)(3) advocacy organization seeking to improve access to appropriate mental health services and achieve better outcomes for children and youths with serious unmet mental health needs and their families. Our review and comments are limited to the Medi-Cal beneficiary population of individuals under age 21 who are eligible for mental health services based on the likelihood of meeting Medicaid medical necessity. We appreciate the opportunity to comment on the proposal.

Overall, the Waiver Proposal is difficult to assess because it presents the material at a high level of generality. Many elements remain to be determined or specified, and there are few details regarding processes that will succeed or fail based on the absent details. Given how long the CalAIM process has steeped, it is hard to understand why the Waiver Proposal is as cursory as it is. What is more, although the CalAIM proposal is referenced a few times in the 1915(b) Waiver Overview, it is not incorporated by reference or included as an appendix. Accordingly, we did not consider it to be part of the Waiver Proposal in developing these comments, except where it is specifically cited.

Although the details are largely missing, there is value in providing input on the proposal. We have grouped our comments as follows:

1. Goals and Purposes

“CalAIM has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing social determinants of health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.” Pg. 2-3.

These goals are fine, so far as they go. Unfortunately, these goals overlook two of the most important objectives of the children and youths’ mental health system: accountability and effective outcomes. Indeed, accountability is never even mentioned in the mental health section of the Waiver Proposal, and only superficially in the Substance Use Disorder (SUD) sections. Failing to ensure accountability from DHCS, MCOs, MHPs, and providers for providing effective and necessary care will severely undermine these proposed reforms.

Similarly, failing to identify and focus on reforms that will improve the lives of children and families is a serious oversight. The need for better life outcomes for youth is fundamental to the mental health system’s success, and so much more than the token nods of “improve quality outcomes” or “plan for active monitoring on program impact” that are called out in the Waiver Proposal.

2. Eligibility and Access to Care

The Waiver Proposal seeks to improve access to care prior to a formal diagnosis, streamline criteria for services to beneficiaries under age 21, adopt a ‘no wrong door’ policy, develop standardized screening and transition tools, integrate SUD and mental health services, and increase coordination among service domains, among other things. Most of these proposals will be important forward steps. How they are implemented is key, however, and the details are mostly missing. Some of the proposals are simply commitments to “clarify” existing law or policy. Absent any new accountability mechanisms, it’s hard to accept that “clarifications” will significantly change service delivery or system outcomes.

Specific issues include:

- a. MCO mental health services for Sacramento and Solano counties are carved out to FFS. Pg. 6. This change, for which no reason is given, could affect seven thousand or more youth according to DHCS data. The Waiver Proposal should explain why this is necessary and how it will impact youth and families.
- b. Standardized assessment and transition tools will be developed. Pps. 9 and 28. DHCS and CDSS have already mandated assessment tools for youth that are not identified in the Waiver Proposal. This appears to be an invitation to re-litigate the CANS and PSC-35 decision, which would be counter-productive, divisive, time-consuming, and expensive. The Waiver Proposal should endorse these tools and use them in its service delivery, quality monitoring, and program management reforms. Additionally, implementing transition tools will need to be accomplished with greater accountability than delegating the triage and referral process to independent agreements or MOUs struck by MHPs and MCOs. Past agreements often have not adequately reflected ESPDT obligations or requirements, have limited or denied SMHS to eligible youth, and have over-subscribed MCO participation, likely substituting MCO non-specialty services for MHP-provided SMHS. Eligibility, service array, service intensity, and reimbursement amount are quite distinct for these two populations, and decisions about which child gets which service are not generally negotiable at the discretion of MHPs and MCOs.
- c. Clarifying that treatment is available prior to establishing a formal diagnosis is important and welcome. Pps. 8, 11, 13, and 27. Unfortunately, this very broad “clarification” does not describe how this will work in practice, or how it compares to eligibility for services based on “A less than significant impairment, but requires mental health services that are not included within the mental health benefits that managed care plans are required to provide” that is due to “A suspected mental disorder that has not yet been diagnosed.” Additionally, “treatment during assessment period” needs to be better described. Pg. 27. First, the list of included services is too limited, and second, the use of “e.g.,” regarding “certain mental health services” raises the question whether only “assessment, plan development, psychotherapy, and collateral” are reimbursable. The more appropriate list would include all medically necessary services, as is required under EPSDT.
- d. Expanding services to include youth experiencing trauma is a positive development. Pg. 25. The limitations added to this expansion are troubling, however. Especially problematic is the cherry-picking of client populations who are exempt from meeting a scoring requirement for eligibility. Not only does this approach run contrary to

Medicaid’s policy of providing medically necessary services to all eligible youth, it seems to dismiss or disregard needs among other at-risk populations, including juvenile justice-involved youth, youth who are sexually exploited or trafficked, LGBTQ youth, and youth in kinship care who are not child welfare-involved, among others. This expansion should base eligibility on medical necessity, much as home and community-based services are, rather than artificial scores or favored populations.

- e. Clarifying that treatment must be provided across domains, pg. 8, and for youth with co-occurring disorders, pg. 9, and endorsing ‘no wrong door,’ pps. 8 and 27, is necessary, but insufficient. These objectives will not be achieved without a big assist from DHCS. The fact that DHCS fails to provide support in the Waiver Proposal for the coordinated use of CANS by DHCS and CDSS, a concrete and critical opportunity to improve treatment across domains, demonstrates how far the agency has to go to change the ‘siloes’ cultures of child-serving systems—including its own.

Similarly, it’s not very helpful to state that “Patients with co-occurring mental health and substance use disorder conditions may be treated by providers in each of the behavioral health delivery systems,” but only if “the covered services are not duplicative and are performed within the provider’s scope of practice, the provider is contracted with the appropriate plan, and the services are billed to the appropriate plan, based on the policies and procedures for that plan: MCP, MHP, DMC-ODS, DMC, and /or FFS.” Pg.

28. While true, this simply restates the existing rules and reminds us of the high burden imposed on clients with co-occurring needs. Nowhere does the Waiver Proposal detail how these service barriers will be overcome. In other words, this appears to be business as usual.

As regards ‘no wrong door,’ the likelihood for success will depend on whether county MHPs change their existing practice of contractually limiting both direct client access to providers, and clinician/provider direct engagement with putative clients. This MHP budget management tool is widespread and effectively bars self-referrals, or even provider referrals. Moreover, the use of access lines and screening with referrals is not new. Also, unless using a statewide screening tool is carefully monitored, and additional items or conditions are prohibited, this avenue into care will end up as gate with a host of county-created limits and roadblocks.

- f. Integration of SUD and mental health service systems. Pg. 2, etc. This process has been ongoing, and the advent of the DMC-ODS has been essential to developing a true behavioral health system for children and youth. The concern here is how slowly it is being developed. That DMC-ODS will continue to be a voluntary opt-in program for five more years, where 21 counties have not joined, thereby denying adequate care to thousands of youths and their families, seems problematic at best. That contract integration for mental health services and SUD treatment isn’t planned until January 2027 is unambitious, to be sure.

3. Services

Mental health services are expected to increase under the Waiver Proposal. Several new services are listed including, peer support, pg. 7, Enhanced Care Management and In Lieu of Services, pg. 7, and mobile response and stabilization, pg. 10. In addition, more youths are likely to be served through broadened eligibility addressed above. Based on what’s presented in the Waiver Proposal, it is difficult to assess whether these proposals will have the intended benefits, and whether those benefits will amount to significant system reform that results in improved outcomes for children, youths, and their families.

Specific issues include:

- a. “A major change going forward for MCMC is the addition of Enhanced Care Management (ECM) and In Lieu of Services (ILOS).” Pg. 7. However, even though the Waiver Proposal states that “[t]he consolidated 1915(b) waiver will provide the authority for the MCMC program in general...” there is no further substantive description of these services. There is some discussion of these services in the State’s 1115 Demonstration Five-year Renewal and Amendment Request, but they are neither cited nor referred to in the Waiver Proposal. This oversight makes it impossible to ascertain how these proposed new services will integrate with the 1915(b) waiver, or what impacts these services may have on access to mental health care or outcomes for youths and their families.
 - b. “DHCS will use the Medicaid State Plan to include peer support specialist services as a distinct service type...” This is a welcome development as peer services can be invaluable for youths and families needing assistance. Unfortunately, DHCS proposes to make the service an option for the counties, and apparently fails to establish a youth peer support specialist as a separate service. One size definitely does not fit all when providing peer support, and absent trained youth peers, this service will fall far short of its promise.
 - c. “DHCS proposes to standardize the domains that should be part of assessment, in alignment with current clinical practice.” Pg. 26. It’s not clear what or whose clinical practice this refers to, but it does not fairly track the Children’s System of Care Principles and it doesn’t reflect the CANS approach, which is a required assessment tool for all youth accessing SMHS. This list seems to emphasize the medical model of services, notably overlooking strengths, family voice and choice, the child’s developmental arc, and makes no mention of collaboration among other domains such as school, child welfare, juvenile justice, etc. Granted, the listed categories might be interpreted to include some of these missing factors. But leaving these elements out does not generate confidence that this vital step in the service system will benefit from a standardized tool developed by DHCS.
 - d. DHCS proposes to “clarify the authority for county mobile response and stabilization teams to provide SMHS through the Family Urgent Response System (FURS) to current and former foster children and youth and their caregivers.” Pg. 10. Once again, supporting this service is a plus for those who may receive it. But mobile crisis for all Medi-Cal recipients is long overdue, as litigation in other state has clarified this is a Medicaid coverable service. See TR. et al v. Dreyfus, 2:09-cv-01677-TSZ. Accordingly, all Medi-Cal beneficiaries under age 21 with full-scope Medi-Cal who meet medical necessity should be provided this service.
 - e. DHCS recognizes the importance of treating justice-involved youths upon release from detention. Pg. 29. This is a powerful commitment, but it also needs to move upstream to serve youths’ needs before release. That means Medi-Cal services need to be available to these youth while detained, using waivers or well-written custody orders to provide access. For example, many of these youths will be eligible for ICC and IHBS upon release, and they can benefit from developing a child and family team before their release. That way, the several weeks it takes to get oriented and coordinated can happen while the youth is in custody, and service interventions and benefits can begin directly upon release. Too often the delay in starting services results in failed engagement, lack of services, and possible recidivism.
4. Funding and Administrative Reform

Behavioral Health Funding reform seems to be an intended “big lift” under this Waiver Proposal. Pg. 8. “To incentivize additional investment in the delivery systems and reduce overall burden on counties and the state, DHCS is proposing to reform behavioral health payment methodologies for counties.” CalAIM Proposal, pg. 78. “These reforms will allow not only for more timely review and final payment, but will enable the county behavioral health system, for the first time, to participate in and design true outcomes and value-based reimbursement structures that reward better overall results and quality of life for Medi-Cal beneficiaries.” Id.

“The state is proposing to reform its behavioral health payment methodologies via a multi-phased approach with the goal of increasing available reimbursement to counties for services provided and to incentivize quality objectives. This proposal would move reimbursement for all inpatient and outpatient specialty mental health and substance use disorder services from CPE-based methodologies to other rate-based/value-based structures that instead utilize intergovernmental transfers to fund the county-supplied non-federal share.” Id.

The state proposes to make this transition by first switching coding from the current HCPCS approach to CPT coding. Then, the state proposes to set reimbursement rates for behavioral health services that are provided to Medi-Cal beneficiaries using intergovernmental transfers, instead of Certified Public Expenditures with its burdensome reconciliation to actual costs process.

As with many other elements of this Waiver Proposal, this change seems like an unambiguous plus. It will likely benefit providers, counties, and the State by simplifying accounting and record-keeping. It is less likely to engender the other benefits the State is seeking, however.

The risks entailed in this approach stem from the lack of an accountability mechanism in the proposal that can ensure that money provided to the counties for behavioral health services will be spent on behavioral health care. Nor is there a mechanism to ensure that services provided to eligible youth are adequate or effective, or even provided at all.

The promise of better data and commensurate better quality without something more than a less onerous accounting system may be magical thinking. Both the counties and DHCS already have plenty of data that could be used to improve performance and quality in the children and youths’ mental health system. The problem is not that there is too little data; it’s that there is insufficient appetite for data-driven decision-making. And that’s driven by county budget decisions made by county administrators and supervisors, not by MHP managers using hard numbers about how many children need treatment, how intensive are the services they need, what should the scope of care be, or how long should we treat youth in care. The bottom line is there is nothing we could identify in the Waiver Proposal that sets any goals, standards, or procedures that themselves will increase quality of care.

In addition, the Waiver Proposal completely ignores the deeply problematic inequities of existing mental health funding and access to care for Medi-Cal recipients. It has long been known that Central Valley counties provide far less access to care than do richer, Coastal counties. Research shows that the poorer performing counties, on average, provide less of their youth population with any services, and for those that do receive care, they get fewer treatment units, more limited scope of treatment, and a shorter duration of services. This is caused, in large measure, by the allocation of Realignment funding begun back in 1991, and then aggravated with funding allocation decisions following 2011 Realignment. Given the very large funding imbalance due to Realignment, and the

consequent lack of services and resultant hardships to thousands of Medi-Cal youths (about 40% of eligible youth live in under-performing counties), it's hard to understand how finance reform could so utterly fail to address this challenge.

Summary

The prospect of serious reform that followed the initiation of CalAIM is now posed to us in this 1915(b) Waiver Proposal, and it is a disappointing offering. Not only is it lacking as a basic explanation of what is intended, it fails to convince that the several promising ideas are likely to be successfully implemented. Most problematic is the complete lack of accountability. There are no standards of care proposed—even though such standards are now the law of the land in California so far as commercial mental health services are concerned. See Wit, et al v. United Behavioral Health, 14-cv-02346-JCS, and SB 855 (Weiner 2020). Even the apparent service expansions generate more questions than answers. Additionally, there are no mechanisms to ensure that finance reform will actually generate quality improvements, and the most pressing financing concern facing Medi-Cal children and families needing mental health services in California is entirely ignored.

The good news is, there's still time to fix this. It may be the case that a better description of what is planned would itself rectify some of the problems raised above. For starters, the Waiver Proposal should explicitly address what parts of the CalAIM proposal are, and are not, included in the Waiver applications. Additionally, a number of concerns about the proposals seem to be self-inflicted wounds that could be mended before the proposal is finalized. More challenging is the alarming lack of accountability in the proposal. This likely stems from DHCS' long tradition of managing contracts with the counties for fraud and abuse, not managing the children's behavioral health system for results. That needs to change, but I fear that won't happen in time to save this Waiver Proposal.

Respectfully,

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May 6, 2021

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CHAIRPERSON
Noel J. O'Neill, LMFT
EXECUTIVE OFFICER
Jane Adcock

- **Advocacy**
- **Evaluation**
- **Inclusion**

Dear Ms. Cooper:

The California Behavioral Health Planning Council thanks you for the opportunity to comment on the proposed CalAIM 1115 and 1915(b) waivers. Pursuant to state law, the Council serves as an advisory body to the Legislature and Administration on the policies and priorities that this state should be pursuing in developing its behavioral health system. Our membership includes persons with lived experience as consumers and family members, professionals, providers, and representatives from state departments whose populations touch the behavioral health system.

The Council's Systems and Medicaid Committee (SMC) supports the CalAIM Initiative as it strives to improve quality outcomes through payment reform and value-based strategies, increases flexibility and reduces complexity in the current system. Given the revisions made to CalAIM in January 2021 as well as the significant changes proposed for the renewal and amendment of the 1115 and 1915(b) waiver authorities, the SMC has developed recommendations in addition to previous input submitted to DHCS in March 2020 and December 2020.

We believe the following recommendations will strengthen the CalAIM proposals to ensure consumers of the public behavioral health system are able to access and receive high-quality services to lead full and purposeful lives. These recommendations encompass providing culturally appropriate and responsive care with respect to all populations including but not limited to immigrant and refugees, children and families, LGBTQI2S and ethnic populations.

Listed below are the Systems and Medicaid Committee (SMC) recommendations for the proposed CalAIM 1115 and 1915(b) waivers on behalf of the California Behavioral Health Planning Council:

- Amplify and expand services provided by Natural Helpers and Traditional Healers to all cultural communities for the Drug Medi-Cal Organized Delivery System (DMC-ODS), Specialty Mental Health Services (SMHS), Managed Care Plans (MCPs), and contracted entities providing behavioral health services.
- Enhance information sharing capabilities to promote effective care coordination and transitions between delivery systems. DHCS may consider utilizing a health information exchange vehicle to help facilitate information sharing across entities.
- Provide specific guidance¹⁹¹⁴ Managed Care Plans (MCPs) and county Mental Health Pla (HPs) to coordinate care, particularly

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for populations receiving the Enhanced Care Management (ECM) and In Lieu of Services (ILOS) benefits.

- Utilize and exchange a single coordination of care document in electronic medical records (EMRs) across entities statewide to leverage and ensure the timely exchange of pertinent patient information.
- Create greater efficiencies to eliminate duplication of certification requirements between mental health and substance use disorder (SUD) systems of care.
- Ensure that the CalAIM proposals result in reduced documentation requirements in order to promote sufficient time for patient care.
- Allow Medi-Cal beneficiaries to receive coordinated services outside of their county of residence to strengthen the No Wrong Door approach to improve access and timeliness of care.

A comprehensive description for each recommendation is provided below:

Recommendation: Amplify and expand services provided by Natural Helpers and Traditional Healers to include all cultural communities for the Drug Medi-Cal Organized Delivery System (DMC-ODS), Specialty Mental Health Services (SMHS), Managed Care Plans (MCPs), and contracted entities providing behavioral health services.

The SMC is supportive of the proposed expansion of services to California's diverse population by allowing Medi-Cal reimbursement for Natural Helpers and Traditional Healers for DMC-ODS, as this policy seeks to improve equity and reduce racial disparities in health outcomes. However, this policy excludes payment for culturally-responsive services and healing practices for the Asian and Pacific Islander, Hispanic, African American, and several other ethnic and cultural communities.

CalAIM also signifies that services provided by Natural Helpers and Traditional Healers are reimbursable in the Drug Medi-Cal Organized Delivery System but no other delivery systems. County Mental Health Plans (MHPs) currently provide culturally-specific services through community-defined practices but are not reimbursed through Medi-Cal. Instead, counties rely on Mental Health Services Act (MHSA), Realignment, and other local funding sources to pay for these services. Inequities and disparities in access and quality of care are likely to persist if Medi-Cal reimbursement for community-defined cultural practices applies only to one delivery system (DMC-ODS), as it disregards populations with co-occurring disorders or varying degrees of mental illness. In order to ensure equity and reduce health disparities across all communities, the SMC is requesting DHCS to seek Medicaid

reimbursement for cultural healing and community-defined practices for all ethnic and cultural communities throughout multiple delivery systems. While the California Behavioral Health Planning Council's focus is aimed towards publicly-funded services delivered to individuals with severe behavioral health conditions, it is important to include these services in Managed Care, in addition to county MHPs, for consistency in care as beneficiaries frequently utilize multiple health care delivery systems.

Recommendation: Enhance information sharing capabilities to promote effective care coordination and transitions between delivery systems. DHCS may consider utilizing a health information exchange vehicle to help facilitate information sharing across entities.

The SMC highly appreciates the inclusion of a "No Wrong Door" approach to service delivery as it seeks to expand access to care and limit confusion and hardship for the beneficiary when navigating entry into the public behavioral health system. However, it is unclear on how patient records will be shared between providers in varying systems of care under the proposed No Wrong Door policy. Each system of care has its own confidentiality requirements around sharing patient health information. Additionally, physicians and health care providers use many different technologies to exchange data and bill for the services they render.

Limitations around patient record and data sharing hinders efforts to improve continuity and coordination of care that is envisioned in CalAIM and ultimately impacts the quality of care that a beneficiary receives. California needs to enhance its robust health care data exchange to achieve greater care coordination and continue moving the health care system toward value-based care.

The success of No Wrong Door relies on having infrastructure in place that enables providers and health care systems to communicate when managing, coordinating, and transferring an individual's care. One way that DHCS can help facilitate providers and health systems to effectively coordinate care for beneficiaries who access multiple systems or move within levels of care is through the implementation of a health information exchange vehicle. In order to protect the rights and privacy of the individual receiving care, this recommendation includes the option for the beneficiary to choose which entities may access their information.

We also encourage DHCS to review Senate Bill 371 for information on how to leverage funding and resources to implement data sharing and bidirectional communication between various health care entities and systems. DHCS may also want to consider viewing regional approaches for data sharing among behavioral health entities as mentioned in Assembly Bill 1132. Additionally, we request that DHCS work with stakeholders to develop strategies to mitigate the barriers to information sharing as it

relates to care coordination for individuals who access multiple care systems.

Recommendation: Provide specific guidance to Managed Care Plans (MCPs) and county Mental Health Plans (MHPs) to coordinate care, particularly for populations receiving the Enhanced Care Management (ECM) and In Lieu of Services (ILOS) benefits.

The SMC recognizes that CalAIM builds in the expansion of providers at the local level by leveraging Managed Care Plans to make services more accessible to our most vulnerable communities through the ECM and ILOS benefits. However, MCPs historically have not had sufficient experience in case management for populations with complex behavioral health needs who often require care in multiple settings and delivery systems. Additionally, it may be difficult for MCPs to navigate outreach and coordination of services to certain populations such as individuals who are homeless and are experiencing a behavioral health condition.

County MHPs and their contracted entities have abundant experience in outreach, coordinating, and delivering care for populations with complex physical and behavioral health care needs. While the proposed inclusion of contracted ECM Lead Care Managers who will serve as a single point of contact for the beneficiary is helpful, the SMC recommends that the state implement clear and detailed guidance between MCPs and MHPs to coordinate care for high-risk, vulnerable populations such as those who will participate in the ECM and ILOS benefits. The guidance would include examples of case management from MHPs and how individuals will effectively move within levels of care.

The guidance would also initiate conversations and planning between MCPs and counties on how to coordinate care for populations that reside in both MCP and MHPs. Conversations may include the development of data sharing agreements, discussions on cost and billing, and partnerships with hospitals and other entities. While the SMC recognizes that these care coordination activities are determined at the local level, the SMC believes that this recommendation will provide MCPs with the direction and support needed to effectively administer case management and care coordination for our most vulnerable populations including but not limited to individuals who are homeless, justice-involved, child welfare recipients, and/or experience SMI, substance use, or co-occurring disorders. We would like to call special attention to care coordination for the Transition-Age Youth (TAY) population as they transition to the adult system of care after the age of 21 to prevent these individuals from falling through the cracks of the system once they are disqualified from the EPSDT benefit.

Recommendation: Utilize and exchange a single coordination of care document in electronic medical records (EMRs) across entities

statewide to leverage and ensure the timely exchange of pertinent patient information.

As Whole Person Care pilots and the Health Homes Program are transitioned to Enhanced Care Management and In Lieu of Services, Managed Care Plans will be responsible for more case management and coordination activities for high-risk, high-needs Medi-Cal beneficiaries. The coordination of care process becomes complex for counties with more than one MCP as each entity operating in the public behavioral health system has its own system for electronic medical records. With the existence of multiple EMRs for both counties and MCPs, there must be a vehicle in place that is commonly used among all parties responsible for managing and coordinating the care for Medi-Cal beneficiaries. Common on-the-ground tools such as standardized screening and transition tools are necessary and helpful in the coordination of care. Aside from these tools, coordination of care documents can be leveraged within existing EMRs to mitigate the likelihood of beneficiaries falling through the cracks when receiving care in multiple settings.

In addition to the recommendation above requesting specific guidance between MCPs and MHPs to strengthen the coordination of care for behavioral health populations with complex needs, the SMC encourages entities to form a standardized process for sharing patient information. The inclusion of a single coordination of care document within EMRs can allow MCP and MHP providers to relay vital information regarding patients who access multiple care systems and services. Therefore, the SMC is requesting that a single coordination of care document be implemented and exchanged across entities statewide in order to improve coordination and timeliness of quality care for Medi-Cal beneficiaries who are likely to access multiple care systems

Recommendation: Create greater efficiencies to eliminate the duplication of certification requirements between mental health and substance use disorder (SUD) systems of care.

CalAIM seeks to reduce complexity and create greater efficiencies in Medi-Cal through system reform and integration strategies. The administrative integration of mental health and substance use disorder services and moving DMC-ODS into a comprehensive 1915(b) waiver supports CalAIM's vision to move Medi-Cal to a more consistent and seamless system. However, there is an existing duplication of effort between the state and the county for provider certification. The process to certify mental health providers is completed at the local level through the county system and then submitted to the state. Certification and provider enrollment for substance use disorder services, however, is completed at the state level for DMC-ODS and Drug Medi-Cal. The SUD certification process often

results in delays and is more difficult to certify at the local level when compared to certification for mental health providers.

Many mental health providers have the knowledge and training to provide services to patients who experience co-occurring substance use disorders but may not have the clearance to treat them due to a lag in DMC-ODS or Drug Medi-Cal certification. Administrative efficiencies should benefit county systems, providers, and patient care. Therefore, the SMC is requesting DHCS to reimagine the certification process for substance use disorder providers so that it is parallel to the mental health certification at the local level.

Recommendation: Ensure that the CalAIM proposals result in reduced documentation requirements in order to promote sufficient time for patient care.

While CalAIM seeks to streamline and reduce the documentation burden, the shift to new processes includes additional monitoring, reporting requirements, timelines, and other administrative activities which can result in spending more time on documentation and less time for patient care. This can impact CalAIM's vision to align system transformation with improved quality outcomes. The SMC requests that DHCS ensure that CalAIM has reasonable documentation requirements to ensure effective monitoring while not adversely impacting direct patient care. The committee would like to review any additional detail regarding documentation, monitoring, and reporting requirements in order to provide further input and recommendations.

Recommendation: Allow Medi-Cal beneficiaries to receive coordinated services outside of their county of residence to strengthen the No Wrong Door approach to improve access and timeliness of care.

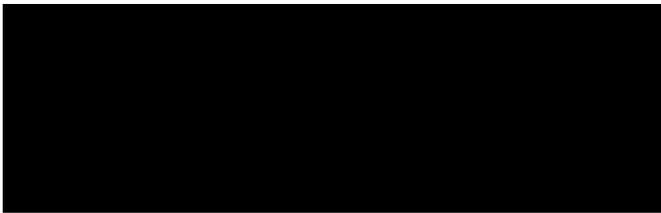
The No Wrong Door approach seeks to ensure that individuals receive the care they need no matter how they enter the system by allowing the delivery of services prior to a diagnosis or completion of an assessment. However, the No Wrong Door policy does not apply on a cross-county basis. There are individuals who may temporarily require non-emergency services outside of their county of residence. These individuals do not have the option to see a Medi-Cal provider outside of their home county unless they go to the Emergency Room which is likely to result in long wait times and higher costs or the care need is inappropriate for the ER.

The inability for Medi-Cal beneficiaries to temporarily receive health services outside of their county impacts access and timeliness to services. The SMC suggests that DHCS implement protocols that allow Medi-Cal beneficiaries to temporarily receive coordinated care between an

individual's county of residence and the county in which they are seeking care. We believe this practice will strengthen the proposed No Wrong Door policy to reduce disruptions in care and ensure that individuals receive services regardless of the delivery system and county of residence.

We hope that the recommendations put forth in this letter are taken into consideration as the Department of Health Care Services seeks federal approval of the CalAIM 1915(b) and 1115 waiver authorities. We appreciate the opportunity to submit comments, and ask to be included in conversations hosted on this topic. If you have any questions, please contact Jane Adcock, Executive Officer, at Jane.Adcock@cbhpc.dhcs.ca.gov.

cc: Kelly Pfeifer, M.D., Behavioral Health Deputy Director
California Department of Health Care Services



Noel J. O'Neill, LMFT
Chairperson

May 6, 2021

Acting Director William Lightbourne
California Department of Health Care Services
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Submitted via email to CalAIM@dhcs.ca.gov

Re: Cal AIM Proposal

Dear Director Lightbourne:

Thank you for the opportunity to submit comments regarding the CalAIM waiver proposals. On behalf of The Children's Partnership and the California Children's Trust, we support the goals and objectives of the CalAIM waiver proposals as part of the overall CalAIM reform package and appreciate the ambitious reforms proposed to make meaningful improvements in the delivery and administration of care to high need users, like children with special health care needs, provided under Medi-Cal. We applaud the leadership of the Newsom Administration to prioritize early childhood development and child wellbeing. We are, however, disappointed that this reform effort did not sufficiently or meaningfully contribute to improving the health care and health of *all* children and families served by Medi-Cal. Given that 60% of California's children (over 5 million) are enrolled in Medi-Cal, we believe this is a missed opportunity to demonstrate California's leadership in supporting child health and wellbeing.

Below we provide some overarching comments about the overall CalAIM reform package as it relates to children's health and also specific comments to the draft CalAIM waiver proposals.

CalAIM Reform Package and Children's Health

Early childhood intervention is the ultimate strategy for preventing *and* managing high-need utilization. CalAIM tackles many important issues in access and care coordination for Medi-Cal's various high-risk populations. While this makes sense given these populations' complex needs, CalAIM does not appear to offer much in the way of Medi-Cal reform for the vast majority of beneficiaries who are not high-need

users but who may instead be “at risk” of becoming high-need users and need timely preventive care to quickly identify and address emerging risks and prevent such users from developing high needs.

A core, yet missing, objective of CalAIM in addressing high-need users should be intervention early in the lives of Medi-Cal enrollees to mitigate and prevent the onset of conditions in the first place. By identifying emerging risks early in a child’s life and following up with appropriate, coordinated and timely care and support services, Medi-Cal can contribute to setting a child’s life on a course of health and wellbeing, thereby avoiding complex needs and conditions in adulthood. For example, health systems should proactively nurture healthy relationships and resilience of young children and their families, and identify and address developmental, social-emotional, behavioral and other related issues at the earliest stages, before they spiral into long-term, high-cost needs. The system must shift from a diagnosis-driven system to an approach that reflects an understanding of the impact of trauma and the social determinants of health on long-term health and mental health outcomes for children and youth. Morbidity, costs, and social determinants of health require a dramatic expansion in access to culturally relevant behavioral health services.

In fact, the Governor’s early childhood development priority appears minimal in this CalAIM proposal, despite the critical role Medi-Cal plays in covering millions of California children – three out of four of whom are children of color. Such a priority minimally surfaces in concept only under the population health management (PHM) requirement on Medi-Cal managed care plans. We see a missed opportunity to more systematically tackle the historical underutilization of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, particularly the alarmingly low rates of preventive care, including blood lead and depression screenings among Medi-Cal children. The following offers specific opportunities to strengthen the CalAIM proposal’s impact on child wellbeing.

- **Payment Reform: Capitation Payment Structures that Drive Full EPSDT Utilization.** Improvements in care management occur when the financing is aligned with those intended objectives and changes. As a result, the most effective tool for directing managed care plans toward emphasizing prevention and full EPSDT utilization is tying those objectives to their capitation payments. We recommend that DHCS’ regional rate setting proposal go further and redesign capitation rates to align more directly with Medi-Cal value-based objectives, with an emphasis on care coordination, prevention and equity. For example, we submitted a suggested payment structure for Medi-Cal children prior to the release of CalAIM, which includes 1) a “minimum spend” requirement for preventive care under EPSDT (e.g. Bright Futures) with withholds; 2) delineated inclusion of care coordination expenses in rate setting plus supplemental payments for incentivizing care coordination, particularly through care coordination partnerships; 3) inclusion of community engagement and, like Oregon, health-related investments or support services in rate setting; and 4) bonus payments for achieving specified measurable objectives. If the existing capitation payments are sufficient to support full EPSDT utilization, this proposed payment structure may not involve additional revenue.
- **Foundational MCP Oversight and Accountability.** The enormous changes that DHCS is proposing require a stronger level of oversight and accountability driven by DHCS when historically DHCS has a poor track record in overseeing the existing MCP contracts with demonstrably stagnant or declining progress on many children’s indicators. We find it concerning that there is very little explicit

discussion in the CalAIM proposal regarding DHCS' plans for additional managed care oversight and accountability. The upcoming re-procurement process is an important opportunity to reset MCP requirements and expectations regarding network adequacy, timely access to care, language access requirements, quality improvement and the reduction of health disparities. As mentioned above, performance measures and improvements should be more directly tied to plan financing, namely their capitation payments. It will be critical to track and report on how managed care plans engage with traditional safety net providers, and how they meet the new demands the state has specified regarding population health and the social determinants of health.

In addition, DHCS must require greater accountability and transparency from both MCPs and county Mental Health Plans (MHP) to meet the federal entitlement to behavioral health care under EPSDT. The MCP contracts should clarify that the MCP remains responsible for the provision of all medically necessary mental health services and has a case management and care coordination obligation to communicate with the County Mental Health Plan to ensure the member can access needed care without delay.

- **Population Health Management Plans.** While we support and appreciate the objective to assess risk and provide care coordination across the entire population, the Population Health Management (PHM) tool even in its most optimal implementation will not alone transform quality care delivery, particularly for the majority of the Medi-Cal population, such as those “at risk” or with “rising risk.” These populations do not have an accompanying Whole Person Care Model as proposed for the “high risk” populations with the enhanced Care Management benefit and the “In Lieu of” Services and corresponding incentive payments.

As mentioned in our rate setting comment above, the MCP payment structure predominantly drives MCP's decision-making and practice. Thus, the payment must be aligned with the Population Health Management strategy: ***Medi-Cal managed care capitation payment should be aligned with driving full EPSDT (e.g. Bright Futures) utilization as well as financial penalties for failure to meet specified preventive care outcomes.*** Financial incentives were proposed under the CalAIM ECM/ILOS initiatives for a reason. Financial incentives, supplemental payments, and/or payment restructuring is needed to invest in PHM capacity and infrastructure particularly around the management of the current underutilization of preventive care and care coordination as well as investments in measuring and tracking care coordination performance.

- **Social Determinants of Health (SDOH) Supports Services as Part of the Preventive Care Model.** For PHMs to be effective at managing preventive care, managed care plans will need clarity on which SDOH-related support services are covered under the medical load in their capitation payment, which are in the non-medical load, and which are social health investments or value-added to be paid by the plan. The specified support services in CalAIM were those proposed in the context of the ILOS for the ECM, which are proposed only to be available for the targeted high-utilizers. Support services for SDOH are also of value to other Medi-Cal populations not just those targeted high-users. One specific example of support services that could benefit Medi-Cal children is dyadic care models, which would build on the promise of the recent family therapy benefit, along with parenting support and education, when they benefit the health of the child. This proposal should maximize Medi-Cal to support healthy childhood development, including in the critical early years (0-5), by strengthening how local systems and communities are better coordinated to support families, through dyadic care,

promotion of local child health home models, support services navigation and health education, and coverage of (and contracting with) community health workers.

- **Secure Medicaid reimbursement for whole-child Community Health Worker services.** As a core child-centered preventive care model of care, California should seek federal Medicaid reimbursement for services provided by community health workers (CHWs) who are directly integrated into the pediatric or maternal care team or for partnerships with community-based organizations who employ community health workers that serve children and families. While formal engagement of CHWs around child health is less recognized than that for adults, evidence shows that CHWs can play an enormously valuable role in improving the health of children, particularly children of color and those with low family incomes. CHWs could provide a range of preventive, education, health system navigation, and care coordination services for all children who are Medi-Cal beneficiaries. The integration of CHWs into care for children can play a valuable role in specifically supporting and promoting child health in a variety of areas including: improving maternal and newborn health, increasing the number of children who receive timely vaccinations, increasing the number of children whose parents seek care for them when they are sick, and reducing child morbidity and mortality, among other benefits. CHW services could also address the alarmingly low access and utilization of preventive services and blood lead screenings for children in Medi-Cal highlighted by the 2019 state auditor's report or the underutilization of preventive services (such as prenatal care, dental care, and immunizations) among children in mixed status and immigrant families. CHWs could also provide doula services during pregnancy, labor, birth and the postpartum period; or mental health services provided by traditional healers. If we are to transform our health care system into one that truly responds to children and their unique needs, particularly children from marginalized backgrounds, we must fully integrate CHWs into that system, leveraging their unique abilities for both adults and children.
- **Schools Included in Payment Reform.** Youth from ages 5 to 18 spend nearly half of their waking hours at school. Despite being a major source of care for Medi-Cal children, CalAIM has not proposed a greater integration and coordination of care between Medi-Cal and early learning or local education agencies. The CalAIM proposal envisions payment reforms to address county behavioral health departments' financial challenges--the certified public expenditure claiming model, audits and documentation requirements, and diagnosis pre-requisites. However, despite LEAs having similar financing challenges, the CalAIM proposal has not similarly addressed the concerns for schools. We urge the department to extend the reforms proposed in CalAIM to LEA BOP and to adopt a delivery system that allows schools to maximize their investments in student health services and as a partnered provider in Medi-Cal children's system of care.

Waiver Proposals

In addition to the above, we extend our support for the Department's waiver requests, particularly for the renewal of out-of-state former foster care coverage, the Global Payment Program, and coverage for low-income pregnant women, and newly proposed services for justice-involved populations. In addition, we provide the following requested modifications to these waiver proposals:

Broaden Peer Supports and Extend to All Medi-Cal Populations. The current proposal highlights the ongoing work to implement SB 803 which provided the legislative authority to begin to develop a Peer Support Specialist certification and instructed the department to seek the necessary state plan

amendments and waivers to provide these services as part of Specialty Mental Health Services for adults. The Peer Support Specialist certification program is currently structured as a county option and therefore access to these evidence-based services for parents and families will be mixed. We recommend, as part of this proposal, making access to Peer Support Specialists a statewide benefit for all Medi-Cal families, so that families impacted by mental health issues in a parent, young person or child have access to this evidence-based and culturally-responsive service.

Extending PATH (health supports) to Preventive Care and Basic Care Coordination Infrastructure.

While we do strongly support this waiver proposal to cover support services and to invest in building the infrastructure around enhanced care management, the department is missing an opportunity in this reform package by not proposing health supports in upstream care, namely preventive care and basic care coordination, particularly for children. The health supports of PATH target just 1% of the Medi-Cal population when the entire population could benefit from health supports.

In addition, DHCS is proposing financial incentives for the enhanced care management benefit infrastructure, which is warranted. However, the basic care coordination infrastructure is also in need of investment and is not being similarly supported in this proposal. We recommend investments in this basic care coordination infrastructure as well.

The CalAIM 1915(b) Waiver Proposal Does Not Go Far Enough to Directly Address the Impact of Racism on the Social and Emotional Health of Children.

Building on the momentum from the Surgeon General’s efforts to achieve universal pediatric screenings for Adverse Childhood Experiences, we believe the reforms that eliminate diagnosis as a criteria will ensure access to SMHS by acknowledging the socioemotional development impacts of trauma and ACES on children and youth do not fall neatly into DSM-IV diagnoses normed and validated on adults. Still, the proposal must be revised to resist pathologizing adversity—as evidenced by proposed tools to “screen in for a high-risk score” for ongoing services. We must honor the wisdom and intelligence of low-income communities to determine their own definition of medical necessity with their care team. Any positive screen, and more importantly, any request for support from a beneficiary, should qualify a child for services and support. We know that experiences of racism can be in the form of subtle but accumulating microaggressions or in the form of systemic inequities in our overall system of care for families and children. We believe that each family and child is the expert in their own experiences and should be able to determine whether their experiences rise to the level of needing support without the use of a rigid screening tool. The proposal must also fully honor the commitment to no wrong door by removing the future creation of a level of care tool and plan; or if such a tool is to be used it must only be used during the course of treatment and treatment cannot be stopped or interrupted until or if there is a transition in care.

The 1915b Waiver Proposal Should Expand the Target Population to Receive ECM and Those Providers Available to Offer ECM. The current criteria for participation in ECM as proposed is narrow and omits important categories of children and youth in need of ECM. DHCS should expand the criteria and include “proxy” criteria, such as school-related criteria, to identify eligible children.

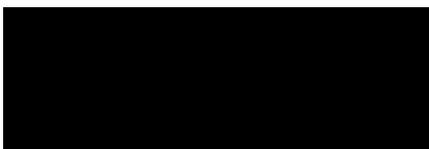
For example, in qualifying criteria for Specialty Mental Health Services, any level of involvement of the child welfare or juvenile justice systems are included. We support the department's inclusion of eligibility reforms for children that aim to improve access to Specialty Mental Health Services (SMHS) by removing the need for a diagnosis and adding child welfare involvement or homelessness as examples. We feel this proposal could go farther in eliminating access gaps for children from Black, Indigenous, and people of color communities who experience even greater levels of ACES and whose families disproportionately experience compounding stressors that predispose them to involvement with the child welfare and juvenile justice systems. By including child welfare and juvenile justice system involvement as qualifying factors, all children who have experienced the destabilizing effects of system-involvement or traumatic will have ready access to services that can meet their needs for healing. Children in the child welfare system are an important group and we applaud their explicit inclusion in these efforts, as we know that children who remain at home, in the custody of a non-offending parent, or with extended kin, experience prolonged toxic stress as a result of being involved with child welfare. However, these same outcomes due to instability and community disinvestment exist in parallel for young people involved in the juvenile justice system with even fewer rights and healing investments afforded to them. We must extend categorical eligibility to all children involved in child welfare and juvenile justice systems, whether under voluntary or court supervision.

In addition, the MCP Enhanced Care Management and In Lieu of Services Contract template provisions should include community health workers in the list of provider types serving in child-serving systems of care ([reference previously submitted comments](#)).

Prioritize whole child health through inclusion of oral health via an extension of the Dental Pilots. We urge the department to continue the progress made in the Local Dental Pilot Projects as part of the Dental Transformation Initiative in supporting the provision of dental services to children in community-based settings. A key component of the Local Dental Pilot Projects (LDPP) has been care coordination and case management for children, and we recommend including a specific proposal for strengthening care coordination inclusive of oral health services. Following the massive investment of the Dental Transformation Initiative designed to improve child oral health outcomes, we urge the department to not miss an opportunity to ensure progress is not stalled in connecting children to care while we await the completion of the external LDPP evaluation.

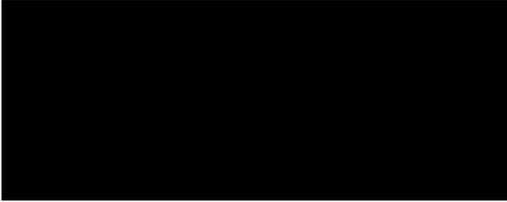
We appreciate this opportunity to provide comments on the department's CalAIM waiver proposals and urge the department to include our recommendations to prioritize the health and wellbeing of California's Medi-Cal-enrolled children. If you have any questions, please contact Kristen Golden Testa at ktesta@childrenspartnership.org.

Sincerely,

A solid black rectangular box redacting the signature of Mayra E. Alvarez.

Mayra E. Alvarez, MHA

President
The Children's Partnership
<https://www.childrenspartnership.org>



Alex Briscoe
Principle
California Children's Trust
<https://cachildrenstrust.org/>

Cc: Jacey Cooper



WESTERN CENTER
ON LAW & POVERTY

May 6, 2021

Sent Via Email

Jacey Cooper, State Medicaid Director and Chief Deputy Director of Health Care Programs
Will Lightbourne, Director
California Department of Health Care Services
1501 Capitol Avenue, MS 4000, P.O. Box 997413
Sacramento, CA 95899

RE: CalAIM Section 1115 demonstration application and Section 1915(b) waiver overview

Dear Jacey and Will,

Please accept these comments on behalf of the National Health Law Program and the Western Center on Law & Poverty regarding the Department's CalAIM Section 1115 demonstration application and Section 1915(b) waiver overview. We appreciate the opportunity to comment. We support the overall goals of the state's CalAIM Initiative but we provide the following detailed comments on particular concerns related to the waivers for consideration. Our comments also do not address the state's anticipated future demonstration request under Section 1115 to seek authority to provide short-term residential treatment services in IMDs for adults with serious mental illness (SMI) and children with serious emotional disturbances (SEDs), in conjunction with the existing SMHS program. We have already provided the Department with our detailed reasons

*NHeLP & Western Center Comments on
CalAIM Section 1115 Demonstration Application
and Section 1915(b) Waiver Overview*

1

for opposing such a proposal and we will reiterate our detailed concerns when the state seeks such a waiver or waiver amendment, no sooner than July 1, 2022.

