May 10, 2015

Andy Slavitt, Acting Administrator
Center for Medicare and Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, MD 21244

Re: Comments on 1115 Waiver Renewal Proposal

Dear Administrator Slavitt,

As consumer advocates for low-income health care consumers we offer the following comments regarding California's 1115 Waiver Renewal