- ***CalAIM Section 1115 demonstration application comments***

For the Secretary to approve a project pursuant to § 1115, the project must:

- be an “experimental, pilot or demonstration” project;
- be likely to promote the objectives of the Medicaid Act;
- waive compliance only with requirements in 42 U.S.C. § 1396a; and
- be approved only “to the extent and for the period necessary” to carry out the experiment.

Discussing each of these limitations a bit further:

First, the state must propose to conduct an “experimental, pilot, or demonstration” project. This demands a “novel approach” to program administration. *Benov v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994). To evaluate whether a proposed project is a valid experiment, the Secretary needs to know what will be tested and how, at the point in time when the project is being approved.

Second, the project must promote the Medicaid Act’s objectives. Congress has made clear that the purpose of Medicaid is to enable states “to furnish[] medical assistance” to individuals “whose income and resources are insufficient to meet the costs of necessary medical services” and to provide “rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.” 42 U.S.C. § 1396-1; 1396d(a) (defining “medical assistance” as provision of, or payment for, specified health care and services). Thus, the “central objective” of the Medicaid Act is “to provide medical assistance.” *Stewart v. Azar*, 366 F. Supp. 3d 125, 138 (D.D.C. 2019); *id.* at 144 (rejecting “promoting health” as an independent objective because the Medicaid Act is “designed ... to address not health generally but the provision of care to needy populations” through a health insurance program).

Third, the Secretary can only waive provisions set forth in section 1396a of the Medicaid Act. The Secretary cannot waive requirements contained in sections 1396b-1396w-5. See Social Security Act, § 1115(a)(1)). Once the Secretary has acted under section 1115(a)(1) to waive compliance with designated provisions in section 1396a, section 1115(a)(2) provides that the costs of “such project” are “regarded as expenditures under the State plan” and, thus, paid for under the same statutory formula that applies for a state’s expenditures under its State plan. *Id.* § 1115(a)(2). Section 1115(a)(2) does not create an independent “expenditure authority” for the Secretary to allow a state to

ignore provisions of the Medicaid Act outside of section 1396a or to rewrite the provisions in section 1396a or any other provision outside of section 1396a. To the contrary, it is a “clean-up” provision that merely provides the authorization necessary for federal reimbursement of expenditures for a project that has been approved under section 1115(a)(1).

Fourth, section 1115 allows approvals only “to the extent and for the period necessary” to carry out the experiment. *Id.* § 1115(a); *see also id.* §§ 1115(e)(2), (f)(6) (limiting the extension of “state-wide, comprehensive demonstration projects” to one initial extension of up to 3 years (5 years, for a waiver involving Medicare-Medicaid eligible individuals) and one subsequent extension not to exceed to 3 years (5 years, for Medicare-Medicaid waivers).¹ Congress did not enact section 1115 to permit the Secretary to make long-term policy changes.

- **Section 3.2 – DMC-ODS**

While we strongly support continuation of the DMC-ODS program and many of the additional services that have become available in the past five years, we are concerned about the proposal to remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period as part of State’s Institutions for Mental Diseases (IMDs) exclusion waiver. The DMC-ODS waiver was the first in the nation to authorize the use of federal dollars for reimbursement for SUD treatment received in IMDs, psychiatric or substance use residential facilities with more than 16 beds. While we have overall concerns, both legal and policy, with the state’s expanded desire to seek approval for reliance of IMDs for people with SUD conditions in order to obtain federal financial participation (FFP) (discussed later), we are also concerned with the expansion of days the state seeks to authorize its use. The IMD exclusion waiver was originally intended to expand access to inpatient substance use treatment in participating counties as part of the whole ASAM continuum of care.

¹ In 2017, a CMS Informational Bulletin announced the intent “[w]here possible, . . . [to] approve the extension of *routine, successful, non-complex*” Section 1115(a) waivers for a period up to 10 years. Ctr. for Medicaid & CHIP Servs., CMS, CMCS Informational Bulletin 3 (Nov. 6, 2017) (emphasis added). The Bulletin should be disregarded because it conflicts with, among other things, section 1115’s limitation of approvals to experimental, pilot, or demonstration projects (not for “routine” projects) and only for the period necessary to carry out the experiment (not to maintain a successful experiment as an ongoing policy).

Importantly, however, because of the risk of institutionalization to which individuals with mental health and SUD have been historically subjected, reliance on residential treatment must be carefully balanced with sufficient availability of community-based services and limitations to avoid overreliance on institutionalization at the expense of evidence-based and patient-tailored community-based care. For that reason, the original waiver limits Medi-Cal coverage to two non-continuous residential stays of up to 90 days in a one-year period. The waiver renewal request seeks to remove that limitation with the only protection being an ambiguous promise that the state “will aim for a statewide average length of stay of 30 days,” despite a clear limitation that is already contained in the current waiver’s terms and conditions.

We believe this change will excessively incentivize residential care even in situations where community-based services are more appropriate, feasible, and would yield more effective results. Furthermore, the Department has failed to provide sufficient evidence to demonstrate the need to increase reimbursable residential treatment days beyond what is already provided in the current waiver. One of the end goals of the DMC-ODS program is to facilitate transfer of beneficiaries from higher levels of care to lower levels of care. For this goal to be achievable, certain limitations on residential treatment must be imposed so that providers are incentivized to work with beneficiaries towards the target of moving to a less restrictive level of care as soon as the individual is admitted to the IMD. The current maximum of two non-continuous 90-day episodes should be sufficient to achieve this goal and should not be expanded through the renewal request.

- **Section 3.3 – Peer Support Specialist Services**

Currently, MHPs provide some peer support services as a component of other services, such as Intensive Care Coordination services, or Wraparound. The waiver request must make clear that nothing in the waiver will alter or diminish the state or managed care plans’ obligations to comply with the state’s Early and Period Screening, Diagnostic & Treatment (EPSDT) Medicaid obligations. Legislation passed last year (SB 805) directed DHCS to allow counties to certify peer support specialists and pay for their services for individuals receiving specialty mental health or SUD services. We agree that peer support is an important component of mental health and substance use disorder services. We are concerned, however, that this service will not reach its full potential in the way DHCS is currently proposing to implement it, based on counties opting in, through a combination of state plan, 1115, and 1915(b) authorities.

Instead, this service should be available to all Medi-Cal beneficiaries who need it throughout the state, in the state plan, and not contingent on whether the person’s

county of residence has opted in to providing the service. We understand that the authorizing legislation directs DHCS to “seek any federal waivers it deems necessary to establish a demonstration or pilot project for the provision of peer support services in counties that agree to participate and provide the necessary nonfederal share funding for the demonstration or pilot project.” WIC 14045.19(a). However, allowing the service to be offered piecemeal based on particular counties’ willingness to contribute the non-federal share is not an appropriate way to extend such important services to Medi-Cal beneficiaries. It simply is not good policy that a beneficiary’s access to this important service should depend on the county in which they live. We recommend that DHCS work with the legislature to obtain authority to add peer support services as a state plan service, available statewide to people with mental health conditions or SUDs when clinically appropriate. That is consistent with Medicaid’s purpose of being a statewide program.

We also emphasize that Peer Support Specialists should not only include individuals with lived experience of mental health conditions, SED, and/or SUDs as well as family or parent partners with experience assisting “loved ones” with these conditions, but also include individuals who have experience with the child welfare (foster care) or juvenile justice systems. Further, the requirement for a peer to be “in recovery” is a subjective standard that should be removed, as this is not a term utilized by the children and youth mental health system, and may limit considering individuals who disagree with the term or goal of “recovery”. Finally, allowing “loved ones” to qualify should be clarified as many parent run organizations that train or recruit parent partners believe that this is a particular qualification that only parents with lived experience through having a child in the system would meet, and not anyone in the child’s life or another interested adult.

We urge DHCS to provide more detail about the required certification requirements or process. This may in fact be the greatest concern and prohibit qualified peers from participating. Many peers or parent partners will not want to be providers if the requirements are onerous or unreasonable. For example, peers who are already employed by a SMHS or DMC provider should be allowed to use that time and experience to meet certification, as they have likely already received extensive training and supervision. Peer Support Specialist certification requirements should only be developed with the input of peers and parent partners, rather than only counties, so as not to be too onerous to attract individuals who could find this process burdensome. A pathway to get certified must include “credit” through direct experience in a program so as not to exclude certain individual peers or parent partners who have extensive experience but are challenged to meet any new “training” or testing requirements that deter participation.

Moreover, the state already can and, is required to, implement peer support specialist services through EPSDT statewide for beneficiaries under age 21. Apart from this waiver, DHCS must ensure that all counties are delivering these services to beneficiaries under age 21 when necessary to correct or ameliorate their behavioral health conditions. This should be explicit in both waivers. We also urge DHCS to ensure that services are available statewide for adults.

- **Section 3.7 – Services for Justice-Involved Populations 30-Days Pre-Release**

We support the goals and objections of CalAIM's waiver proposal to connect individuals leaving incarceration with Medi-Cal prior to their release. It is well-established that justice-involved populations have high health needs, including behavioral health and substance use disorder needs, and Medi-Cal coverage is essential to achieve continuity of care, better post-release health outcomes, and to reduce recidivism. We generally support the goals outlined in the waiver but more information about how it will work in practice is needed. The state proposed an experiment in the current Medi-Cal 2020 Waiver related to justice-involved populations through the Whole person Care (WPC) pilots. Yet no information regarding the evaluation or results of those specific pilots is included in this waiver to build on the need for further demonstrations or pilots in this new request. At least nine WPC pilots under the current 1115 waiver targeted individuals recently released from jails or prisons; these nine counties (Kern, Kings, LA, Mendocino, Placer, Riverside, San Diego, San Joaquin, Santa Cruz, plus the Small County Whole Person Care Collaborative) reported that an estimated 6050 10 justice-involved individuals were enrolled in the WPC pilot cumulatively. See UCLA Ctr. for Health Pol'y Res., *Interim Evaluation of California's Whole Person Care (WPC) Program* 61, 121 (2019),

<https://healthpolicy.ucla.edu/publications/Documents/PDF/2020/wholepersoncare-report-jan2020.pdf>. The goals of the WPC pilots overlap with those listed in the current demonstration request, including to “reduce inappropriate emergency and inpatient utilization” and “improve health outcomes[.]” *1115 Waiver Request* at 35.

In addition, under those pilots, justice-involved individuals received services similar to those contemplated in the current request, including care coordination and case management services, housing support services, and peer support. *Id.* at 128-131. While the interim evaluation reflects only the first two years of the WPC program, data in the appendix of the report shows that ED visits and hospitalization rates for justice-involved populations largely remain consistent pre-WPC and during the pilots. *Id.* at 347-352. In order to demonstrate that the current waiver request is an experiment, more information is needed about the findings from these similar existing pilots and the state

should indicate how the current request for a new waiver will test something different or new to that which was already evaluated under the WPC pilots.

DHCS should also provide more clear information on how it will evaluate the program. Section 6 of the waiver request states that hypotheses related to justice-involved populations will be evaluated using usage and diagnosis data, California Outcomes Measurement Systems (CalOMS) data, quality measures such as the Healthcare Effectiveness Data and Information Set (HEDIS), surveys and interviews, and pharmacy data. However, DHCS should provide more information about what these measures entail and the specific methods it intends to employ to evaluate this unique population.

In addition to outcome measures, we recommend two modifications to the program in order to ensure that its goals are met. First, the proposal calls for individuals to receive in-reach ECM and clinical consultation services 30 days prior to their release from incarceration and states that Medi-Cal managed care plans will deliver ECM services. However, a more detailed timeline is needed in order to ensure that this is both possible and likely to occur. If managed care plans will be performing these services, eligible individuals leaving incarceration will need to first enroll in Medi-Cal and then enroll in a plan of their choice in many non-COHS counties. Medi-Cal enrollment and then plan choice is generally a two-step process, and California's legal limit for Medi-Cal application processing time is 45 days. In order for managed care plans to perform these tasks, the Medi-Cal enrollment process will need to begin an additional 45 days prior to the 30 days before release for those inmates not already on Medi-Cal. Here, Ohio can serve as an example; there, programming for pre-release enrollment in Medicaid and managed care plans begins approximately 90 days prior to release. See Jesse Janetta et al, *Ohio's Medicaid Pre-Release Enrollment Program 2*, Urban Inst. (2017), https://www.urban.org/sites/default/files/publication/88051/ohio_medicaid_1.pdf.

Second, the demonstration request touts California's requirement that counties suspend, rather than terminate, Medi-Cal eligibility while individuals are incarcerated. However, California's suspension policy only applies for the first year of incarceration; after one year, Medi-Cal is terminated. Implementing indefinite suspension of Medi-Cal eligibility would greatly facilitate continuity of care for individuals leaving incarceration. This will reduce burdensome re-application processes and ease the transition from incarceration to community-based care.

Finally, the waiver proposal targets specific adults with particular conditions, including: chronic mental illness; substance use disorders; chronic diseases (e.g., Hepatitis C, diabetes); intellectual or developmental disability; traumatic brain injury; HIV; and pregnancy. Yet how the state or managed care plans will be notified of these particular

individuals once incarcerated, how the jails or prisons will be informed of who these inmates are, and how these individuals will be tracked and evaluated post-release as part of this demonstration is not clear in the proposed request. There is also no mention of the mental health plan (MHP) or Drug Medi-Cal (or DMC-ODS) program's obligations to track and serve these youth or adult inmates with mental health or substance use disorders either before or when they leave jail or prison as part of the demonstration. All of these details seem important to address for the experiment or demonstration to be successful and the goals outlined in the waiver to be tracked, measured and achieved.

- **Section 3.8 – Providing Access and Transforming Health Supports**

We support the proposal for Providing Access and Transforming Health Supports (PATH) training and technical assistance to develop ECM and ILOS provider network. Through the WPC pilots, counties have successfully partnered with non-traditional providers who do not bill Medi-Cal but have experience working with population targeted for ECM and ILOS. These partnerships include community-based organizations that provide housing support services or work in Medical Legal Partnership. WPC counties have expressed concerns that the shift in delivery system to Medi-Cal managed care plans may result in many of these partnerships discontinuing. Rather than terminating these contracts and losing the valuable lessons learned from WPC pilots and other evaluation, these providers should be supported in their move to contracting with Medi-Cal managed care plans to provide ECM and ILOS.

Considering the uncertainty of whether PATH funding request will be approved, we urge the Department to consider state-funding to build provider network regardless of federal approval. Because the Department has indicated housing support services is the ILOS that is closest to being a statewide benefit, we encourage specific funding be set aside for homeless service providers with the cultural competency to provide evidence-based housing support services. In addition, we recommend the funding go directly to community-based providers to help them build the staffing and infrastructure needed to bill, report, and contract with Medi-Cal plans.

In a recent [letter](#), DHCS staff indicated DHCS intends to seek federal approval for a benefit to fund housing support services, and that DHCS staff expects managed care plans to have sufficient capacity to have a robust network of service providers able to offer services as a benefit by 2024. Therefore, we recommend DHCS establish a date certain of January 2024, by which DHCS will seek federal approval of a housing support services benefit. Promoting a date certain will entice providers to develop their capacity

to be able to receive reimbursement from managed care plans, and for Medi-Cal managed care plans to build capacity toward an adequate network statewide.

- **Section 1915(b) waiver overview comments**
 - **Medi-Cal Managed Care (pg. 4)**

Currently, there is a huge disparity for Medi-Cal managed care enrollees for those enrolled in Knox-Keene licensed plans, and those enrolled in unlicensed plans. The availability of consumer protections including additional external review options for plans that are Knox-Keene licensed has led to greater access to care in licensed plans, and has become a hurdle to access in plans that are not licensed. For example, the Health Consumer Alliance has seen serious barriers to gender-affirming care for transgender and non-binary Medi-Cal beneficiaries who are enrolled in unlicensed COHS plans. While transgender and non-binary individuals also experience barriers to care in licensed plans, the backstop availability of DMHC complaints and IMR, while not a perfect solution, has helped beneficiaries in those plans to access the care they need. Meanwhile, in unlicensed COHS plans, neither DHCS staff nor the ALJs who hear State Fair Hearings have clinical expertise in gender-affirming care, nor is the Fair Hearing process an accessible or timely solution for resolving disputes about the medical necessity of particular Medi-Cal covered services. Without consistent licensing requirements for all plans, beneficiaries will continue to access unequal access to services that should be consistently covered by Medi-Cal across the state.

Moreover, since no DMC/DMC-ODS plan or MHP is subject to Knox-Keene licensure, the barriers are stark across the state for beneficiaries who need specialty behavioral health services. Beneficiaries who need these services have no recourse to seek an independent clinical review of the behavioral health services they seek, and again, the fair hearing process is not an adequate process to resolve disputes about the medical necessity of care. The fact that so few beneficiaries pursue fair hearings over specialty behavioral health services speaks to the inadequacies of that process in resolving beneficiaries' complaints.

As part of the waiver renewal process, we urge DHCS to require all managed care plans that deliver services to beneficiaries to become Knox-Keene licensed. Licensure is necessary to ensure consistency across the state, and to protect beneficiaries' access to important covered services. Alternatively, these consumer rights must apply to all plan types

We are pleased that DHCS at the Stakeholder Advisory Committee meeting committed to performing plan readiness before transitioning new populations into managed care. This proposal would also move existing managed care populations into fee-for-service, however, so we urge DHCS to similarly engage in a readiness review process of its fee-for-service networks and systems for these transitioning populations. DHCS has previously developed robust processes to ensure plan readiness when populations transition into managed care that include network reviews, cultural competency training requirements for plan staff and network providers, facility site reviews. DHCS should draw on this previous experience to develop similar readiness processes both for the plans who will be enrolling new populations as a result of the changes implemented by the waiver AND for its fee-for-service system, which will also begin serving new populations. Moreover, given that the transitioning populations include large numbers of immigrants, DHCS must pay special attention to readiness in terms of linguistic and cultural competency. Its network reviews must ensure that plan and fee-for-service networks are equipped to serve immigrant populations, and provide in-language services to LEP beneficiaries.

At the Stakeholder Advisory Committee meeting DHCS also committed to providing stakeholders with more information about its process for outreach and enrollment of transitioning populations. Ensuring that beneficiaries receive timely advance notice of the upcoming changes, and information about their options and protections during the transition, is key to ensuring that the transition proceeds as smoothly as possible, and we appreciate that DHCS plans to seek stakeholder review of key policy documents in this area, and draft beneficiary notices.

Similarly, DHCS should specify that transitioning beneficiaries are entitled to continuity of care protections, whether they are moving into managed care or fee-for-services. Existing law and guidance provides no such protection for beneficiaries moving from managed care into fee-for-service, so we especially urge DHCS to ensure that these populations receive the same protections and the populations moving into managed care. DHCS can draw on its existing policies for continuity of care when beneficiaries move from fee-for-service to managed care to develop similar policies for these upcoming transitions.

To ensure that these transitions are as smooth as possible, we recommend that DHCS invest in providing consumer assistance to beneficiaries during the transition process. Such assistance could include navigation assistance to help beneficiaries understand how to access care in a new delivery system, and assistance with procedures such as continuity of care.

We recommend that DHCS institute a consistent process to allow beneficiaries to disenroll from managed care into fee-for-service when they are not able to access services that they need through their managed care plan. DHCS should look to the existing MER and disenrollment processes set forth in regulation to develop a process for disenrollment that will ensure that beneficiaries have access to the care they need.

- **Specialty Mental Health Services (pg. 8) + Attachment 2: Overview of CalAIM Behavioral Health Policies (pg. 20)**

We generally support the proposal to make clear that the medical necessity criteria to access specialty mental health services must be consistent with federal law under EPSDT, as well as the apparent expanding of criteria for services for beneficiaries under age 21 with conditions that put them at risk for a mental health disorder due to experiencing trauma, involvement in child welfare or homelessness.(Criteria 1). But we need more clarity about DHCS’s specific approach. Medicaid comparability or statewideness federal requirements may need to be addressed if certain children and youth would be eligible to receive these specialty mental health services because they have a high ACES score, are in foster care or experiencing homelessness (Criteria 1), while others (e.g. Medi-Cal eligible children simply “at risk” of out of home placement or involved in juvenile justice who don’t otherwise have a mental health disorder) would not meet that criteria and therefore not eligible for specialty mental health services under this proposal unless they meet the more specific requirements of Criteria 2. *1915(b) Waiver* at 25. In order to make this access more clear and equitable to all children and youth, DHCS should modify Criteria 1 to clarify that the circumstances listed (trauma score, foster care involvement or homelessness) are examples but not specific requirements to meeting the “high risk” conditions.

We support the proposal to revise the clinical auditing protocol to align with the revised documentation requirements. As part of these revisions, we recommend that DHCS require MHPs to provide documentation of their care coordination processes during the Triennial Review process. DHCS should evaluate the implementation and effects of MHPs’ policies during the audit process. DHCS should expand the review of its new, dialogue-focused approach to the MHP audit process to include interviews with enrollees, providers, and stakeholders in the county to paint a more comprehensive picture of whether MHP care coordination practices are effective and robust enough to ensure continuous access to mental health and physical health care. Finally, DHCS should annually evaluate MHPs. While conducting annual on-site reviews might not be

feasible, DHCS at a minimum should conduct annual documentation review in a process similar to the Medi-Cal Managed care Plans (MCP) medical audits process.

We also support the proposal to allow MHPs to authorize treatment during the assessment period, before a beneficiary has necessarily received a formal diagnosis. This proposal needs more clarity. How is this different from what is currently allowed under state policy? What are the specific medically necessary services that cannot be provided before a diagnosis is given? How many visits are allowed w/o diagnosis, what services are covered, and what can an MHP deny if the provider does not have diagnosis to determine medical necessity? Similar clarity is needed for MCPs as well.

We support DHCS's proposal to implement a "no wrong door" policy that clarifies that reimbursement is available for behavioral health assessments and specified treatment before formal diagnosis. While we believe that state law already should allow beneficiaries to self-refer for specialty behavioral health services and to access non-duplicative services across Drug Medi-Cal, DMC-ODS, and SMHS delivery systems, and MCPs (in particular beneficiaries under age 21), we acknowledge that it has not happened in reality for a variety of reasons. We appreciate that DHCS is clarifying the policy to ensure that beneficiaries can access appropriate specialty behavioral health services when they need them, even from more than one delivery system at the same time, and we believe additional clarity on this policy will be needed to make this work. Furthermore, we strongly advocate for continuity of care (as existing state policy requires) so that beneficiaries are not forced to change providers while in treatment nor forced to move from one delivery system to another when they are receiving ongoing mental health services (discussed further below).

We also support DHCS's proposal to clarify that SMHS are appropriate and reimbursable when treatment criteria are met when a beneficiary has a co-occurring SUD. Again, MHPs are already required to deliver SMHS when criteria are met regardless of any co-occurring conditions, including SUD. The presence of co-occurring SUD has often presented a practical challenge to MHPs' delivering services to beneficiaries, however, so we appreciate that DHCS is clarifying its policy here and ensuring that MHPs will be able to draw down appropriate Medicaid funds to deliver these services.

We commend DHCS for proposing to develop standardized screening and transition tools for both adults and for beneficiaries under age 21. We have previously urged DHCS to standardize these tools, as there is considerable variation across the state which leads to serious inconsistencies in the availability of specialty behavioral health

services. We continue to have questions about how DHCS will implement these proposals, however. In particular, these tools must not be used to deny medically necessary services by requiring certain criteria or conditions be met that are not legally consistent with EPSDT.

We appreciate that the proposed screening criteria for access to SMHS have been clarified to make clear for beneficiaries under age 21, SMHS are appropriate whenever a beneficiary needs a SMHS to correct or ameliorate a mental illness or condition discovered by screening services. So, for example, if the child is determined to need crisis or intensive care coordination services (or other SMHS), but does not meet the existing screening criteria for referral to an MHP, they can get the SMHS, even if they also need ongoing psychotherapy provided by a qualified MCP contracted provider at the same time. Without this additional criteria, a child or youth may be inappropriately denied SMHS that are medically necessary.

Moreover, we have a number of questions about how the standardized screening tool will play out in practice: What specific tool will be used for adults or children (under age 21)? When will stakeholders be able to review a draft of it? Will the tool address all behavioral health needs? If the screening tool may be completed by non-licensed staff and may be completed in-person or remotely (including telephone and telehealth), how will screening by phone or telehealth be sufficient to determine what services a beneficiary needs, given they are not qualified providers? How does this tool relate to the required ACES screen, and the EPSDT screens required for all children by CHDP or MCPs? If it is only a delivery system screen (for adults and children) how will it comply with EPSDT screen or medical necessity requirements (for children), given the different services covered by the plans? We look forward to engaging with DHCS further on these details.

Similarly, while the idea of having a standardized transition tool to move beneficiaries from one plan to another to receive mental health services appears to be a commendable proposal, such a policy and tool ignores beneficiaries who need both SMHS and other MCP covered services at the same time. It also potentially leads to an undesirable and nontherapeutic practice of forcing beneficiaries to change providers during treatment for everything if they are “required to transition all services”. Through all of the transition processes, it is important to consider how changing providers is non-therapeutic, can layer on additional stresses for all beneficiaries with mental health needs, in particular children and families, especially for youth who have had many adults, including system-involved adults and service providers, coming in and out of their lives. The system should not exacerbate existing trauma by forcing provider

transitions except when absolutely necessary. Similar questions arise regarding the identification of SUD needs and for transition of beneficiaries with co-occurring disabilities or conditions.

Overall, any transition process must be designed to ensure the beneficiary gets appropriate care and services as soon as needed from one system or the other, and maintain established therapeutic relationships to the greatest extent possible. In addition, the beneficiary's appeal rights must be adhered to and a denial based on medical necessity is not the only basis on which a plan is required to issue a written notice of adverse benefits determination giving the beneficiary a right to appeal.

We support the proposal to update assessment and documentation requirements, and encourage DHCS to apply the same requirements across the state, as well as to eliminate unnecessary and burdensome requirements not required by federal regulation. DHCS should provide more detail on how these requirements will be modified, what specific requirements will be evaluated (the state Medicaid Plan, state regulations, plan contracts, county providers contracts & provider manuals), the anticipated time frame for these changes and what stakeholder input will be sought.

We also generally support the proposal to integrate Medi-Cal's behavioral health system at an administrative level. We encourage DHCS to take integration further by using this waiver as the first step toward implementing full integration of the behavioral and physical health systems in Medi-Cal. This behavioral integration should really be required during this waiver period, rather than 5 years from now. There is no good policy reason to delay it. Additionally, the inoperability of data systems needs to be addressed to allow for more effective care coordination, and quality and outcome measurement.

- **Monitoring Approach (pg. 14)**

We generally agree with DHCS's monitoring approach, but would like to see the steps DHCS plans to take spelled out in more detail. Specifically, we recommend that DHCS link to existing monitoring documents where they exist, including any changes needed to conform to changes implemented by this waiver, and spell out the protocols it will institute where nothing exists already. Monitoring is a critical part of ensuring plans are delivering the services required as part of their contracts.

- **Attachment 3: DMC-ODS Program Description (pg. 31)**

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is an essential component of California's efforts to fight the ongoing opioid overdose epidemic as well as the overall burden of SUDs among the State's population. As the first Medicaid 1115 Waiver specifically designed to improve access to SUD treatment in the nation, the state program has been a model to ensure low-income individuals with SUD have access to the whole continuum of substance use care in a coordinated and patient-centered system. The DMC-ODS program has been commended for facilitating access to the different ASAM levels of care that serve the needs of Medi-Cal beneficiaries and for expanding coverage for effective supportive services, such as case management and recovery services.

While challenges remain, particularly around beneficiary education and intake, continuation and expansion of the DMC-ODS program is necessary to a successful response to the prevalence of this chronic condition. As such, we fully support the Department's request to continue the DMC-ODS program. We also support some of the clarifications and modifications that the Department sought through the extension request and that have been incorporated into the renewal request, including increased access to SUD treatment for American Indians and Alaska Natives; clarifying that reimbursement for assessment and treatment is available before definite diagnosis; clarifying the terms and components of recovery services; ensuring access to MAT at all levels of care, including while individuals are undergoing residential treatment, by ensuring that all DMC-ODS providers are either offering MAT on site or have the capacity to refer beneficiaries to MAT with other providers; and adding coverage for Early Intervention services and clarifying that a DSM diagnosis is not necessary to access such services.

Despite our overall support for the DMC-ODS program, we have concerns about some of the program's components and some of the modifications the Department is seeking through the CalAM proposal. While we agree with the Department's intent to move the coverage authority for most DMC-ODS services from a Section 1115 waiver to State Plan authority and to a Section 1915(b) waiver for delivery system purposes, we have concerns about the legitimacy or efficacy of continuing to allow counties to opt in to the program and provide these important SUD services. As we have explained on various occasions, California can achieve the goal of the DMC-ODS program and improve access to care for beneficiaries with SUD without the need to request a Section 1115 waiver. Section 1115 waivers are only available to implement true experiments that advance the purposes of the Medicaid Act. Since the beginning, California has been

unable to clearly lay out an experimental purpose for why waiving statewideness through 1115 is necessary. That continues to be the case with the CalAIM proposal and the lack of an experimental purpose and a measurable hypothesis becomes even more evident when considering that the demonstration is currently in its sixth year. Nothing would justify continuation of an 1115 experiment at this point and there is no legitimate or appropriate policy justification to maintain the option to provide these services on a county-by-county basis. This is why we fully support the proposal to move away from a Section 1115 waiver for most of the DMC-ODS components.

However, we are concerned that DHCS is still requesting a statewideness waiver now through the use of a Section 1915(b) waiver, even though it proposes to move the coverage authority for the DMC-ODS benefits to the State Plan. Failing to make SUD services and evidence-based treatment available to all beneficiaries regardless of which county they live in may have a costly effect on the State because it will have to spend more on overdose treatment and response and because of the overall detrimental effect that the overdose epidemic has on the economy (see <https://www.ajmc.com/view/the-economic-burden-opioid-epidemic-on-states-case-of-medicaid> and <https://www.aha.org/news/headline/2019-10-16-report-opioid-crisis-cost-us-economy-631b-2015-2018>). In addition, waiving statewideness does not advance any of the four allowable purposes for a 1915b waiver because the State is not looking to restrict the types of providers from which beneficiaries can receive the services, but instead to restrict the specific services that beneficiaries may receive based on their county of residence.

We also firmly believe that policy considerations and the need to make evidence-based SUD services available to all who Medicaid beneficiaries need them, should drive the State to expand the DMC-ODS program services to all counties. While we acknowledge the efforts that the Department has undertaken and will undertake to incentivize the remaining counties to opt in, we see no reason to maintain the two-tier system and urge the Department to reconsider the decision to waive the federal statewideness requirement with respect to the DMC-ODS program. Only twenty-one counties are currently not participating in DMC-ODS, but all of these are rural counties currently facing problems with [lack of provider availability](#) and many are among the [hardest hit by the opioid epidemic](#). For that reason, the Department should consider mandating adoption of the DMC-ODS program (and all of the services covered) in all counties at the same time that it works with counties to ensure availability of services by allowing for the provision of services through a regional approach. Notwithstanding our position, however, we ask DHCS to at least consider limiting the statewideness waiver

to the next two years, while it rolls out the requirement for all counties to join the program, either individually or through partnerships with neighbouring counties.

Finally, we urge the Department to further clarify the role that EPSDT plays within the DMC-ODS program. We appreciate the fact that the CalAIM proposal clarifies that the EPSDT criteria should be followed at all times and that it takes precedence over the ASAM adolescent criteria. However, we urge the Department to further clarify the EPSDT criteria by amending the proposal to reflect the fact that the ASAM adolescent treatment criteria shall be used *only* to the extent it is necessary to determine the placement level of care, but not as a condition of eligibility for services.

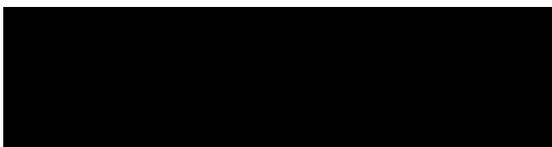
In addition, we remain concerned that beneficiaries under 21 residing in non-DMC-ODS counties are not receiving DMC-ODS services even when those are necessary to correct or ameliorate a substance use-related condition, as required under the EPSDT mandate. Because the waiver does not alter the state's EPSDT obligations, individuals under 21 should have access to these services regardless of their county of residence. The Department has the obligation to ensure that DMC-ODS services are available in non-DMC-ODS counties for individuals under 21 who are eligible under EPSDT. When those services are not available, the Department must require non-DMC-ODS counties to provide individuals under 21 with such services, as required under EPSDT, even if that requires the provision of such services by a DMC-ODS county provider. We are disappointed that the CalAIM proposal does not include language to that effect.

We look forward to working with the Department to implement CalAIM as well as the 1115 and 1915(b) waivers, if approved. Please contact Kim (lewis@healthlaw.org) if you have any questions about these comments or would like to meet to discuss them further.

Sincerely,



Kim Lewis
National Health Law Program



Linda Nguy
Western Center on Law & Poverty



**CALIFORNIA
HOSPITAL
ASSOCIATION**

*Providing Leadership in
Health Policy and Advocacy*

May 6, 2021

Jacey Cooper
Chief Deputy Director Health Care Programs and State Medicaid Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA, 95814

Via email: CalAIMWaiver@dhcs.ca.gov

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

Dear Ms. Cooper:

On behalf of our more than 400 hospital and health system members, the California Hospital Association (CHA) is pleased to submit comments on the Section 1115 CalAIM demonstration and Section 1915(b) waiver, released for public comment on April 6, 2021. CHA supports the Department of Health Care Services' (DHCS) goals of the CalAIM initiatives and recognizes the important role that Section 1115 waivers have played in Medi-Cal over the years. These waivers have proven successful in reforming our public health care systems, expanding coverage to nearly 1 million people prior to the implementation of the Affordable Care Act, and encouraging innovation through alternate payment models. California has a strong track record of success with its demonstrations, and we are supportive of building on this strong foundation to further innovate the way care is delivered under the CalAIM initiatives.

Specifically, we are supportive of the two new initiatives and the decision to continue the Global Payment Program (GPP) included in the Section 1115 waiver, and the decision to align the delivery systems by creating a consolidated Section 1915(b) waiver that advances delivery system integration and focuses on whole-person care.

New Initiatives: PATH Payments and Services for Justice-Involved Populations 30-Day Pre-Release

CHA appreciates the inclusion of Providing Access and Transforming Health (PATH) payments in the new Section 1115 waiver, intended to provide a glide path for the transition of the Whole Person Care program into the managed care delivery system. As experienced during the implementation efforts of the Whole Person Care pilots in the Medi-Cal 2020 waiver, the additional services and care coordination needed to provide quality care cannot happen overnight. Implementing the enhanced care management (ECM) benefit statewide and offering plans the option to deliver in-lieu-of-services (ILOS) will provide the tools necessary to be successful. However, especially in new communities, there will be a need for additional investments to support IT systems and build capacity for ECM/ILOS partners. Including the PATH payments recognizes this need and CHA is supportive of this initiative.

CHA also supports the other new initiative included in the Section 1115 waiver, designed to provide services for justice-involved populations 30-days pre-release. Today, hospitals regularly provide care to

state and county inmates within the hospital; however, this is reactive care. This new initiative to enter state and county correctional facilities and provide targeted Medi-Cal services to eligible justice-involved populations is a proactive measure that should be applauded as an effort to further improve health equity. While we recognize including this initiative as part of the 1115 waiver requires it to be a demonstration, we believe the long-term benefits will be great and the eligibility criteria and covered services could be expanded.

Continuing Initiatives: Global Payment Program

Within the Medi-Cal 2020 waiver, California initiated the GPP, a pilot program designed to support the efforts of California's public health care systems to promote the delivery of more cost-effective and higher-value care to the state's remaining uninsured individuals. This includes incentives for public health care systems to shift the focus of the care they deliver for the uninsured toward primary and preventive services. Without the Medi-Cal 2020 waiver, the flexibility designed to support the expansion of services that use preventive and non-traditional services would never have happened. All of this was accomplished with a restructuring of existing funding streams — Medi-Cal disproportionate share hospital payments.

Now, five years in, the independent evaluation has shown positive results. Public health care systems built new and strengthened existing infrastructure, increased access to care among the uninsured, and utilization showed an increase in outpatient non-emergent non-behavioral health services. The flexibility worked — today, public health care systems are providing more cost-effective care, rather than volume of services.

CHA supports the state's request for another five years of GPP and the inclusion of the Safety Net Care Pool funding. While California has been successful in lowering the uninsured rate over the years, the unfortunate reality of COVID-19 pandemic has erased years of progress. Therefore, continuing the GPP with the ongoing Safety Net Care Pool funding will be essential to the ongoing transformation within our public health care systems and our state's recovery effort from the pandemic.

CalAIM 1915(b) Waiver

CHA appreciates the comprehensive approach that includes a wide array of services designed to meet the behavioral, developmental, physical, and oral health needs of all Medi-Cal members in an integrated, patient-centered, whole-person fashion. Standardizing and moving toward integration of delivery systems represents a significant step forward in reforming our fractured delivery system. It also provides California an opportunity to build upon the lessons learned from numerous managed care transitions over the years, and successful programs like the Whole Person Care pilots and Health Homes Program.

CHA supports the efforts to implement a CalAIM 1915(b) waiver that brings each of the delivery systems into one federal authority, with the goal of standardizing federal requirements to the extent possible and reducing administrative complexity. We appreciate the additional flexibility with the 1915(b) waiver structure that allows for the state to demonstrate cost effectiveness versus demonstrating budget neutrality. As the state enters into the implementation phases of CalAIM, the additional investments may not generate immediate savings; however, we believe many of these initiatives — Behavioral

Health payment reform and regional contracting, expansion of Drug Medi-Cal Organized Delivery System, etc. — will yield long-term and ongoing cost effectiveness.

Specifically, shifting Whole Person Care from a Section 1115 waiver program to Medi-Cal managed care will provide greater availability of this expanded benefit structure, but we acknowledge this also imposes a greater responsibility on the Medi-Cal managed care plans. As result, CHA urges DHCS to increase oversight of the Medi-Cal managed care plans and their subcontractors to ensure that not only are basic obligations being met, but these additional benefits and requirements are available for Medi-Cal beneficiaries.

CHA appreciates the opportunity to comment on the proposed CalAIM Section 1115 & 1915(b) Waivers. If you have any questions, please do not hesitate to contact me at rwitz@calhospital.org or (916) 552-7642.

Sincerely,

/s/

Ryan Witz
Vice President, Health Care Financing Initiatives

The UCLA Center for Children’s Oral Health would like to thank the Department of Health Care Services for the intention of the CalAIM waiver proposal.

Our faculty and partners hope that this will truly help increase access and improve oral health outcomes for children.

In response to the proposal, it will be important to clarify what measures will be employed to monitor and evaluate the goals of CalAIM. Implementation of programs to support increased dental service utilization, especially within vulnerable and underserved populations, needs to also include metrics that can determine if these services are having the intended impact and if not, these measurements can help guide process improvements so that California residents in the most need are getting the appropriate care through this waiver.

It will be vital to identify core measures and ensure a process for monitoring and tracking.

Further, to best facilitate access to and utilization of services available through the CalAIM waiver, care coordination protocols need to be clearly defined and responsibilities need to be designated to ensure that no family slips through the cracks.

Additionally, standardized monitoring and evaluation of care coordination services and outcomes, including regular performance reports for providers and contractors, will be necessary to measure the impact of this program.

Incentivizing providers appropriately for achieving performance standards will also encourage service fidelity and that providers meet reporting requirements. These standards will allow for continuous quality improvement with the goal of high-quality patient outcomes.

UCLA Center for Children’s Oral Health UCCOH
www.uccoh.org



YOUTH SERVICES POLICY GROUP

L.A. County

*Advocating for a youth-friendly
substance use system of care*

May 5, 2021

Will Lightbourne, Director
California Department of Healthcare Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, California 95899

Submitted via email to CalAIM@dhcs.ca.gov

Dear Director Lightbourne:

On behalf of the L.A. County Youth Services Policy Group (YSPG), we applaud your leadership in working to enhance and improve upon the updated CalAIM proposal and the 1115 Demonstration and 1915(b) Waiver. Transforming the Medi-Cal system is a monumental task and the process and detail of implementation is crucial to achieving maximal positive health outcomes. The YSPG strongly supports the goals and changes outlined in the updated proposal. By way of this letter, we offer some additional **youth-specific recommendations** for your consideration that have to do with ensuring the newly improved Medi-Cal system is transformed in a manner that comprehensively supports the medical and behavioral health needs of all children, youth and families residing in California. Below we provide our recommendations outlined by specific areas of the updated CalAIM proposal and the 1115 Demonstration and 1915(b) Waiver:

We applaud DHCS confirming that beneficiaries under the age of 21 are eligible to receive DMC-ODS services without a diagnosis under EPSDT. However, while youth will now be guaranteed access to needed substance use disorder treatment services through the EPSDT benefit, we urge DHCS to specify such additional comprehensive services to ensure transparency and accountability that EPSDT-eligible DMC services are available, offered consistently, and are in alignment with the intent of CalAIM within the behavioral health systems serving eligible beneficiaries under the age of 21 at a statewide level.

- **Recommendation:** We recommend that DHCS adopt/use specific language in the revised proposal that specifies the additional types of youth-centered comprehensive services that eligible youth beneficiaries under 21 are able to receive under EPSDT including: outreach, screening, assessment, care coordination, family/caregiver education and support groups, mentoring, recreational therapies, and clinical supervision. This is important since the federal Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) Medicaid youth benefit provides assurance that: “*beneficiaries under the age of 21 are eligible to receive all appropriate and medically necessary services needed to correct or ameliorate health conditions that are coverable under Section 1905(a) Medicaid authority. Nothing in the DMC-ODS overrides any EPSDT requirements.*”

We commend DHCS for the proposed efforts at consolidating the 1915(b) Waiver and implementing contracts and guidance that update the SMHS program requirements for both adults and youth beneficiaries under 21 to ensure access to appropriate care and to standardize the access to the SMHS delivery system statewide. A very critical streamlining change entails creating additional criteria for youth beneficiaries under 21 at high risk of developing mental health conditions due to experiencing trauma, such as involvement in child welfare or homelessness. However, given the co-occurring nature of substance use with these mental health conditions, as well as other issues, such as first episode psychosis and psychotic disorders (linked to cannabis use and methamphetamine use) and suicidality and depression (linked to alcohol and opioid use), **the integration and inclusion of substance use risk and substance use disorder services** in the SMHS service delivery streamlined criteria changes as additional criteria is critical.

- **Recommendation:** We recommend that DHCS ensures that the proposed guidance associated with SMHS service delivery streamlining of “additional criteria” is inclusive of substance use risk and substance use disorder services.

We strongly support DHCS’s adoption of a “no wrong door” policy in the revised proposal. However, it is not clear that substance use services are integrated and coordinated in a person-centered manner that focuses on meeting consumer needs under this policy.

- **Recommendation:** To ensure clarity of the implementation of the “no wrong door policy” in the updated proposal, we recommend specific language be included that clarifies how SMHS and substance use risk and substance use disorder services will be aligned and how there will be parity and equity in terms of: (1) utilizing assessments that identify SMHS and substance use challenges, and (2) developing treatment plans and service delivery models that address SMHS and substance use needs. We believe that instituting these additional changes will truly reflect a “no wrong door approach” service system that is inclusive of all behavioral health agencies, and places the consumer’s needs first, recognizing the value of services offered from all behavioral health disciplines.

We commend DHCS for recognizing the need for Early Intervention services and the inclusion of the ASAM 0.5 benefit for youth beneficiaries under 21 who are engaging in substance risk behaviors and do not meet clinical criteria for a Substance Use Disorder diagnosis. However, it is not clear that the proposed “Early Intervention services and ASAM 0.5 benefit” is inclusive of evidence based services that are youth-centered and developmentally appropriate to comprehensively address the diverse challenges associated with substance use risk issues.

- **Recommendation:** We urge DHCS to ensure the definition of the Early Intervention ASAM 0.5 benefit expands beyond the traditional SBIRT service model implemented in primary care settings that are designed to “identify risk” and “refer” (service coordination) to behavioral health settings where risk can be appropriately assessed using early intervention service models that address youth risk comprehensively. These models include, for example, Teen Intervene, which include clinical-based sessions with youth and parent/caregivers using evidence based behavioral interventions designed to address individual youth developmental stages of change and needs, including psychiatric assessment and services, mentoring, contingency management, family/caregiver education and support groups, anger management, recreational therapies, and case management.

The addition of Contingency Management services will add great value to the service delivery toolbox of DMC-ODS providers in achieving positive health outcomes.

- **Recommendation:** As a newly included evidence-based practice, we recommend that DHCS work with counties to provide dedicated funding for training providers in the utilization of Contingency Management and that youth Contingency Management services are tailored to meet the developmental needs of youth populations along the continuum of care with clear protocols that include specifics on training requirements, service provision (i.e., types of reinforcers and contingency services), implementation plans (i.e., feasible reinforcement schedules and youth centered behavioral targets), site monitoring of service delivery, and fidelity assurance.

We strongly support the addition of peer support specialist services, traditional healers and natural helpers in the updated proposal. With the inclusion of these roles in behavioral health settings, California will align with the majority of other states in the U.S. that recognize the value of lived experience and community knowledge in ensuring access to and utilization of the health and behavioral health safety net.

- **Recommendation:** The Peer Support Specialist certification program authorized by SB 803 is currently structured as a County option and therefore access to these evidence-based services for parents and families will be mixed. We strongly recommend making access to Peer Support Specialists a statewide benefit for all Medi-Cal youth beneficiaries under 21 so that youth and families impacted by mental health and substance use disorder issues have access to this evidence-based and culturally-responsive service.

We salute DHCS' efforts to clarify allowable components of recovery services, including when and how beneficiaries, including justice-involved individuals, may access recovery services. However, the proposal still lacks cultural sensitivity to youth-specific programming needs.

- **Recommendation:** Given the importance of recovery support services for the youth system of care, we recommend that specific language be added to clarify how the services will be developmentally appropriate and address the recovery needs of youth beneficiaries under 21, including guidance on updated assessment for understanding remission needs and parental/caregiver inclusion in recovery services (family education, support and therapy).

The Los Angeles County Youth Services Policy Group is committed to advocating on behalf of youth and families in California to ensure that they have equitable access to quality-driven behavioral health care services that comprehensively address their unique, developmental needs. Youth are our future and we are confident that through our continued partnership, we can build a behavioral health system of care that is dedicated to supporting the health and wellbeing of our youth. On behalf of the YSPG, I thank you for the opportunity to submit the above-referenced comments and recommendations. Please feel free to contact me either via email at jfarber@hycinc.org or telephone at (323) 640-9781 with any questions or items for requiring follow-up discussions.

Sincerely,



L.A. County Youth Services Policy Group
Executive Director, Helpline Youth Counseling

L.A. County Youth Services Policy Group

Asian American Drug Abuse Program
Behavioral Health Services
California Community Foundation
Canon Human Services
Children's Hospital Los Angeles
Clínica Romero
Community Clinic Association of L.A. County
Didi Hirsch
Eggleston Youth Center
Families for Children
Hathaway/Sycamores
Helpline Youth Counseling
Koreatown Youth and Community Center
Lundquist Institute/Options for Recovery
Los Angeles Centers for Alcohol & Drug Abuse
Maryvale
MELA Counseling Services
Phoenix House
Rancho San Antonio
Shields for Families
SPIRITT Family Services
Tarzana Treatment Centers, Inc.
The Los Angeles Trust for Children's Health
The Teen Project



May 6, 2021

Will Lightbourne, Director
Jacey Cooper, Chief Deputy Director & State Medicaid Director
California Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Re: CalAIM 1115 and 1915(b) Waiver Renewals

Dear Directors Lightbourne and Cooper:

For decades, the federal 1115 and 1915(b) waivers have been a foundational part of the Medi-Cal program. With the support of the Centers for Medicare and Medicaid Services (“CMS”), California’s 1115 waivers have included innovative programs such as Whole Person Care (“WPC”), and the 1915(b) waivers have authorized our State’s long-standing specialty mental health service freedom of choice waiver. Since first announced in 2019, California’s 16 community-based, local plans have been supportive of the vision of CalAIM and the opportunity it presents to improve care and outcomes for the Medi-Cal beneficiaries we serve. On behalf of these plans, which serve over 8 million Medi-Cal managed care beneficiaries, the Local Health Plans of California (“LHPC”) submits the enclosed comments in support of DHCS’ 1115 and 1915(b) waiver renewal proposals. Our letter also raises important considerations and questions regarding the proposal for jail and prison in-reach services and the Providing Access and Transforming Health (“PATH”) program.

Services for justice-involved populations 30-days prior to release. The 1115 waiver requests authorization for federal Medicaid matching funds for a specific set of jail and prison in-reach services 30-days prior to release. These services include enhanced care management (“ECM”), a 30-day supply of medication, and clinical consultation. Related CalAIM proposals include a pre-release Medi-Cal application process to be administered by counties and the re-entry population is also included as one of the seven ECM populations of focus. Given that this population is at high risk for poor health outcomes and, upon transition back to the community will have numerous social risk factors, we are supportive of the proposal to provide in-reach services. However, there are important components of this proposal which we believe need further consideration to ensure it is feasible to operationalize.

Jail in-reach. Individuals incarcerated in county jails may be serving sentences as short as days or weeks, or – due to 2011 realignment, which realigned certain felony convictions from the state to counties – may be serving longer sentences upwards of a year. This is an important factor when considering how to provide 30-day in-reach to this population. Additionally,

release dates are often moving targets, making it challenging to organize and plan services. We understand this proposal builds on the innovative and successful work of Los Angeles County's Whole Person Care Pilot program, but we question how these services will be provided under a managed care structure.

As DHCS is aware, enrollment into the managed care plan is a necessary precursor for providing covered services. When mapping out the process that must occur prior to delivery of jail in-reach services, particularly for those whose Medi-Cal eligibility has been terminated or suspended, it is difficult to envision how this will be operationalized through the plans. The pre-release application, including plan selection and enrollment, will need to occur before in-reach services can be provided and reimbursed. Unless DHCS is proposing a different process for plan enrollment or another mechanism for these services to be reimbursed, the pre-release application, plan selection and enrollment, would need to occur well before the 30-day in-reach period. The waiver proposal is lacking important details that may further explain DHCS' vision for this program. We recommend the final waiver describe in more detail how in-reach services would be delivered through managed care and request further discussion with DHCS about this proposal.

Prison in-reach. While the jail and prison populations are similar, the process and coordination required for implementing in-reach services are different for individuals incarcerated in state prisons and will present unique challenges that need to be considered. Although release dates for individuals incarcerated in state prison are more certain than jail release dates, there will be different entities involved in a pre-release application and enrollment process (note: while this is not addressed in the waiver, we assume this will be a necessary step prior to delivery prison in-reach services) and different providers responsible for delivering in-reach services. Additionally, unlike the jail population, individuals incarcerated in state prisons are located throughout the state. Their prison location is often driven by the seriousness of the offense, level of security needed, or health conditions. The county of release for prisoners often changes at or near the release date, which could complicate managed care enrollment and delay services. These differences will make implementing prison in-reach services extremely complex. While the waiver seeks authority to implement in-reach services on January 1, 2023, it also recognizes that implementation may occur in phases. We believe a longer time horizon will be needed to implement in-reach services to individuals incarcerated in state prisons given the complexities and challenges that will need to be overcome to implement this program.

PATH. The 1115 waiver also seeks authority for federal matching funds for the PATH program to support infrastructure, capacity building, and IT systems for ECM and in lieu of services ("ILOS") providers and provide additional resources for coordination between justice-involved entities to support in-reach services. Given the significant investments needed to successfully implement ECM and ILOS, we are supportive of this proposal which we believe will complement the proposed managed care incentive program. However, we request more detail about the PATH program, including the proposed funding amount and the specific activities or infrastructure that will be supported by the program. This information will be critical as plans

and their county partners prepare for transitioning WPC and HHP, and implementation of ILOS and ECM for the additional populations of focus in the coming years.

Continuous eligibility. Medi-Cal churn will be a particular challenge for the populations served by ECM and ILOS given that these populations, by definition, will be individuals with complex health, behavioral health, and social needs. We request that DHCS consider any opportunities to seek authority for continuous eligibility to support successful implementation of ECM and ILOS by reducing Medi-Cal enrollment churn.

Thank you for your leadership in proposing these historic and ambitious federal waivers. Local plans are proud partners of DHCS and look forward to continuing to work together to ensure the success of ECM, ILOS, and the other transformative proposals in CalAIM.

Sincerely,



Linnea Koopmans
Interim CEO

May 6, 2021

Will Lightbourne, Director
California Department of Health Care Services
1500 Capitol Avenue
Sacramento, CA 95814

submitted via email to CalAIMWaiver@dhcs.ca.gov

RE: Public Comments on California 1115 & 1915(b) Waiver Proposal

Dear Director Lightbourne,

The San Francisco Community Clinic Consortium, which represents 12 community health centers serving approximately 112,000 low-income patients, appreciates the opportunity to comment on the proposed CalAIM Section 1115 and Section 1915(b) Waiver Amendment and Renewal Applications.

The San Francisco Community Clinic Consortium commends the Administration's commitment to implement CalAIM, an initiative that will lead to broad delivery system, program, and payment reforms across Medi-Cal. We see many positive changes in the proposal. However, we do have concerns and recommendations, and would like to share them below for your review and consideration. Specifically, In the paragraphs below, we detail the following:

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

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

Comments

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

We are aware of the time and investment the state committed to the design and vision of Medi-Cal Rx. However, providers and health plans have systems in place today that ensure pharmacy access for Medi-Cal beneficiaries. The implementation of Medi-Cal RX has been delayed, but we are currently uncertain as to when our pharmacies would have to make this transition. Because of critical dollars currently provided through use of the 340-b program, we would prefer that community health centers be exempted from the move to Fee for Services from Medi-Cal Managed

Care. If this is not possible, we seek as long a delay as possible, particularly because we are still working above and beyond our capacity in the COVID 19 pandemic. Our clinics have taken a major role in getting vaccines to the most vulnerable populations, and we anticipate that will be going on for several months. Next, there will be extensive work to make sure that preventive services for our patients that may have been delayed during the COVID crisis, get back to or exceed previous levels. For community health centers, this is a particularly difficult time for a pharmacy transition with an uncertain start date.

Recognizing the rapidly evolving pandemic response, as well as the current challenges and unknown resolution to conflict concerns with the project's contractor vendor, we recommend the department delay the pharmacy transition and consider removing the transition from its waiver proposal.

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

The CalAIM proposal will ensure that beneficiaries receive the care they need no matter how they enter the system and where they are in the system. Currently, treatment services are not available until a patient completes an assessment, which often can be counterproductive to patient engagement, especially for patients in crisis or in substance withdrawal. For that reason, we applaud the Administration proposal regarding allowing treatment during the assessment period and the "no wrong door" proposal that will ensure provider's ability to render necessary medical services to patients. However, questions remain as to how providers can comply with, and bill for, those services if they are not contracted with a county specialty mental health (SMH) and substance use disorder (SUD) health plan.

Health centers often are the entry into the SMH/SUD system, yet many of our health centers are not contracted providers with the county SMH/SUD health plans. There have been various problems in transitioning our patients to the county-based systems. Our patients often need culturally and linguistically appropriate care that is not currently accessible in our county SMH/SUD health plan, particularly when the clients find themselves in crisis. Of course, we are working with our county to improve SMH/SUD transitions, but currently several of our clinics find themselves in the position of needing to provide services for severely mentally ill clients without adequate resources. For that reason, we ask DHCS to provide clarification on how non-contracted providers can provide medically necessary services prior to an assessment.

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

The Cal AIM proposal will integrate county mental health plans and Drug Medi-Cal Organized Delivery Systems into a single behavioral health plan. Although we recognize a statewide need to enhance access to both sets of services in a coordinated manner, we see several issues that need to be addressed to ensure that counties are prepared to adequately meet the demand for services and patients/families can be assured they are receiving the highest quality of care. We are concerned with how the state will hold county behavioral health plans accountable for performance, and in San Francisco we are eager to learn how the issues of language and cultural appropriateness will be accessed. We need to know that our county mental health and Drug Medi-Cal Organized Delivery system can provide adequate, timely, coordinated care, with special attention paid to mono lingual clients and those clients who have specific needs, for example, transgender clients and clients experiencing homelessness. As a specific example, currently patients who need an appointment at the county are told that they can come and wait during a half day block for an assessment. However, it is not realistic that someone experiencing a severe mental health problem wait for several hours without adequate support.

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

The San Francisco Community Clinic Consortium is pleased to see the inclusion of Enhanced Care Management and In-lieu-of Services in the Cal AIM proposal as well as the Administration's commitment to ensure adequate funding is allocated for these services in this year's budget. For example, we have several programs currently operating in San Francisco that demonstrate the importance and value of food-based interventions for our patients which should be expanded. When community-based research was done with people experiencing homelessness in San Francisco, they specifically mentioned the need for a significant expansion of intensive case management. To ensure successful implementation of these elements, however, it is important that community-based organizations, including health centers, have the tools and resources needed to work together. Supports are needed to guarantee data exchange throughout the county, establish payment relationships, and measure value and outcomes.

5. DHCS must ensure the public has opportunity to review and comment on many policy changes that are described in the waivers but are not included as part of the waiver proposal.

While we appreciate the opportunities to comment on the 1115 and 1915(b) waivers and expect DHCS will release other policy changes for public comment in the future, we would like to underscore the importance of gathering and incorporating stakeholder input into final policies. Specifically, we request extensive public comment and engagement on the following items noted in the proposal:

- A standardized screening tool for county Behavioral Health plans and Medi-Cal managed care plans to use to guide beneficiaries toward the delivery system that is most likely to meet their needs.
- A standardized transition tool for MHPs and MCPs to use when a beneficiary's condition changes, and they would be better served in the other delivery system.
- A process for facilitated referral and linkage from county correctional institution release to county specialty mental health, Drug Medi-Cal, DMC-ODS, and Medi-Cal MCPS when the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

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

Again, the San Francisco Community Clinic Consortium appreciates this opportunity to submit comments on the waiver proposal. We look forward to working with you to implement these major changes. If you have any questions, please contact Deena Lahn at dlahn@sfccc.org or 415 355-2262.

Sincerely,



Deena Lahn
Vice President, Policy and External Affairs
The San Francisco Community Clinic Consortium



May 6, 2021

Will Lightbourne
Director
Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899

RE: Support for CalAIM Section 1115 Demonstration Application and Section 1915(b) Waiver Overview

Dear Mr. Lightbourne:

On behalf of SPUR, I am writing to share our support for the CalAIM Section 1115 Demonstration Application and Section 1915(b) Waiver Overview. The CalAIM comprehensive waiver proposal represents an important opportunity to address social determinants of health, chronic disease, healthcare costs, and healthcare utilization among Medi-Cal beneficiaries.

SPUR sees the transition to providing In Lieu of Services (ILOS) as a key way to address social determinants of health. We are particularly supportive of the inclusion of Medically-Supportive Food and Nutrition as part of the menu of services – an addition to the proposal that we, and more than 100 organizations across the state, see as a critical to providing the necessary spectrum of interventions that improve health care outcomes, reduce health care costs and mitigate health disparities.¹ If this menu of services is approved in the final waiver application, California will join Massachusetts, North Carolina and Oregon in providing comprehensive food-based supports to eligible Medicaid recipients. We look forward to continuing to work with the Department on ensuring the full spectrum of Medically-Supportive Food and Nutrition interventions are implemented.

To help secure the positive outcomes of ILOS implementation, we are excited to see the inclusion of funding authority to support the tools and resources needed for health plans and community-based organizations to work together, including the ability to exchange data, establish payment relationships and measure outcomes. Funding like this will be key to building the capacity needed to implement the ambitious goals of the CalAIM proposal.

For these reasons we are supportive of the CalAIM Section 1115 Demonstration Application and Section 1915(b) Waiver Overview and look forward to seeing additional guidance as it is released.

Sincerely,



Katie Ettman
Food and Agriculture Senior Policy Associate

¹ Sign-on Letter: Expanding Medically-Supportive Food and Nutrition Services
https://www.spur.org/sites/default/files/2020-03/CalAIM%20Public%20Comment%203_6_20.pdf



May 6, 2021

Dr. Kelly Pfeifer
Deputy Director, Behavioral Health
Department of Health Care Services
1501 Capitol Mall
Sacramento, CA 95814

Re: Public Comment - Section 1915(b) Waiver, Recovery Services

Dear Dr. Pfeifer:

By way of introduction, I would like to give you a brief description of the California Coalition of Addiction Recovery Advocates (CCARA):

CCARA is the first organization of collective associations and entities formed solely to promote treatment and recovery advancements from the consumers' point of view in California. It is not managed or owned by treatment companies or investors; it is purely consumer oriented and focused. Its primary goals are threefold:

1. To reduce the stigma of addiction
2. To create "recovery friendly communities"
3. To reduce the social, health, and economic impacts of addiction

Given these goals, we are keenly interested in the 1915 (b) waiver that was recently released for public comment. We believe that the waiver, in addition to tremendous opportunities being brought to the state via the American Rescue Package, the Coronavirus Response and Relief Supplemental Appropriations Act, the American Families Plan, and multiple opioid settlement cases, has created a moment in time to take a "bigger picture" view of treatment and recovery by addressing the shortcomings we are now experiencing in the recovery side of the equation.

We have reviewed the draft waiver and are tremendously thankful that the department has chosen recovery services as one of the three highlighted areas of improvement for substance use disorder. The document states that one of the intentions of the renewal is to, "clarify the allowable components of recovery services." It also states that UCLA will measure the use of recovery services: "UCLA

examines the number of recovery services claims and uses surveys and interviews to measure the usage and challenges associated with recovery services.”

We find it interesting that “recovery services” are defined very broadly in the document as “services to prevent relapse.” Although this is sufficiently broad and could cover just about anything, it does not reflect the current scientific or academic understanding of the components generally now considered “recovery services.” We must respectfully point out that recovery concepts are insufficiently described by the document which may lead to poor implementation after the waiver is approved.

CCARA recommends that a section, similar to the one describing peer support specialists, be added to the document to better reflect what “recovery services” are and their importance to outcomes of the waiver. We also recommend that several outcome measurements be included in the table that identifies how progress will be documented.

Recovery Services:

As per the Substance Abuse and Mental Health Services Agency, the definition of recovery is:

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

SAMHSA has delineated four major dimensions that support a life in recovery:

1. Health - Overcoming or managing one’s disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
2. Home - A stable and safe place to live
3. Purpose - Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society
4. Community - Relationships and social networks that provide support, friendship, love, and hope

It would be very important to include this definition and to design recovery services to align with the four dimensions of recovery (examples of services that could be placed in each dimension are attached).

We understand the function of the waiver is to present broad concepts to the Centers for Medicaid and Medicare and that there may be limited bandwidth to include all of our ideas. However, we do consider the waiver to be very weak in this regard as it is and would urge that the department consider making some improvements in this area.

Data and Outcomes:

CCARA respectfully requests that the data collected regarding recovery services be made more robust. In addition to surveys and interviews to measure the usage and challenges associated with recovery

services, CCARA believes that data on many items can be quantified: the number of recovery residence beds, the number of information campaigns, the number of life skills programs, and the number of RCOs created all can be counted. Additionally, counties need to be prompted to engage in creating these services. Perhaps a general count of how many counties have even begun the process of contracting for recovery services would produce data that would be helpful.

Recovery Innovations in Other State Waivers:

We have reviewed waivers from other states and are intrigued by:

District of Columbia:

DBH-supported Peer-Operated Centers, which are community Drop-in Centers that provide mutual support, self-help, advocacy, education, information, and referral services. Their primary goal is to assist people with psychiatric illnesses, who may also have co-occurring SUD and/or other medical conditions, to regain control of their lives and of their recovery process. The Drop-in Centers promote an environment that is conducive to self-directed recovery, based on consumer experience, knowledge and input; and

Rhode Island:

Expansion of funding to recovery centers throughout the state to enhance community connections for those in recovery.

Vermont:

Day Recovery/Psychoeducation, Including Recovery Education: Group recovery activities in a milieu that promotes wellness, empowerment, a sense of community, personal responsibility, self-esteem and hope. These activities are consumer-centered; they provide socialization, daily skills development, crisis support, and promotion of self-advocacy.

Recovery Centers that provide non-clinical services that assist with establishing community connections that lead to employment, housing, and other social supports in a safe, drug- and alcohol-free environment. Recovery Centers are committed to supporting a person's efforts in preventing relapse and, should relapse occur, in quickly returning to recovery. Individual services revolve around the support from the Peer Recovery Coach, an individual in active recovery from substance use disorder who has received Peer Recovery Coach training. The Recovery Centers also offer several groups to support recovery, such as: • Evidence-Based Practice (EBP) groups o Making Recovery Easier o Seeking Safety o Wellness Recovery Action Planning (WRAP) • Community Groups o Yoga, Meditation, Acupuncture o Age-specific recovery groups o Ongoing 12 Step meetings.

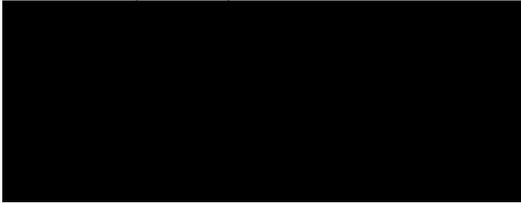
These waivers were approved with specific recovery services in them leading us to believe that CMS will consider these types of programs for California's renewal.

Continuum of Care:

Due to the chronic nature of the disease of addiction, recovery services must be available throughout the continuum of care; from prevention to long established recovery. Prevention from relapse must be part of prevention efforts, particularly for young people. There should be no artificial barrier to funding for school, college, and community recovery efforts within the prevention “silo.” There also should be no condition that a person must first be diagnosed with SUD in order to receive recovery services. CCARA highly recommends that both of these distinctions be added to the waiver.

On behalf of CCARA, I wish to thank the department on the terrific work in being the first waiver of this type in the country. I also wish to extend our expertise in the recovery area so that we can build a “recovery ready” California for the future.

Thank you for your consideration,



Devon Wayt
Chair

Recovery Services Examples:

1. Health: “angel assistance” where people in recovery assist law enforcement and health systems to keep people safe; community based Naloxone programs;
2. Home: recovery residence capacity building; training for quality improvements to recovery residence housing; stigma reduction for MAT use in recovery housing; good neighbor public relations activities to promote community acceptance of recovery housing; investments in mommy/daddy and me housing;
3. Purpose: information campaigns about “multiple pathways” to recovery; core messaging about what it is like to be a person in recovery; core messaging about what it is like to be an ally; aid and assistance to families to discover how to live as families in recovery; improvement of recreational activities that support young people in recovery; reduction of workforce stigma; creation of more programs such as E.P.I.C. Engaged; Peer Driven; Integrated; Community, a “peer-to-peer” model that uses a 12-week curriculum to teach life skills;
4. Community: create Recovery Community Organizations (Faces and Voices RCOs); stigma reduction campaigns; creation of recovery community programs that use shared spaces for recovering people to meet and socialize using peer recovery services; support existing recovery centers and cafes and use them as models to expand this resource; collegiate and high school campus recovery programs; recovery high schools; expanded use of Assessment of Recovery Capital (ARC) tool.



San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

*Will Lightbourne, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814*

*Jacey Cooper, Chief Deputy Director & State Medicaid Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814*

Submitted via: CalAIMWaiver@dhcs.ca.gov

May 6, 2021

Re: [CalAIM Section 1115 & 1915\(b\) Waivers](#)

Dear Mr. Lightbourne and Ms. Cooper:

The San Francisco Health Network (SFHN), on behalf of the San Francisco Department of Public Health (SFDPH) endorses the strategic goals, guiding principles and proposed innovations as put forth in the proposed Medi-Cal 2020 Section 1115 demonstration amendment (CalAIM) and Section 1915(b) managed care waiver. SFDPH supports this important transformation of key aspects of the Medi-Cal delivery system in order to improve health outcomes for Medi-Cal beneficiaries and other low-income and vulnerable populations in California, which aligns with the goals of SFDPH.

SFHN provides direct health services to thousands of insured and uninsured residents of San Francisco, including those most socially and medically vulnerable. SFHN is a community of top-rated clinics, hospitals and programs operated by the Health Department that connects San Franciscans to quality health care. Every year we serve more than 100,000 people in our clinics and hospitals, including Zuckerberg San Francisco General, the only trauma center serving all of San Francisco and northern San Mateo County, and Laguna Honda Hospital and Rehabilitation Center. We provide continuous care for people across their life course in clinics, hospitals, at home, in jail or transitional housing. As the City's public health system, we also provide emergency, trauma, mental health and substance abuse care to any San Franciscan who needs it.

Thank you for this opportunity to comment on the draft CalAIM Section 1115 demonstration application and Section 1915(b) waiver overview. SFDPH has created a steering committee consisting of departmental leads for CalAIM transition, provisions, and implementation. The committee has prepared comments on public health care system-specific CalAIM components, which are provided below. These comments are informed by our experience as the primary safety net health care delivery system for San Francisco, as well as by conversations with relevant key stakeholders from our systems of care.

- Behavioral Health Payment Reform:** The current CalAIM proposal would transition counties from cost-based reimbursement for BH services to standard fee-for-service (FFS)

reimbursement supported by intergovernmental transfers (IGT). Transitioning to FFS would help to incentivize outcomes and quality, but we have concerns regarding the proposal to standardize rates across multiple counties. Such a change would create winners and losers depending on each county's cost of living. High-cost counties, like San Francisco, would likely not be reimbursed at a level that fully covers the cost of providing services while low-cost counties may be reimbursed at rates higher than required to cover service costs. Each county in California delivers specialty mental health services and is currently reimbursed in their own cost structures – transitioning to fee-for-service reimbursement should not force counties to reimburse below or above cost. Even mitigations such as averaging counties based on high and low-cost tiers are imperfect as there are still cost differences between those counties.

Recommendations:

- **Establish cost-plus FFS reimbursement rates that fully cover the costs of services for counties and enable system reinvestment.** We recommend that DHCS collaborate with counties and outside subject matter experts as needed to develop a “cost, plus” rate-setting methodology that begins with historical cost data and makes rational adjustments to reflect population characteristics, market factors, and delivery system goals.

2. **Providing Access and Transforming Health (PATH) Supports:** As San Francisco transitions into CalAIM, we applaud the inclusion of PATH payments as an important mechanism to ensure a successful transition from Whole Person Care to a managed care structure.

Recommendation:

- In order to ensure successful transition from WPC to CalAIM, a significant amount of work will need to be done in the areas including but not limited to capacity building, programmatic infrastructure, staff hiring, building out electronic health record and multi-agency data sharing over the next five years. PATH payments must be adequately funded in order to effectively support infrastructure development, public health care system providers, and their efforts to maintain and expand the services to targeted populations.

3. **Global Payment Program (GPP):** Under the GPP, San Francisco has taken steps to improve population health through preventive care, chronic condition management, and early intervention along with efforts to enhance timely coordination of care. SF has also increased efforts to ensure access to care for everyone regardless of insurance status.

Recommendation:

- Uninsured patients should receive the same comprehensive range of services – physical and behavioral health, and social services – as those in Medi-Cal have received through Whole Person Care and now CalAIM. To achieve this programmatic equity, and to make meaningful strides in providing equitable care, an Equity Sub-Pool is proposed to catalyze comprehensive and coordinated services for the uninsured. This Equity Sub-Pool would create the opportunity for the remaining uninsured to experience the benefits of care coordination, patient-centered care, and resulting improved health outcomes. We

recommend that the final proposal include a more substantive description of the Equity Sub-Pool, including specific activities.

- With ongoing uncompensated costs incurred for serving the remaining uninsured, the next five years of the GPP must include Safety Net Care Pool funding. These funds have proven to be critical in helping SF provide services to the remaining uninsured during the first five years of the GPP.

4. Whole Person Care transition to CalAIM (ECM & ILOS)

- a. **Racial Equity Strategy for the delivery of ECM and ILOS:** The policy and implementation decisions being made in CalAIM can either risk retrenching health disparities, or aid in their amelioration. Given the explicit aim of ECM and ILOS services to service those with some of the highest medical and social need, these programs must be implemented in a manner that will address longstanding health challenges for the communities of color that make up the largest proportion of Medi-Cal beneficiaries, along with other marginalized population.

Recommendations:

- Ensure there is racial equity in the composition of ECM focus populations;
- Assess disparities in ECM enrollment and provide assistance to MCPs to address them;
- Ensure racial equity in provision of ILOS.

- a. **ILOS Member Eligibility:** The proposed processes specified within the Requirement Document for determining member eligibility for ECM and ILOS raises concerns. While determining eligibility based on claims data may be familiar and convenient for Managed Care Plans (MCPs), claims data alone is insufficient to identify highly vulnerable members who would benefit from ECM/ILOS. This method of determining eligibility is problematic for people experiencing homelessness (PEH). Their medical providers may not know housing status (i.e. individuals may actively withhold this information due to stigma) or their medical provider may not use an ICD-10 code that marks them as experiencing homelessness. Exclusively using a claims-based approach will likely result in fewer members qualifying for EMC/ILOS, thereby excluding members within our community from these benefits.

Recommendations:

- We recommend that an exclusively claims-based or algorithm-determined eligibility approach should not be used by MCPs. With regards to enrolling PEH, HMIS data should be used to determine homelessness status.
- DHCS should provide a customer journey map that shows clear steps for the ECM eligibility and enrollment process – including how it will work from a member request, provider referral or MCP identification process. This map should include timelines and steps for authorization, assignment, member communications, and Lead Case Manager assignment.

- b. **ECM and ILOS Provider Eligibility:** Non-traditional providers of WPC services, like homelessness service providers who do not provide behavioral health or medical care (and thus do not have a billing or Medicaid enrollment/credentialing path), should continue to be eligible as ECM and ILOS providers under CalAIM, even if this requires creative solutions to gathering encounter data and billing.

Recommendations:

- DHCS should ensure ECM providers get paid for outreach attempts, in addition to enrollment.
- MCPs should not be able to exclude ECM/ILOS providers due to barriers to billing or credentialing.
- DHCS should provide a template, developed based on the input from and experience of WPC counties, that can be used for billing by non-traditional providers who are not able to become Medicaid enrolled.
- DHCS should provide in-depth technical assistance and support for those providers who have a path to Medicaid enrollment.

- c. **ILOS Services:** Some of the most innovative Whole Person Care interventions are designed to be continued through ILOS. Much of SF WPC work has been in the ILOS area rather than ECM. The MCPs may have varied interest in continuing this work, despite language encouraging them to do so, and their interest may be influenced both by the rates offered and by the capacity of the county to offer the services.

Recommendations:

- In counties with successful implementation of ILOS services, DHCS should incentivize the MCP to “turn on” the ILOS service for that county even if they aren’t ready to do so for their entire service area.
- DHCS should consider allowing counties to prioritize which 2-3 ILOS services the MCP must implement by 2023. This could be done using the Community Health Needs Assessment or other local processes.

- d. **Outreach Reimbursement:** The draft ECM/ILOS guidance and template documents suggest that MCPs will be identifying members eligible for ECM and directing ECM providers to engage those individuals. Based on our experience during the WPC pilot, this kind of outreach and engagement requires considerable time and patience to build trust, especially to marginalized populations. Currently, WPC provides reimbursement for SF pilots’ outreach efforts for enrolling members through its Outreach and Engagement Fee for Service. While DHCS intends for the proposed ECM payment to take into account outreach efforts that occurred prior to initiation of services, it does not account for those who were engaged, but did not enroll.

Recommendations:

- Outreach to eligible, but not yet subscribed Medi-Cal clients should be reimbursable if the individual enrolls within a certain timeframe (60-90 days) of the outreach. This could be paid via incentives or direct payment for outreach activity within a member month.
- DHCS should ensure that providers receive up-front funding to conduct any outreach expected of them by their MCP.

- e. **Data Sharing:** Under CalAIM, MCPs are responsible for risk stratifying their enrolled populations and offering a menu of care management interventions at different levels of intensity, with ECM at the highest intensity level. In order to provide more patient centered and streamlined care, data collected by MCPs should be shared with patients’ health care systems.

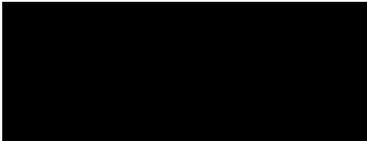
Recommendations:

- Plans should be required to share the risk and needs data they collect with healthcare providers. This includes the new patient screens, the plan-identified risk tier, and any other relevant social determinants or needs data that would facilitate the patient's care.
- Health plans should be required to share records of clinical care they or their contracted services provide to primary care providers and systems.

Thank you for considering San Francisco Health Network's concerns and input on the CalAIM Section 1115 & 1915(b) Waivers. The transition to CalAIM presents significant opportunities and challenges, and will require substantial staffing, financial resources, and collaboration between numerous stakeholders to implement successfully. We request that DHCS continue to remain mindful of these needs and ensure that proposals come with enough flexibility to ensure their successful implementation and sustainability across California. Further, we request that DHCS guarantee there is accountability and coordination between health plans and local healthcare delivery systems throughout the development and implementation of the various CalAIM provisions.

We are available to further discuss our concerns and look forward to being a part of a process that will increase services to vulnerable individuals and streamline administrative inefficiencies.

Sincerely,



Claire Horton, MD, MPH

Chief Medical Officer, San Francisco Health Network, SFDPH

Attending physician, Richard Fine People's Clinic, Zuckerberg San Francisco General Hospital
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May 6, 2021

Mr. Will Lightbourne
Director
Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, California 95899-7417

Re: Public Comment - Section 1915(b) Waiver

Dear Director Lightbourne,

On behalf of the California Consortium of Addiction Programs and Professionals (CCAPP), the largest statewide consortium of community-based for profit and nonprofit substance use disorder treatment agencies, and addiction focused professionals, providing services to over a 100,000 California residents annually in residential, outpatient, and private practice settings, we write to you to make recommendations concerning the 1915(b) Waiver as follows:

Staffing Requirement Flexibility

CCAPP requests that the waiver extension include a modification to the staffing requirements contained in the original waiver so that California's most educated, trained, and experienced counselors can be utilized to their highest degree in the Drug Medi-Cal Organized Delivery System.

At this time, alcohol drug counselors of the highest caliber are asked to have their work reviewed and overseen by colleagues with far less experience, formal education, and no competency exam specific to addiction treatment. This layer of "oversight" by inexperienced, non-trained workers creates the following problems:

- Clients are not receiving the highest level of care where treatment decisions are being managed by non-specialists who are simply performing an unnecessary oversight function; seasoned professionals, with higher levels of competency, are actually making these clinical decisions.
- Interns, fresh out of college, signing treatment decisions made by competent, experienced, addiction-focused experts is a discouragement to these professionals and inhibits others who specialize in the area of addiction from seeking higher positions on the career ladder.
- Removing frontline mental health workers to tend to oversight where it is not necessary drains critical resources desperately needed for mental health cases.

- Maintaining a double layer of clinical decision making diverts salaries from the substance use disorder workforce, which suffers critical shortages, in part due to inadequate pay.
- CMS has approved other waivers with professional requirements for counselors (without supervision) at the certified level, or at a licensed level where a bachelor's degree is required (see: *Appendix A: SUD Waiver State Requirements* for examples).
- CMS currently allows reimbursement for counselors under Utah's state Medicaid plan who do not hold master's degrees, thus advanced counselors with bachelor's degrees are acceptable at the federal level (see *Appendix B: Billing Eligibility and Reimbursement Under Medicaid*).
- The mental health system recognizes professionals with bachelor and associate level educations (mental health rehabilitation specialists) who work under program supervision; there is no similar distinction for alcohol drug counselors.
- Each of the three counselor certifying organizations approved by the department designate advanced counselors who have bachelor's degrees and predetermined years of experience making it easy to identify them for higher levels of responsibility and safe delivery of services.

Allowing alcohol drug counselors who have a bachelors or master's degree and four years' experience providing care in an addiction treatment environment would reduce workforce shortages, balance the esteem of the treatment team members, and enhance services provided under the DMC-ODS. Such an amendment would not conflict with CMS policy and could be easily achieved with a short definition of "Advanced Alcohol Drug Counselor." Please see: *Appendix C: Advanced Certified Alcohol Drug Counselor Amendment to DMC-ODS Waiver*, for suggested language to achieve this technical change.

30-Day "Goal" for Length of Stay

CCAPP understands that the extension must include a "goal" to work toward a 30-day length of stay as per CMS guidance released on November 1, 2017 (SMD # 17-003). However, one must assume that more than one-half of residential stays would be significantly less than 30 days. In order to reach this "goal" would providers be encouraging residential placements to leave before the duration of treatment is reached? Placing an artificially low cap on the number of covered days is at odds with clinical best practices, since it incentivizes providers and counties to approach treatment as a one-size-fits-all program rather than a tailored response to an individual's unique needs.

CCAPP is extremely concerned that a 30-day authorization for coverage, with no limitations on the number of episodes, could eventually lead to a 60 or 90 days per calendar year limitation. This would be more disastrous than the current two-episode cap.

Reimbursement for Services Pre-Diagnosis

CCAPP understands that beneficiaries may need to receive mental health services prior to diagnosis in the delivery system under certain conditions, even if ultimately the beneficiary is determined not to have a mental disorder. However, unless the mental health provider has adequate staff who are competent to treat substance use disorder, there should be language in the waiver that encourages prompt referral to an appropriate level of

SUD-specific care. There also should be strong language regarding the type of SUD screening and the personnel who perform such screenings. Because SUD programs must utilize appropriate mental health professionals to screen for dual diagnosis, the same standard must be applied in mental health settings where staff may be ill-prepared to conduct adequate SUD placements.

Integration:

CCAPP supports an integrated, whole-person approach to treatment. However, integration must preserve SUD specialty treatment within the integrated system. The strengths of SUD-specific professionals must not be supplanted with licensed professionals with very little education and training in SUD and no competency exam specific to the disease of addiction. Similarly, SUD professional staff must not be “cost factored” into a lesser position within an integrated treatment system. Historically low salaries for SUD professionals, in comparison to mental health professionals, must be addressed in the new, integrated model.

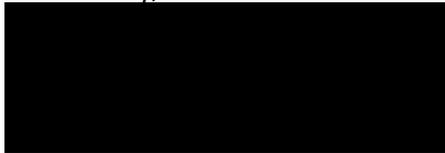
The waiver presents a bold opportunity to equalize career ladders and deliver truly integrated treatment teams to Californians. Creating career ladders for mental health and substance use disorders that have equal levels will encourage greater entry into these careers and forward progression along one’s career ladder. Each type of professional should mirror their counterpart on the treatment team. Associate and bachelor level professionals are required to meet specific education, experience, and testing benchmarks and are required to follow a designated code of conduct. Non-licensed mental health practitioners should be held to similar standards.

Recovery Services:

“Recovery services” are defined very broadly in the document as “services to prevent relapse.” This definition does not reflect the current scientific or academic understanding of the components generally now considered “recovery services.” CCAPP recommends that a more robust definition of recovery services be added to the language to include, as a bare minimum, recovery housing and recovery drop-in centers with peer support specialists staffing them. CCAPP also recommends that recovery services not be dependent upon an SUD diagnosis or ASAM level of care designation (pre-diagnosis). Attestation of recovery status or other form of self-disclosure should be sufficient to access these services (similar to EPSDT).

CCAPP is grateful to the Department and all staff who created the groundbreaking demonstration project and is thankful for your department’s efforts in this area.

Sincerely,



Chief Executive Officer

c.c. Dr. Kelly Pfeifer, Janelle Ito-Orille

Appendix A: SUD Waiver State Requirements

Maine, Comment Period Open:

SUD Professional/Staff Waiver Requirements:

The service will be delivered at an intensity and duration determined to be clinically appropriate to address the individual's needs. Services will be conducted by community Mental Health Rehabilitation Technicians (MHRT/C) professionals certified within the State of Maine with a minimum education level of Associate Degree in an approved human services field. The MHRT/C will be supervised by a Certified Clinical Supervisor (CCS), who is a licensed mental health professional qualified to deliver alcohol and drug counseling services or a Licensed Alcohol and Drug Counselor (LADC) with additional training in clinical supervision.

Determination of medical necessity, completion of the ASAM Six Dimensions of multidimensional assessment, and the placement recommendations must be made by an alcohol and drug counselor.

Requirements for Determining Medical Necessity:

Current SUD Counselor Requirements:

§6214-D. Licensed alcohol and drug counselor; qualification for licensure

1. Eligibility. To be eligible to practice as a licensed alcohol and drug counselor, an applicant must:

- A. Be at least 18 years of age; [PL 2003, c. 347, §16 (NEW); PL 2003, c. 347, §25 (AFF).]
- B. Have taken and passed an examination as prescribed by board rule; [PL 2003, c. 347, §16 (NEW); PL 2003, c. 347, §25 (AFF).]
- C. Have paid an application and license fee under section 6215; and [PL 2003, c. 347, §16 (NEW); PL 2003, c. 347, §25 (AFF).]
- D. Meet one of the following requirements:
 - (1) Complete 2,000 hours of documented supervised practice in alcohol and drug counseling as a certified alcohol and drug counselor;
 - (2) Possess an associate or bachelor's degree from an accredited college or university in clinically based behavioral sciences or addiction counseling or a related field as defined by board rule, complete course work as defined by board rule and complete a minimum of 4,000 hours of documented supervised practice in alcohol and drug counseling, except that an applicant who holds a bachelor's degree from an accredited college or university that meets the requirements of this subparagraph and who has completed at least 18 credit hours of course work in addiction counseling need only complete a minimum of 2,000 hours of documented supervised practice in alcohol and drug counseling; or
 - (3) Possess a master's degree from an accredited college or university in clinically based behavioral sciences or addiction counseling or a related field as defined by board rule, complete course work as defined by board rule and complete a minimum of 2,000 hours of documented supervised practice in alcohol and drug counseling, except that an applicant who holds a master's degree from an accredited college or university that meets the requirements of this subparagraph and who has completed at least 12 credit hours of course work in addiction counseling need only complete a minimum of 1,500 hours of documented supervised practice in alcohol and drug counseling.

Alaska Waiver, approved

SUD Professional/Staff Waiver Requirements:

Provider Qualifications: Licensed physicians, licensed physician assistants, licensed advanced nurse practitioners, licensed registered nurses supervised by a physician or advanced nurse practitioner, licensed practical nurses supervised by a physician or advanced nurse practitioner, mental health professional clinicians (AK Medicaid provider type including licensed clinical social workers, licensed marriage and family therapists, licensed master’s social workers, licensed clinical psychologists, licensed psychological associates, & licensed professional counselors), substance use disorder counselors, behavioral health clinical associates or behavioral health aide, peer support providers (w/ lived experience, working under supervision of a mental health professional clinician w/complete training/certification, w/continuing education).

Provider Qualifications- Providers qualified to be reimbursed for eligible services provided to eligible service recipients include licensed physicians, licensed physician assistants, licensed advanced nurse practitioners, licensed registered nurses supervised by a physician or advanced nurse practitioner, licensed practical nurses supervised by a physician or advanced nurse practitioner, mental health professional clinicians (AK Medicaid provider type including licensed clinical social workers, licensed marriage and family therapists, licensed master’s social workers, licensed clinical psychologists, licensed psychological associates, licensed professional counselors), substance use disorder counselors (AK certified Chemical Dependency Counselor I or II and Chemical Dependency Clinical Supervisor), and behavioral health clinical associates.

SUD Professional/Staff Development:

Thus, every Waiver region has significant MH and SUD workforce capacity shortages. There are only two Waiver regions that do not have geographical areas designated as HPSA—Anchorage and Fairbanks. We plan to use the Waiver as an opportunity not only to recruit and retain a qualified addiction workforce, but to begin to elevate the level of professionalism in the substance abuse treatment field by expanding the educational requirements for certification. These modifications will bring Alaska’s certification requirements into alignment with ASAM over the course of the Waiver. An initial step will be to survey each Waiver region hub to determine the specific SUD workforce needed to provide Waiver services. Addiction professionals in Alaska are certified by the Alaska Commission for Behavioral Health Certification (ACBHC). Certification is based on coursework, experience, and examination. A college degree is not required, but candidates with degrees in related fields can move through the ranks more quickly; degreed candidates also need to complete fewer contact hours of specific board-mandated coursework. Thus, there are two tracks: a degree track and a non-degree track--for certification as either a Counselor Technician, a Chemical Dependency Counselor I, a Chemical Dependency Counselor II, or a Clinical Supervisor. The framework for the certification process is the National Association of Alcoholism and Drug Abuse Counselors—now called NAADAC, the Association for Addiction Professionals. All Alaska certified addiction professionals must complete Ethics and Confidentiality training; all NAADAC training is deemed approved by ACBHC.

Training is also provided by the Regional Alcohol and Drug Abuse Counselor Training (RADACT) Program. RADACT is a nonprofit organization that coordinates and delivers on-site training to individuals who are in process of pursuing certification. RADACT also provides correspondence courses and offers a three-week intense

training academy. As of January 2018, Alaska has approximately 1022 certificate holders which include 133 Counselor Technicians, 481 Chemical Dependency Counselors I's, 188 Chemical Alaska 1115 SUD Waiver Implementation Plan March 13, 2019 32 Dependency Counselors IIs, 69 Chemical Dependency Clinical Supervisors, and 16 Chemical Dependency Administrators. We will review existing certification standards and requirements and align them with the knowledge, skills, and abilities for staff which are listed in ASAM criteria, Third Edition, for Residential Levels 3.1, 3.3, and 3.5 for adults and Levels 3.1 and 3.5 for youth. A list of action items and expected implementation timeline related to addiction residential workforce development is provided in the table below: Action Timeline Develop list of certified addiction professionals located in existing SUD residential providers Will be completed by March of 2019 Work with ACBHC to modify existing certification standards to align with ASAM Levels 3.1, 3.3, and 3.5 staffing requirements Will be completed by August of 2019.

Current SUD Counselor Requirements:

Substance Abuse Counselor Requirements in Alaska

The Alaska Commission for Behavioral Health certifies Alaska's chemical dependency professionals. Certification is based on coursework, experience, and examination. A college degree is not required, but candidates with degrees in related fields can move through the ranks more quickly. Degreed candidates also need to complete fewer contact hours of specific board mandated coursework.

Degree Track

The board has put together a matrix of certification requirement information for individuals with college degrees (<http://www.akcertification.org/files/Matrix%20CDC%20with%20Degree.pdf>). The following degrees are considered potentially certification qualifying: counseling, addiction, psychology, sociology, social work, psychiatric nursing, and human services. Degrees at any level may be considered, as can certificates from accredited institutions (<http://www.akcertification.org/files/CDC%20I%20Application.pdf>). Decisions are made on an individual basis. Counselors must meet additional training and examination requirements at each level.

Chemical Dependency Counselor I

A degreed technician will not need any additional coursework to move up to counselor level, provided NAADAC ethics and confidentiality coursework was taken within the prior two years.

The prospective addiction counselor will, however, need 100 hours of supervised practicum. Practicum must include 35 hours of practice in evaluating clients using the DSM/ASAM. It must include 35 hours of practice evaluating community readiness and developing prevention plans. 30 hours must be spent in case management and development of treatment plans. All practicum work must be supervised.

Additionally, the candidate will need at least one year of work experience. (The board will determine on a case by case basis whether the degree can substitute for one of the two years of experience that is required of a non-degreed applicant.)

Chemical Dependency Counselor II

This level of certification requires three years of experience (6,000 hours). The degreed counselor will need two additional courses: special issues and documentation and quality assurance. The former is 16 contact hours, the latter, 12 contact hours. Ethics and confidentiality coursework must be repeated if it was not taken within the previous two years.

An additional 100 hours of practicum is required. 60 hours are to be spent in treatment planning, evaluation, and case management. 20 each are to be spent in quality assurance case review and clinical team leadership.

At this stage, the counselor will take a certification exam: the NAADAC level I or II or the MAC.

Ohio, Approved

SUD Professional/Staff Waiver Requirements:

Standards of Care: Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

Current SUD Counselor Requirements:

Ohio substance abuse counselors are licensed by the Ohio Chemical Dependency Professionals Board. Counseling licenses are issued at three levels: Licensed Chemical Dependency Counselor II (LCDC II), Licensed Chemical Dependency Counselor III (LCDC III), and Licensed Independent Chemical Dependency Counselor (LICDC). All require education, supervised practice, and examination. The distinguishing factor is degree level; higher licenses also have more stringent curriculum requirements.

The Board also issues Chemical Dependency Counselor Assistant licenses. For these, no college degree is required.

Educational Requirements: Chemical Dependency Counselor II and III

The foundation for a Licensed Dependency Counselor II license is an associate's degree in a behavioral science field or in nursing; a candidate can also qualify with a baccalaureate degree in any field. The foundation for a Licensed Dependency Counselor III credential is a bachelor's degree in behavioral science or nursing.

The candidate will need to complete 180 hours of chemical dependency education. There must be 24 hours in each of the following areas:

- Addiction theories
- Diagnosis and assessment of addiction
- Relationship counseling with the addicted

There must be 18 hours in each of the following:

- Pharmacology
- Treatment planning
- Group processes and techniques

The following content areas require 12 hours:

- Prevention
- Legal/ ethical issues

The remaining 30 hours are to be in addition counseling strategies and procedures.

An academic semester hour may be credited as 15 hours, an academic quarter hour as ten. At least half of the required hours must be earned in the five years preceding application.

Educational Requirements: Licensed Independent Chemical Dependency Counselor

An LICDC must have a behavioral science degree at at least the master's level. The candidate will need to document education in ten Board-mandated areas. Requirements are as follows. There must be 80 clock hours each in counseling and psychotherapy theories and assessment and diagnosis; assessment and diagnosis coursework must cover measurement and appraisal. There must be 40 hours each in human development, psychopathology, counseling procedures, relationship therapy, group process and techniques, research methods and statistics, and cultural competency. There must be 30 clock hours in professional ethics.

Semester hours can be converted to clock hours at a 1:15 ratio. The application form includes a description of coursework that would be qualifying under each content area. The Board will allow candidates to split courses which cover more than one content area and apply some hours to each.

400 hours of practicum, internship, or other supervised experience will be required. The Board also requires master's level candidates to have 180 hours of education that is specific to chemical dependency counseling; the 180 hours are to be distributed in the same manner as they are for LCDC I or LCDC II licensing.

Experience and Practical Training Requirements

Whatever the educational level, a candidate will need at least 2,000 hours of work experience or supervised internship before a counseling license can be issued.

The candidate must have 220 hours of practical experience in core functions. Hours are to be distributed as follows: 30 hours each in individual counseling and group counseling, 25 in treatment planning, and 20 each in family counseling and 'reports and record keeping'. The trainee will also need 15 hours of case management and 10 hours in each of the following: screening, intake, assessment, orientation, client education, referral, consultation and crisis intervention. The 220 hours may be included as part of the 2,000 experience hours.

The Board requires that 20% of the required experience hours be spent in the 'counseling' core area.

Examination Requirement

The chemical dependency counselor candidate must take the ADC examination . Board approval is required. Examinations are computer-delivered. The Board notes that there are testing sites not only in Ohio but in bordering states as well.

The examination is waived for professionals who already hold a license in a field that includes AOD (alcohol and drug service provision) in its scope of practice. In this instance, candidates will submit a waiver form.

Appendix B: Billing Eligibility and Reimbursement Recommended Under Medicaid

<https://aspe.hhs.gov/report/credentialing-licensing-and-reimbursement-sud-workforce-review-policies-and-practices-across-nation/billing-eligibility-and-reimbursement>

Facilitator 3.2: State Supports for Providers in Contracting with MCOs

As mentioned previously, the transition to a managed care model brings with it a number of new challenges for providers. Although states impose certain parameters for MCOs, such as network adequacy standards and minimum quality reporting requirements, MCOs have some flexibility in selecting their network members and in setting the terms of provider contracts. For providers who need to join multiple MCO networks to establish a client base or to retain their existing clients, this often involves meeting multiple sets of criteria and administrative practices. One approach to addressing this barrier is for states to impose some regulations protective of providers on Medicaid MCOs, such as model contracting language (Falcone & Berke, 2018). This removes some of the barriers to joining insurance networks, especially because Medicaid is usually the largest payer in the state.

Case in point

In transitioning its Medicaid program from FFS to managed care, **New York** established some regulations on Medicaid MCOs to ease the challenges that providers encounter in joining networks. These include the following:

- All MCOs are required to set up web-based portals to communicate with their networks, eliminating the need for telephone or fax interactions that are more burdensome and not as readily conducive to standard recordkeeping.
- Network adequacy regulations include opioid treatment programs as essential services, and prior authorization cannot be required for SUD services. These regulations apply to commercial plans as well as Medicaid plans.
- To ease the transition to the new payment model, MCOs are required to pay outpatient behavioral health providers (**licensed or certified**) the Medicaid FFS rates for the first 2 years of their joining the MCO's network.
- MCOs are prohibited from obliging their network providers to accept pre-negotiated rates for services and supports not covered by Medicaid.
- MCOs are prohibited from requiring credentials above and beyond those required by the state as a condition of joining their networks.
- The state requires that MCO staff involved in medical necessity or provider grievance decisions have clinical experience relevant to the case under consideration.

Appendix C:

Advanced Certified Alcohol Drug Counselor Amendment to DMC-ODS Waiver

1. Request for technical, no cost change to the DMC-ODS program regarding, adding certified counselors to section 132. Drug Medi-Cal Definitions (e)(ii) and (iii), and 135. Outpatient Services, 135 (i) (G), 136. Intensive Outpatient Treatment, and 139. Withdrawal Management:

ii. The initial medical necessity determination for the DMC-ODS benefit must be performed through a face-to-face review or telehealth by a Medical Director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA) as defined in Section 3(a), or Advanced Certified Alcohol Drug Counselor (ACADC) as defined in Section 3(_). After establishing a diagnosis, the ASAM Criteria will be applied to determine placement into the level of assessed services.

iii. Medical necessity qualification for ongoing receipt of DMC-ODS is determined at least every six months through there authorization process for individuals determined by the Medical Director, licensed physician or LPHA, or ACADC to be clinically appropriate; except for NTP services which will require reauthorization annually.

135. Outpatient Services (ASAM Level 1) Counseling services are provided to beneficiaries (up to 9 hours a week for adults, and less than 6 hours a week for adolescents) when determined by a Medical Director, or Licensed Practitioner of the Healing Arts or Advanced Certified Alcohol Drug Counselor to be medically necessary and in accordance with an individualized client plan. Services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community. Services can be provided in-person, by telephone or by telehealth.

135. I G. The treatment plan will be consistent with the qualifying diagnosis and will be signed by the beneficiary and the Medical Director, or LPHA, or ACADC.

136. Intensive Outpatient Treatment (ASAM Level 2.1) structured programming services are provided to beneficiaries (a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for adolescents) when determined by a Medical Director , or Licensed Practitioner of the Healing Arts or Advanced Certified Alcohol Drug Counselor to be medically necessary and in accordance with an individualized client plan. Lengths of treatment can be extended when determined to be medically necessary.

139. Withdrawal Management (Levels 1, 2, 3.2, 3.7 and 4 in ASAM) services are provided in a continuum of WM services as per the five levels of WM in the ASAM Criteria when determined by a Medical Director or Licensed Practitioner of the Healing Arts or Advanced Certified Alcohol Drug Counselor as medically necessary and in accordance with an individualized client plan.

2. Request for technical, no cost change to the DMC-ODS program as part of the 12-month extension request regarding, adding a definition of Advances Certified Counselors to section 146. DMC-ODS Provider Specifications:

146. (e)Advanced Certified Alcohol Drug Counselors must be certified by an organization approved by the Department of health Care Services, have a baccalaureate degree, and four years of experience in a substance use disorder setting. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis.

ALAMEDA COUNTY
HEALTH CARE SERVICES



AGENCY
COLLEEN CHAWLA, Director

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May 7, 2021

Angeli Lee
Amanda Font
Director's Office Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, California 95899-74131700

Re: Medicaid Section 1115 Demonstration Five-Year Renewal and Amendment Request: CalAIM Demonstration

Dear Ms. Lee and Ms. Font,

Thank you for the opportunity to comment on the Medicaid Section 1115 Demonstration Five-Year Renewal and Amendment Request. Alameda County has partnered successfully with the Department of Health Care Services to utilize these Section 1115 Medicaid waivers to transform our system of care. Alameda County's Health Care Services Agency (HCSA) recognizes the importance of this work to support our safety net systems, improve health outcomes for Medi-Cal beneficiaries using whole person care and social determinants of health approaches, and reduce complexity and variation across the Medi-Cal managed care system.

Over the last five years, Alameda County's Whole Person Care pilot (Alameda County Care Connect) significantly invested in system-wide infrastructure, coordination, and networks to transform the system of care. Specifically, the Whole Person Care pilot has:

- Strengthened Alameda County's cross-sector networks, enabling better collaboration to support whole person care and coordination and allowing for rapid and successful deployment of resources to system-wide challenges, such as COVID-19;
- Created a data infrastructure that enables data sharing and care coordination across health, housing, social services, and other sectors with over 100 participating programs and over 900 users;
- Supported the transformation of the housing system and continuum of care, including developing and supporting transitional and emergency housing options, expanding permanent supportive housing units (216% increase between 2019-2020 from 179 to 386 units), the creation and expansion of multi-disciplinary street outreach teams (10 teams county-wide); and establishing a single department to manage housing work (Office Homeless Care and Coordination);
- Launched and supported system wide quality improvement efforts, which resulted in improved care coordination across sectors and the creation of two programs to better support people experiencing behavioral health crises; and
- Developed a series of 122 cross sector training activities which has been attended by 1096 staff from 100 organizations across 12 sectors.

Alameda County Health Care Services appreciates DHCS's continued recognition of the value of Whole Person Care efforts by building on the work and integrating supports into both CalAIM and the elements of the 1115 demonstration renewal. HCSA is currently collaborating with the Managed Care Plans to ensure the transitions between Whole Person Care and CalAIM happen as smoothly as possible. Shifting Whole Person Care from an

1115 pilot program to a Managed Care structure, however, will offer both opportunities and challenges. As you work to refine this comprehensive proposal, Alameda County Health Care Services Agency (HCSA) offers the following feedback for DHCS consideration and discussion.

Comments on Providing Access and Transforming Health (PATH) Supports

HCSA appreciates the inclusion of PATH payments and incentives as part of the 1115 demonstration renewal proposal. HCSA is well positioned through experience with Whole Person Care to support providers through transitions to CalAIM, ensuring continuity of services for clients and continued access for managed care members. Managed Care Plans should leverage already established Whole Person Care networks and infrastructure to organize the delivery of CalAIM's Enhanced Care Management and In Lieu of Services but cannot do so without appropriate supports and incentives.

1. ***Leveraging and investing in existing data exchange efforts and infrastructure:*** Alameda County strongly supports this waiver funding to be made available for data exchange efforts critical for CalAIM success. This should include data transformation from non-clinical data systems like HMIS into MCP standard claim formats to promote housing ILOS capacity, shared records to facilitate care coordination between ECM, ILOS, and other providers, and training and support for provider agencies to access and use shared data systems. As the data exchange efforts and infrastructure will support ECM, ILOS, as well as the later Population Health Management efforts, incentives and supports for these efforts may be included in service rates, but should also be considered as part of administrative infrastructure needed to support overall program administration.
2. ***Support for outreach and engagement services:*** CalAIM ECM provides for intensive wrap-around case management for consumers experiencing homelessness. We understand that this benefit is likely to define the scope to include outreach to facilitate that enrollment. We have learned through Alameda County's WPC that there is significant and lengthy outreach necessary to build the trust necessary for that enrollment. Where the PATH funding is intended to be used in part to support CalAIM services, it would be hugely supportive to the success of ECM if this support could be used for consumer outreach in particular.
3. ***Incentives and supports for provider and partner agencies to meet Managed Care administration requirements:*** Alameda County are well versed in the target populations, but many existing providers will require additional support and coordination as they integrate into Medi-Cal. This will necessitate capacity development resources at organizational as well as the system level. For example, provider organizations will need training, time, and additional resources to meet managed care contracting, data collection, finance, and other requirements.
4. ***Specific incentives to support workforce development and capacity building:*** As the system becomes more focused on providing care from a whole person perspective, we have to provide concurrent supports and training for providers and case managers, who increasingly are being asked to address emerging and complex issues more effectively and efficiently with fewer resources and support than ever. A unique feature of Alameda County's Whole Person Care pilot is the development of the Care Connect Academy, an initiative that aims to train providers specifically for cross-sector work that bridges silos. Supporting the workforce pipeline, recruitment, development, and retention is critical to ensuring that the safety net system of care functions smoothly and effectively. Additionally, strategic investments and incentives to support foundational whole person care system knowledge and coordinated skills development may result in a more effective and coordinate ECM/ILOS workforce systemwide.

Comments on Peer Support Specialist Services

1. *Expanding the role of Peer Support Specialists to align with WPC principles:* Alameda County’s WPC pilot’s Consumer and Family Engagement Program has developed a Consumer Fellowship as well as a Peer to Peer Advisor Program, both of which aim to center consumer experiences in program development. A critical lesson learned of this work is the need to ensure that *social supports* are considered in health service delivery. The populations we serve are not simply individuals; they have family, social, and other relationship dynamics and live within and across systems and institutions —all of which influence and impact their health and wellbeing. The inclusion of the Peer Support Specialist as *only* existing in the DMC, Medi-Cal SMHS, and DMC-ODS programs limits the possible impact of this role. HCSA proposes that this role be expanded to focus and interface across county health and human services, which better aligns with the clinical integration and coordination principles of WPC and advancing the aim of health equity. The objectives of the Peer Support Specialist should also include stabilizing an individual in their community and supporting social engagement through establishing and strengthening the member’s existing and desired supports, including family and other social networks.

Comments on Services for Justice-Involved Populations 30 Days Pre-Release

1. HCSA strongly supports the inclusion of services for Justice-involved populations 30 days pre-release. We hope that these services are defined using a Whole Person Care lens and will include a range of services to support the varying needs of these populations pre- and post-release.

Comments on the GPP Equity Pool

1. HCSA strongly supports the concept of the Equity Pool, but would like to see a more detailed description of the Equity Pool, activities included, and a clearer definition of the social determinants of health and social needs that the Pool would address.

Thank you again for the opportunity to provide comment during the public stakeholder process. For questions or clarifications, please contact Liz Taing at elizabeth.taing@acgov.org. We look forward to developments in this important proposal.

Sincerely,



Kathleen Clanon, MD
Agency Medical Director



Colleen Chawla | Director
Alameda County Health Care Services Agency



American Indian
Health & Services
Santa Barbara, CA

Bakersfield American
Indian Health Project
Bakersfield, CA

Friendship House Assoc.
of American Indians
San Francisco, CA

Fresno American Indian
Health Project
Fresno, CA

Indian Health Center of
Santa Clara Valley
San Jose, CA

Native American
Health Center
Oakland, CA
San Francisco, CA

Native Directions, Inc.
Manteca, CA

Sacramento Native
American Health Center
Sacramento, CA

San Diego American
Indian Health Center
San Diego, CA

United American Indian
Involvement
Los Angeles, CA

May 7, 2021

Will Lightbourne, Director
California Department of Health Care Services
1500 Capitol Avenue
Sacramento, CA 95814

Submitted via email to CalAIMWaiver@dhcs.ca.gov

RE: Public Comments on California 1115 & 1915(b) Waiver Proposal

Dear Director Lightbourne,

The California Consortium for Urban Indian Health (CCUIH) and our Urban Indian Health Program (UIHP) members appreciate the opportunity to comment on the proposed CalAIM Section 1115 and Section 1915(b) Waiver Amendment and Renewal Applications. CCUIH is an alliance of Indian Health Service (IHS) funded UIHPs that supports health promotion and access for American Indian/Alaska Natives (AIAN) living in cities throughout California. California has the largest population of Urban Indians in the country and is home to 10 UIHPs, representing nearly one-quarter of the total UIHPs nationwide.

CCUIH commends the Administration's commitment to implement CalAIM, an initiative that will lead to a broad delivery system, program, and payment reforms across Medi-Cal. We see many positive changes in the proposal. However, we do have concerns and recommendations, and would like to share them below for your review and consideration.

Substance Use Disorder (SUD) Treatment for AIANs

CCUIH appreciates DHCS's efforts to include critical pieces of the Indian Health Program Organized Delivery System (IHP-ODS) in the current Waiver Proposal. While these inclusions are helpful, they alone cannot replace the full implementation of the IHP-ODS. IHP-ODS is a model developed by Urban and Tribal leaders to ensure access to culturally relevant services.

UIOs look forward to the inclusion of traditional healers and natural helpers as billable services. CCUIH requests DHCS act quickly in consulting with Tribes and UIOs regarding allowable evidence-based practices. As DHCS is aware, UIOs recently secured 100% FMAP for two years, and we expect this provision of law to be extended beyond its current sunset date. An expected outcome of this development is that UIHPs will receive similar or equal reimbursement rates as Tribal Health Programs and IHS facilities. DHCS must ensure UIHPs, including residential treatment facilities receive 100% FMAP for services provided by traditional healers and natural helpers. While the details of this implementation are still pending, CCUIH requests DHCS take UIO's inclusion in 100% FMAP into account as they determine how to engage with Indian Health Care Providers in



implementing CalAIM and the Drug Medi-Cal Organized Delivery System (DMC-ODS). Additionally, we appreciate DHCS's efforts to expand SUD services to AIAN patients, and the opportunity for consultation on what 'evidence-based practices' Indian Health Care Providers must use. However, CCUIH requests DHCS maintain the option for the Indian health care delivery system to operate the IHP-ODS as has been developed over the past few years.

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

The CalAIM proposal will ensure that beneficiaries receive the care they need no matter how they enter the system and where they are in the system. Currently, treatment services are not available until a patient completes an assessment, which often can be counterproductive to patient engagement, especially for patients in crisis or in substance withdrawal. For that reason, we applaud the Administration proposal regarding allowing treatment during the assessment period and the "no wrong door" proposal that will ensure provider's ability to render necessary medical services to patients. However, questions remain as to how providers can comply with, and bill for, those services if they are not contracted with a county specialty mental health (SMH) and substance use disorder (SUD) health plan. Health centers often are the entry into the SMH/SUD system, yet few health centers are contracted providers with their county SMH/SUD health plans. This arrangement often leaves health centers in a financially disadvantaged position where they must provide needed services under federal law but cannot bill for those services. ***DHCS must abide by the provisions of 42 CFR § 438.14 which requires "Indian Health Care Providers whether participating or not, be paid for covered services provided to Indian enrollees who are eligible to receive services from such providers."*** It is imperative that DHCS acknowledge the provisions of 42 CFR § 438.14 and continue to observe these protections in Federal law.

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

The CalAIM proposal will integrate county mental health plans and DMC-ODS into a single behavioral health plan. Although we recognize a statewide need to enhance access to both sets of services in a coordinated manner, we see several issues that need to be addressed in order to ensure that counties are prepared to adequately meet the demand for services and patients/families can be assured they are receiving the highest quality of care. Most notably, we are concerned with how the state will hold county behavioral health plans accountable for performance with managed care responsibilities, especially when the administration of two discrete programs are consolidated. Recent statewide audits of SMH plans found that counties were deficient in meeting quality and timely access goals. In fact, 2017/18 External Quality Review Organization (EQRO) reported that several SMH plans did not have performance improvement plans, functioning quality improvement committees, and failed to meet culture-specific and community defined best practices for communities, perpetuating ongoing disparities in access and care. Thus, while CCUIH agrees that the integration of SMH/SUD into specialty behavioral health is necessary, there must be necessary safeguards to ensure access to timely and quality SMH/SUD services.



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

CCUIH is pleased to see the inclusion of Enhanced Care Management and In-lieu-of Services in the CalAIM proposal as well as the Administration's commitment to ensure adequate funding is allocated for these services in this year's budget. However, to ensure successful implementation of these elements, it is important that community-based organizations, including UIHPs, have the tools and resources needed to work together. We are encouraged by the inclusion of the Providing Access and Transforming Health Supports, which is necessary to transition existing services and build up capacity, including payments for new staffing and infrastructure. Supports are also needed to guarantee data exchange, establish payment relationships, measure value and outcomes, and ensure that beneficiaries remain at the center of care.

We are concerned with several program elements that might impact their current operation and infrastructure, namely implementation of a new care management system and process, new care referral process or new claim submission process, new patient assignment process and other. Yet more is needed. Therefore, we respectfully ask DHCS to ensure ample resources and support available to ECM and ILOS providers.

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

We are aware of the time and investment the state committed to the design and vision of Medi-Cal Rx. However, providers and health plans have systems in place today that ensure pharmacy access for Medi-Cal beneficiaries. Delaying the transition at the last minute, as was done in December 2020 and again in April 2021, will undermine already strained delivery systems and further confuse and worry Medi-Cal beneficiaries. To that end, we ask DHCS to continue to delay the pharmacy transition to ensure no disruption in pharmaceutical access and guarantee patient access to their current pharmacy through the COVID-19 pandemic. The pharmacy transition will negatively impact UIHPs and services provided to our AIAN patients. Recognizing the rapidly evolving pandemic response, as well as the current challenges and unknown resolution to conflict concerns with the project's contractor vendor, we recommend the department delay the pharmacy transition and consider removing the transition from its waiver proposal.

DHCS must ensure the public has an opportunity to review and comment on many policy changes that are described in the waivers but are not included as part of the waiver proposal.

While we appreciate the opportunities to comment on the 1115 and 1915(b) waivers and expect DHCS will release other policy changes for public comment in the future, we would like to underscore the importance of gathering and incorporating stakeholder input into final policies. Specifically, we request extensive public comment and engagement on the following items noted in the proposal:

- A standardized screening tool for county Behavioral Health plans and Medi-Cal managed care plans to use to guide beneficiaries toward the delivery system that is most likely to meet their needs.



California Consortium for Urban Indian Health

CCUIH Strengthening The Organizations That Strengthen Our Communities

- A standardized transition tool for MHPs and MCPs to use when a beneficiary's condition changes and they would be better served in the other delivery system.
- A process for facilitated referral and linkage from county correctional institution release to county specialty mental health, Drug Medi-Cal, DMC-ODS, and Medi-Cal MCPS when the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

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

Again, CCUIH appreciates this opportunity to submit comments on the waiver proposal. We look forward to working with you to implement these major changes. If you have any questions, please contact Virginia Hedrick at: 916-285-5824

Respectfully,



Virginia Hedrick, MPH (Yurok/Karuk)
Executive Director

The CalAIM 1915(b) waiver proposal does not go far enough to directly address the impact of racism on the social and emotional health of children. The proposal must be revised to:



Resist pathologizing adversity—as evidenced by proposed tools to “screen in for a high risk score” for ongoing services. We must honor the wisdom and intelligence of low income communities to determine their own definition of medical necessity. Any positive screen, and more importantly, any request for support from a beneficiary should qualify a child for services and support.



Fully honor the commitment to no wrong door by removing the future creation of a level of care tool and plan—or if such a tool is to be used it must only be used during the course of treatment and treatment can not be stopped or interrupted until or if there is a transition in care.



Clarify unanswered questions about the potential risks related to moving county mental health plans from a Certified Public Expenditure (CPE) methodology to Intergovernmental Transfer (IGT).



May 6, 2021

RE: California Advancing and Innovating Medi-Cal (CalAIM) Public Comment from the Marin County Oral Health Program

To Whom it May Concern:

The Marin County Oral Health Program is an organization within Marin County Health and Human Services that works to lower oral health disparities throughout the county by implementing access and education initiatives and increasing oral health communication. On behalf our program, I wanted to take the time to thank the Department of Health Care Services (DHCS) for allowing public comment on CalAIM and for their work in improving the overall CalAIM goals.

As you may know, having positive dental health outcomes is integral in ensuring positive overall health outcomes. Ensuring that medical patients have dental coverage as well as access to preventive dental services, such as fluoride varnish treatments and dental check-ups, helps to improve oral health. That is why dental coverage surrounding preventive treatments and increase care-coordination (specifically in Medical-Dental integration) is so important and is why the Marin Oral Health Program has been focusing our efforts to improve upon these measures in Marin County. While Marin County fairs better than the state's averages in certain oral health outcomes, initiatives like fluoride varnish treatments and care-coordination are gap areas that need improvements upon and areas that CalAIM could help to support.

Oral health is often considered the gateway to overall health, especially considering how ramifications of poor dental health lead to poorer overall health outcomes. Preventive treatments, such as fluoride varnish treatments, provide strong protective barrier for patients against dental caries and dental decay. These preventive measures are typically administered by dental providers; however, administration by medical providers is highly encouraged and we hope that CalAIM can work to strengthen their encouragement, or even incentivization, of medical practitioners to provide preventive dental treatments. Encouraging medical providers to provide preventive treatments can help provide patients with a baseline of dental protection if they do not have a dental home and provide some level of dental care they might not ordinarily receive. However, lack of encouragement or recommendations in providing these services can lead to a continued lack of treatment administration in medical offices and, in some cases, can lead the patient to not receiving any form of dental prevention. It is our hope that CalAIM acts in the best interests of their patients by to encouraging, or even incentivizing, the administration of these preventive treatments in a medical setting to best protect their patient's overall health.

Another area of concern that we are hoping CalAIM addresses is increased care coordination so that there is no disruption of care between medical and dental care sides. In our county, we are strengthening our efforts to promote medical-dental integration and care-coordination as a top priority in healthcare so that patients have their whole health covered. It is often that dental care is left out of

conversation when discussing a person's overall health. Increasing care-coordination and medical-dental integration can help ensure that dental problems are recognized by a patient's provider, are referred to a dental provider for care, and that a patient's oral health is not left out of the conversation when discussing a patient's overall health. By having medical providers, especially within managed care plans, advocate for their patients to receive dental care, dental care utilization could potentially increase. With an increase in dental care utilization, we hope to see a decrease in episodic dental care (acute or emergency care) and an increase in preventive care, which can lead to positive dental health outcomes long term. We are hoping that CalAIM can work to strengthen their efforts to promote care-coordination and medical-dental integration that all patients have a dental home and access to care, especially within their managed care plans.

We hope that the initiatives CalAIM will implement will help increase access to dental care and help improve dental health disparities by working to address barriers in obtaining preventive care, increasing preventive care treatment options, and advocating for medical-dental integration and care coordination. Our organization would like to continue this conversation with DHCS about how to improve oral health care through CalAIM and managed care plans and we look forward to working with DHCS in the future.

Thank you very much for your consideration of our comments.

Danika Ng, MPH

Marin County Oral Health Program
20 North San Pedro Rd., STE 2020
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P: 415-473-7059
E: Dng@marincounty.org



CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.

Submitted via e-mail at CalAIMWaiver@dhcs.ca.gov

May 7, 2021

Department of Health Care Services
Director's Office
Attn: Angeli Lee and Amanda Font
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Re: Notice of Intent to Submit Amendments and Renewals of Section 1115 Demonstration and
Section 1915(b) Waiver

Dear Ms. Lee and Ms. Font:

The California Rural Indian Health Board (CRIHB), comprised of 58 Federally Recognized Tribes and 18 Tribal Health Programs (THP), provides the input and recommendations below.

During the April 30, 2021, Department of Health Care Services (DHCS) Tribal and Designees of Indian Health Programs webinar regarding CalAIM waivers, Tribal representatives expressed that adequate state government-to-Tribal government consultation on the topics presented by the department needs to occur. Consultation is a deliberative process that aims to create effective collaboration and informed state decision-making. Consultation is built upon the government-to-government exchange of information and promotes enhanced communication that emphasizes trust, respect, and shared responsibility. Communication should be open and transparent without compromising the rights of Indian Tribes or the government-to-government consultation process. State consultation conducted in a meaningful and good-faith manner further facilitates effective department operations. To that end, the department should seek and promote cooperation, participation, and efficiencies between agencies with overlapping jurisdiction, special expertise, or related responsibilities regarding a departmental action with Tribal implications. Efficiencies derived from the inclusion of Indian Tribes in the department's decision-making processes through Tribal consultation will help ensure that future department action is achievable, comprehensive, long-lasting, and reflective of Tribal input.

CRIHB recommends additional consultation sessions be conducted on the topics raised by the department as several of the proposals will impact Tribes, Tribal clinics, and Tribal clinic patients, with one or more potentially having an adverse effect. For example, the department has recently proposed eliminating the Tribal Uncompensated Care program that has been in operation since 2013. As noted during the meeting, CRIHB is in opposition to eliminating the Tribal Uncompensated Care program due to the adverse impact on AIAN patients served by Indian Health Service Memorandum of Agreement (IHS MOA) THPs.

Insufficient time was afforded for Tribes and THPs to review, respond to, and work with the DHCS CalAIM proposals. We need additional time for analysis and response to your 10-page document. Several proposed changes were not explicitly outlined in previous CalAIM planning discussions or have been impacted by recent policy changes, including the final version of the approved 20-0044 State Plan Amendment.

CRIHB requests the extension of the Tribal Uncompensated Care program for certain optional benefits previously eliminated from the Medi-Cal state plan. These services are provided by THPs operating under the authority of the Indian Self-Determination Education Assistance Act (ISDEAA) to Indian Health Service eligible Medi-Cal beneficiaries. This program has served as an essential lifeline and equalizer for IHS MOA clinics. IHS MOA clinics would otherwise have lost access to over \$8.5 million in reimbursement for optional benefits such as acupuncture, chiropractic, dental, optometry, podiatry, psychological, and speech therapy services. Given the precarious nature of the economy and potential Medi-Cal budget cuts in the future, it is critical to ensure that THPs who choose to remain in the IHS MOA Medi-Cal designation can continue to be reimbursed for optional benefits that are excluded from the Medi-Cal program.

Another factor to take into consideration is that proposing the elimination of uncompensated care visits while THPs are recovering from the economic impact of the global pandemic, including Covid-19 related care and vaccination, is an additional burden to place on Tribal communities at this critical time.

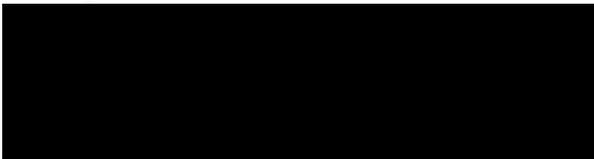
CRIHB seeks further clarification from DHCS regarding the reference to evidence-based practices as part of the Drug Medi-Cal Organized Delivery System (DMC-ODS). The section on page six of the document regarding substance use disorder (SUD) treatment for AIAN, states that DHCS will seek "federal reimbursement for DMC-ODS services provided by traditional healers and natural helpers using culturally specific evidence-based practices." It states that Indian Health Care Providers will be required "to use at least two evidence-based practices as defined in DMC-ODS and/or from a list developed by DHCS in consultation with Tribal and Urban partners." A search of DHCS online shows the following presentation, <https://www.dhcs.ca.gov/Documents/California%27sTribalSubstanceUseDisorderUpdate.pdf> however, a listing of approved "culturally specific evidence-based practices" was not found. Traditional healing can provide anecdotal substantiation of effectiveness; however, the requirement of a rigorous evidence-based methodology may become a barrier to behavioral health program use as described by the department for DMC-ODS eligibility. Further

clarification and discussion are needed to ensure that a definition and interpretation of valid evidence is mutually agreed upon by Tribes, Tribal Health Programs, and DHCS.

Considering the proposed changes brought about by the CalAIM program, CRIHB requests that additional technical assistance and support be provided to THPs to support their engagement in these new initiatives. CRIHB also requests that the Indian Health Program Organized Delivery System (IHP-ODS) be included as an option within the 1115-1915 Waivers submitted by DHCS. The implementation of the Tribal Federally Qualified Health Center (Tribal FQHC) designation has raised questions about whether Tribal FQHC providers can engage in reimbursement for SUD through the DMC-ODS or whether they are excluded due to their new FQHC designation. Please clarify whether Tribal FQHC providers will be eligible to receive reimbursement through the DMC-ODS.

Please give Tribes and THPs additional time to engage in this important stakeholder process. CRIHB, Tribes, and THPs want to have meaningful engagement with DHCS to have the most successful version of the CalAIM program. If you have any questions, please contact Rosario Arreola Pro at 916-929-9761, ext. 1300 or at rarreolapro@crihb.org.

Respectfully,



Mark LeBeau, PhD
Chief Executive Officer
California Rural Indian Health Board, Inc.



May 5, 2021

Department of Health Care Services
Director's Office
Attn: Angeli Lee and Amanda Font
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Re: Public Comment Regarding the Medi-Cal Rx Initiative as Incorporated in the CalAIM Section 1115 Demonstration Application and 1915(b) Waiver Proposals

Dear Director Lightbourne:

Family HealthCare Network writes to object to the incorporation of the so-called "Medi-Cal Rx" initiative as part of the CalAIM Demonstration Application and 1915(b) Waiver Proposals (collectively, "Cal-AIM"). To the extent CalAIM incorporates Medi-Cal Rx into its framework, Family HealthCare Network urges the Department of Health Care Services ("DHCS") to consider the negative effects on federally-qualified health centers ("FQHCs") and their patients. Medi-Cal Rx creates unnecessary barriers to healthcare access and hinders FQHCs' efforts to provide high-quality care to California's most vulnerable and underserved patients.

Family HealthCare Network is an FQHC that cares for Medi-Cal and uninsured patients in Tulare, Kings, and Fresno Counties. Our mission is to provide comprehensive, high-quality health care services to those who need it most. The majority of our Medi-Cal patients are among the 11 million beneficiaries enrolled in Medi-Cal managed care. In addition to the many services we provide, we have integrated pharmacy services into our practice through six in-house pharmacies and 146 contract pharmacies.

Integrating pharmacy and medical services within the Medi-Cal managed care delivery system allows Family HealthCare Network to better serve patients. We can serve as a one-stop-shop for all of our patients' medical needs, which enables us to help patients readily follow their treatment plan. Doctors can directly coordinate all of the patient's care, monitor their medication compliance, and provide additional services as necessary. This model of care leads to better health outcomes and removes barriers for traditionally underserved patients.

Additionally, Family HealthCare Network annually saves an estimated 10 million dollars through participation in Medi-Cal managed care and the 340B Drug Discount Program. The savings allow Family HealthCare Network to provide vital services to more patients, such as transportation assistance, subsidized prescriptions, substance abuse treatment programs, and expanded clinician availability. These benefits are not available to FQHCs when reimbursed for pharmacy on a FFS basis. As a result of the current managed care system, Family HealthCare

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www.fhcn.org



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The ACOG
1995

Network patients have better access to more services, just as Congress intended in enacting the 340B program.¹

As Health & Human Services Secretary Xavier Becerra has stated, “the more medical care 340B covered entities can provide with their limited resources and state reimbursement, the further state-Medicaid budgets will go in serving the States’ uninsured and underinsured residents.”² As California’s Attorney General, Secretary Becerra recognized that 340B savings are vital to expanding access to medication and other services that “help create a continuum of care for patients,” which ultimately leads to improved public health outcomes.

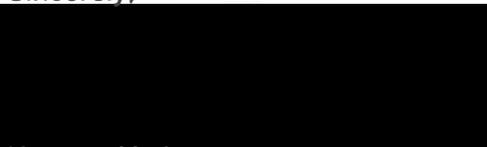
Yet, Medi-Cal Rx will impede our and other FQHCs’ ability to provide these critical services to patients. The proposed FFS reimbursement, compounded by the loss of 340B savings, will force FQHCs to reduce services. This directly undermines the whole-person care approach and the purpose of Medi-Cal, which is to improve access to healthcare and reduce health inequities.

Please see the attached public comment from the Community Health Center Alliance for Patient Access (“CHCAPA”) raising concerns about the impact of Medi-Cal Rx on the 11 million Medi-Cal patients who would be directly impacted by Medi-Cal Rx. Family HealthCare Network incorporates by reference the CHCAPA public comment letter into this letter. Family HealthCare Network fully shares CHCAPA’s concerns and agrees with its conclusion that DHCS has not fully considered or examined the heavy costs of Medi-Cal Rx.

In conclusion, Family HealthCare Network urges DHCS not to include implementation of Medi-Cal Rx as part of CalAIM, to fully analyze the impact it will have on the Medi-Cal program, and to provide a transparent process for stakeholders to provide meaningful input and alternatives for DHCS’ consideration. Doing so will enable Family HealthCare Network and DHCS to “work in partnership to provide individuals access to affordable healthcare, including prescription drugs” as now-Secretary Becerra described.

Thank you for your time and consideration. Family HealthCare Network looks forward to working with DHCS on this critical issue that affects over 11 million Medi-Cal beneficiaries.

Sincerely,



Kerry Hydash
President & CEO
Encl.

¹ The purpose of the 340B program is to enable FQHCs to “stretch scarce federal resources” to provide expansive, high-quality services to the Medi-Cal patients who need them most. (H.R. Rep. No. 102-384, pt. 2, at 10.)

² Bipartisan Attorneys General 340B letter to former HHS Secretary Alex Azar, Dec. 14, 2020, available at: <https://oag.ca.gov/news/press-releases/attorney-general-becerra-leads-bipartisan-coalition-340b-drug-pricing-program>.

May 03, 2021

Via Electronic Submission (CalAIMWaiver@dhcs.ca.gov)

Department of Health Care Services
Director's Office
Attn: Angeli Lee and Amanda Font

Re: Public Comment Regarding Removal of Pharmacy Services from Medi-Cal Managed Care in Conjunction with CalAIM Section 1915(b) Waiver Proposal

Dear Director Lightbourne:

The Community Health Center Alliance for Patient Access ("CHCAPA"), a non-profit organization composed of 31 federally-qualified health centers ("FQHCs") and support organizations, writes to object to the California Department of Health Care Service ("DHCS") proposal to carve pharmacy benefits or services by a pharmacy billed on a pharmacy claim out of Medi-Cal managed care in connection with implementation of DHCS' California Advancing and Innovating Medi-Cal ("CalAIM"). The proposed removal of pharmacy benefits and services from Medi-Cal managed care is also known as "Medi-Cal Rx."¹

Medi-Cal Rx is antithetical to the stated goals of CalAIM. Indeed, in the Background and Overview section of the Executive Summary, DHCS touts the benefits of Medi-Cal managed care as follows:

Medi-Cal has significantly expanded and changed over the last ten years, most predominantly because of changes brought by the Affordable Care Act and various federal regulations as well as state-level statutory and policy changes. During this time, the DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans are able to offer more complete care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries. [Emphasis added.]

CHCAPA agrees that Medi-Cal managed care plans are able to offer more complete care coordination and care management than is possible through a fee-for-service ("FFS") system. Carving pharmacy benefits or services by a pharmacy billed on a pharmacy claim out of managed care, and instead reimbursing these benefits or services on a FFS basis, increases,

¹ Specifically, page 18 of the CalAIM Executive Summary and Summary of Changes, Proposal 3.1, identifies as an element of "Managed Care Benefit Standardization" that benefits to be carved out include: "4/1/21: Pharmacy benefits or services by a pharmacy billed on a pharmacy claim."

<https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Executive-Summary-02172021.pdf> Medi-Cal Rx was not implemented on 4/1/21, and has not been implemented to date, with no implementation date yet announced to the public.

rather than decreases, system fragmentation and renders care coordination and care management more, rather than less, difficult.

Integrating pharmacy and medical services in managed care allows FQHCs to better serve patients. The FQHCs can serve as a one-stop-shop for all of their patients' medical needs, and integration facilitates the FQHCs' ability to assist patients in following their treatment plan, including pharmacy. Doctors can directly coordinate all of the patient's care, monitor their medication compliance, and provide additional services as necessary. This model of care leads to better health outcomes and removes barriers for historically underserved patients.

Additionally, providing pharmacy benefits and services in the context of Medi-Cal managed care enables FQHCs to effectively leverage discount drug pricing available through the 340B Drug Pricing Program. The savings available through participation in the 340B program allow FQHCs to provide vital services to more patients, such as transportation assistance, subsidized prescriptions, substance abuse treatment programs, and expanded clinician availability. These benefits are not available to FQHCs when reimbursed on a FFS basis. As a result of the current managed care system, FQHC patients have better access to more services, as Congress intended in enacting the 340B program.²

As Health & Human Services Secretary Xavier Becerra has stated, "the more medical care 340B covered entities can provide with their limited resources and state reimbursement, the further state-Medicaid budgets will go in serving the States' uninsured and underinsured residents."³ As California's Attorney General, Secretary Becerra recognized that 340B savings are vital to expanding access to medication and other services that "help create a continuum of care for patients," which ultimately leads to improved public health outcomes.

Yet, Medi-Cal Rx will impede FQHCs' ability to provide critical services to patients. The proposed FFS reimbursement, compounded with the loss of 340B savings and COVID-19 financial losses, will force FQHCs to reduce services. This directly undermines the whole-person care approach and the purpose of the Medi-Cal program and CalAIM, which is to improve access to healthcare and reduce health inequities.

Finally, federal Medicaid law prohibits states from waiving the FQHC reimbursement requirements described in 42 U.S.C. § 1396a(bb) under a 1915b waiver.⁴ California's Medi-Cal program does not currently have a compliant manner of reimbursing FQHCs for Medi-Cal's share of the cost of providing pharmacy services outside of the managed care system.

On the dispensary side, DHCS has not implemented the requirements of Welfare & Inst. Code § 14132.01 relating to reimbursement of Medi-Cal drugs provided through a clinic dispensary and has made no attempt to ensure that the dispensing fee for FQHC pharmacies or

² The purpose of the 340B program is to enable FQHCs to "stretch scarce federal resources" to provide expansive, high-quality services to the Medi-Cal patients who need them most. (H.R. Rep. No. 102-384, pt. 2, at 10.)

³ Bipartisan Attorneys General 340B letter to former HHS Secretary Alex Azar, Dec. 14, 2020, available at: <https://oag.ca.gov/news/press-releases/attorney-general-becerra-leads-bipartisan-coalition-340b-drug-pricing-program>.

⁴ 42 U.S.C. § 1396n(b).

dispensaries reimbursed under the fee-for-service alternative payment methodology are not less than the specific FQHC site would receive under the PPS floor. Moreover, the Mercer study that supported the pharmacy fee-for-service dispensing fees completely failed to address the requirements of 42 U.S.C. § 1396a(bb)(6)(B).

In addition, Medi-Cal has failed to adopt a standard for avoiding duplicate discounts on drugs dispensed through contract pharmacies, as required under HRSA's 2010 Contract Pharmacy Guidance, thus the transition would eliminate use of contract pharmacies for fee-for-service claims.

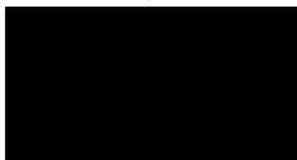
As a result, if Medi-Cal Rx is approved as part of the 1915b waiver, FQHCs will no longer be able to dispense Medi-Cal covered drugs through clinics' dispensaries or contract pharmacies, and will not be reimbursed at their actual cost of providing the mandatory FQHC services benefit, in violation of 42 U.S.C. § 1396n(b), resulting in a backdoor waiver of the FQHC reimbursement and service requirements in violation of federal law

Please see the attached letter from CHCAPA to the Centers for Medicare and Medicaid Services ("CMS"), dated April 16 2021, for a full description of our substantive and procedural concerns regarding Medi-Cal Rx.

In conclusion, CHCAPA agrees with Secretary Becerra that FQHCs and DHCS should "work in partnership to provide individuals access to affordable healthcare, including prescription drugs." Therefore, CHCAPA urges DHCS not to include implementation of Medi-Cal Rx as part of CalAIM, to fully analyze the impact it will have on the Medi-Cal program, and to provide a transparent process for stakeholders to provide meaningful input and alternatives for DHCS' consideration.

Thank you for your time and consideration. CHCAPA looks forward to working with DHCS on this critical issue that affects over 11 million Medi-Cal beneficiaries.

Sincerely,

A large black rectangular redaction box covering the signature of the sender.

President

Encl.

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April 16, 2021

VIA OVERNIGHT DELIVERY

Teresa DeCaro, Acting Director
State Demonstrations Group,
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, MD 21244-1850

Re: Community Health Center Alliance for Patient Access Request that CMS Reject California's Removal of Pharmacy Services from Managed Care, as proposed in Attachment N to the State of California's Section 1115 Waiver Extension

Dear Director DeCaro:

As follow-up to my previous letter dated March 18, 2021, please see the enclosed letter from the Community Health Center Alliance for Patient Access ("CHCAPA"). CHCAPA's letter provides a comprehensive description of the serious flaws and consequences of the so-called "Medi-Cal Rx" initiative.

CHCAPA is an organization of 31 California Federally-qualified health centers and support organizations throughout California whose mission is to ensure access to care for underserved communities. The list of CHCAPA's affiliate members includes the following organizations:

Avenal Community Health Center	Hill Country Health & Wellness Center	San Ysidro Health
Clinicas de Salud del Pueblo	Imperial Beach Community Clinic	Shasta Community Health Center
Community Health Centers of the Central Coast	La Maestra Family Clinic	South of Market Health Center
Desert AIDS Project	MCHC Health Centers	TrueCare
Family Health Centers of San Diego	Mission Area Health Associates	United Health Centers of the San Joaquin Valley
Gardner Family Health Network	Omni Family Health	Vista Community Clinic
Golden Valley Health Centers	Open Door Community Health Centers	WellSpace Health
HealthRIGHT 360	Ravenswood Family Health Network	Central California Partnership for Health (Affiliate Support Organization)
	San Francisco Community Health Center	

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Teresa DeCaro, Acting Director
April 16, 2021
Page 2

Thank you for your consideration. Please direct any questions, follow-up discussion, or responses to me via email or phone.

Thank you,



Kathryn E. Doi
Partner

cc: Xavier Becerra, Secretary, Health and Human Services
Liz Richter, Acting Administrator, Centers for Medicare and Medicaid Services
Heather Ross, Project Officer, Centers for Medicare and Medicaid Services
Will Lightbourne, Director, California Department of Health Care Services
Jacey Cooper, Chief Deputy Director, California Department of Health Care Services
Rob Bonta, California Attorney General
Darrel W. Spence, California Supervising Deputy Attorney General
Joshua Sondheimer, California Deputy Attorney General

April 16, 2021

VIA FEDERAL EXPRESS

Teresa DeCaro, Acting Director
State Demonstrations Group
Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, MD 21244-1850

Re: California's Removal of Pharmacy Services from Managed Care, as proposed in Attachment N to the State of California's Section 1115 Waiver¹

Dear Director DeCaro:

The Community Health Center Alliance for Patient Access ("CHCAPA") writes to inform CMS of significant problems with the California Department of Health Care Service's ("DHCS") proposed Attachment N to its 1115(a) Medicaid Waiver, entitled "Medi-Cal 2020" (Project Number 11-W-00193/9). Specifically, CHCAPA has serious concerns about the proposed removal of pharmacy services from managed care, an initiative called "Medi-Cal Rx."

CHCAPA urges CMS to reject the Medi-Cal Rx proposal for four reasons. First, California's fee-for-service ("FFS") reimbursement method fails to adequately fund Federally-Qualified Health Centers ("FQHCs") at the level that federal law requires. Second, Medi-Cal Rx deprives FQHCs of the 340B Drug Pricing Program ("340B") savings that currently fund numerous whole-person care services for the most vulnerable Medi-Cal beneficiaries. Third, DHCS did not follow the legal process for amending the 1115 Waiver, and misled the public and CMS regarding Medi-Cal Rx's negative effects on providers and patients. Fourth, Medi-Cal Rx undermines Medicaid's central objective of providing health care to low-income patients and does not produce any significant savings.

Despite its implications for health care for over 11 million Medi-Cal beneficiaries, DHCS has not thoroughly considered how Medi-Cal Rx affects the Medi-Cal program, Medi-Cal beneficiaries, or overall Medi-Cal costs. At minimum, CMS should require an additional 30-day public comment period and for DHCS to provide a detailed analysis of how Medi-Cal Rx affects underserved beneficiaries and FQHCs. See 42 C.F.R. § 431.412(a)(2), (c)(3).

I. California's fee-for-service reimbursement method for Medi-Cal pharmacy services will not reimburse FQHCs at the level federal law requires.

Federal law requires California to reimburse FQHCs at 100 percent of their costs. See 42 U.S.C. § 1396a(bb); *Tulare Pediatric Health Care Ctr. v. Dep't of Health Care Svc's*, 41 Cal. App. 5th 163, 171 (2019).

¹ This letter provides the substantive information for CMS to consider as it evaluates Medi-Cal Rx as promised in the earlier letter from CHCAPA's counsel, dated March 18, 2021 (attached as **Exhibit A**).

Managed care is California's predominate Medi-Cal delivery system. Roughly 83 percent of Medi-Cal beneficiaries – over 11 million people – are enrolled in managed care.² About 70 percent of pharmacy services spending occurs in managed care.³ As CMS knows, managed care plans negotiate directly with FQHCs to establish reimbursement rates for pharmacy services that generally reimburse FQHCs at 100 percent of their costs. Because managed care plans cover the vast majority of pharmacy claims, California and DHCS have not addressed deficiencies in the state's other delivery systems.

California did not design its non-managed care delivery systems to adequately reimburse FQHCs for their costs. First, by statute, California's FFS methodology only pays FQHCs their "actual acquisition cost for the drug," plus either a professional fee or dispensary fee. See Cal. Welf. & Inst. Code § 14105.46(d). The professional fee is capped at \$10.05, or \$13.20, depending on the pharmacy's annual claim volume. *Id.* § 14105.45(b)(1)(B). Similarly, the dispensary fee is set at \$12 or \$17 for certain take-home drugs. *Id.* § 14132.01(b)(2). However, these fee amounts did not account for FQHCs' costs when the State adopted them⁴. Additionally, DHCS has not created a billing mechanism for dispensing medication through a dispensary license. See Francisco Castillon Decl. ¶ 14 (attached as **Exhibit B**).

Second, California's prospective payment system ("PPS") rate is similarly flawed. The PPS method reimburses providers on a "per visit basis," but California excludes a patient's visit to a pharmacist as a reimbursable "visit." See Cal. Welf. & Inst. Code § 14132.100(g). Further, if an FQHC experiences a cost increase due to changes in its scope of services, it faces an automatic 20 percent reduction of the total new costs before the new PPS rate is set. See Dean Germano Decl. ¶ 19 (attached as **Exhibit C**).

In short, Medi-Cal Rx will replace California's managed care delivery system with undeveloped systems that do not comply with federal law. Therefore, CMS should reject Medi-Cal Rx.

II. Medi-Cal Rx undermines the 340B Program by depriving FQHCs of the savings they use to provide comprehensive care to underserved communities.

The purpose of the 340B program is to enable FQHCs to "stretch scarce federal resources" to provide expansive, high-quality services to the Medi-Cal patients who need them most.⁵ Managed care currently generates necessary savings for FQHCs to do exactly that.

California FQHCs, including CHCAPA affiliates, leverage 340B savings to provide better care to their patients and communities. For example, Family Health Centers of San Diego uses its 340B savings to provide expanded vision services, substance abuse recovery programs, and mobile

² See Medi-Cal Monthly Eligible Fast Facts, DHCS, February 2021, at p. 9 available at: <https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-November2020.pdf>

³ "The 2019-20 Budget: Analysis of the Carve Out of Medi-Cal Pharmacy Services From Managed Care," California Legislative Analyst's Office, April 5, 2019, at p. 6. (hereinafter "LAO Carve-Out Report").

⁴ See "Professional Dispensing Fee and Actual Acquisition Cost Analysis for Medi-Cal – Pharmacy Survey Report," Mercer Government Human Services Consulting, January 4, 2017, at p. 4.

⁵ See H.R. Rep. No. 102-384, pt. 2, at 10.

health services to low-income patients. Ricardo Roman Decl. ¶ 13 (attached as **Exhibit D**). Shasta Community Health Center's 340B savings enable it to subsidize prescription costs for the poorest patients, some of whom will pay a maximum of \$10 for their medication. Germano Decl. ¶ 2. The Desert AIDS Project uses its 340B savings to employ four infectious disease physicians and provide ongoing HIV and STD testing to combat the spread of HIV. David Brinkman Decl. ¶ 7 (attached as **Exhibit E**). These are just a few examples of how the managed care system enables FQHCs to use 340B savings the way Congress intended.

Nevertheless, DHCS seeks to deprive FQHCs of these 340B savings by moving all pharmacy services into an undeveloped FFS system. California's FFS model will not support the vital whole-person care programs upon which the most vulnerable FQHC patients rely. Instead, FQHCs will experience a "significant loss" in order for the State of California to gain an uncertain amount of savings for its general fund⁶. Without 340B savings, FQHCs will have to cut services to already underserved Medi-Cal patients. See, e.g., Castillon Decl. ¶¶ 12-13.

Thus, Medi-Cal Rx causes a reduction in patient services, which DHCS neither mentioned nor even considered in its Extension Request.

III. CMS should neither excuse nor permit DHCS to obtain approval for Medi-Cal Rx through a flawed and misleading public process.

A. DHCS improperly submitted Medi-Cal Rx as a "technical" change contrary to federal law and the Special Terms and Conditions of California's 1115 Waiver.

Federal law and the Special Terms and Conditions of California's 1115 Waiver ("STCs") require that "substantial" changes to benefits, delivery systems, reimbursement methods, and other "comparable program elements" occur as amendments to the 1115 Waiver. 42 C.F.R. § 431.412(c); STC III, Section 7. Amendments require the State to follow specific public processes and to provide detailed information and analyses on the impact of the proposed change. STC III, Section 8. CMS has the authority to deny or delay approval of any amendment based on California's violation of the STCs. *Id.*

Medi-Cal Rx is undoubtedly a substantial change to the delivery and reimbursement of Medi-Cal pharmacy services. It completely removes the pharmacy benefit from the managed care delivery system, and places it into the FFS delivery system. The FFS system, in turn, has an entirely different reimbursement method that will underfund FQHCs, as discussed.

Moreover, Medi-Cal Rx will "fundamentally alter" how more than 11 million Medi-Cal beneficiaries receive treatment. See Kelvin Vu Decl. ¶ 8 (attached as **Exhibit F**). For example, doctors currently are able to access the availability of prescriptions and their patient's adherence to their treatment plan in real-time. *Id.* If a pharmacy does not have a prescription in stock, the doctor will know immediately and can adjust the order. *Id.* ¶ 5. As a result, the patient is more likely to get their medication and adhere to their treatment plan. *Id.* ¶¶ 5-8. But not under Medi-Cal Rx. Instead, Medi-Cal Rx removes the doctor's ability to coordinate with a pharmacy, and creates a new barrier for the patient to access the prescriptions they need. Vu Decl. ¶ 8; Paramvir Sidhu Decl. ¶¶ 5-9 (attached as **Exhibit G**).

⁶ LAO Carve-Out Report, at p. 1.

Despite these substantial changes to Medi-Cal, DHCS submitted Medi-Cal Rx as a “technical” amendment. See Extension Request at p. 14. The only analysis DHCS provided was that Medi-Cal Rx would “reflect the transition of pharmacy benefits to the fee-for-service delivery system effective January 1, 2021.” *Id.* This is a description, not an analysis. DHCS further described Medi-Cal Rx in the two short paragraphs, with no mention of the differences in delivery systems, the shortcomings of non-managed care reimbursement methods, the impact on 340B savings and the patient services they fund, or the real effects on patients and their doctors. See *id.*

CMS should treat Medi-Cal Rx as the substantial amendment that it is. CMS cannot allow DHCS to avoid its obligation to fully describe and understand Medi-Cal Rx. Accordingly, CMS should reject Medi-Cal Rx, or at the very least, require DHCS to provide additional information and more time for public input. See 42 C.F.R. § 431.412(a), (c).

B. DHCS has been implementing Medi-Cal Rx without CMS’ approval.

Federal law and the STCs prohibit DHCS from implementing major changes to California’s Waiver without CMS’ approval. See *Cal. Ass’n of Rural Health Clinics v. Douglas*, 738 F.3d 1007, 1017-18 (9th Cir. 2013); STCs III, Sections 7-8.

DHCS is not waiting for CMS to move forward with Medi-Cal Rx. For example, it has unilaterally set and changed two different “effective” dates that did not depend on CMS approval. See Extension Request at p. 14⁷. DHCS contracted with Magellan Medicaid Administration to create a Medi-Cal Rx customer service center. Providers have already had to register for secure Medi-Cal Rx portals and participated in Medi-Cal Rx trainings. The State of California created a supplemental payment pool in its state budget because of the losses FQHCs will suffer under Medi-Cal Rx. Germano Decl. ¶¶ 4-15. DHCS has begun to implement Medi-Cal Rx without CMS approval and without understanding its consequences.

DHCS’ unapproved implementation of Medi-Cal Rx is already affecting providers. For example, Family Health Centers of San Diego has had to undergo a complete budget review anticipating the loss of 340B savings, and has dedicated significant staff time to enroll in Medi-Cal Rx provider portals and to track Medi-Cal Rx updates. Fran Butler-Cohen Decl. ¶ 9 (attached as **Exhibit H**). Providers have also had to register for and participate in several different trainings, answer readiness surveys, and provide claims information for calculating their professional dispensing fee under FFS. See, e.g., DHCS Medi-Cal Rx Monthly Bulletin (attached as **Exhibit I**). These efforts distract FQHCs from patient service, such as providing free testing and vaccines to combat the spread of COVID-19. See *id.* ¶¶ 6-8.

In sum, DHCS is violating federal law and the STCs by implementing Medi-Cal Rx without CMS’ approval. CMS should not allow DHCS to do so, and should accordingly reject Medi-Cal Rx.

⁷ See also Medi-Cal Rx Transition home page, available at: <https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx>

C. DHCS prevented meaningful public input regarding Medi-Cal Rx through misleading public notices and a rushed public comment process.

States must allow for “meaningful public input” when submitting 1115 Waiver amendments or extension requests. 42 C.F.R. §§ 431.408(a)(1)(i), 431.412 (c)(2)(ii). This requires states to provide a “comprehensive description” discussing who will be impacted by the proposals, changes to the existing demonstration, and how the state received and considered public comments. See 42 C.F.R. §§ 431.408(a), 431.412(a), (c).

DHCS hindered “meaningful” public input regarding Medi-Cal Rx. Specifically, DHCS claimed that there was “no impact” to FQHCs in its Tribal Notice⁸. However, the state’s Legislative Analyst’s office explicitly stated that Medi-Cal Rx would directly affect FQHC funding and patient care coordination⁹. Also, DHCS held only two public hearings within 20 days of announcing the proposed Extension.

Although CMS waived some of the technical notice requirements, it certainly did not allow DHCS to falsely downplay the impact of the Extension Request and Medi-Cal Rx¹⁰. As the public was denied meaningful input into Medi-Cal Rx, CMS should not allow DHCS to implement it.

D. DHCS’ Waiver Extension Request misled CMS by unfairly minimizing CHCAPA’s legitimate and detailed objections to Medi-Cal Rx.

DHCS was obligated to provide CMS with a “report of the issues” raised in public comments and how it addressed them. 42 C.F.R. § 431.412(a)(viii), (c)(vii).

Yet DHCS did not provide an honest report of the public comments to CMS. In its Extension Request, DHCS misrepresented CHCAPA’s extensive concerns in one sentence: “one commenter objected to the state’s plan to carve-out the pharmacy benefit.” Extension Request at p. 45. The “one commenter” was a collection of nearly 20 health centers across California that signed onto a CHCAPA-led comment letter. The “objection” was a detailed letter describing numerous problems with the FFS and PPS reimbursement methods and the overall disruption Medi-Cal Rx will cause. DHCS’ characterization hid serious public concerns from CMS.

DHCS’ response to CHCAPA’s concerns was similarly sparse. In a single paragraph, DHCS claimed that it “must” move the pharmacy benefit out of managed care in order for pharmacy services to move from managed care. See Extension Request at p. 49. By contrast, DHCS provided detailed summaries and responses for comments that were generally or strongly supportive of its Extension proposals. See Extension Request at 44-49. DHCS cannot provide one-sided information in order to obtain CMS’ approval of a flawed initiative.

⁸ DHCS Tribal Notice of Proposed Change to Medi-Cal Program, July 22, 2020 at p. 2, available at: <https://www.dhcs.ca.gov/Documents/1115-1915bWaiverTribalNotice7-22-20.pdf>

⁹ LAO Carve-Out Report, at pp. 1, 13-14

¹⁰ See CMS Completeness Letter, dated Oct. 1, 2020

CMS cannot adequately evaluate Medi-Cal Rx based on the scant information DHCS provided regarding its scope and costs. At best, DHCS failed to provide accurate and sufficient information to CMS. Therefore, CMS should decline to approve Attachment N and Medi-Cal Rx until these important issues have been addressed.

IV. Medi-Cal Rx impedes Medicaid's primary objective by depriving beneficiaries of high-quality care, and is not likely produce the savings DHCS claims.

Any change to California's Medicaid Waiver must promote the objectives of Medicaid. See 42 U.S.C. § 1315(a). Medicaid's most fundamental objective is to provide comprehensive, high-quality medical care to people who would not have access to it otherwise. See *id.* § 1396-1.

Medi-Cal Rx directly undermines Medicaid's purpose in two ways. First, it will eliminate vital patient services for beneficiaries. Because of the COVID-19 pandemic, FQHCs in California are facing an estimated loss of \$530 million dollars¹¹. Medi-Cal Rx will exacerbate FQHCs' financial strain by shifting 340B savings to the state while underpaying FQHCs through FFS. These cuts will force FQHCs to eliminate key services for their patients, including transportation assistance, mobile health initiatives, and prescription subsidies. See, e.g., Castillon Decl. ¶¶ 12-13; Germano Decl. ¶¶ 2, 16; Brinkman Decl. ¶ 9.

Second, Medi-Cal Rx will diminish the quality of care for the remaining FQHC services. It will disrupt Medi-Cal care coordination, severely undermining the whole-person care model that DHCS expects FQHCs to follow. See Vu Decl. ¶ 8; Sidhu Decl. ¶¶ i5-9. It will also disrupt important medical intervention programs that combat substance abuse and opioid addiction. See Vu Decl. ¶ 10. Medi-Cal Rx will therefore lead to fewer services and worse health outcomes during a pandemic that has claimed the lives of over 60,000 Californians.

Medi-Cal Rx will cause significant disruption without any real financial benefit to California. DHCS has not provided any thorough analysis to support its claim of savings, and actually excluded such claims from its final submission to CMS. See Extension Request at pp. 37, 49. In fact, an internal DHCS analysis shows that while Medi-Cal Rx would yield a net savings of \$5.8 billion, the fee-for-service pharmacy costs would grow to about \$5.65 billion¹². By its own analysis, DHCS knows that Medi-Cal Rx *might* save the state a maximum of \$400 million over an unknown period of time.

Studies by reputable entities also cast doubt on whether Medi-Cal Rx will yield significant state savings, if any. The Legislative Analyst's Office noted that even if there is some net savings, the amount is "highly uncertain"¹³. Further, an independent analysis found that moving pharmacy benefits into fee-for-service would actually result in a net *increase* of as much as \$757 million to

¹¹ See "Financial Impact of COVID-19 on California Federally Qualified Health Centers," California Health Care Foundation, available at: <https://www.chcf.org/wp-content/uploads/2021/03/FinancialImpactCOVID19CaliforniaFQHCInfographic.pdf>

¹² May 2020 Medi-Cal Local Assistance Estimate, DHCS, at PC page 107, available at: https://www.dhcs.ca.gov/dataandstats/reports/mceestimates/Documents/2020_May_Estimate/M2099-Medi-Cal-Local-Assistance-and-Appropriation-Estimate.pdf

¹³ LAO Carve-Out Report, at pp. 1, 11-12

California's General Fund over five years¹⁴. Thus, any benefits of Medi-Cal Rx are limited and uncertain.

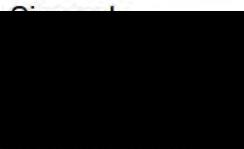
In sum, Medi-Cal Rx subverts – not promotes – Medicaid's core objective of providing low-income people with access to health care. CMS should therefore reject the proposal, especially during an ongoing pandemic when the health care system needs stability.

V. Conclusion

Medi-Cal Rx is an undeveloped proposal that directly undermines the purpose of Medicaid. Medi-Cal Rx will significantly disrupt patient care and create new barriers to access for the sake of speculative state savings. DHCS cannot upend an entire delivery system affecting over 11 million Medi-Cal beneficiaries under the label of a "technical" change to its Waiver. By providing insufficient and misleading information to the public and to CMS, DHCS violated federal law and its contract with CMS.

Accordingly, CHCAPA urges CMS to reject the Medi-Cal Rx proposal. At minimum, CMS should use its authority to treat Medi-Cal Rx as a substantive amendment and require DHCS to follow the formal amendment process specified in the Code of Federal Regulations and the Special Terms and Conditions of the Waiver.

Thank you for your time and consideration.



Anthony White
President, CHCAPA

CC: Xavier Becerra, Secretary, Health and Human Services
Liz Richter, Acting Administrator, Centers for Medicare and Medicaid Services
Heather Ross, Project Officer, Centers for Medicare and Medicaid Services
Will Lightbourne, Director, California Department of Health Care Services
Jacey Cooper, Chief Deputy Director, California Department of Health Care Services
Rob Bonta, California Attorney General
Darrel W. Spence, California Supervising Deputy Attorney General
Joshua Sondheimer, California Deputy Attorney General

¹⁴ Assessment of Medi-Cal Pharmacy Benefits Policy Options, The Menges Group, May 15, 2019 at p. 3, available at: https://www.themengesgroup.com/upload_file/assessment_of_medi-cal_pharmacy_benefits_policy_options.pdf.



Exhibit A
to letter dated 4/16/2021

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March 18, 2021

VIA FEDERAL EXPRESS

Judith Cash, Director
State Demonstrations Group
Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, MD 21244-1850

Re: Community Health Center Alliance for Patient Access ("CHCAPA") Request that CMS Pause Its Consideration to Proposed Attachment N to the State of California's Medi-Cal 2020 Section 1115 Waiver Demonstration to Allow for Comment

Dear Ms. Cash:

We represent the Community Health Center Alliance for Patient Access ("CHCAPA") and individual Federally-qualified health centers in federal court litigation challenging the State of California's implementation of the Medi-Cal Rx program to transition the pharmacy benefit from Medi-Cal managed care to fee-for-service reimbursement. (*Community Health Center Alliance for Patient Access, et al. v. Lightbourne, et al.*, United States District Court for the Eastern District of California, Case No. 2:30-cv-02171-JAM-KJN.)

On Tuesday, March 9, 2021, a hearing was held on the Defendants' (the California Department of Health Care Services and its Director Will Lightbourne) motion to dismiss and the Plaintiffs' motion for a preliminary injunction. At the hearing, Judge Mendez indicated on the record that he was granting the motion to dismiss with leave to amend the complaint because CMS has not yet acted on Attachment N to the State's 1115 Waiver. Attachment N was submitted to CMS by the State of California on December 24, 2020 and would result in the removal of the pharmacy benefit from the list of covered services under Medi-Cal managed care, thus effectuating the Medi-Cal Rx transition. During the hearing, the judge encouraged the Plaintiffs to raise with CMS the legal challenges to Medi-Cal Rx and Attachment N that Plaintiffs raised in the federal lawsuit. In the minutes of the proceeding, the judge ordered Plaintiffs to "wait to file an amended complaint until after CMS acts on the approval sought by Defendants."¹

Consistent with the judge's recommendations, we are writing on behalf of the Plaintiffs to request that CMS pause its consideration of Attachment N to give us time to submit a

¹ Copies of the proposed Attachment N, the December 24, 2020 email message from the Department of Health Care Services ("DHCS") transmitting Attachment N to CMS, CMS' December 29, 2020 response to DHCS regarding the status of Attachment N, and the Court's March 9, 2021 minutes of proceeding are attached to this letter for your reference as Exhibits A, B, C, and D, respectively.

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comprehensive letter outlining the reasons why approval of Attachment N and implementation of Medi-Cal Rx will result in a violation of the federal Medicaid and 340B laws. Since there is currently no Go Live date for the Medi-Cal Rx transition, we request that we be granted a minimum period of 45-days to submit our substantive comments.²

We also encourage CMS adopt an open and transparent process for its consideration of Attachment N to allow Plaintiffs and other stakeholders an opportunity to provide public input into CMS' decision-making process. The 1115 Waiver extension request and associated notices did not describe the Medi-Cal Rx transition, did not attach the proposed Attachment N and inaccurately stated there would be no impact on FQHCs, and therefore, there has been no opportunity for the public and stakeholders to weigh in on the impact of Medi-Cal Rx on patient care and the delivery system.

The proposed Attachment N will change the pharmacy delivery system for the roughly 8.8 million Medi-Cal beneficiaries who receive their health care through Medi-Cal managed care, a significant change for the beneficiaries, as well as the providers and health plans that are a part of their health care delivery system. To date, there has been no public examination of the consequences of removing the pharmacy benefit from managed care, including the resulting impact on coordination of care, oversight of pharmacy usage and patient compliance, or Medi-Cal's ability to deliver the whole person integrated care if the pharmacy benefit is carved out of managed care and delivered and administered by the State.

Such a sea change should not occur in a vacuum, but only after a public process that allows for identification of the key issues and allows for a careful review of the public policy and legal ramifications of such a major disruption to the health care delivery system for millions of low income Californians. To this end, because Attachment N substantially changes the original demonstration design and was not submitted as part of the original 1115 Waiver extension request, we request that CMS exercise its discretion to direct an additional 30-day public comment period pursuant to 42 C.F.R. 431.412(a)(2) and (c)(3).

We also request that CMS timely notify us of any action taken with respect to the State of California's request for approval of Attachment N so we might return to court as provided by the judge's order.

Your attention to this matter is greatly appreciated.

Very truly yours,



Kathryn E. Doi
Partner

KED:KQD
Encls.

² DHCS' announcement that the April 1, 2021 Go Live date for Medi-Cal Rx was being suspended with no new date announced, is attached as **Exhibit E**.

Judith Cash, Director
March 18, 2021
Page 3

cc: (VIA U.S. MAIL)
Xavier Becerra, Secretary, Health and Human Services
Liz Richter, Acting Administrator, Centers for Medicare and Medicaid Services
Will Lightbourne, Director, California Department of Health Care Services
Lindy Harrington, Deputy Director, California Department of Health Care Services
Darrell W. Spence, California Supervising Deputy Attorney General
Joshua Sondheimer, California Deputy Attorney General
Anthony White, President, CHCAPA

Exhibit A



**Attachment N
Capitated Benefits Provided in Managed Care**

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Acupuncture Services	Other Practitioners' Services and Acupuncture Services	Acupuncture services shall be limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.	X ¹	X ¹	X ¹	X ¹	X ¹	X ¹
Acute Administrative Days	Intermediate Care Facility Services	Acute administrative days are covered, when authorized by a Medi-Cal consultant subject to the acute inpatient facility has made appropriate and timely discharge planning, all other coverage has been utilized and the acute inpatient facility meets the requirements contained in the Manual of Criteria for Medi-Cal Authorization.	X ⁵ X ^{3,965}	X ⁵ X ^{3,965}	X	X ⁵ X ³	X ⁵ X ³	X ⁵ X ³
<u>Audiological Services</u>	<u>Audiology Services</u>	<u>Audiological services are covered when provided by persons who meet the appropriate requirements</u>	<u>X¹</u>	<u>X¹</u>	<u>X¹</u>	<u>X¹</u>	<u>X¹</u>	<u>X¹</u>
Behavioral Health Treatment (BHT)	Preventive Services - EPSDT	The provision of medically necessary BHT services to eligible Medi-Cal members under 21 years of age as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate and state plan.	X ¹⁰ X ⁷⁶	X ¹⁰ X ⁷⁶	X ¹⁰ X ⁷⁶	X ¹⁰ X ⁷⁶	X ¹⁰ X ⁷⁶	X ¹⁰ X ⁷⁶
Blood and Blood Derivatives	Blood and Blood Derivatives	A facility that collects, stores, and distributes human blood and blood derivatives. Covers certification of blood ordered by a physician or facility where transfusion is given.	X	X	X	X	X	X
California Children Services (CCS)	<u>Service is not covered under the State Plan EPSDT</u>	California Children Services (CCS) means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.	<u>X</u>	<u>X</u>	<u>X⁹ X⁶X⁴</u>	<u>X</u>	<u>X</u>	<u>X</u>

**Attachment N
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Certified Family nurse-Nurse practitioner-Prac titioner	Certified Family Nurse Practitioners' Services	A certified family nurse practitioners who provide services within the scope of their practice.	X	X	X	X	X	X
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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Certified Pediatric Nurse Practitioner Services	Certified Pediatric Nurse Practitioner Services	Covers the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks; can also include primary care services.	X	X	X	X	X	X
Child Health and Disability Prevention (CHDP) Program	<u>EPSDT</u>	A preventive program that delivers periodic health assessments and provides care coordination to assist with medical appointment scheduling, transportation, and access to diagnostic and treatment services.	X	X	X ⁴	X	X	X
Childhood Lead Poisoning Case Management (Provided by the Local County Health Departments)	<u>EPSDT</u>	A case of childhood lead poisoning (for purposes of initiating case management) as a child from birth up to 21 years of age with one venous blood lead level (BLL) equal to or greater than 20 µg/dL, or two BLLs equal to or greater than 15 µg/dL that must be at least 30 and no more than 600 calendar days apart, the first specimen is not required to be venous, but the second must be venous.	X	X	X	X	X	X
Chiropractic Services	Chiropractors' Services	Services provided by chiropractors, acting within the scope of their practice as authorized by California law, are covered, except that such services shall be limited to treatment of the spine by means of manual manipulation.	X ¹	X ¹	X ¹	X ¹	X ¹	X ¹

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Chronic Hemodialysis	Chronic Hemodialysis	Procedure used to treat kidney failure - covered only as an outpatient service. Blood is removed from the body through a vein and circulated through a machine that filters the waste products and excess fluids from the blood. The "cleaned" blood is then returned to the body. Chronic means this procedure is performed on a regular basis. Prior authorization required when provided by renal dialysis centers or community hemodialysis units.	X	X	X	X	X	X
Community Based Adult Services (CBAS)		<p>CBAS Bundled services: An outpatient, facility based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals and transportation to eligible Medi-Cal beneficiaries.</p> <p>CBAS Unbundled Services: Component parts of CBAS center services delivered outside of centers, under certain conditions, as specified in paragraph 95.</p>	X	X	X	<u>X</u>	<u>X</u>	<u>X</u>
Comprehensive Perinatal Services	Extended Services for Pregnant Women- Pregnancy Related and Postpartum Services	Comprehensive perinatal services means obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy and 60 days following delivery.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Dental Services (Covered under Denti Medi-Cal)		Professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws and associated structures; the use of drugs <u>administered in-office</u> , anesthetics and physical evaluation; consultations; home, office and institutional calls.						
Drug Medi-Cal Substance Abuse Services	Substance Abuse Treatment Services	Medically necessary substance abuse treatment to eligible beneficiaries.						
Durable Medical Equipment	DME	Assistive medical devices and supplies. Covered with a prescription; prior authorization is required.	X	X	X	X	X	X
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and <u>EPSDT Supplemental Services</u>	EPSDT	<u>EPSDT is the Medicaid program's benefit for children and adolescents, providing a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act.</u> Preliminary evaluation to help identify potential health issues.	X²⁶	X⁶⁷	X⁶⁷	X⁶⁷	X⁶⁷	X⁶⁷
Erectile Sexual Dysfunction Drugs		FDA-approved drugs that are <u>may</u> be prescribed for <u>a male or female sexual dysfunction are non-benefits of the program.</u> patient experiences an inability or difficulty getting or keeping an erection as a result of a physical problem.						

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Expanded Alpha-Fetoprotein Testing (Administered by the Genetic Disease Branch of DHCS)		A simple blood test recommended for all pregnant women to detect if they are carrying a fetus with certain genetic abnormalities such as open neural tube defects, Down Syndrome, chromosomal abnormalities, and defects in the abdominal wall of the fetus.						
Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances	Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes, and Other Eye Appliances	Eye appliances are covered on the written prescription of a physician or optometrist.	X ^B	X ^B	X ^B	X ^B	X ^B	X ^B
Federally Qualified Health Centers (FQHC) (Medi-Cal covered services only)	FQHC	Services described in 42 U.S.C. Section 1396d(a)(2)(C) furnished by An an entity defined in Section 1905 of the Social Security Act (42 United States Code U.S.C. Section 1396d(l)(2)(B)).	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Health Home Program Services	Health Home Program Services	The community based care management entity assigns care managers, such as nurses or other trained professionals, to help members who have chronic conditions find the right health care or other services in their communities. Health Home Program services: Comprehensive Care Management; Care Coordination; Health Promotion; Comprehensive Transitional Care; Individual and Family Supports; and Referral to Community/Social Supports; are defined in the CMS- approved Health Home Program SPAs, and include any subsequent amendments to the CMS- approved Health Home Program SPAs.	X¹⁴X⁸⁷	X¹⁴X⁸⁷	X¹⁴X⁸⁷	X¹⁴X⁸⁷	X¹⁴X⁸⁷	X¹⁴X⁸⁷
Hearing Aids	Hearing Aids	Hearing aids are covered only when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation including a hearing aid evaluation which must be performed by or under the supervision of the above physician or by a licensed audiologist.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Home and Community-Based Waiver Services (Does not include EPSDT Services)		Home and community-based waiver services shall be provided and reimbursed as Medi-Cal covered benefits only: (1) For the duration of the applicable federally approved waiver, (2) To the extent the services are set forth in the applicable waiver approved by the HHS; and (3) To the extent the Department can claim and be reimbursed federal funds for these services.						
Home Health Agency Services	Home Health Services-Home Health Agency	Home health agency services are covered as specified below when prescribed by a physician and provided at the home of the beneficiary in accordance with a written treatment plan which the physician reviews every 60 days.	X	X	X	X	X	X
Home Health Aide Services	Home Health Services-Home Health Aide	Covers skilled nursing or other professional services in the residence including part-time and intermittent skilled nursing services, home health aide services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.	X	X	X	X	X	X
Hospice Care	Hospice Care	Covers services limited to individuals who have been certified as terminally ill in accordance with Title 42, CFR Part 418, Subpart B, and who directly or through their representative volunteer to receive such benefits in lieu of other care as specified.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Hospital Outpatient Department Services and Organized Outpatient Clinic Services	Clinic Services and Hospital Outpatient Department Services and Organized Outpatient Clinic Services	A scheduled administrative arrangement enabling outpatients to receive the attention of a healthcare provider. Provides the opportunity for consultation, investigation and minor treatment.	X	X	X	X	X	X
Human Immunodeficiency Virus and AIDS drugs (Jan 1 – Mar 31, 2021) Prior to April 1, 2021		Human Immunodeficiency Virus and AIDS drugs that are listed in the Medi-Cal Provider Manual			X ⁵			

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Hysterectomy	Inpatient Hospital Services	Except for previously sterile women, a nonemergency hysterectomy may be covered only if: (1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile, (2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in and (3) The individual has been informed of the rights to consultation by a second physician. An emergency hysterectomy may be covered only if the physician certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.	<u>X</u>	<u>X</u>	X	<u>X</u>	<u>X</u>	<u>X</u>
Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Indian Health Services (Medi-Cal covered services only)		Indian means any person who is eligible under federal law and regulations (25 U.S.C. Sections 1603c, 1679b, and 1680c) and covers health services provided directly by the United States Department of Health and Human Services, Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by <u>contract</u> .	X	X	X	X	X	X

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In-Home Medical Care Waiver Services and Nursing Facility Waiver Services		In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in-home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	X	X	X	X	X	X
Inpatient Hospital Services	Inpatient Hospital Services	Covers delivery services and hospitalization for newborns; emergency services without prior authorization; and any hospitalization deemed medically necessary with prior authorization.	X	X	X	X	X	X
Intermediate Care Facility Services for the Developmentally Disabled	Intermediate Care Facility Services for the Developmentally Disabled	Intermediate care facility services for the developmentally disabled are covered subject to prior authorization by the Department. Authorizations may be granted for up to six months. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care.	X ⁵ X ³	X ⁵ X ³	X	X ⁵ X ³	X ⁵ X ³	X ⁵ X ³

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Intermediate Care Facility Services for the Developmentally Disabled Habilitative	Intermediate Care Facility Services for the Developmentally Disabled Habilitative	Intermediate care facility services for the developmentally disabled habilitative (ICF-DDH) are covered subject to prior authorization by the Department of Health Services for the ICF-DDH level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF-DDH or for continuation of services shall be initiated by the facility on forms designated by the Department. Certification documentation required by the Department of Developmental Services must be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care.	X ⁵ X ³	X ⁵ X ³	X	X ⁵ X ³	X ⁵ X ³	X ⁵ X ³

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Intermediate Care Facility Services for the Developmentally Disabled-Nursing-		Intermediate care facility services for the developmentally disabled-nursing (ICF/ID-N) are covered subject to prior authorization by the Department for the ICF/ ID-N level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF/ID-N or for continuation of services shall be initiated by the facility on Certification for Special Treatment Program Services forms (HS 231). Certification documentation required by the Department of Developmental Services shall be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care.	X ⁵ X ³	X ⁵ X ³	X	X ⁵ X ³	X ⁵ X ³	X ⁵ X ³
Intermediate Care Services	Intermediate Care Facility Services	Intermediate care services are covered only after prior authorization has been obtained from the designated Medi-Cal consultant for the district where the facility is located. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care.	X ⁵ X ^{3,965}	X ⁵ X ^{3,965}	X	X ⁵ X ³	X ⁵ X ³	X ⁵ X ³
Laboratory, Radiological and Radioisotope Services	Laboratory, X-Ray and Laboratory, Radiological and Radioisotope Services	Covers exams, tests, and therapeutic services ordered by a licensed practitioner.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Licensed Midwife Services	Other Practitioners' Services and Licensed Midwife Services	The following services shall be covered as licensed midwife services under the Medi-Cal Program when provided by a licensed midwife supervised by a licensed physician and surgeon: (1) Attendance at cases of normal childbirth and (2) The provision of prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Local Educational Agency (LEA) Services	Local Education Agency Medi- Cal Billing Option Program Services	LEA health and mental health evaluation and health and mental health education services, which include any or all of the following: (A) Nutritional assessment and nutrition education, consisting of assessments and non-classroom nutrition education delivered to the LEA eligible beneficiary based on the outcome of the nutritional health assessment (diet, feeding, laboratory values, and growth), (B) Vision assessment, consisting of examination of visual acuity at the far point conducted by means of the Snellen Test, (C) Hearing assessment, consisting of testing for auditory impairment using at-risk criteria and appropriate screening techniques as defined in Title 17, California Code of Regulations, Sections 2951(c), (D) Developmental assessment, consisting of examination of the developmental level by review of developmental achievement in comparison with expected norms for age and background, (E) Assessment of psychosocial status, consisting of appraisal of cognitive, emotional, social, and behavioral functioning and self-concept through tests, interviews, and behavioral evaluations and (F) Health education and anticipatory guidance appropriate to age and health status, consisting of non- classroom health education and anticipatory guidance based on age and developmentally appropriate health education.						

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Long Term Care (LTC)		Care in a facility for longer than the month of admission plus one month. Medically necessary care in a facility covered under managed care health plan contracts	X⁵ X^{3,965}	X⁵ X^{3,596}	X⁵³	X⁵ X^{3,5}	X⁵ X^{3,5}	X⁵ X^{3,5}
Medical Supplies (Jan 1– Mar 31, 2021)Prior to April 1, 2021	Medical Supplies	Medically necessary supplies when prescribed by a licensed practitioner. Does not include incontinence creams and washes	X	X	X	X	X	X
Medical Supplies (effective April 1, 2021 onward)	Medical Supplies	Medically necessary supplies when prescribed by a licensed practitioner. Does not include medical supplies carved-out to Medi-Cal Rx that are billed by a pharmacy on a pharmacy claim including medical supplies described in the Medi-Cal Rx All Plan Letter (APL 20-020).¹	X	X	X	X	X	X
Medical & Non-Medical (NMT) Transportation Services	Transportation-Medical & Non-Medical (NMT) Transportation (NMT) Services	Covers ambulance, litter van and wheelchair van medical transportation services are covered when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care. NMT is transportation by private or public vehicle for	X	X	X	X	X	X

¹ <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf>

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		<u>beneficiary's</u> sies <u>people who do not have another way to get to their appointment.</u>						
Multipurpose Senior Services Program (MSSP)		MSSP sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community.	X ⁹ <u>X</u> ⁶⁵	X ⁹ <u>X</u> ⁶⁵	X ⁹ <u>X</u> ⁶⁵			
Nurse Anesthetist Services	Other Practitioners' Services and Nurse Anesthetist Services	Covers anesthesiology services performed by a nurse anesthetist within the scope of his or her licensure.	X	X	X	X	X	X
Nurse Midwife Services	Nurse-Midwife Services	An advanced practice registered nurse who has specialized education and training in both Nursing and Midwifery, is trained in obstetrics, works under the supervision of an obstetrician, and provides care for mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Optometry Services	Optometrists' Services	Covers eye examinations and prescriptions for corrective lenses. Further services are not covered.	X	X	X	X	X	X
Outpatient Mental Health	Outpatient Mental Health	<p>Services provided by licensed health care professionals acting within the scope of their license for adults and children diagnosed with a mental condition as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Services include:</p> <ul style="list-style-type: none"> • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient Services for the purpose of monitoring drug therapy • Outpatient laboratory, drugs, supplies and supplements • Screening and Brief Intervention (SBI) • Psychiatric consultation for medication management 	X ²	X ²	X ²	X ²	X ²	X ²

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Organized Outpatient Clinic Services	Clinic Services and Organized Outpatient Clinic Services	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in- home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	X	X	X	X	X	X
Outpatient Heroin Detoxification Services	Outpatient Heroin Detoxification Services	Can cover of a number of medications and treatments, allowing for day-to-day functionality for a person choosing to not admit as an inpatient. Routine elective heroin detoxification services are covered, subject to prior authorization, only as an outpatient service. Outpatient services are limited to a maximum period of 21 days. Inpatient hospital services shall be limited to patients with serious medical complications of addiction or to patients with associated medical problems which require inpatient treatment.						
Part D Drugs		Drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act.						
Pediatric Subacute Care Services	Nursing Facility Services and Pediatric Subacute Services (NF)	Pediatric Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit.	X ⁵ X ³	X ⁵ X ³	X	X ⁵ X ³	X ⁵ X ³	X ⁵ X ³

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Personal Care Services	Personal Care Services	Covers services which may be provided only to a categorically needy beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services.	X⁹X⁶⁵₁₄	X⁹X⁶⁵₁₄	X⁹X⁶⁵₁₄			
Pharmaceutical Services and Prescribed Drugs <u>(effective Jan 1 – Mar 31, 2024)</u> Prior to April 1, 2021	Pharmaceutical Services and Prescribed Drugs	Covers medications including prescription and nonprescription and total parenteral and enteral nutrition supplied by licensed physician.	X	X	X	X	X	X
<u>Pharmaceutical Services and Prescribed Drugs (effective Apr 1, 2021 onward)</u>	<u>Pharmaceutical Services and Prescribed Drugs</u>	<p>Covers medications other than those carved-out to Medi-Cal Rx including prescription and nonprescription and total parenteral and enteral nutrition supplied by licensed physician.</p> <p><u>Does not include pharmacy benefits carved-out to Medi-Cal Rx that are billed by a pharmacy on a pharmacy claim including covered outpatient drugs, physician administered drugs (PADs), medical supplies, and enteral/parenteral nutritional products as described in the Medi-Cal Rx All Plan Letter (APL 20-020).</u></p> <p>Covers medications other than those carved-out to Medi-Cal Rx including prescription and nonprescription and total parenteral and</p>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>

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		enteral nutrition supplied by licensed physician.						
Physician Services	Physician Services	Covers primary care, outpatient services, and services rendered during a stay in a hospital or nursing facility for medically necessary services. Can cover limited mental health services when rendered by a physician, and limited allergy treatments.	X	X	X	X	X	X
Podiatry Services	Other Practitioners' Services and Podiatrists' Services	Office visits are covered if medically necessary. All other outpatient services are subject to <u>the same</u> prior authorization <u>procedures that govern physicians</u> , and are limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk. Services rendered on an emergency basis are exempt from prior authorization.	X⁴	X⁴	X⁴	X⁴	X⁴	X⁴
Preventive Services	Preventive Services	All preventive services articulated in the state plan.	X	X	X	X	X	X

**Attachment N
Capitated Benefits Provided in Managed Care**

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Prosthetic and Orthotic Appliances	Prosthetic and Orthotic Orthotic Appliances	All prosthetic and orthotic appliances necessary for the restoration of function or replacement of body parts as prescribed by a licensed physician, podiatrist or dentist, within the scope of their license, are covered when provided by a prosthetist, orthotist or the licensed practitioner, respectively	X	X	X	X	X	X
Psychology, Physical Therapy and, Occupational Therapy, Speech Pathology and Audiological Services	Psychology Listed as Other Practitioners' Services and Psychology, Physical Therapy and, Occupational Therapy, Speech Pathology, and Audiology Services	Psychology, Physical therapy and, occupational therapy, speech pathology and audiological services are covered when provided by persons who meet the appropriate requirements	X^{1,1,2*}	X^{1,1,2}	X^{1,1,2*}	X^{1,1,2}	X^{1,1,2}	X^{1,1,2}
Psychotherapeutic drugs	Services not covered under the State Plan	Psychotherapeutic drugs that are listed in the Medi-Cal Provider Manual	X	X	X⁸	X	X	X
Rehabilitation Center Outpatient Services	Rehabilitative Services	A facility providing therapy and training for rehabilitation <u>on an outpatient basis</u> . The center may offer occupational therapy, physical therapy, vocational training, and special training.	X	X	X	X	X	X
Rehabilitation Center Services	Rehabilitative Services	A facility which provides an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.	X	X	X	X	X	X

**Attachment N
Capitated Benefits Provided in Managed Care**

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Renal Homotransplantation	Organ Transplant Services	Renal homotransplantation is covered only when performed in a hospital which meets the standards established by the Department for renal homotransplantation centers.	X	X	X	X	X	X
Requirements Applicable to EPSDT Supplemental Services.	EPSDT	Early and Periodic Screening, Diagnosis and Treatment: for beneficiaries under 21 years of age; includes case management and supplemental nursing services; also covered by CCS for CCS services, and Mental Health services.	X	X	X	X	X	X
Respiratory Care Services	Respiratory Care Services	A provider trained and licensed for respiratory care to provide therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities affecting the pulmonary system and aspects of cardiopulmonary and other systems.	X	X	X	X	X	X
Rural Health Clinic Services	Rural Health Clinic Services	Services described in 42 U.S.C. Section 1396d(a)(2)(B) furnished by a rural health clinic as defined in 42 U.S.C. Section 1396d(l)(1) Covers primary care services by a physician or a non-physician medical practitioner, as well as any supplies incident to these services; home nursing services; and any other outpatient services, supplies, and equipment and drugs.	X⁸ X	X⁸ X	X⁸ X	X⁸ X	X⁸ X	X⁸ X
Scope of Sign Language Interpreter Services	Sign Language Interpreter Services	Sign language interpreter services may be utilized for medically necessary health care services	X	X	X	X	X	X
Services provided in a State or Federal Hospital		California state hospitals provide inpatient treatment services for Californians with serious mental illnesses. Federal hospitals provide services for certain populations, such as the military, for which the federal government is responsible.						

**Attachment N
Capitated Benefits Provided in Managed Care**

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Short-Doyle Mental Health Medi-Cal Program Services	Short-Doyle Program	Community mental health services provided by Short-Doyle Medi-Cal providers to Medi-Cal beneficiaries are covered by the Medi-Cal program.						
Skilled Nursing Facility Services ⁷	Nursing Facility Services and Skilled Nursing Facility Services	A skilled nursing facility is any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program.	X ⁵ X ^{3,965}	X ⁵ X ^{3,965}	X	X ⁵ X ³	X ⁵ X ³	X ⁵ X ³
Special Private Duty Nursing	Private Duty Nursing Services ^{EPSDT}	Private duty nursing is the planning of care and care of clients by nurses, whether a registered nurse or licensed practical nurse.	X ⁶⁷	X ⁶⁷	X ⁶⁷	X ⁶⁷	X ⁶⁷	X ⁷⁶
Specialty Mental Health Services		Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.						
Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities	Special Rehabilitative Services	Specialized rehabilitative services shall be covered. Such service shall include the medically necessary continuation of treatment services initiated in the hospital or short term intensive therapy expected to produce recovery of function leading to either (1) a sustained higher level of self care and discharge to home or (2) a lower level of care. Specialized rehabilitation service shall be covered.	X ⁵ X ³	X ⁵ X ³	X	X ⁵ X ³	X ⁵ X ³	X ⁵ X ³

Attachment N
Capitated Benefits Provided in Managed Care

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

<u>Speech Pathology</u>	<u>Speech Pathology</u>	<u>Speech pathology services are covered when provided by persons who meet the appropriate requirements</u>	<u>X¹</u>	<u>X¹</u>	<u>X¹</u>	<u>X¹</u>	<u>X¹</u>	<u>X¹</u>
State Supported Services		State funded abortion services that are provided through a secondary contract.	X	X	X	X	X	X

**Attachment N
Capitated Benefits Provided in Managed Care**

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Subacute Care Services	Nursing Facility Services and Skilled Subacute Care Services SNF	Subacute care services are a type of skilled nursing facility service, which is provided by a subacute care unit.	X ⁵ X ^{3,965}	X ⁵ X ^{3,965}	X	X ⁵ X ³	X ⁵ X ³	X ⁵ X ³
Swing Bed Services	Inpatient Hospital Services	Swing bed services is additional inpatient care services for those who qualify and need additional care before returning home.	X	X	X	X	X	X
Targeted Case Management Services Program	Targeted Case Management	Persons who are eligible to receive targeted case management services shall consist of the following Medi-Cal beneficiary groups: high risk, persons who have language or other comprehension barriers and persons who are 18 years of age and older.						
Targeted Case Management <u>and</u> Services-	Targeted Case Management	<u>Persons who are eligible to receive targeted case management services shall consist of the following Medi-Cal beneficiary groups: high risk, persons who have language or other comprehension barriers and persons who are 18 years of age and older.</u> Targeted case management services shall include at least one of the following service components: A documented assessment identifying the beneficiary's needs, development of a comprehensive, written, individual service plan, implementation of the service plan includes linkage and consultation with and referral to providers of service, assistance with accessing the services identified in the service plan, crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or						

Attachment N
Capitated Benefits Provided in Managed Care

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

		reduce a crisis situation for a specific beneficiary, periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified or discontinued.							
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**Attachment N
Capitated Benefits Provided in Managed Care**

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Transitional Inpatient Care Services	Nursing Facility and Transitional Inpatient Care Services	Focus on transition of care from outpatient to inpatient. Inpatient care coordinators, along with providers from varying settings along the care continuum, should provide a safe and quality transition.	X	X	X	X	X	X
Tuberculosis (TB) Related Services	TB Related Services	Covers TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.						

¹ ~~Chiropractic Optional benefits-Optional benefits~~ coverage is limited to only beneficiaries in “Exempt Groups”:
 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities; 3) beneficiaries who are pregnant; 4) CCS beneficiaries; 5) beneficiaries enrolled in the PACE; and 6) beneficiaries who receive services at an FQHC (including Tribal) or RHC. Services include: Chiropractic Services, Audiologist and Audiology Services, and Speech Pathology.

² Services provided by primary care physicians; psychiatrists; psychologists; licensed clinical social workers; or other specialty mental health provider. Solano County for Partnership Health plan (COHS) covers specialty mental health, and Kaiser GMC covers inpatient, outpatient, and specialty mental health services.

³ ~~Fabrication of optical lenses only covered by GenCal Health.~~

⁴ ~~Not covered by GenCal~~ Covered by GenCal as of 7/1/2016

⁵⁻³ ~~Only covered for the month of admission and the following month.~~

⁶⁻⁴ ~~Not covered by Gold Coast Health Plan.~~

Attachment N
Capitated Benefits Provided in Managed Care

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Covered by CenCal Health, Central California Alliance for Health, and Health Plan of San Mateo (effective July 1, 2018). Covered by Partnership HealthPlan of California (effective January 1, 2019) and CalOptima (effective January July 1, 2019).

~~⁷⁻⁵Only covered in Health Plan of San Mateo and CalOptima.~~

~~⁸Only covered in Health Plan of San Mateo~~

~~⁹⁻⁶⁵Services covered under managed care only in MLTSS Eligible Beneficiary Authorized Counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara, and Riverside. IHSS benefits are not part of this covered service.~~

~~¹⁰⁻⁷⁶Benefit coverage is limited to only beneficiaries under 21 years of age for services rendered pursuant to EPSDT program requirements.~~

~~¹¹⁻⁸⁻⁷Health Home Program (HHP) service coverage is limited to only those beneficiaries specified in the HHP State Plan Amendments (SPAs), including any subsequent amendments to the CMS-approved HHP SPAs. HHP services will be provided only through the Medi-Cal managed care delivery system to beneficiaries enrolled in managed care. Individuals receiving benefits through the fee-for-service (FFS) delivery system who meet HHP eligibility criteria, and who wish to receive HHP services, must instead enroll in an MCP to receive all services, including HHP services. HHP services will not be provided through a FFS delivery system. The HHP-specific provisions of the Medi-Cal 2020 demonstration freedom of choice waiver, and managed care delivery system implementation Medicaid authority, are in effect for any CMS-approved HHP SPAs - including SPA requirements specific to eligible populations, geographic limitation approved providers, and any other SPA requirements, including any subsequent amendments to the CMS- approved HHP SPAs -for the duration of the Medi-Cal 2020 demonstration.~~

Attachment N

Capitated Benefits Provided in Managed Care

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

⁸The fabrication of eyeglasses lenses are carved out statewide to FFS Medi-Cal contracted optical laboratories, except specialty lenses, including lenses that exceed contract lab ranges.

⁹California Children Services covered in COHS counties with the exception of Ventura County (Gold Coast Health Plan)

Exhibit B



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FW: CA Medi-Cal 2020 Attachment N Updates for Pharmacy Carve-out



[Redacted Name]
[Redacted Email Address]

[Redacted]

[Redacted]

Attachment N Updates ...
119 KB

Attachment N Updates ...
104 KB

Show all 2 attachments (223 KB) Download all

[Redacted]

From: Font, Amanda@DHCS <Amanda.Font@dhcs.ca.gov>
Sent: Thursday, December 24, 2020 10:17 AM
To: Ross, Heather V. (CMS/CMCS) <Heather.Ross@cms.hhs.gov>; Nawara, Lorraine (CMS/CMCS) <Lorraine.Nawara1@cms.hhs.gov>; Taylor, Julian (CMS/CMCS) <Julian.Taylor@cms.hhs.gov>
Cc: Young, Cheryl (CMS/CMCS) <Cheryl.Young@cms.hhs.gov>; Zolynas, Brian (CMS/CMCS) <Brian.Zolynas@cms.hhs.gov>; Cooper, Jacey@DHCS <Jacey.Cooper@dhcs.ca.gov>; Toyama, Aaron@DHCS <Aaron.Toyama@dhcs.ca.gov>; McGowan, Benjamin@DHCS <Benjamin.McGowan@dhcs.ca.gov>; Dodson, Anastasia@DHCS <Anastasia.Dodson@dhcs.ca.gov>; Davis, Kirk@DHCS <Kirk.Davis@dhcs.ca.gov>; Cisneros, Bambi@DHCS <Bambi.Cisneros@dhcs.ca.gov>; Retke, Michelle@DHCS <Michelle.Retke@dhcs.ca.gov>; Lee, Angeli@DHCS <Angeli.Lee@dhcs.ca.gov>
Subject: CA Medi-Cal 2020 Attachment N Updates for Pharmacy Carve-out

Good Morning,

DHCS formally submits the attached updated Attachment N as a technical amendment request to the California Medi-Cal 2020 Demonstration Special Terms and Conditions (STCs).

Changes to Capitated Benefits Provided in Managed Care (Attachment N), an attachment to the California Medi-Cal 2020 Demonstration STCs, stem from recent legislative or administrative changes in Medi-Cal benefit policy including but not limited to the California State Auditor's assessment of the efficacy of preventive care services for children, the State's Medi-Cal Rx initiative, and the restoration of optional benefits as a result of SB 78 and AB 678. These changes are proposed to be effective on January 1, 2021, in conjunction with the State's request to extend the Medi-Cal 2020 Demonstration for 12 months, which is currently under CMS review.

Changes to Attachment N include:

- Clarification of capitated benefits categorized under the Early and Periodic Screening, Diagnostic and Treatment entitlement.

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- In-Home Medical Care Waiver Services was removed.
- Other services updated for clarification include: hysterectomy within all managed care model types and non-emergency medical transportation.
- Updates were made to previously optional benefits, such as fabrication of lenses and the provision of podiatry services with prior authorization.
- Alameda county was removed from the list of Coordinated Care Initiative (CCI) counties.
- Updates to service definitions for dental and outpatient mental health and outpatient rehabilitative services, Federally Qualified Health Care Centers (FQHCs), and Rural Health Clinics.
- Footnotes were appropriately updated to reflect all changes.

Please let us know if CMS has any questions on this amendment request. Thank you, and happy holidays!

Amanda Font
California Department of Health Care Services
Director's Office



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Exhibit C



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FW: CA Medi-Cal 2020 Attachment N Updates for Pharmacy Carve-out

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

From: Ross, Heather V. (CMS/CMCS) <Heather.Ross@cms.hhs.gov>
Sent: Tuesday, December 29, 2020 3:35 AM
To: Font, Amanda@DHCS <Amanda.Font@dhcs.ca.gov>; Nawara, Lorraine (CMS/CMCS) <Lorraine.Nawara1@cms.hhs.gov>; Taylor, Julian (CMS/CMCS) <Julian.Taylor@cms.hhs.gov>
Cc: Young, Cheryl (CMS/CMCS) <Cheryl.Young@cms.hhs.gov>; Zolynas, Brian (CMS/CMCS) <Brian.Zolynas@cms.hhs.gov>; Cooper, Jacey@DHCS <Jacey.Cooper@dhcs.ca.gov>; Toyama, Aaron@DHCS <Aaron.Toyama@dhcs.ca.gov>; McGowan, Benjamin@DHCS <Benjamin.McGowan@dhcs.ca.gov>; Dodson, Anastasia@DHCS <Anastasia.Dodson@dhcs.ca.gov>; Davis, Kirk@DHCS <Kirk.Davis@dhcs.ca.gov>; Cisneros, Bambi@DHCS <Bambi.Cisneros@dhcs.ca.gov>; Retke, Michelle@DHCS <Michelle.Retke@dhcs.ca.gov>; Lee, Angeli@DHCS <Angeli.Lee@dhcs.ca.gov>
Subject: RE: CA Medi-Cal 2020 Attachment N Updates for Pharmacy Carve-out

Good morning Amanda,

Thank you for the information. CMS will review the attachment. I would like to let the state know that CMS will not be incorporating this attachment into the STCs for the temporary extension request for December 31, 2020, but we are going to review the information to be updated to the STCs with the other updates to the CA STCs within the state's original extension request. CMS understands that the pharmacy update is not to happen until April 1, 2021 and we are working to make sure this attachment will be incorporated before that time.

If you have additional questions, please reach out to Julian Taylor and myself to discuss.

Thank you
Heather Ross

From: Font, Amanda@DHCS <Amanda.Font@dhcs.ca.gov>
Sent: Thursday, December 24, 2020 1:17 PM
To: Ross, Heather V. (CMS/CMCS) <Heather.Ross@cms.hhs.gov>; Nawara, Lorraine (CMS/CMCS) <Lorraine.Nawara1@cms.hhs.gov>; Taylor, Julian (CMS/CMCS) <Julian.Taylor@cms.hhs.gov>

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<Aaron.Toyama@dhcs.ca.gov>; McGowan, Benjamin@DHCS <Benjamin.McGowan@dhcs.ca.gov>; Dodson, Anastasia@DHCS <Anastasia.Dodson@dhcs.ca.gov>; Davis, Kirk@DHCS <Kirk.Davis@dhcs.ca.gov>; Cisneros, Bambi@DHCS <Bambi.Cisneros@dhcs.ca.gov>; Retke, Michelle@DHCS <Michelle.Retke@dhcs.ca.gov>; Lee, Angeli@DHCS <Angeli.Lee@dhcs.ca.gov>

Subject: CA Medi-Cal 2020 Attachment N Updates for Pharmacy Carve-out

Good Morning,

DHCS formally submits the attached updated Attachment N as a technical amendment request to the California Medi-Cal 2020 Demonstration Special Terms and Conditions (STCs).

Changes to Capitated Benefits Provided in Managed Care (Attachment N), an attachment to the California Medi-Cal 2020 Demonstration STCs, stem from recent legislative or administrative changes in Medi-Cal benefit policy including but not limited to the California State Auditor's assessment of the efficacy of preventive care services for children, the State's Medi-Cal Rx initiative, and the restoration of optional benefits as a result of SB 78 and AB 678. These changes are proposed to be effective on January 1, 2021, in conjunction with the State's request to extend the Medi-Cal 2020 Demonstration for 12 months, which is currently under CMS review.

Changes to Attachment N include:

- Clarification of capitated benefits categorized under the Early and Periodic Screening, Diagnostic and Treatment entitlement.
- Clarification of specific drug and medical supplies categories both prior to, and after, the April 1, 2021 implementation of Medi-Cal Rx, to make necessary updates associated with Medi-Cal Rx initiative.
- In-Home Medical Care Waiver Services was removed.
- Other services updated for clarification include: hysterectomy within all managed care model types and non-emergency medical transportation.
- Updates were made to previously optional benefits, such as fabrication of lenses and the provision of podiatry services with prior authorization.
- Alameda county was removed from the list of Coordinated Care Initiative (CCI) counties.
- Updates to service definitions for dental and outpatient mental health and outpatient rehabilitative services, Federally Qualified Health Care Centers (FQHCs), and Rural Health Clinics.
- Footnotes were appropriately updated to reflect all changes.

Please let us know if CMS has any questions on this amendment request. Thank you, and happy holidays!

Amanda Font
California Department of Health Care Services
Director's Office



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Exhibit D



Christopher M. House

From: caed_cmecf_helpdesk@caed.uscourts.gov
Sent: Tuesday, March 9, 2021 4:14 PM
To: CourtMail@caed.uscourts.dcn
Subject: [EXTERNAL] Activity in Case 2:20-cv-02171-JAM-KJN Community Health Center Alliance for Patient Access et al v. Lightbourne et al Order on Motion to Dismiss.

This is an automatic e-mail message generated by the CM/ECF system. Please DO NOT RESPOND to this e-mail because the mail box is unattended.

*****NOTE TO PUBLIC ACCESS USERS***** Judicial Conference of the United States policy permits attorneys of record and parties in a case (including pro se litigants) to receive one free electronic copy of all documents filed electronically, if receipt is required by law or directed by the filer. PACER access fees apply to all other users. To avoid later charges, download a copy of each document during this first viewing. However, if the referenced document is a transcript, the free copy and 30 page limit do not apply.

U.S. District Court

Eastern District of California - Live System

Notice of Electronic Filing

The following transaction was entered on 3/9/2021 at 4:13 PM PST and filed on 3/9/2021

Case Name: Community Health Center Alliance for Patient Access et al v. Lightbourne et al

Case Number: [2:20-cv-02171-JAM-KJN](#)

Filer:

Document Number: 37(No document attached)

Docket Text:

MINUTES for proceedings held via video conference before District Judge John A. Mendez: MOTION HEARING re Plaintiffs' pending [22] Motion for Preliminary Injunction and Defendants' pending [23] Motion to Dismiss held on 3/9/2021. A. Stroud, R. Boyle and K. Doi appeared via video for the plaintiffs. J. Sondheimer appeared via video for the defendants. The Court and Counsel discussed Plaintiffs' pending Motion for Preliminary Injunction and Defendants' pending Motion to Dismiss. After arguments, for the reasons stated on the record, the Court GRANTED Defendants' [23] Motion to Dismiss without prejudice and ORDERED Plaintiffs wait to file an amended complaint until after CMS acts on the approval sought by Defendants. Court Reporter: J. Coulthard. [TEXT ONLY ENTRY] (Michel, G.)

2:20-cv-02171-JAM-KJN Notice has been electronically mailed to:

Andrew W. Stroud astroud@hansonbridgett.com, calendarclerk@hansonbridgett.com,
MFrancis@hansonbridgett.com

Anjana N. Gunn anjana.gunn@doj.ca.gov, adayananthan@gmail.com

Darrell Warren Spence darrell.spence@doj.ca.gov

Joshua Sondheimer joshua.sondheimer@doj.ca.gov, nora.lyman@doj.ca.gov, rowena.manalastas@doj.ca.gov

Kathryn Ellen Doi kdoi@hansonbridgett.com, CalendarClerk@hansonbridgett.com,
chouse@hansonbridgett.com, mfrancis@hansonbridgett.com

Regina Mary Boyle rboyle@cliniclaw.com

Tara L. Newman tara.newman@doj.ca.gov, tnewman@gmail.com

2:20-cv-02171-JAM-KJN Electronically filed documents must be served conventionally by the filer to:

Exhibit E



From: DHCS Communications <DHCSCommunications@DHCS.CA.GOV>
Sent: Wednesday, February 17, 2021 5:12 PM
To: DHCSSTAKEHOLDERS@MAILLIST.DHCS.CA.GOV
Subject: [EXTERNAL] Important Update on Medi-Cal Rx

Dear Stakeholders,

The Department of Health Care Services (DHCS) is delaying the planned Go Live date of April 1, 2021, for Medi-Cal Rx because of the need to review new conflict avoidance protocols submitted by Magellan Health, the project's contracted vendor.

In January 2021, Centene Corporation announced that it plans to acquire Magellan. Centene operates – through subsidiaries – managed care plans and pharmacies that participate in Medi-Cal. This transaction was unexpected and requires additional time for exploration of acceptable conflict avoidance protocols to ensure that there will be acceptable firewalls between the corporate entities to protect the pharmacy claims data of all Medi-Cal beneficiaries, and to protect other proprietary information.

Medi-Cal Rx remains of utmost importance to the State of California as a tool to standardize the Medi-Cal pharmacy benefit statewide under one delivery system. It will improve access to pharmacy services with a network that includes approximately 94 percent of the state's pharmacies. Medi-Cal Rx will also apply statewide utilization management protocols to all outpatient drugs, standardizing the experience for all Medi-Cal beneficiaries and providers. Medi-Cal Rx will also strengthen California's ability to negotiate state supplemental drug rebates with drug manufacturers, helping to reduce pharmaceutical costs.

DHCS anticipates providing further information in May.

If you have any questions, please feel free to direct them to the Medi-Cal Rx Project Team at RxCarveOut@dhcs.ca.gov.

Thank you,
DHCS

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From: Medi-Cal Rx Education and Outreach Team <postmaster@dhcs.ca.gov>
Sent: Wednesday, February 17, 2021 5:53 PM
To: Kathryn E. Doi
Subject: [EXTERNAL] Medi-Cal Rx News: Important Update on Medi-Cal Rx

MCRxSS Announcement

The [Important Update on Medi-Cal Rx](#) alert posted to the Medi-Cal Rx Web Portal on 2/17/2021.

If the above link does not take you to the alert, then simply copy and paste the following link into your browser to access the Bulletins and News page: <https://medi-calrx.dhcs.ca.gov/provider/pharmacy-news>.

***Please note: Internet Explorer is no longer a supported web browser. Please utilize Chrome, Microsoft Edge, or another supported web browser when clicking on links for the Medi-Cal Rx Web Portal.



Our Mailing Address is:

P.O. Box 2088 Rancho Cordova, CA 95741-2088, United States

[Unsubscribe](#)



Important Update on Medi-Cal Rx

February 17, 2021

The Department of Health Care Services (DHCS) is delaying the planned Go-Live date of April 1, 2021, for Medi-Cal Rx because of the need to review new conflict avoidance protocols submitted by Magellan Health, Inc. (Magellan), the project's contracted vendor.

In January 2021, Centene Corporation announced that it plans to acquire Magellan. Centene operates – through subsidiaries – managed care plans and pharmacies that participate in Medi-Cal. This transaction was unexpected and requires additional time for exploration of acceptable conflict avoidance protocols to ensure that there will be acceptable firewalls between the corporate entities to protect the pharmacy claims data of all Medi-Cal beneficiaries, and to protect other proprietary information.

Medi-Cal Rx remains of utmost importance to the State of California as a tool to standardize the Medi-Cal pharmacy benefit statewide under one delivery system. It will improve access to pharmacy services with a network that includes approximately 94 percent of the state's pharmacies. Medi-Cal Rx will also apply statewide utilization management protocols to all outpatient drugs, standardizing the experience for all Medi-Cal beneficiaries and providers. In addition, Medi-Cal Rx will strengthen California's ability to negotiate state supplemental drug rebates with drug manufacturers, helping to reduce pharmaceutical costs.

DHCS anticipates providing further information in May. Please note that DHCS will be working to update and/or remove, as applicable, provider guidance and associated Medi-Cal Rx provider bulletins/Newsflash articles in the coming weeks to reflect this change.

Exhibit B
to letter dated 4/16/2021

1 HANSON BRIDGETT LLP
KATHRYN E. DOI, SBN 121979
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4 Facsimile: (916) 442-2348
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6 REGINA M. BOYLE, SBN 164181
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10 Attorneys for Plaintiffs
COMMUNITY HEALTH CENTER ALLIANCE
11 FOR PATIENT ACCESS, ET AL.

12
13 **UNITED STATES DISTRICT COURT**
14 **EASTERN DISTRICT OF CALIFORNIA, SACRAMENTO DIVISION**

15
16 COMMUNITY HEALTH CENTER
ALLIANCE FOR PATIENT ACCESS, et
17 al.,

18 Plaintiffs,

19 v.

20 WILLIAM LIGHTBOURNE, Director of the
California Department of Health Care
21 Services, CALIFORNIA DEPARTMENT
OF HEALTH CARE SERVICES.

22 Defendants.
23

Case No. 2:20-CV-02171-JAM-KJN

**DECLARATION OF FRANCISCO
CASTILLON IN SUPPORT OF
PLAINTIFFS' MOTION FOR A
PRELIMINARY INJUNCTION**

Judge: Hon. John A. Mendez
Date: March 9, 2021
Time: 1:30 p.m.
Crtrm.: 6

24
25 I, Francisco Castillon, declare as follows:

26 1. I am the Chief Executive Officer ("CEO") at Omni Family Health ("OFH")
27 and have held this role since May 2011. As CEO, I am responsible for overseeing the
28 organization of thirty-five (35) health centers and four (4) pharmacies. In addition, I have

1 oversight of OFH's 340B Program. I have reviewed the data relevant to impact of the
2 Medi-Cal Rx Transition on OFH in connection with the preparation of this declaration. I
3 have personal knowledge of the facts set forth herein, and if called to do so, could and
4 would testify competently thereto. I make this declaration in support of the plaintiffs'
5 motion for a preliminary injunction.

6 2. OFH is a Federally-Qualified Health Center ("FQHC") that receives federal
7 grant funds under Section 330 of the Public Health Service Act that meets all
8 requirements in Section 330 of the Public Health Service Act. OFH has been in business
9 since 1978 and operates health centers in Kern, Fresno, Tulare, and Kings Counties.

10 3. OFH provides pharmaceutical services through four licensed pharmacies
11 and two clinic dispensaries, as well as through eighty (80) 340B contract pharmacies.

12 4. In order to comply with applicable State and Federal law relating to the
13 340B program OFH has registered each of our FQHC sites that dispenses drugs to Medi-
14 Cal beneficiaries in the Medicaid Exclusion File, indicating that we dispense only 340B
15 drugs to our Medi-Cal patients.

16 5. In 2019 our cost of providing pharmacy services, including the cost of
17 pharmaceuticals, through in-house pharmacies, contract pharmacies and our clinic
18 dispensary license was \$7,085,757.00

19 6. Approximately seventy percent of the patients utilizing our pharmacy
20 services were Medi-Cal beneficiaries, thus Medi-Cal's share of the total cost was
21 approximately \$4,960,029.90.

22 7. OFH carved its pharmacy services costs out of our Medi-Cal prospective
23 payment rate as to our in-house and contract pharmacy services, and is currently
24 reimbursed for these services under the fee schedules applicable to California's
25 Alternative Payment Methodology ("APM"). As a practical matter, this means that we are
26 reimbursed by Medi-Cal managed care plans at a negotiated rate under the APM.

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1 8. OFH does not dispense 340B drugs (or any drugs) to Medi-Cal
2 beneficiaries who are reimbursed by Medi-Cal's fee-for-service system through contract
3 pharmacies.

4 9. OFH's in-house pharmacies dispense an extremely limited volume of drugs
5 to Medi-Cal fee-for-service beneficiaries since the majority of our Medi-Cal patients are
6 enrolled in managed care plans. Medicaid managed care plans, under non-
7 discrimination provisions of State and Federal law, are prohibited from paying FQHCs
8 less than they pay to other health care providers furnishing similar services.

9 10. Fee-for-service reimbursement paid to 340B Covered Entities, including
10 OFH, is limited to the "actual acquisition cost for the drug, as charged by the
11 manufacturer at a price consistent with Section 256b of Title 42 of the United States
12 Code, plus the professional dispensing fee" of either \$10.05 or \$13.20, depending on the
13 pharmacy's dispensing volume. This has not had a significant negative impact on OFH
14 to-date, since we have had few prescriptions reimbursed under this methodology.

15 11. Under this fee-for-service reimbursement methodology, however, the cost
16 of the drug must be determined by the FQHC on a claim-by-claim basis, which would
17 eliminate the benefit intended for the 340B program (allowing us to stretch scarce federal
18 resources through the gap between generally applicable reimbursement and the special
19 discount accorded 340B covered entities), but it would significantly increase our
20 administrative and facility costs associated with dispensing these drugs, since we would
21 no longer be able to fill Medi-Cal prescriptions through low-cost contract pharmacies.

22 12. If the Medi-Cal Rx Transition became effective on April 1, 2021,
23 approximately seventy percent of our prescriptions would be filled through Medi-Cal's
24 340B-specific fee-for-service reimbursement schedule. This will require changes to our
25 current operations, which may include discontinuing home delivery of drugs to those
26 unable to come to the clinic for health reasons or due to a lack of transportation.
27 Additionally, we would need to discontinue stocking of more expensive medications.

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1 13. If the Medi-Cal Rx Transition became effective, there is a risk that we will
2 have to close the two pharmacies that are carved into our PPS rate, since we are not
3 reimbursed for the cost of these drugs except through a historical assessment of costs
4 that has not kept up with the changes in drug prices, and since we are not reimbursed for
5 pharmacy visits on a per-visit basis. These two pharmacies serve agricultural, rural
6 areas, in which many of our patients are undocumented, and for whom filling
7 prescriptions through our health center is the sole available option. Many of our patients
8 have no access to a pharmacy within a 30-minute drive. We are currently able to fill their
9 prescriptions for the uninsured on a sliding fee scale, consistent with the "open door"
10 requirements applicable to health centers. If we are unable to continue providing
11 pharmaceutical services to these patients at our current level, there will be a severe
12 impact on the quality of care we are able to provide. Our most vulnerable patients will not
13 be able to receive required medications from us, and unless they are able to find another
14 source of care, will likely discontinue taking medications. This would particularly impact
15 patients with diabetes, heart conditions, and patients receiving treatment for opioid
16 addiction through our Medication Assistant Therapy ("MAT") program. Many of our
17 migrant farmworker patients are working in the field all day. They cannot just pop into a
18 local pharmacy, particularly if ours is forced to close.

19 14. California law requires FQHCs that are reimbursed for pharmaceutical
20 services outside of their PPS rate to be reimbursed for drugs dispensed to Medi-Cal
21 beneficiaries through a dispensary in accordance with Welfare & Inst. Code § 14132.01.
22 With the exception of Medi-Cal beneficiaries enrolled in the Family Planning Access Care
23 and Treatment Program ("Family PACT"), there is currently no billing system in place that
24 would permit us to be reimbursed under this statute.

25 15. Additionally, our reimbursement for Family PACT drugs has at no time been
26 assessed by DHCS to ensure that it fully covers our cost of providing such services.

27 16. According to the Uniform Data System ("UDS") report that OFH submitted
28 to the federal Health Resources and Services Administration ("HRSA") for 2019, OFH

1 provided primary care services to 131,449 unduplicated patients, and had 588,936
2 patient visits (encounters). The distribution of OFH patients as a percentage of poverty
3 guidelines is 62,160 patients (47.29%) at 100 percent and below the federal poverty
4 level; 10,102 patients (7.69%) at 101 to 150 percent of the federal poverty level; 4,009
5 patients (3.05%) at 151 to 200 percent of the federal poverty level; 2,433 patients
6 (1.85%) at over 200 percent of the federal poverty level; and 52,745 patients (40.13%)
7 whose percent of the federal poverty level is unknown.

8 17. OFH also reported the following with respect to the special populations
9 served by our clinics: Migrant/Seasonal = 41,735 patients, Homeless patients = 647, and
10 Veterans = 163.

11 18. The UDS report also captured OFH's demographic makeup, the largest
12 categories consist of the following: Hispanic/Latino = 52,573 and White Non-
13 Hispanic/Latino = 27,644, followed by African American = 5,582.

14 19. As reported on our UDS report, with respect to OFH visits involving patients
15 with two or more diseases/diagnoses, the most common diseases/diagnoses involved
16 were: Diabetes Mellitus = 37,494 visits, Overweight and Obesity = 48,295, Hypertension
17 = 52,168, and Heart Disease = 4,747. In addition, the most common visits provided for
18 mental health conditions and substance disorders were: anxiety disorder/PTSD = 37,001,
19 depression and mood disorders = 39,324, and other mental disorders (excluding drug or
20 alcohol dependence) = 22,011.

21 20. OFH's participation in the 340B Drug Pricing Program helps it to stretch
22 scarce resources and meet the needs of its medically underserved patients, including
23 uninsured and underinsured patients. Federal law and regulations, as well as OFH's
24 mission, require that every penny of 340B savings be invested in services that expand
25 access for its medically underserved patient population. OFH passes the 340B savings
26 on to its patients by providing uninsured patients of OFH making less than 200 percent of
27 the federal poverty limit a sliding scale discount on all services including significant
28 discounts for medication at OFH's in-house pharmacy. In addition to providing access to

1 affordable medications for low-income uninsured patients through our sliding scale
 2 discount and other prescription savings programs, OFH's 340B savings are reinvested
 3 into the cost of providing services that the Medi-Cal program does not include in OFH's
 4 prospective payment system per-visit rate, such as having in-house outreach staff, case
 5 managers, care coordinators, referral staff, call center staff, pharmacy technicians, and
 6 other ancillary support that enhance services provided by the primary care team.

7 21. OFH's current 340B prescription drug program includes five (5) onsite and
 8 eighty (80) contract pharmacy sites. From January 1, 2020 through September 30, 2020,
 9 OFH's in-house pharmacies filled 228,791 prescriptions, 26,861 of which were
 10 prescriptions filled for uninsured patients. OFH's 80 contract pharmacies filled nearly
 11 10,000 prescriptions, of which over 10 percent were dispensed for uninsured patients.

12 22. OFH's 2019 UDS report also identified two key payer groups who made up
 13 over 80 percent of the overall payer mix:

14	Medi-Cal Managed Care (MCO)	93,214 patients (71%)
15	Uninsured	13,821 patients (11%)
16	Total	107,035 patients (82%)

17 23. In 2019, OFH recognized an estimated net 340B income (reimbursement
 18 minus drug costs and program overhead) of \$4,200,000 (over 70% of total) from filling
 19 Medi-Cal managed care (MCO) patient prescriptions. This net 340B benefit was and
 20 continues to be used for "stretching scarce Federal resources as far as possible,
 21 reaching more eligible patients and providing more comprehensive services" not typically
 22 covered by Medi-Cal managed care (MCO) including the following. Our fifth pharmacy
 23 having opened only recently, the numbers presented represent the totals from 4
 24 pharmacies.

25 24. Five in-house pharmacies ensure access to affordable prescription drugs
 26 through:

- 27 • Free home delivery and delivery options for patients residing in rural
 28 areas without local pharmacy access.

- 1 ▪ Opening new locations to expand access to services and outreach to
- 2 new patients, including clinic and pharmacy onsite services.
- 3 ▪ Ensuring adequate resource funding for clinic programs and onsite
- 4 pharmacies that have demonstrated nationally having a significant
- 5 positive impact on emergency room utilization, improved coordination
- 6 of care, and improved outcomes for such chronic conditions as
- 7 asthma and diabetes.

8 25. OFH estimates 340B savings generated from our pharmacies through the
9 340B Drug Pricing Program account for about 20 percent of our direct patient care
10 staffing expenses.

11 26. The 340B Drug Pricing Program requires drug manufacturers to provide
12 discounted pharmaceuticals to health centers and other covered entities – which makes
13 the prescriptions affordable for all patients, including the uninsured. In addition, the
14 savings retained by OFH are utilized to serve even more patients and to increase
15 comprehensive services at no cost to the taxpayer. Because of this action taken by
16 California’s Governor to eliminate 340B savings, patient services and programs such as
17 having a call center, referral center, case management, onsite pharmacies, pharmacy
18 technicians, care coordinators, and in-house behavioral services, and dental services are
19 at risk of being significantly reduced or eliminated. This, in turn, puts our patients at risk
20 for increased access to care issues, as well as health problems that increase health care
21 costs to the entire primary care medical home health care system. In addition to the loss
22 of services, higher costs, poorer patient outcomes, and loss of employee positions, losing
23 contract pharmacy 340B savings would negatively affect strategic plans for a much
24 needed facility expansion aimed at increasing our ability to serve more of the uninsured is
25 frightening and will be devastating to the health outcomes of our patients.

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I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 19th day of December 2020, in Sacramento, California.



Francisco Castillon



Exhibit C

to letter dated 4/16/2021

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COMMUNITY HEALTH CENTER ALLIANCE
11 FOR PATIENT ACCESS, ET AL.

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UNITED STATES DISTRICT COURT

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EASTERN DISTRICT OF CALIFORNIA, SACRAMENTO DIVISION

15

16 COMMUNITY HEALTH CENTER
ALLIANCE FOR PATIENT ACCESS, et
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18 Plaintiffs,

19 v.

20 WILLIAM LIGHTBOURNE, Director of the
California Department of Health Care
21 Services, CALIFORNIA DEPARTMENT
OF HEALTH CARE SERVICES.

22 Defendants.
23

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25 I, C. Dean Gemano, declare as follows:

26 1. I am the Chief Executive Officer ("CEO") of Shasta Community Health
27 Center ("SCHC") and have been in this position since 1992. I am a past Board President
28 of the California Primary Care Association ("CPCA") and am currently Board Emeritus

Case No. 2:20-CV-02171-JAM-KJN

**DECLARATION OF C. DEAN GERMANO
IN SUPPORT OF PLAINTIFFS' MOTION
FOR A PRELIMINARY INJUNCTION**

Judge: Hon. John A. Mendez

Date: March 9, 2021

Time: 1:30 p.m.

Crtrm.: 6

1 with CPCA. I am also a past Chair of the Shasta County Public Health Advisory Board,
2 and past-Chair and current member of Golden Umbrella and Senior Nutrition Centers
3 (Dignity Health Affiliates) Advisory Board in Redding, California. I am also past Chair and
4 current member of the Health Alliance of Northern California ("HANC"), an organization
5 that represents Federally Qualified Health Centers ("FQHCs") in the Shasta region,
6 working with hospitals and medical groups to create positive community health systems
7 changes in our region. Beginning in 2006, I was selected to the Board of The California
8 Endowment (the "Endowment"), a \$3+ billion statewide healthcare foundation dedicated
9 to improving the health and well-being of all Californians. In 2012, I served as Vice-Chair
10 of the Board of the Endowment, and then served as its Chair until my nine-year term
11 ended in 2015. I have personal knowledge of the facts set forth herein, and if called to do
12 so, could and would testify competently thereto. I make this declaration in support of the
13 plaintiffs' motion for a preliminary injunction.

14 2. As CEO of SCHC, I am responsible for overseeing care to 40,000
15 unduplicated patients, providing over 130,000 visits a year in a multi-specialty type
16 practice that includes mental health and dental. Over 92% of SCHC's patients live below
17 200% of the federal poverty line. I also have oversight of our 340B Program. For many
18 years, the savings that SCHC has retained through the discounted drug purchase prices
19 available through the 340B program has been used to benefit our patients through such
20 things as the passing of the 340B price to our uninsured and underinsured patients,
21 allowing us to charge many sliding fee patients no more than \$10 for prescriptions at our
22 contract pharmacies, and providing services such as transportation assistance, covering
23 a significant portion of lab costs for sliding fee patients, and covering patient education
24 services and gap funding for departments that are not profitable, such as telemedicine.
25 In 2019, SCHC's 340B Medi-Cal savings totaled \$1.79 million. The Medi-Cal transition to
26 managed care would result in a loss of these savings and would force SCHC to make
27 cuts to these programs that will have a negative impact on patient care and service to our
28 community.

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DECLARATION OF C. DEAN GERMANO IN SUPPORT OF
PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

1 3. Following the Governor’s announcement of the pharmacy transition in
2 January 7, 2019, , the California Primary Care Association (“CPCA”) began to advocate
3 with the Department of Health Care Services (the “Department”) to address the revenue
4 impact that FQHCs were going to experience as a result of the pharmacy transition. I
5 was familiar with these efforts through my participation with CPCA as an emeritus board
6 member and through my active participation in various CPCA committees and meetings.

7 4. The Department ultimately agreed to support legislation that would
8 establish a “supplemental payment pool” (“SPP”), which is intended to compensate
9 community health centers who will lose Medi-Cal managed care 340B savings if the State
10 transitions the pharmaceutical benefit away from managed care plans and into fee for
11 service.

12 5. In connection with establishing the SPP, in the fall of 2019, the Department
13 and CPCA asked community health centers to report their projected loss of 340B savings
14 to the State. According to CPCA, 109 community health centers submitted data to the
15 State and 91 submitted data to CPCA and the State. The total amount of lost savings
16 reported by the community health centers that responded to the data request was
17 \$105 million. CPCA staff and the CPCA board also appointed a “Solutions Team” to
18 work with the Department regarding implementation of the SPP. I was one of the people
19 appointed to the Solutions Team.

20 6. The Governor’s January 2020 budget included the SPP for non-hospital
21 based clinics in the sum of \$105 million (\$52.5 million in State funds; \$52.5 million in
22 presumed federal matching funds). In February 2020, CPCA staff and the Solutions
23 Team met with Department leadership regarding implementation of the SPP.

24 7. In March, COVID-19 hit and the Department’s focus shifted to addressing
25 the pandemic. CPCA and others urged the Newsom Administration to delay the
26 pharmacy transition given the challenges that were already facing FQHCs, which were on
27 the front line of the pandemic serving the low income communities that were

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1 disproportionately impacted by the pandemic. The Administration did not agree to a
2 delay.

3 8. In May, analysts predicted a \$54 billion state budget deficit due to COVID-
4 19. Dozens of programs and services were proposed to be cut in the Governor's May
5 Revise budget, including the \$105 million SPP.

6 9. Ultimately, the SPP was adopted in the Budget Trailer Bill, and codified as
7 California Welfare & Institutions Code § 14105.467, which became effective on June 29,
8 2020. This legislation requires the Department to "establish, implement, and maintain a
9 supplemental payment pool for nonhospital 340B community clinics, subject to an
10 appropriation by the Legislature." Qualifying FQHCs are to receive fee-for-service-based
11 supplemental payments from a fixed-amount payment pool to compensate them for their
12 loss of 340B program revenue.

13 10. Section 14105.467(b) further provides: "Beginning January 1, 2021, and
14 any subsequent fiscal year to the extent funds are appropriated by the Legislature for the
15 purpose described in this section, the department shall make available fee-for-service-
16 based supplemental payments from a fixed-amount payment pool to qualifying
17 nonhospital 340B community clinics in accordance with this section and any terms of
18 federal approval"

19 11. Section 14105.467 also requires the Department to establish a stakeholder
20 process that "shall be utilized to develop and implement the methodology for distribution
21 of supplemental pool payments to qualifying nonhospital 340B community clinics."
22 Section 14105.467 further requires the Department to conduct at least three meetings
23 with stakeholders and to finalize the methodology for distribution no later than October 1,
24 2020.

25 12. Two stakeholder meetings were held in August and September 2020.
26 Some of the Department's articulated goals/requirements for the process included:

27 (a) The federal government (the Centers for Medicare and
28 Medicaid Services, or CMS) would approve the federal matching funds.

1 (b) The purpose of the SPP is to mitigate the impact of the
2 pharmacy transition on community health centers.

3 (c) The SPP would be simple to administer.

4 (d) The SPP will be renewed annually.

5 (e) The SPP will be equitably distributed among the FQHCs
6 losing the benefit of the 340B savings as long as the proposed distribution
7 is acceptable to CMS.

8 13. Unfortunately, accomplishing these goals has been more challenging than
9 anticipated and the October 1, 2020 statutory deadline for finalizing the methodology for
10 distribution is now long past and the methodology for distribution of the SPP is not
11 finalized today, as 2020 comes to a close.

12 14. In addition, CPCA has been told by the Department that the Department will
13 be submitting a State Plan Amendment (“SPA”) to authorize the SPP. To date, based on
14 the information posted on the Department’s website relating to proposed or pending
15 SPAs, no proposed SPA has been submitted relating to the SPP, nor has any other
16 federal approval been requested or obtained for the SPP.

17 15. Some of the challenges with the SPP concept that have surfaced are:

18 (a) Not all FQHCs who will suffer a loss of 340B savings submitted
19 data in response to the 2019 request of CPCA and the Department, such that
20 the \$105 million that was to fund the SPP for the current fiscal year will not
21 fully compensate all FQHCs who are participating in the 340B program for
22 the loss of the 340B revenue.

23 (b) The allocation methodology under discussion would allow
24 FQHCs that did not submit data regarding the loss in 340B savings in
25 response to the 2019 call for data to participate in the SPP, such that FQHCs
26 that did submit data will not be fully reimbursed in the amount reported and
27 FQHCs that did not submit data will receive a share of the SPP.

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1 (c) We have been advised that CMS is requiring that all FQHCs be
2 eligible to participate in the SPP, not just FQHCs that submitted survey data
3 in 2019, and not just FQHCs that will be losing 340B savings. In addition,
4 the proposal is for FQHCs to submit claims for supplemental payments based
5 on submission of *medical claims*, not *pharmacy claims*, such that FQHCs that
6 did not even participate in the 340B program will share in the SPP, and
7 resulting in a further reduction of supplemental payments to the FQHCs that
8 will be losing revenue due to the pharmacy transition. Moreover, FQHCs with
9 high average pharmacy costs but fewer visits would receive less than the
10 amount of their loss in 340B savings and FQHCs with relatively low average
11 pharmacy costs but a high visit count would receive more than the amount of
12 their loss in 340B savings. The only way to prevent this result would be for
13 FQHCs to agree to a redistribution of payments they receive from the Medi-
14 Cal program in order to fulfill the purpose of the SPP, which was to
15 compensate FQHCs who participate in the 340B program for lost savings.
16 This would require an enormous administrative burden and the nearly full
17 cooperation of the health centers, including those who would claim a windfall
18 from this methodology at the expense of those who will otherwise incur real
19 losses as a result of these changes.

20 16. For the foregoing reasons, by all appearances, the SPP will not be a short-
21 or long-term viable solution to address the significant financial impact that the pharmacy
22 transition will have on FQHCs like SCHC.

23 17. Shasta County, where SCHC is located, has been hard hit by COVID-19.
24 SCHC is at the heart of the battle against the COVID-19 pandemic in Shasta County. As
25 the largest community clinic organization serving the area, SCHCs services are provided
26 in an already disadvantaged community and one hit hardest by the pandemic. As
27 evidenced by the positivity rates seen at SCHC, health center patients carry more
28 COVID-19 burden than the general population. Since the onset of the pandemic in

1 March 2020, SCHC has performed 1,883 COVID-19 PCR tests with a 6% overall test
2 positivity rate. SCHC has also performed over 3,231 COVID point-of-care tests (same
3 day results) with an overall positivity rate of 11.7%. These results are taken from the
4 start of the pandemic in March 2020 to December 22, 2020. In the last weeks of
5 November and into December 2020, SCHCs test positivity rate fluctuated between 12
6 and 17.5% for both types of COVID testing. Thus, SCHC, and FQHCs like ours, are at
7 ground zero of the COVID-19 pandemic. Eliminating the savings we realize through the
8 current 340B structure would be devastating to our ability to continue to care for a
9 population with such high test positivity rates. As we near 2021, the drain on SCHC has
10 become even more grave. With high levels of virus in the community, our providers and
11 support staff are becoming positive at higher rates. The staffing shortage that creates
12 along with the dual struggle of increased demand for testing while trying to first vaccinate
13 our own staff and then the high-risk populations we care for put SCHC at particular
14 disadvantage.

15 18. If the pharmacy transition is allowed to move forward on April 1, 2021,
16 SCHC will need to implement an immediate reduction of the amount of prescription drugs
17 we could subsidize for our sliding fee patients. In addition, we would likely cut
18 telemedicine services, which would have a large impact on access to specialists in our
19 largely rural area. Patients, some of whom have little or no transportation, would be
20 forced to travel several hours to access these services, and, as a result of the revenue
21 impact, we would also likely have to cut back transportation assistance. Access to
22 affordable medications and to services such as telemedicine sub-specialty care would be
23 a major set-back in our mostly rural underserved region. The loss of patient education
24 services, that is not typically covered by anyone except maybe through grants, would be
25 a major loss. As a major provider of care for the medically underserved in this region, the
26 loss of access capacity would be felt throughout of community. About a third of our
27 county is low income and we care for about 70% of the low income population, what
28 happens to our programs and services is deeply felt.

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DECLARATION OF C. DEAN GERMANO IN SUPPORT OF
PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

1 19. Over the years, SCHC has submitted change-in-scope-of-services requests
2 (“CSOSRs”) to DHCS in connection with changes in the scope of SCHC’s services that
3 increased costs and constituted grounds for an adjustment to SCHC’s prospective
4 payment system rates. In connection with each of these CSOSRs, at the end of the audit
5 process, DHCS applied the 80% adjustment factor to reduce the increase in SCHC’s
6 actual and reasonable costs by 20% before adding the adjusted increase to SCHC’s PPS
7 rates.

8 20. In my capacity as CEO of SCHC I am also a member of the Board of
9 Directors of Partnership Health Plan of California (“PHP”), a non-profit community based
10 health care organization that contracts with the State to administer Medi-Cal benefits
11 through local care providers, as the Shasta County Community Health Center
12 Representative. In this role, I am familiar with the contract that the State has with Medi-
13 Cal managed care plans like PHP to manage the care of the Medi-Cal beneficiaries who
14 receive their health care through Medi-Cal managed care. One of the most critical
15 elements of the agreement between the State and a Medi-Cal managed care plan is the
16 range of capitated benefits that will be provided to Medi-Cal beneficiaries under the plan,
17 which is reflected in Attachment N to California’s 1115 Waiver. The State pays the
18 managed care plan a capitated rate per patient to manage and coordinate the covered
19 services that are listed on the list of capitated benefits, and the managed care plan is
20 responsible for contracting with downstream providers to provide those services. Thus, a
21 change to the list of capitated benefits provided in managed care is a major substantive
22 change that has a ripple effect from the State to the managed care plans to the providers
23 of health care services to the Medi-Cal beneficiaries who receive those services. Such a
24 change is not a “technical” change because it has a real and substantive impact up and

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1 down the chain relating to the provision of services, including the benefits available to
2 the Medi-Cal beneficiaries who will receive those services.

3 I declare under penalty of perjury under the laws of the United States of America
4 that the foregoing is true and correct.

5 Executed this 22nd day of December, 2020, in Redding, California.

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Exhibit D

to letter dated 4/16/2021

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COMMUNITY HEALTH CENTER ALLIANCE
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12
13 **UNITED STATES DISTRICT COURT**
14 **EASTERN DISTRICT OF CALIFORNIA, SACRAMENTO DIVISION**

15
16 COMMUNITY HEALTH CENTER
ALLIANCE FOR PATIENT ACCESS, et
17 al.,

18 Plaintiffs,

19 v.

20 WILLIAM LIGHTBOURNE, Director of the
California Department of Health Care
Services, CALIFORNIA DEPARTMENT
21 OF HEALTH CARE SERVICES.

22 Defendants.
23

Case No. 2:20-CV-02171-JAM-KJN

**DECLARATION OF RICARDO ROMAN
IN SUPPORT OF PLAINTIFFS' MOTION
FOR A PRELIMINARY INJUNCTION**

**Judge: Hon. John A. Mendez
Date: March 9, 2021
Time: 1:30 p.m.
Crtrm.: 6**

24 I, Ricardo Roman, declare as follows:

25 1. I am the Chief Financial Officer ("CFO") at Family Health Centers of San
26 Diego ("FHCS") and have held this role since September 2010. As CFO, I report
27 directly to the Chief Executive Officer ("CEO") and am responsible for leading and
28

1 overseeing all financial aspects of FHCSO, including accounting, financial reporting,
2 budgeting, and other financial matters. In addition, I am responsible for the oversight of
3 our 340B program. I have reviewed the data and associated outcomes relevant to the
4 impact of the Medi-Cal Rx Transition on FHCSO in connection with the preparation of this
5 declaration. I have personal knowledge of the facts set forth herein, and if called to do
6 so, could and would testify competently thereto. I make this declaration in support of the
7 plaintiffs' motion for a preliminary injunction.

8 2. FHCSO is a Federally Qualified Health Center ("FQHC") that receives
9 federal grant funding under Section 330 of the Public Health Service Act. FHCSO meets
10 all current statutory requirements under Section 330 of the Public Health Service Act.
11 FHCSO has served the medically underserved communities of San Diego County since
12 1970, with the transition of the Chicano Free Clinic to Logan Heights Family Health
13 Center, the flagship clinic of FHCSO. FHCSO has since transformed into the tenth
14 largest health center in the country (47 service delivery sites), providing care to over
15 149,000 patients each year, of whom 90 percent are low income (under 200% of Federal
16 Poverty Level) and 31 percent are uninsured. FHCSO serves all patients regardless of
17 their ability to pay.

18 3. FHCSO provides pharmaceutical services primarily through one hundred
19 and eighty one (181) 340B contract pharmacies.

20 4. In order to comply with applicable State and Federal law relating to the
21 340B program, FHCSO has registered each of our FQHC sites that dispenses drugs to
22 Medi-Cal beneficiaries in the Medicaid Exclusion File, indicating that we dispense only
23 340B drugs to our Medi-Cal fee-for-service patients.

24 5. FHCSO does not dispense 340B drugs (or any drugs) to Medi-Cal
25 beneficiaries who are reimbursed by Medi-Cal's fee-for-service system through contract
26 pharmacies. We exclude the dispensing of 340B drugs to Medi-Cal fee-for-service
27 beneficiaries, in part because the reimbursement does not cover our cost of dispensing
28 drugs under the fee-for-service reimbursement methodology, under which we would be

1 paid at “actual acquisition cost” plus a \$10.05 or \$13.20 dispensing fee.

2 6. FHCS D’s in-house pharmacies dispense an extremely limited volume of
 3 drugs to Medi-Cal fee-for-service beneficiaries since the majority of our Medi-Cal patients
 4 are enrolled in managed care plans. Medicaid managed care plans, under non-
 5 discrimination provisions of State and Federal law, are prohibited from paying FQHCs
 6 less than they pay to other health care providers furnishing similar services.

7 7. Fee-for-service reimbursement paid to 340B Covered Entities, including
 8 FHCS D, is limited to the “actual acquisition cost for the drug, as charged by the
 9 manufacturer at a price consistent with Section 256b of Title 42 of the United States
 10 Code, plus the professional dispensing fee” of either \$10.05 or \$13.20, depending on the
 11 pharmacy’s dispensing volume. This has not had a significant negative impact on
 12 FHCS D to-date, since we have had few prescriptions reimbursed under this
 13 methodology.

14 8. If the Medi-Cal Rx Transition becomes effective on April 1, 2021, we would
 15 entirely discontinue dispensing drugs to Medi-Cal beneficiaries through our contract
 16 pharmacies, and we would need to identify additional funds to subsidize our existing
 17 pharmacy facility and drug costs.

18 9. According to the most recent FHCS D Uniform Data System (UDS) report
 19 submitted to the federal Health Resources & Services Administration (HRSA) for 2019,
 20 FHCS D conducted clinic visits with the following distribution of services for the 149,244
 21 unduplicated FQHC patient population.

22

23 Clinical Service	Number of Patients	Percent of Patients	Number of Visits	Percent of Visits
24 Medical (Primary Care)	126,178	84.54%	457,021	50.73%
25 Dental	24,344	16.31%	70,816	7.86%
26 Mental Health	18,819	12.61%	110,624	12.28%
27 Substance Abuse	1,504	1.01%	18,046	2.00%
28 Other Professional Services	28,844	19.33%	121,286	13.46%

Vision	13,149	8.81%	16,120	1.79%
Enabling Services	28,560	19.14%	107,022	11.88%
Total	N/A	N/A	900,935	100.00%

Note: Total number and percent of patients is not applicable since individual patients may have received more than one visit across the seven categories of patient visits or encounters.

10. The distribution of FHCS D patients as a percentage of federal poverty guidelines in 2019 was 109,876 (73.62%) at or below 100 percent of the federal poverty guideline and 134,225 (89.94%) at or below 200 percent of the federal poverty guideline. Please note: the percent of patients at or below 100 percent of the federal poverty guideline, is included in the value for the patients at or below 200 percent of the federal poverty guideline.

11. In 2019, FHCS D’s payer mix included the following key groupings:

- Medicaid/CHIP 87,330 patients (58.51%)
- None/Uninsured 46,966 patients (31.47%)
- Medicare 8,159 patients (5.47%)
- Other Third-Party Payers 5,688 patients (3.81%)
- Dually Eligible 1,101 patients (.74%)

12. Other population and/or patient important demographic and clinical management-related indicators reported in the 2019 FHCS D filed UDS report included:

Indicator	Number of Patients	Percent of Patients
Special Populations		
Homeless	26,859	18.00%
School-Based	9,131	6.12%
Veterans	1,841	1.23%
Agricultural	1,214	.81%
Age		
Children (<18 years)	36,659	24.56%
Adults (18 to 64 years)	102,429	68.63%
Adults (65 and over)	10,156	6.80%

1	Race		
2	Asian	9,506	6.37%
3	Native Hawaiian/Other Pacific Islander	1,090	.73%
4	Black/African American	13,331	8.93%
5	American Indian/Alaska Native	839	.56%
6	White	91,968	61.62%
7	More than 1 Race	6,249	4.19%
8	Race Unreported/Refused	26,261	17.60%
9	Ethnicity		
10	Hispanic/Latino	81,076	54.33%
11	Non-Hispanic	56,032	37.54%
12	Ethnicity Unreported/Refused	12,136	8.13%
13	Medical Conditions		
14	Hypertension	23,482	15.73%
15	Diabetes	13,015	8.72%
16	Asthma	7,025	4.71%
17	Symptomatic/Asymptomatic HIV	1,361	.91%
18	Prenatal Care Patients		
19	Number of Patients	3,650	100.00%
20	Number of Patients who Delivered	2,017	55.26%
21	Chronic Disease Management		
22	Use of Appropriate Meds for Asthma	1,127	93.70%
23	Statin Therapy for Prevention & Treatment of Cardiovascular Disease	13,663	78.70%
24	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	2,245	89.67%
25	Controlling High Blood Pressure	21,886	69.74%
26	Diabetes: Controlling Hemoglobin A1c	12,656	64.08%
27	% of Patients Seen for Follow-up within 90 days of first ever HIV diagnosis	46	86.96%

28 13. The purpose of the 340B program is to enable covered entities “to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.” FHCS D’s participation in the 340B program allows the organization to stretch scarce resources to meet the needs of the medically underserved residents of San Diego County. This includes the most vulnerable high-risk populations (e.g., uninsured, underinsured, elderly, and disabled patients). Under federal law, regulation, and program guidance, grantee programs are expected to reinvest their 340B net savings directly back into services provided to their patient populations. From July 1, 2018 to June 30, 2019, FHCS D’s 340B onsite pharmacy and contract pharmacy

1 programs recognized total gross revenues from the Medi-Cal managed care ("MCO")
2 patient population of \$13,329,936 with a net program savings (gross revenues less
3 program and drug replenishments costs) of \$5,113,166. FHCS D utilized these net 340B
4 savings to fund the following services and programs in circumstances where health
5 reimbursements do not keep up with the costs.

- 6 • Affordable Patient Medication & Pharmacy Programs
- 7 • HIV and Hep C Patient Screening and Care Management
- 8 • Expanded Patient Vision Services
- 9 • Increased Access to Mobile Medical & Mental Health Services
- 10 • Expanded Older Adult Patient Services
- 11 • Critical Workforce Development Initiatives
- 12 • Expanded Clinical Patient Services
- 13 • Patient Weight Management Program
- 14 • Expanded Patient Health Education
- 15 • Urgent Care Services
- 16 • Patient Clinical Care Coordination/Patient Case Management
- 17 • Expanded Patient Specialty Services
- 18 • Patient Quality Improvement Staff and Programs
- 19 • Clinical Computer Upgrades
- 20 • Clinical Infrastructure Upgrades
- 21 • Patient Substance Abuse and MAT Programs
- 22 • Clinical Lab and Point of Care Testing Upgrades
- 23 • Expanded Podiatry Services
- 24 • Patient Security Control
- 25 • PHI Security and Server Upgrades

26 14. Under HRSA regulation and grantee scope of service requirements and
27 guidance, FQHCs utilize their 340B net savings to:

28

- 1 • Provide uninsured patients with access to prescription drugs paid for
- 2 by the health center;
- 3 • Subsidize care for the patient population with incomes below 200
- 4 percent of federal poverty guidelines who participate in FHCS D's
- 5 sliding-scale payment programs; and
- 6 • Subsidize care not covered under Medi-Cal or other key payers (e.g.,
- 7 Medicare, California Children's Services, etc.).

8 15. FHCS D's MCO patient population accounts for approximately 71 percent of
9 the 340B savings achieved through FHCS D's onsite pharmacy and contract pharmacy
10 programs. From July 1, 2020 to June 30, 2021 (annualized), the FHCS D 340B pharmacy
11 programs are anticipated to generate gross revenues of \$39,107,192 with net program
12 savings (gross revenues minus program and drug replenishment costs) of \$17,256,644.
13 This is based on estimates of filling 709,156 prescriptions (annualized) or 59,096
14 pharmacy claims per month. The estimated loss in net 340B benefits due to the Medi-
15 Cal pharmacy program transition will be \$12,164,687 (71 percent of total net 340B
16 Program savings). These lost savings will have a negative impact on access, targeted
17 patient clinical disease state programs, and enabling services for the most vulnerable
18 patients. As a result, an unnecessary adverse impact will occur in such important quality
19 and cost related indicators including: unnecessary emergency room/urgent care
20 utilization, increased hospital admissions, increases in diabetes complications rates,
21 lower health screening rates, and lower improvement of disease management outcomes.

22 16. The 340B Drug Pricing Program requires drug manufacturers to provide
23 discounted pharmaceuticals to health centers and other covered entities – which makes
24 prescription drugs affordable for all FQHC patients, including the uninsured and
25 underinsured. In addition, the savings retained by FHCS D allow it to continue to serve
26 more patients and to increase comprehensive services at no cost to the taxpayer.
27 Because of the action taken by California's Governor to eliminate 340B savings, patient
28 services and programs described above are at risk of being reduced significantly or

1 eliminated entirely. Patients will see longer wait times for appointments and decreased
2 access to key support services such as patient-centered care coordination. Additionally,
3 there will be an impact to the ratio of provider and clinic support staff to patients, resulting
4 in negative patient outcomes. The Medi-Cal program and entire FQHC medical
5 home/patient-centered care coordination model will have increased costs due to higher
6 emergency room utilization, increased hospitalizations due to complications from chronic
7 diseases (e.g., diabetes, congestive heart failure), and decreased ability to provide such
8 services as diabetes patient support, medication therapy management, and expanded
9 access to primary care, mental health, and substance abuse treatment. Strategic
10 planning involving sustaining necessary resources to support important clinic functions
11 that require more resources, such as outreach, education, care coordination, and
12 diabetes support will be impacted severely. The effect of this pharmacy transition is a
13 major threat to the sustainability of California's primary care safety net program.

14 17. FHCSO is also at the heart of the battle against the COVID-19 pandemic in
15 San Diego County. As the largest community clinic organization serving the area,
16 FHCSO's clinics are located in already disadvantaged communities and those hardest hit
17 by the pandemic. As evidenced by the positivity rates seen at FHCSO, health center
18 patients carry more COVID-19 burden than the general population. Since the pandemic
19 onset, FHCSO has performed 35,213 COVID-19 PCR tests with a 16.9% overall test
20 positivity rate. Despite that high positivity over many months, each week in November
21 and December 2020, our test positivity continued to climb to a current rate of 28.5%,
22 more than double California's current test positivity rate of 12.2%. In short, FHCSO and
23 FQHCs across the state are at ground zero of the COVID-19 pandemic. Eliminating the
24 savings realized through the current 340B structure would be devastating to our ability to
25 continue to care for a population with such high test positivity rates. As we near 2021, the
26 drain on FHCSO resources has made it increasingly difficult to maintain quality
27 healthcare for the communities we serve. With high levels of virus in the community, our
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1 providers and support staff are also testing positive at higher rates than the County
2 average. The resulting personnel shortage and dual struggle of increased demand for
3 testing while trying first to vaccinate our staff and then the high-risk populations we care
4 for are placing an unprecedented burden on our health care delivery system.

5 18. Over the years, FHCS D has submitted change-in-scope-of-services
6 requests ("CSOSRs") to DHCS in connection with changes in the scope of FHCS D's
7 services that increased costs and constituted grounds for an adjustment to FHCS D's
8 prospective payment system rates. In connection with each of these CSOSRs, at the
9 end of the audit process, DHCS applied the 80% adjustment factor to reduce the
10 increase in FHCS D's actual and reasonable costs by 20% before adding the adjusted
11 increase to FHCS D's PPS rates.

12 19. FHCS D has other concerns about the CSOSR process, as well. For
13 example, as part of the CSOSR process, a health center with multiple sites is required to
14 submit a home office cost report in addition to a cost report for each site that is seeking a
15 change to its rate based on a change in the scope of its services. 340B drug costs
16 associated with a health center's contract pharmacy arrangements are not included in the
17 reimbursable costs of the health center because the contract pharmacy (such as a
18 Walgreen's or CVS or corner drug store) incurs all of the costs associated with managing
19 and dispensing the drugs, with the exception of the payment for the replenishment of the
20 drugs, which is paid for by the health center. In connection with an FHCS D CSOSR that
21 is currently under consideration by DHCS, DHCS is proposing to treat FHCS D's 340B
22 drug costs as a non-reimbursable cost center and to allocate an amount of FHCS D's total
23 overhead costs to the non-reimbursable cost center based on the proportion of overall
24 costs represented by the "costs" of the 340B drugs. This proposed adjustment to the
25 home office cost report will result in lower rates for the sites that are undergoing the
26 CSOSR because a disproportionate amount of home office costs will be allocated to the
27 340B drug costs and away from sites that actually use and benefit from the costs
28

1 associated with FHCS's home office. This is just one example of a variety of
2 adjustments made by DHCS to a health center's CSOSR that result in the lowering of the
3 adjustment to the health center's PPS rate in addition to the 20% haircut, also in violation
4 of federal law.

5

6 I declare under penalty of perjury under the laws of the United States of America
7 that the foregoing is true and correct.

8 Executed this 22nd day of December 2020, in San Diego, California.

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Ricardo F

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Exhibit E

to letter dated 4/16/2021

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10 Attorneys for Plaintiffs
 11 COMMUNITY HEALTH CENTER ALLIANCE
 12 FOR PATIENT ACCESS, ET AL.

12 **UNITED STATES DISTRICT COURT**
 13 **EASTERN DISTRICT OF CALIFORNIA, SACRAMENTO DIVISION**

14 COMMUNITY HEALTH CENTER
 15 ALLIANCE FOR PATIENT ACCESS, et
 16 al.,

17 Plaintiffs,

18 v.

19 WILLIAM LIGHTBOURNE, Director of the
 20 California Department of Health Care
 21 Services, CALIFORNIA DEPARTMENT
 22 OF HEALTH CARE SERVICES.

23 Defendants.

Case No. 2:20-CV-02171-JAM-KJN

**DECLARATION OF DAVID BRINKMAN
 IN SUPPORT OF PLAINTIFFS' MOTION
 FOR A PRELIMINARY INJUNCTION**

Judge: Hon. John A. Mendez
 Date: March 9, 2021
 Time: 1:30 p.m.
 Crtrm.: 6

24 I, David Brinkman, declare as follows:

25 1. I am the Chief Executive Officer ("CEO") at Desert AIDS Project ("DAP")
 26 and have held this role since 2006. As CEO, I am responsible for overseeing the
 27 Federally Qualified Health Center ("FQHC") and our 340B Program. I have reviewed the
 28 data and associated outcomes relevant to the impact of the Medi-Cal Rx Transition on

1 DAP in connection with the preparation of this declaration. I have personal knowledge of
 2 he facts set forth herein, and if called to do so, could and would testify competently
 3 hereto. I make this declaration in support of the plaintiffs' motion for a preliminary
 4 injunction.

5 2. DAP was founded in 1984 by a group of community volunteers in the face
 6 of the AIDS crisis. Since that time, DAP has been named one of the "Top 20 HIV/AIDS
 7 Charities" and has expanded its mission to other disenfranchised members of the
 8 Coachella Valley community. Today, DAP is a FQHC that serves over 7,000 active
 9 clients, almost a third of which are living with, affected by, or at-risk for HIV/AIDS. The
 10 majority of DAP's clients are low-income, with more than 75 percent of the immediate
 11 population living under 200 percent of the Federal Poverty Level. DAP receives federal
 12 grant funding under Section 330 of the Public Health Service Act. DAP meets all current
 13 statutory requirements under Section 330 of the Public Health Service Act. DAP also is a
 14 340B-eligible Ryan White Part A (RWI) grantee provider organization.

15 3. According to the most recent DAP Uniform Data System ("UDS") report
 16 submitted to the federal Health Resources and Services Administration ("HRSA") for
 17 2019, DAP conducted clinic visits with the following distribution of services for the 7,487
 18 unduplicated FQHC patient population.

Clinical Service	* Number of Patients	* Percent of Patients	Number of Visits	Percent of Visits
Medical (Primary Care)	5,359	49.05%	19,247	47.29%
Dental	1,031	9.44%	5,275	12.96%
Mental Health	888	8.13%	5,492	13.49%
Substance Abuse Disorder	23	0.21%	130	0.32%
Enabling Services	3,624	33.17%	10,554	25.93%
Total	10,925	N/A	40,698	100.00%

26 * Total percent of patients is not applicable since individual patients may have received
 27 more than one visit across the four categories of patient visits or encounters.

28 ///

- 1 • Increase services (dental, housing, community health, STI clinic, and
2 various vocational programs).

3 Under HRSA regulation and grantee scope of service requirements and guidance,
4 FQHCs utilize their 340B net savings to:

- 5 • Provide uninsured patients with access to prescription drugs paid for by
6 the health center;
- 7 • Subsidize care for the patient population with incomes below 200 percent
8 of federal poverty guidelines who participate in DAP's sliding-scale
9 payment programs; and
- 10 • Subsidize care not covered under Medi-Cal or other key payers.

11 8. DAP's 340B Program utilizing contract pharmacy has continued to grow
12 significantly. In 2020 (based on YTD reporting), the DAP 340B contract pharmacy
13 program is anticipated to generate gross revenues of \$27,600,000 with net program
14 savings (gross revenues minus program and drug replenishment costs) of \$11,932,123.
15 The estimated loss in net 340B benefits due to the Medi-Cal pharmacy program transition
16 will be \$3,000,000 (approximately 30 percent of total net 340B Program savings).

17 9. The 340B Drug Pricing Program requires drug manufacturers to provide
18 discounted pharmaceuticals to health centers and other covered entities – which makes
19 prescription drugs affordable for all FQHC patients, including the uninsured and
20 underinsured. In addition, the savings retained by DAP allows it to continue to serve
21 more patients and to increase comprehensive services at no cost to the taxpayer.
22 Because of the action taken by California's Governor to eliminate 340B savings, patient
23 services and programs described above are at risk of being reduced significantly or
24 eliminated entirely. DAP's anticipated impact of eliminating \$3,000,000 in funding would
25 put 30-40 jobs at risk in DAP's community health, client support services, and HIV/STD
26 testing programs. Furthermore, patients will see longer wait times for appointments and
27 decreased access to key support services such as patient-centered care coordination.
28 Additionally, there will be an impact to the ratio of provider and clinic support staff to

1 patients, resulting in negative patient outcomes. The Medi-Cal program and the entire
2 FQHC medical home/patient-centered care coordination model will have increased costs
3 due to higher emergency room utilization, increased hospitalizations due to complications
4 from chronic diseases (e.g., HIV, Hepatitis, congestive heart failure), and decreased
5 ability to provide such services as medication therapy management, and expanded
6 access to primary care, mental health, and substance abuse treatment. Strategic
7 planning involving sustaining necessary resources to support important clinic functions
8 that require more resources, such as outreach, education, care coordination, and STD
9 testing will be impacted severely. The effect of this pharmacy transition is a major threat
10 to the sustainability of California's primary care safety net program.

11 I declare under penalty of perjury under the laws of the United States of America
12 that the foregoing is true and correct.

13 Executed this 16th day of December 2020, in Palm Springs, California.

14
15 A black rectangular redaction box covering the signature of David Brinkman.

16
17 David Brinkman



Exhibit F

to letter dated 4/16/2021

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COMMUNITY HEALTH CENTER ALLIANCE
11 FOR PATIENT ACCESS, ET AL.

12
13 **UNITED STATES DISTRICT COURT**
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15

1 Medical Center, where I also served as Chief Resident in my final year. As a family
2 physician, I regularly interact with patients, prescribe medications, and ensure my
3 patients are receiving their medications and following the treatment regimens. As the
4 Chief Medical Officer, I also receive reports from the other physicians about the provision
5 of services to their patients, including concerns about challenges and suggestions for
6 improving services. The majority of Open Door's patients are Medi-Cal beneficiaries who
7 are members of a Medi-Cal managed care plan ("MCP"). I have personal knowledge of
8 the facts set forth herein, and if called to do so, could and would testify competently
9 thereto. I make this declaration in support of Plaintiffs' Reply to Defendants' Opposition
10 to the Motion for a Preliminary Injunction.

11 2. Open Door is a Federally Qualified Health Center that receives federal
12 grant funds under Section 330 of the Public Health Services Act. Open Door is
13 committed to providing excellent health care and health education to medically
14 underserved patients in the Humboldt and Del Norte Counties, two rural counties in the
15 far northwest region of Northern California along the coast. Open Door currently
16 operates twelve community health centers across both counties, serving more than
17 55,000 patients each year while employing nearly 700 members of the community.

18 3. Humboldt and Del Norte Counties are predominately rural, and tend to rank
19 near the bottom for health outcomes among California counties. Like many rural areas,
20 our patients struggle with widespread problems of poverty, opioid use disorder, lack of
21 health education, lack of reliable housing and transportation, and numerous other socio-
22 economic barriers to health care that directly affect their well-being in the short and the
23 long term. As a physician who has worked in this community for ten years, I am well-
24 aware that these socio-economic problems often cause my patients to forego necessary
25 medical treatments in order to focus on other urgent aspects of their lives, such as going
26 to work to support their families, or using their limited incomes to buy food or pay rent
27 instead of paying for their prescribed medications.

28 ///

1 4. Open Door is committed to meeting our patients where they need us to be.
2 To that end, we operate under a patient-centered medical home model (“Medical Home”)
3 that allows us to coordinate an individual patient’s care across specialties so that we treat
4 the whole person, rather than individual symptoms. As their Medical Home, Open Door
5 proudly serves as a one-stop-shop for all of our patients’ medical needs, as well as their
6 unique needs for accessing transportation assistance, housing, and food. The Medical
7 Home also helps patients follow their medical treatment plans because they do not need
8 to go to multiple facilities – all of their providers are in one place, which greatly improves
9 the patients’ overall health outcomes.

10 5. The Medical Home includes coordination with pharmacy services and the
11 MCP member services team. The ability for me as a prescribing physician to work
12 directly with the MCP and case managers greatly improves my patients’ ability to access
13 necessary treatments. For example, if I prescribe a Lidocaine patch – a non-opioid
14 chronic pain treatment – I will have access to real-time information regarding what the
15 cost will be to the patient, when and if the patient is able to pick up the patch, or if the
16 patch is not covered by the patient’s plan. If the Lidocaine patch is not available for some
17 reason, I am able to find out immediately and make same-day adjustments to the
18 treatment plan so that my patient’s needs are met. This is just one concrete example of
19 how the pharmacy benefit’s inclusion in managed care facilitates medical services for
20 both doctors and patients, leading to better care and outcomes for the most vulnerable,
21 medically underserved people in California.

22 6. The inclusion of the pharmacy benefit in managed care also enables me to
23 tailor my treatment plan to the patient’s needs. With the pharmacy and medical benefits
24 linked, the current managed care model allows me to see and track if my patients are
25 getting their prescriptions, taking them on schedule, re-filling them as prescribed, and
26 returning for medical follow-ups on time. This information is critical to creating a
27 treatment plan for my patients, tracking their progress and condition, and scheduling
28 necessary follow-up appointments.

1 7. It is my understanding that, effective April 1, 2021, the Medi-Cal Rx initiative
2 will transfer the pharmacy benefit out of managed care and into a fee-for-service model.
3 This will directly undermine Open Door's Medical Home model and my ability to treat my
4 patients effectively. For example, disconnecting pharmacy services from medical
5 services will require our patients to take multiple trips to receive their care and their
6 medication. For most of my patients, this is not simply one more errand in their day – it is
7 an insurmountable barrier because they do not have access to reliable transportation to
8 make multiple trips, or they cannot take additional time from work during the day, or they
9 need to be home to take care of children or other family members.

10 8. Additionally, Medi-Cal Rx will fundamentally alter the way I and other Medi-
11 Cal providers at FQHCs will be able to treat our patients. For example, I will no longer
12 have access to real-time information as to the availability of medications or my patients'
13 adherence to the treatment plan. Using the example of the Lidocaine patch discussed
14 above, under the Medi-Cal Rx fee-for-service model, I would prescribe the patch and my
15 patient would have to make a separate trip to a pharmacy to get it. However, if that
16 pharmacy does not have it in stock or the pharmacist needs prior authorization, I will no
17 longer be notified as part of managed care and will not necessarily be advised that my
18 patient was unable to pick up their prescription. Because of the type of patients I work
19 with and the challenges they face in making multiple trips to different healthcare
20 providers, there is a high likelihood that my patient would forego the treatment altogether.
21 I would not discover the problem until months later in a follow-up visit with my patient, at
22 which point their condition and pain has worsened because they could not access the
23 treatment I prescribed.

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1 9. It is also my understanding that Medi-Cal Rx will also change Open Door's
2 and other FQHCs' reimbursement for drugs purchased under the federal 340B drug
3 discount program. I am gravely concerned that the proposed fee-for-service
4 reimbursement, actual acquisition costs of the drug plus a nominal dispensing fee, would
5 not cover the cost of providing necessary pharmacy services to my patients.

6 10. In addition, the savings and reimbursement Open Door receives from the
7 340B program go directly to providing additional, much-needed services for our patients that
8 are not otherwise reimbursed by Medi-Cal. One key example is Open Door's Medication
9 Assistance ("MAT") Program. MAT provides access to the medication buprenorphine,
10 also known as Suboxone, which is scientifically proven to help patients struggling with
11 opioid use disorder to overcome and manage their addiction. The drug is very
12 expensive, so without 340B pricing, our patients would not be able to receive it at all.
13 Additionally, MAT includes support groups that help patients maintain sobriety, which
14 requires efforts from case managers and member services staff. However, these
15 counseling services are not reimbursable by the Medi-Cal program, and are instead
16 directly funded by 340B revenue and savings. Without services like our MAT Program,
17 Open Door's patients will be denied access to a highly effective treatment option that can
18 help them get away from opiates and improve their overall lifestyle.

19 11. Based on my experience as a family physician at an FQHC, I believe that
20 Medi-Cal Rx will create additional barriers to healthcare services that my patients are
21 already struggling to obtain. It will change the way I treat my Medi-Cal patients, as well
22 as how those patients access their Medi-Cal benefits. I am greatly concerned that
23 removing the pharmacy benefit from managed care will directly prevent Open Door's
24 ability to serve as the one-stop-shop Medical Home that our patients depend on to treat
25 their unique and varied needs. Additionally, the loss of 340B revenue will force Open
26 Door to cut off critical resources for patients who are struggling with opioid use disorder
27 and other chronic conditions.

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I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on this 2 day of February, 2021, in Arcata, California.



DR. KELVIN VU



Exhibit G
to letter dated 4/16/2021

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10 Attorneys for Plaintiffs
COMMUNITY HEALTH CENTER ALLIANCE
11 FOR PATIENT ACCESS, ET AL.

12
13 UNITED STATES DISTRICT COURT

14 EASTERN DISTRICT OF CALIFORNIA, SACRAMENTO DIVISION
15

16 COMMUNITY HEALTH CENTER
ALLIANCE FOR PATIENT ACCESS, et
17 al.,

18 Plaintiffs,

19 v.

20 WILLIAM LIGHTBOURNE, Director of the
California Department of Health Care
21 Services; CALIFORNIA DEPARTMENT
OF HEALTH CARE SERVICES,
22

23 Defendants.

Case No. 2:20-CV-02171-JAM-KJN4

**DECLARATION OF DR. PARAMVIR
SIDHU IN SUPPORT OF PLAINTIFFS'
REPLY TO DEFENDANTS' OPPOSITION
TO THE MOTION FOR A PRELIMINARY
INJUNCTION**

Judge: Hon. John A Mendez

Date: March 9, 2021

Time: 1:30 p.m.

Crtrm.: 6

24 I, Dr. Paramvir Sidhu, declare as follows:

25 1. I am currently a family physician at Family Health Care Network ("FHCN"),
26 where I have worked for the last ten years. I also currently serve as Chief Clinical Officer
27 at Family Health Care Network. I received my medical training in India and completed
28 my residency in family medicine at the Riverside Community Medical Center, Riverside,

1 California. As a family physician, I regularly interact with patients, prescribe medications,
2 and ensure my patients are receiving their medications and following the treatment
3 regimens. As the Chief Clinical Officer, I also receive reports from the other physicians
4 about the provision of services to their patients, including concerns about challenges and
5 suggestions for improving services. The majority of FHCN patients are Medi-Cal
6 beneficiaries who are members of a Medi-Cal managed care plan ("MCP"). Although
7 FHCN is not a named plaintiff in this action, it is an affiliate of the Community Health
8 Center Alliance for Patient Access. I have personal knowledge of the facts set forth
9 herein, and if called to do so, could and would testify competently thereto. I make this
10 declaration in support of Plaintiffs' Reply to Defendants' Opposition to the Motion for a
11 Preliminary Injunction.

12 2. FHCN is a Federally Qualified Health Center ("FQHC") that receives federal
13 grant funds under Section 330 of the Public Health Services Act. FHCN is committed to
14 providing excellent health care and health education to medically underserved patients in
15 the Tulare, Kings and Fresno Counties, three rural counties in the San Joaquin Valley of
16 Central California. FHCN currently operates forty-one (41) community health centers
17 across these counties, serving more than 221,000 patients each year while employing
18 nearly 1,500 members of the community.

19 3. The patients we serve from Tulare, Kings and Fresno counties are
20 predominately from rural communities, and tend to rank near the bottom for health
21 outcomes among California counties. Our patients struggle with widespread problems of
22 poverty, lack of health education, lack of reliable housing and transportation, and
23 numerous other socio-economic barriers to health care that directly affect their well-being
24 in the short and the long term. A large majority of our patients are Seasonal and Migrant
25 farmworkers who suffer from severe health care disparities. As a physician who has
26 worked in this community for ten years, I am well aware that these socio-economic
27 problems often cause my patients to forego necessary medical care in order to focus on
28 other urgent aspects of their lives. These patients have to choose between utilizing their

1 limited resources to either buy food or pay rent to support their families, or pay for their
2 prescribed medications.

3 4. FHCN is committed to meeting our patient's needs and provide access to
4 quality medical care to everyone. We are Joint Commission Accredited clinics and we
5 operate under a patient-centric medical home model ("Medical Home") that allows us to
6 coordinate an individual patient's care across specialties so that we treat the whole
7 person, rather than individual symptoms. As their Medical Home, FHCN proudly serves
8 as a one-stop-shop for all of our patients' medical needs, as well as their unique needs
9 for accessing transportation assistance, housing, and food and connect the patients with
10 resources in the communities. The Medical Home also helps patients follow their medical
11 treatment plans because they do not need to go to multiple facilities – all of their
12 providers are in one place, which greatly improves the patients' overall health outcomes.

13 5. A part of the Medical Home also includes pharmaceutical services for our
14 patients. Having pharmacies in our health centers and medications under the 340B
15 program allows me as a prescribing physician to work directly with the pharmacists and
16 greatly improve my patients' ability to access necessary treatments. For example, if I
17 prescribe Insulin– a lifesaving treatment for diabetes – I will have access to real-time
18 information as to when and if the patient is able to pick up the medication at a very
19 affordable price. If the Insulin is not available for some reason or not covered by the
20 patient's plan, the pharmacist is able to call and inform me and provide alternatives to the
21 medication. This allows me to make same-day adjustments to the treatment plan and
22 patient leaves the visit with medications. Relatedly, our in-house pharmacists have
23 access to a patient's Electronic Health Record, allowing them to track prescription
24 dosages and types, which enhances patient safety. For example, our pharmacist can
25 see and verify the weight of a pediatric patient who is prescribed antibiotics for an
26 infection, verify the dosage calculation, and consult with me prior to the patient leaving
27 the health center. Another example would be the pharmacist reviewing the medical
28 record and noting additional medications or supplements listed in the patient's medication

1 list that could have contraindications when taken with the prescribed medication. Again,
2 this can be discussed with me before the patient leaves the health center. These are just
3 a few concrete examples of how the pharmacy benefit's inclusion in managed care
4 facilitates medical services for both doctors and patients, leading to better care and
5 outcomes for the most vulnerable, medically underserved people in California.

6 6. The inclusion of the pharmacy benefit in managed care also enables me to
7 tailor my treatment plan to the patient's needs. First, with the pharmacy and medical
8 benefits linked, the current managed care model allows me to see if my patients are
9 getting their prescriptions, taking them on schedule, re-filling them as prescribed, and
10 returning for medical follow-ups on time. This information is critical to creating a
11 treatment plan for my patients, tracking their progress and condition, and scheduling
12 necessary follow-up appointments. Second, the 340B savings allow us to operate a
13 robust in-house pharmacy program, including a Director of Pharmacy who sits on our
14 Medical Director Team. This coordination allows us to create a formulary for our
15 pharmacy specific to the clinical needs of our patient population and at the lowest
16 acquisition price possible, benefiting our patients both clinically and financially. Without
17 the 340B program, this cross-collaboration and comprehensive care management will not
18 be possible, as the dramatic cuts that would need to be made to our in-house pharmacies
19 would no longer allow us to have a Director of Pharmacy, and pharmacists would no
20 longer be able to dedicate time to comprehensive care management.

21 7. It is my understanding that, effective April 1, 2021, the Medi-Cal Rx initiative
22 will transfer the pharmacy benefit out of managed care and into a fee-for-service model.
23 This will directly undermine FHCN's Medical Home model and my ability to treat my
24 patients effectively. For example, disconnecting pharmacy services from medical
25 services will require our patients to take multiple trips to receive their care and their
26 medication. For most of my patients, this is not simply one more errand in their day – it is
27 an insurmountable barrier because they don't have access to reliable transportation to
28 make multiple trips, or they cannot take additional time from work during the day, or they

1 need to be home to take care of children or other family members.

2 8. It is also my understanding that Medi-Cal Rx will also change FHCN's and
3 other FQHCs' reimbursement for drugs purchased under the federal 340B drug discount
4 program. I am gravely concerned that the proposed fee-for-service reimbursement,
5 actual acquisition costs of the drug plus a nominal dispensing fee, would not cover the
6 cost of providing necessary pharmacy services to my patients. It will also impact our
7 ability to provide other benefits that are significant to our patients. For instance, we
8 currently have an extensive patient transportation program that provides door-to-door
9 service from a patient's home to the health center, which we would need to be scaled
10 back or eliminated if we no longer received revenue from the 340B program.
11 Additionally, we will have to increase the nominal fee offered to uninsured patients on our
12 pharmacy sliding fee scale, which will increase the costs for patients who cannot afford
13 higher out-of-pocket expenses for medical care. Such a change could result in uninsured
14 patients forgoing prescriptions, leading to worse health outcomes.

15 9. Medi-Cal Rx will also fundamentally alter the way I and other Medi-Cal
16 providers at FQHCs will be able to treat our patients. For example, FHCN has a Diabetic
17 clinic where the goal is to provide coordinated diabetic care to patients. This includes the
18 patient getting education about diabetes from health educators, necessary screenings
19 and immunizations, and behavioral-health counseling. These services are in addition to
20 medical care and treatment the physicians provide during the same (single) visit for the
21 patient. Using the example of the Insulin discussed above, under the Medi-Cal Rx fee-
22 for-service model, I would have to prescribe the Insulin and my patient would have to
23 make a separate trip to a pharmacy to get it. However, if that pharmacy does not have it
24 in stock, the cost is too high, or the pharmacist needs prior authorization, I will not be
25 notified immediately that my patient was unable to pick up their prescription. Because of
26 the type of patients I work with and the challenges they face in making multiple trips to
27 different healthcare providers, there is a high likelihood that my patient would forego the
28 treatment altogether. I would not discover the problem until months later in a follow-up

1 visit with my patient, at which point their condition has worsened and severe
2 complications developed because they could not access the treatment I prescribed, or
3 the supportive Diabetic clinic services. The result for that patient is deteriorated clinical
4 outcomes and, most likely, costly trips to the emergency room paid for by the Medi-Cal
5 program for a Medi-Cal beneficiary.

6 10. In addition, the savings and reimbursement FHCN receives from the 340B
7 program go directly to providing additional, much-needed services for our patients that are
8 not otherwise reimbursed by Medi-Cal. One key example is FHCN's Medication
9 Assistance Program ("MAT"). MAT provides access to the medication buprenorphine,
10 also known as Suboxone, which is scientifically proven to help patients struggling with
11 opioid addiction to overcome and manage their addiction. The drug is very expensive, so
12 without 340B pricing, our patients would not be able to receive it at all. Additionally, the
13 MAT clinic includes counseling that help patients maintain sobriety, which requires efforts
14 from Behavioral Health and member services staff. However, some of these ancillary
15 services provided in the MAT clinic as well as the above mentioned Diabetic clinic are not
16 reimbursable by the Medi-Cal program, and are instead directly funded by 340B revenue
17 and savings. Without programs like MAT, FHCN's patients will be denied access to a
18 highly effective treatment option that can help them get away from opiates and improve
19 their overall lifestyle.

20 11. Based on my experience as a family physician at an FQHC, I believe that
21 Medi-Cal Rx will create additional barriers to healthcare services that my patients are
22 already struggling to obtain. It will change the way I treat my Medi-Cal patients, as well
23 as how those patients access their Medi-Cal benefits. I am greatly concerned that
24 removing the pharmacy benefit from managed care will directly interfere with FHCN's
25 ability to serve as the one-stop-shop Medical Home that our patients depend on to treat
26 their unique and varied needs. Additionally, the loss of 340B revenue will force FHCN to
27 cut off critical resources for patients who are struggling with opioid addiction and other
28 chronic conditions like Diabetes.

1 I declare under penalty of perjury under the laws of the United States of America
2 that the foregoing is true and correct.

3 Executed on this 5 day of February, 2021, in VISALIA, California.
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9 DR. PARAMVIR SIDHU
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Exhibit H

to letter dated 4/16/2021

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 9 Email: rboyle@cliniclaw.com



10 Attorneys for Plaintiffs
 COMMUNITY HEALTH CENTER ALLIANCE
 11 FOR PATIENT ACCESS, ET AL.

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UNITED STATES DISTRICT COURT

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EASTERN DISTRICT OF CALIFORNIA, SACRAMENTO DIVISION

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16 COMMUNITY HEALTH CENTER
 ALLIANCE FOR PATIENT ACCESS, et
 17 al.,

Plaintiffs,

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v.

20 WILLIAM LIGHTBOURNE, Director of the
 California Department of Health Care
 21 Services; CALIFORNIA DEPARTMENT
 OF HEALTH CARE SERVICES,

Defendants.

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Case No. 2:20-CV-02171-JAM-KJN4

DECLARATION OF FRAN BUTLER-COHEN IN OPPOSITION TO MOTION TO DISMISS PLAINTIFFS' COMPLAINT

Judge: Hon. John A. Mendez

Date: February 23, 2021

Time: 1:30 p.m.

Crtrm.: 6

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I, Fran Butler-Cohen, declare:

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1. I am the Chief Executive Officer ("CEO") at Family Health Centers San

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Diego ("FHCS") and have held this role since 1986. I have reviewed the data and

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associated outcomes relevant to the impact of Medi-Cal Rx on FHCS in connection with

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the preparation of this declaration. I have personal knowledge of the facts set forth

1 herein, and if called to do so, could and would testify competently thereto. I make this
2 declaration in support of Plaintiffs' Opposition to Defendants' Motion to Dismiss.

3 2. FHCSD is a Federally Qualified Health Center ("FQHC") that receives
4 federal grant funding under Section 330 of the Public Health Services Act. FHCSD has
5 served the medically underserved communities of San Diego County since 1970, with the
6 transition of the Chicano Free Clinic to Logan Heights Family Health Center, FHCSD's
7 flagship clinic. FHCSD has since transformed into the tenth largest health center in the
8 country, providing care to over 149,000 patients each year, of whom 90 percent are low
9 income and 31 percent are uninsured. FHCSD serves all patients regardless of their
10 ability to pay.

11 3. FHCSD staff is on the front lines of battling COVID-19. Since April 2020,
12 FHCSD has provided free COVID-19 testing to as many patients as the staff can
13 manage. During this time, demand for FHCSD services has skyrocketed. To try to meet
14 our patients' testing needs, FHCSD has purchased additional lab equipment and
15 increased the number of lab shifts, but it is still not enough. FHCSD is also piloting rapid
16 testing and notification systems to quickly identify patients with COVID-19 and reduce
17 community spread. Additionally, we have set up a separate obstetrics clinic for mothers
18 who have tested positive for COVID-19. These steps have proven necessary, since,
19 among the patients we serve, the COVID positivity rate in the second week of January
20 2021 was 35 percent, more than double the average statewide rate for the same time
21 period.

22 4. In an effort to take care of patients and to avoid sending them to hospitals –
23 which currently cannot handle an additional influx of patients – FHCSD has also ramped
24 up its ability to care for the sickest, non-emergent patients. Instead, we have started
25 Monoclonal Antibody administration for the sickest, non-emergent patients at one of our
26 clinic sites, and are opening a second infusion site in Chula Vista, a known hot spot, as
27 soon as possible.

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1 5. Despite the heroic efforts of our health care workers – who have shouldered
2 the burden of coming to work every day risking their own health and the health of their
3 families – FHCS D staff is stretched beyond its limits and is struggling to continue. We
4 currently have seventy (70) members of our team out of work due to COVID, which hurts
5 FHCS D's ability to meet patients' needs and county demands. We have started an
6 emergency child care program to keep our workers on the job when they have no other
7 childcare options. We have also started an Employee Food Pantry Program so that
8 employees who have lost income can feed their families.

9 6. Now, with the development of a COVID-19 vaccine, San Diego County is
10 asking FHCS D to submit information regarding how many vaccinations we could
11 administer to the general public, which requires me and the FHCS D staff to study
12 guidance from the Centers for Disease Control and the Department of Defense to
13 implement massive public vaccination events, in addition to juggling the current
14 emergency needs of our patients and community.

15 7. Simultaneously, FHCS D is still required to commit time to fielding
16 government audits and meet with the State and Managed Care Organizations on metric
17 performance. In addition, FHCS D is currently in the beginning stages of a random federal
18 340B audit that has already taken several hundred hours of staff time in preparation and
19 document submission. At the same time, the Health Resources and Services
20 Administration is requesting capital funding grantees submit previously unrequired data
21 and qualitative information to help them design future grant programs. Moreover,
22 FHCS D has had to make significant modifications to contract pharmacy arrangements to
23 ensure our patients receive affordable medications due to the attack on the 340B
24 program by pharmaceutical manufacturers. All of this comes against the backdrop of the
25 State of California awarding a contract valued at approximately \$80 million annually to a
26 for-profit company (Magellan Medicaid Administration, Inc.) recently purchased by
27 Centene, a publicly traded NYSE corporation worth \$76 billion for \$2.2 billion dollars to
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1 facilitate the state in their plan that will remove hundreds of millions of dollars from the
2 state's health care safety-net.

3 8. It is unconscionable that during this time of perpetual crisis, when our staff
4 and other healthcare workers have sacrificed so much to serve the communities that
5 need them most, FHCS and other FQHCs are required to prepare and plan for Medi-
6 Cal Rx, which will result in drastic funding reductions due to changes in reimbursement.
7 Additionally, the loss of 340B funding that helps stretch our resources to expand
8 healthcare access will further reduce staff and desperately needed health services.

9 9. Although the "effective" date of Medi-Cal Rx has been moved to April 1,
10 2021, the implementation of Medi-Cal Rx has been underway for many months, requiring
11 health centers to adjust our conduct in a number of ways. Examples of some of the
12 activities FHCS has had to undertake in anticipation of the "go live" date for Medi-Cal
13 Rx include:

- 14 • A complete budget review and assessment of programs currently
- 15 funded through 340B savings, including the potential for lay-offs,
- 16 elimination of support programs, and reduction in hours and types of
- 17 services provided to our patients.
- 18 • Meetings with vendors that currently support in-house pharmacy
- 19 operations to ensure systems remain compliant following full
- 20 implementation.
- 21 • Subscribe to and dedicate staff time to monitor, review and bring
- 22 forward issues noted in regular updates from the Medi-Cal Rx
- 23 Subscription Service
- 24 • Secure Provider Portal access and enroll approximately 250
- 25 prescribing providers into the provider portal, necessitating hundreds
- 26 of hours of administrative staff time.

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1 patients who have suffered the most throughout the COVID-19 emergency will also bear
2 the burden of the Medi-Cal Rx initiative's consequences.

3 I declare under penalty of perjury under the laws of the United States of America
4 that the foregoing is true and correct.

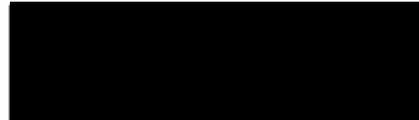
5 Executed this 20th day of January, 2021, at San Diego, California.

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FRAN BUTLER-COHEN

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Exhibit I

to letter dated 4/16/2021



Medi-Cal Rx Monthly Bulletin

April 1, 2021

The monthly bulletin consists of alerts, bulletins and notices posted to the [Medi-Cal Rx Web Portal](#) within the previous month.

Contents

1. [Changes to the Contract Drugs List Effective April 1, 2021](#)
2. [Updates to the List of Covered Enteral Nutrition Products](#)
3. [Medi-Cal Provider Training Schedule](#)
4. [Prescriber Phone Campaign](#)
5. [Medi-Cal Rx Pharmacy Provider and Prescriber Readiness Survey](#)
6. [Pharmacy Provider Self-Attestation Period Begins April 2021](#)
7. [Portal Registration](#)

1. Changes to the Contract Drugs List Effective April 1, 2021

The below changes have been made to the Contract Drugs List effective April 1, 2021.

For more information, see the [Contract Drugs List](#) on the Medi-Cal Rx Web Portal.

Drug Name	Description	Effective Date
Asenapine	FDA-approved indication specific to beneficiaries residing in nursing home removed.	April 1, 2021
Cabotegravir/Rilpivirine	Added to CDL with a restriction.	April 1, 2021
Exenatide	Extended release injectable suspension vial obsolete. Removed from CDL.	April 1, 2021
Leuprolide Acetate	Injection and powder for injection removed from CDL. Labeler restriction updated to 00074 only.	April 1, 2021

Drug Name	Description	Effective Date
Lurasidone Hydrochloride	FDA approved indication specific to beneficiaries residing in nursing home removed.	April 1, 2021
Morphine Sulfate/Naltrexone	Drug obsolete. Removed from CDL.	April 1, 2021
Nevirapine	Labeler restriction (00597) added to liquid only.	April 1, 2021
Propranolol	Additional liquid strength (1.28 mg/ml) added to CDL with a restriction.	April 1, 2021
Relugolix	Added to CDL with a restriction.	April 1, 2021
Sodium Zirconium Cyclosilicate	Added to CDL with labeler code restriction.	April 1, 2021

2. Updates to the List of Covered Enteral Nutrition Products

Effective for dates of service on or after March 1, 2021, the [List of Covered Enteral Nutrition Products](#) has been updated on the Medi-Cal Rx Web Portal. Effective for dates of service on or after April 1, 2021, products deleted from the List of Covered Enteral Nutrition Products will no longer be reimbursable, even with an approved prior authorization. The Maximum Acquisition Cost (MAC) for these products is no longer guaranteed.

3. Medi-Cal Provider Training Schedule

The transition of all administrative services related to Medi-Cal pharmacy benefits billed on pharmacy claims from the existing intermediaries, Medi-Cal Fee-for-Service (FFS) or Managed Care Plan (MCP) providers, will transition to the new Medi-Cal Rx vendor, Magellan Medicaid Administration, Inc. (MMA).

This article serves as a guide to outline the trainings planned for March 2021 until the Medi-Cal Rx implementation that will assist pharmacy providers, prescribers, and their staff as they transition to Medi-Cal Rx.

User Administration Console Training

All Medi-Cal Rx pharmacy providers, prescribers, and their staff will need to complete registration in order to access the secure areas of the Medi-Cal Rx Web Portal. Access to the secured Medi-Cal Rx Provider Portal starts with registration via the User Administration Console (UAC) application.

Training Information:

To assist pharmacy providers, prescribers, and their staff with UAC registration, there are job aids and computer-based trainings (CBTs) available to walk users through the registration process. Those materials are as follows:

- [UAC Quick Start Guide](#)
- [UAC Tutorial #1: Start Registration Process](#)
- [UAC Tutorial #1 Supplement: Alternate Address Instructions](#)
- [UAC Tutorial #2: Complete Registration](#)
- [UAC Tutorial #4: Granting Access for Yourself and Staff](#)

If you run into any issues or have any questions about the UAC registration process, feel free to attend an office hours session with one of our Pharmacy Representatives (PSRs) who can assist with the process.

To register for a UAC office hours session, please email the Medi-Cal Rx Education and Outreach Team at MediCalRxEducationOutreach@MagellanHealth.com and provide the following information in your email:

- Name of individual
- Provider name
- National Provider Identifier (NPI)
- Phone #
- Email address
- Preferred date and time of Office Hours session

As of April 1, 2021 UAC Office Hours Sessions will be offered on an as-needed basis. Please contact the Medi-Cal Rx Education and Outreach Team at

MediCalRxEducationOutreach@MagellanHealth.com to schedule a session.

Saba LMS Training

Saba is the one-stop shop for Education and Outreach information for Medi-Cal Rx pharmacy providers and prescribers. Topics to be covered during the Saba training sessions include how to view the Education and Outreach events calendar, how to register to attend an event or take an online course, and how to complete evaluations of training effectiveness.

Training Information:

Training for Saba includes a job aid with step-by-step instructions:

[Medi-Cal Rx Saba™ Provider Job Aid](#)

In addition, the Medi-Cal Rx Education and Outreach Team will offer live webinar sessions via Hewlett Packard Enterprise (HPE) MyRoom™. To register to attend a live webinar, please email Medi-Cal Rx Education and Outreach at

MediCalRxEducationOutreach@MagellanHealth.com and provide the following information in your email:

- Name of individual
- Provider name
- National Provider Identifier (NPI)
- Phone #
- Email address
- Preferred date and time of training session

Before enrolling in a Saba training session, providers will need to confirm in their email if they have completed the following tasks:

- Registered successfully for UAC
- Received a PIN letter and completed UAC registration
- Registered as the Delegated Administrator or have been created as a user by the Delegated Administrator
- Have added or been granted access to the Saba application

As of April 1, 2021, Saba Training Sessions will be offered on an as needed basis. Please contact the Medi-Cal Rx Education and Outreach Team at

MediCalRxEducationOutreach@MagellanHealth.com to schedule a session.

Medi-Cal Rx Transition and Resources and Web Portal Training

This training is intended to give pharmacy providers and prescribers an overview of the Medi-Cal Rx Transition and the resources that are available on the Medi-Cal Rx Web Portal. Topics that will be covered in this training include the following:

- Medi-Cal Rx background and high-level changes affecting pharmacy providers and prescribers
- Point-of-Sale (POS) Technical and Operational Readiness
- Web Claims Submission and overview of the Finance Portal

Training Information:

Training will be available via job aids and live webinars coming April 2021.

Training sessions for Medi Cal Rx Transition and Resources and Web Portal will be offered via a series of videos and job aids with step-by-step instructions. In addition, the Medi-Cal Rx Education and Outreach Team will offer live webinar sessions via HPE MyRoom™. To register to attend a live webinar, please refer to the Saba Training Calendar for specific dates and times.

Pharmacy providers and prescribers that need to take this training will first need to make sure they have successfully registered for UAC and have been granted access to the Saba application.

Medi-Cal Rx Transition and Resources and Web Portal Training Sessions (April 2021)	
Dates	Times
April 2021	Please refer to the Saba Training Calendar for specific dates and times.

Prior Authorization Training

A Prior Authorization (PA), previously known as a Treatment Authorization Request (TAR), requires providers to obtain approval before rendering certain services such as prescriptions.

This training will be intended for pharmacy providers and prescribers that plan to use the new Medi-Cal Rx Secured Portal to submit PAs.

Training Information:

Training will be available via job aid and live webinars 30 days prior to Medi-Cal Rx go-live.

When available, live webinar training will be available via Saba. Providers and prescribers that need to take this training will first need to make sure they have successfully registered for UAC and have been granted access to both the Saba and PA applications.

Web Claims Submission Training

This training will give providers an overview of the new Medi-Cal Rx Web Claims Submission system. Providers currently using a POS system to process prescription claims can still continue to submit web claims via this channel.

Training Information:

Training will be available via job aid and live webinars 30 days prior to Medi-Cal Rx go-live.

When available live webinar trainings will be available via Saba. Pharmacy providers and prescribers and their staff that need to take this training will first need to make sure they have successfully registered for UAC and have been granted access to both the Saba and Medi-Cal Rx Web Claims Submission applications.

4. Prescriber Phone Campaign

Pharmacy Service Representatives (PSRs) will begin reaching out by phone to introduce the new Medi-Cal Rx Web Portal and available resources and functionality. This outreach to prescribers will accomplish the following:

- Provide guidance on how to start registration for the Secured Provider Portal.
- Inform prescribers of currently available training and resources for Medi-Cal Rx.

All Medi-Cal Rx providers, including pharmacies, prescribers, and their staff, will need to complete secure Web Portal registration in order to access Education and Outreach training calendars, training course enrollment, and resources located in the Medi-Cal Rx Learning Management System (LMS), Saba. All Education and Outreach events will be posted in a calendar on Saba, and providers will have the ability to enroll in web-based, instructor-led, or computer-based training.

To access Saba, providers need to utilize the User Administration Console (UAC) application. Click the **Medi-Cal Rx Training** hyperlink on the [Education & Outreach page](#) of the Medi-Cal Rx Web Portal or go directly to the [UAC website](#). UAC office hours are available to assist providers in successfully completing UAC registration.

To register for an Office Hours session, please email MediCalRxEducationOutreach@magellanhealth.com and include the following information:

1. Name of Individual
2. Provider Name
3. National Provider Identifier (NPI)
4. Phone Number
5. Email Address
6. Preferred Date and Time of Office Hours Session

5. Medi-Cal Rx Pharmacy Provider and Prescriber Readiness Survey

How do you and your peers currently conduct business for Medi-Cal pharmacy services? We'd love to hear from you! The results of the [Medi-Cal Rx Pharmacy Provider and Prescriber Readiness Survey](#) will be used to tailor training offerings for Medi-Cal Rx to ensure you are prepared for the upcoming transition. The information you provide is confidential and will be used only for future training.

6. Pharmacy Provider Self-Attestation Period Begins April 2021

Although currently delayed, Medi-Cal pharmacy benefits will eventually be transitioned to and thereafter administered through the Fee-for-Service (FFS) delivery system for all Medi-Cal beneficiaries (generally referred to as "Medi-Cal Rx"). The Department of Health Care Services (DHCS) has partnered with Magellan Medicaid Administration, Inc. (MMA) to provide a wide variety of administrative services and support for Medi-Cal Rx.

MMA has contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health and Benefits LLC, to administer the annual pharmacy provider self-attestation survey for professional dispensing fee reimbursement. The objective of the next self-attestation survey is to assign professional dispensing fee rates for Medi-Cal-enrolled pharmacies beginning July 1, 2021 and ending June 30, 2022.

DHCS, through Mercer, will be initiating the provider self-attestation process in April 2021 for the 2020 calendar year reporting period for those pharmacy providers seeking the higher of two professional dispensing fee rates determined by annual prescription volume. Key changes to the self-attestation process include the following:

- The provider self-attestation period for the calendar year 2020 reporting period will run from April 1 through April 30, 2021 (in previous years, the survey period was January 15 through the end of February).
- Mercer, on behalf of MMA and DHCS, will administer the provider self-attestation survey with options for online submission or an email submission of a Microsoft® Excel®-formatted template.
- In addition to the standard online submission, pharmacies will have an additional survey submission option that will allow a bulk submission for multiple locations. The new template will allow a corporate office for chain-affiliated stores under common ownership to submit multiple stores in one self-attestation survey file.

As in previous years, newly approved FFS pharmacy providers that are notified of their Medi-Cal enrollment approval after the attestation period closes will automatically receive the higher dispensing fee. However, those same providers will have to attest for subsequent reporting periods in order to continue to be eligible for the higher dispensing fee in subsequent fiscal years.

Pharmacy providers may refer to the updated [Pharmacy Provider Self-Attestation FAQs](#) for more information.

DHCS reminds the Medi-Cal pharmacy FFS provider community to closely monitor upcoming Medi-Cal pharmacy bulletins for additional information regarding future updates by signing up via the [Medi-Cal Rx Subscription Service](#).

For updates on Medi-Cal Rx, please visit the [Medi-Cal Rx Web Portal](#) and the [DHCS Medi-Cal Rx Transition website](#). In addition, DHCS encourages stakeholders to review the [Medi-Cal Rx Frequently Asked Questions \(FAQ\) document](#), which continues to be updated as the project advances.

7. Portal Registration

What is Medi-Cal Rx and When Does it Happen?

Medi-Cal Rx is the name the Department of Health Care Services (DHCS) has given to the collective pharmacy benefits and services that will be administered through the Fee-for-Service (FFS) delivery system by its contracted vendor, Magellan Medicaid Administration, Inc. (MMA). Medi-Cal Rx will include all pharmacy services billed as a pharmacy claim, including but not limited to outpatient drugs (prescription and over the counter), Physician-Administered Drugs, enteral nutrition products, and medical supplies.

DHCS is delaying the planned Go-Live date of April 1, 2021, for Medi-Cal Rx. For more information, please see the [Important Update on Medi-Cal Rx](#) alert dated February 17, 2021.

What Should I Do Now?

Start by visiting the new [Medi-Cal Rx Web Portal](#) to review general information about the transition and to access registration and training for the Web Portal. This website serves as a platform to educate and communicate on Medi-Cal Rx resources, tools, and information. To stay informed, sign up for the [Medi-Cal Rx Subscription Service \(MCRxSS\)](#). Similarly, closely monitor Medi-Cal Rx news and bulletins for additional information regarding any future updates.

Next, register for the secure Medi-Cal Rx Provider Portal. Providers will need to complete registration for the User Administration Console (UAC) application. UAC is a registration tool that controls and manages a user's access to the secure section of the Medi-Cal Rx Web Portal and associated applications.

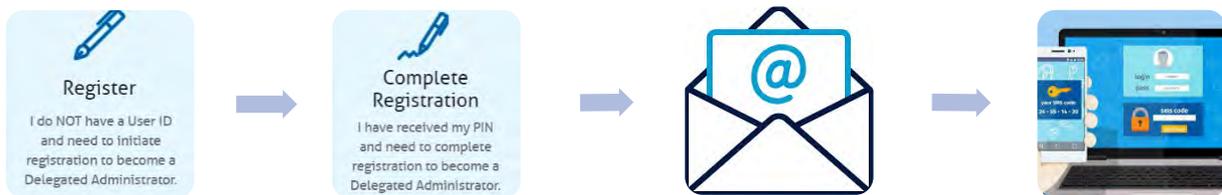
The following systems are available in the secured section on the Medi-Cal Rx Provider Portal:

- Prior Authorization System
- Secure Chat and Messaging Features
- Beneficiary Eligibility Lookup
- Web and Batch Claims Submission
- Education & Outreach Calendar and Training Registration

Refer to the [UAC Quick Start Guide](#) (PDF) and the information below for assistance with registering for UAC.

UAC Registration

All Medi-Cal Rx providers, including pharmacies, prescribers, and their staff, will need to complete secure web portal registration in order to access education and outreach training calendars, training course enrollment, and resources located in the Medi-Cal Rx Learning Management System (LMS), Saba. All Education and Outreach events will be posted in a calendar on Saba and providers will have the ability to enroll in web-based, instructor-led, or computer-based training. To access Saba, providers need to utilize the UAC application. Click the hyperlink under **Medi-Cal Rx Training** on the [Education & Outreach page](#) of the Medi-Cal Rx Web Portal, or go directly to the [UAC website](#). UAC office hours are available to assist providers in successfully completing UAC registration. To register for an Office Hours session, please email MediCalRxEducationOutreach@MagellanHealth.com and include the following information in your email: name of individual, provider name, National Provider Identifier (NPI), phone number, email address, and preferred date and time of Office Hours session.



To register, visit <https://uac.magellanrx.com>.

- Click **Register**
- Complete required fields (*)
- Click **Validate Org**
- Continue entering as many IDs as necessary
- Click **Submit**

You will receive a letter with a PIN number.

- Return to the UAC website
- Click **Complete Registration**
- Complete required fields (*)
- Click **Validate Org**
- Continue entering and validating all necessary IDs
- Click **Submit**

You will receive an email with an activation link (check spam or junk folder).

- Click activation link
- Confirmation screen appears indicating *You Have Been Successfully Added*
- Click on link in confirmation screen directing you to UAC application
- Here you can assign access and create accounts

Assign access/privileges and organizations.

- The first time you log into UAC, set up multifactor authentication
- Continue with sections 2.0, 3.0, and 4.0 in the Medi-Cal Rx UAC Quick Start Guide located at <https://medi-calrx.dhcs.ca.gov/home/education>

Christopher M. House

From: UPS <pkginfo@ups.com>
Sent: Monday, April 19, 2021 7:22 AM
To: Christopher M. House
Subject: [EXTERNAL] UPS Delivery Notification, Tracking Number 1ZA47F260198305886



Hello, your package has been delivered.

Delivery Date: Monday, 04/19/2021

Delivery Time: 10:20 AM

Left At: DOCK

Signed by: ANDRE

HANSON BRIDGETT LLP

Tracking Number:

[1ZA47F260198305886](#)

Ship To:

CENTER FOR MEDICAID & CHIP SERVICES
7500 SECURITY BOULEVARD,
MAIL STOP S2-25-26
BALTIMORE, MD 212441850
US

Number of Packages:

1

UPS Service:

UPS Next Day Air®

Package Weight:

2.0 LBS

Reference Number:

37366.3

Reference Number:

FHCSD / CHCAPA

Reference Number:

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To Whom It May Concern,

If Behavioral Health was to move to an IGT FFS model, how would the following be handled:

1. Would there be a mechanism for a county to claim for federal reimbursement in a situation in which the allowable costs exceed the standard FFS rates? As an example, if the FFS rate established for Case Management was \$2.00 per minute but the actual cost for to the county to provide the case management service was \$4.00 per minute, would there be a way for the county to draw down federal funds for the unreimbursed \$2.00 difference per minute? In the cost reimbursement world we live in now, there is such a mechanism (through the cost settlement process). Does the IGT FFS model allow for such a "truing up" of costs or would the county only receive the FMAP based on the original \$2.00 claim as opposed to the \$4.00 actual cost? If there is no "truing up" then the county in this example would end up losing out in terms of federal reimbursement received unless they doubled their units of service, correct? Is the idea here that for those counties that have higher actual cost rates than the newly enacted FFS rates, they can make up the difference by performing many more Medi-Cal units of service in order to make themselves whole?
2. Will there be any way for counties to claim federal reimbursement for non-client based services? Under the current cost-based arrangement, counties claim directly for utilization review/quality assurance costs, administrative costs and other types of costs (e.g. Medi-Cal Outreach, Medi-Cal Eligibility Intake, etc.) without billing it as a unit of service model contained within direct service billing. Much of what counties do cannot be easily fit into a FFS billing model. Will there be a way to claim federal reimbursement for some of these important activities?
3. Mechanically, how will the IGT process work? Will the county be expected to cut a check directly to DHCS who in turn will seek reimbursement from CMS? What will DHCS charge for their services? 5%? 10%? As an example, let's say that a county sends \$1 million to DHCS for anticipated allowable Medi-Cal expenses. Through the IGT process, DHCS secures \$1 million in federal match which brings the total amount to \$2 million. Would DHCS apply its fee (let's say 5%) to the \$1 million figure or the \$2 million figure?
4. In the example I gave above where the county ponies up \$1 million and CMS contributes their own \$1 million which brings the total amount to \$2 million, how do you foresee an audit taking place? Do you anticipate that a state and/or federal auditor would expect to see \$2 million in Medi-Cal allowable expenses? Is it correct to assume that in an IGT model that when a county puts up \$1 and then that is matched by the federal government, bringing the grand total to \$2, that the county must be able to prove that there was at least \$2 in total Medi-Cal allowable expenses? If that's not the case, how would a state or federal auditor verify that the federal match was used for Medi-Cal related expenses? What would you recommend that a county keep in its audit file for such a situation?

Thank you.

--

Patrick Sutton, MSW, MHA

President

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May 6, 2021

Submitted via email – CalAIM@dhcs.ca.gov



Will Lightbourne, Director
Jacey Cooper, State Medicaid Director and Chief Deputy of
Health Care
California Department of Healthcare Services
Attn: Angeli Lee and Amanda Font
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Re: Feedback on the CalAIM 1915(b) and 1115 Demonstration Waivers

Dear Directors Lightbourne and Cooper:

The California Association of Social Rehabilitation Agencies (CASRA) is submitting the following comments concerning DHCS' proposed Section 1915(b) and Section 1115 demonstration waiver applications and the package of proposed State Plan and related contractual changes referred to as the "CalAIM Demonstration".

First, on behalf of CASRA's 25 member organizations located throughout California, all of whom contract with their local county mental health department(s) to provide a wide range of services under both the 1915(b) and 1115 waivers, we would like to express our thanks to the Department for your willingness to engage in an open dialogue throughout the CalAIM planning process. We are also pleased to see that many of the recommendations that were brought forward through the stakeholder process have manifested themselves in the overall CalAIM Demonstration. Because of this, we have very few comments to share with respect to specific items contained in the 1915(b) waiver and 1115 demonstration proposals but feel it important to express our concerns regarding next steps and the eventual implementation of the entire CalAIM Demonstration.

The benefits of CalAIM must be shared by all parties involved in service delivery:

The CalAIM Demonstration brings with it the promise for tremendous positive change in the way that care is delivered to California's most vulnerable. DHCS as the single State agency for Medicaid has played and will play a critical role in the evolution of this care. This role however is complicated by the way in which the responsibility for the delivery of behavioral healthcare has been divided between the State and counties in California. That responsibility is once again split in many counties between the county behavioral health/mental health department and private providers. CASRA believes that this complexity, while necessary to meet the unique care needs of various populations, also demands all involved parties to remember that each component - DHCS, the counties and private providers must benefit from the fiscal flexibility, administrative relief, and revised access and eligibility criteria that are at the heart of the CalAIM Demonstration.

P.O BOX 388 – 815 MARINA VISTA, SUITE D - MARTINEZ, CA 94553 – 925.229.2300

CASRA believes that there is a real danger that some counties, for any number of reasons, may fail to pass along the full benefit of the Demonstration to their contract providers and the clients they serve. An example of such a failure would be if some or all SMHS plans decide to keep intact their added and onerous documentation requirements despite determinations or guidance from DHCS granting relief from those requirements.

Concerns such as this are the result of years of cumulative experience on the part of private providers throughout California. CASRA member agencies have long had to contend with the vagaries of their local behavioral health department(s), most, if not all of which layer additional documentation and signature requirements upon those required by DHCS and Medicaid in an apparent attempt to guard against future audit troubles. These attempts are usually ill-informed, misguided and highly idiosyncratic. Private providers operating in multiple counties are further hampered by having to deal with the combined burden of simultaneously addressing the multiple unique documentation requirements of each county in which they serve clients.

This current state of affairs has increased the cost of service delivery by forcing direct care staff to spend in excess of one-third of their time on documentation rather than client care. This has, and if left unchecked, will continue to result in staff burnout and high turnover. This in a field that already suffers from severe workforce shortfalls across all provider types. As mentioned previously, this is only one example of how implementation may cause the vision of CalAIM to fall short.

Additional concerns arise with respect to passing along the highly anticipated flexibilities that should result from moving from a Certified Public Expenditure (CPE) to an Intergovernmental Transfer (IGT) financing mechanism and the resulting shift from a cost-based to a rate-based reimbursement approach. The full benefits of this financing shift must not only be enjoyed by MHPs, but they must also be shared with private providers if the full value of CalAIM is to be realized. Specific areas of concern include the setting of rates between DHCS and CMS, and between MHPs and private providers; ensuring that the shift from HCPCS codes to CPT codes doesn't harm the financial viability of the system; and that the structure of the IGT supports system infrastructure and administration.

Given the depth and breadth of the Demonstration, CASRA believes that DHCS must take a much more involved and highly focused oversight role than the Department has in the past. Although we recognize that each California county has its unique needs and they require a certain amount of flexibility necessary to meet these needs, we see nothing in the CalAIM Demonstration that if enforced by DHCS would result in a loss of flexibility that would make it overly difficult to address these needs.

DHCS should move forward with beneficial State Plan and related contractual changes regardless of waiver negotiation outcomes:

Although CASRA certainly hopes that the Center for Medicare and Medicaid Services (CMS) looks favorably on all aspects of the 1915(b) and 1115 waiver requests, we are well aware of the possibility that some elements of the requests might be modified or dropped entirely as a result of negotiations between DHCS and CMS. CASRA urges DHCS to move forward with all of the proposed State Plan and related contractual changes that are not specifically dependent upon the waiver requests regardless of the outcome of those negotiations. By themselves, the proposed State Plan and contractual changes, if made, represent significant positive steps forward in improving access and care.

Implementation is an iterative process – there will be a need for continued stakeholder feedback and Demonstration modifications:

As mentioned previously, CASRA was pleased with the stakeholder process that occurred in the early stages of formulating what is now the CalAIM Demonstration. CASRA is also well aware, and as DHCS has made clear that implementing the Demonstration will be an exceedingly heavy lift for the Department, counties and contracted organizations. We also know that even the most well thought out of proposals will experience unforeseen obstacles as implementation unfolds.

We fully anticipate that modifications of the CalAIM Demonstration will be necessary as implementation of its many components move forward. We encourage the Department to reengage with stakeholders in a planful and purposeful manner to seek their input regarding those elements of the Demonstration that are working well as well those that are encountering difficulties and to co-create effective solutions.

Workforce, Workforce, Workforce

Although outside the scope of the waivers, the ongoing workforce shortage and diversity problem in California’s behavioral health system must be addressed if the Demonstration is to have any chance at success. As mentioned previously, DHCS must use all available means to reduce the documentation burden. Given the rough estimate of staff spending one-third of their time on documentation, a 50% reduction in this burden would result in an immediate 15% increase in available staff time to provide services, and it would help to reduce staff burnout.

The public behavioral health system must also make full use of the flexibility of provider type that already exists. The shortage of licensed providers is well documented and had been the focus of many if not most workforce development efforts over the past twenty years. Although important, these efforts have not done much to address the overall workforce shortage and continue to face the same daunting barriers that have limited their effectiveness. The much-anticipated addition of Peer Providers offers a glimmer of hope with respect to addressing the workforce shortage, but Peer Providers alone will not be able to fill the need. Medi-Cal’s unlicensed provider categories, which include Mental Health Rehabilitation Specialists and Other Qualified Providers should be the targets of future workforce development efforts as the educational pathways to those provider types are more affordable, more available and more accessible to the diverse individuals so desperately needed by the behavioral health system.

Maintaining a focus on behavioral health in an integrated system:

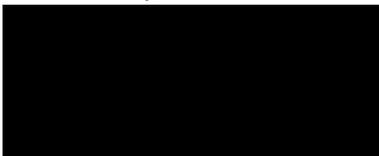
As stated in the DHCS overview, the overarching long-term goal of the CalAIM Demonstration is to move California closer to delivery system integration and an alignment of funding, data reporting, quality and infrastructure in order to mobilize, incentivize and support care delivery toward common goals. CASRA is in full support of this important and challenging endeavor. At the same time, we are also very aware of the history of behavioral health services in general and mental health services in particular within the overall health care delivery system. In the past those with mental health conditions and the care they received existed on the margins of the broader healthcare arena. Even today, despite decades of advocacy, those services make up a small percentage of overall health care expenditures in California. In many ways the existence of the bifurcated delivery of physical health care and mental health care, with

mental health services being “carved-out” and made the responsibility of counties with respect to SMHS was a response to that advocacy. It was only by being carved out as a separate benefit under a separate administrative structure with separate funding streams that mental health could be equitably and successfully addressed.

As we move toward the delivery system integration envisioned by the CalAIM Demonstration, CASRA agencies believe it is vitally important to remember the history of second-class status that has been endured by those living with mental health conditions and the years of advocacy that resulted in a separate delivery system. The special needs of those experiencing mental health challenges will continue to exist in an integrated health care delivery system. If that integrated system is to be successful, those special needs will need to be addressed in a comprehensive fashion.

We thank you for the opportunity to voice CASRA’s concerns and we stand willing and eager to assist the Department in the successful implementation of the CalAIM Demonstration.

Sincerely,



Chad Costello, CPRP
Public Policy Director
California Association of Social Rehabilitation Agencies
chad@casra.org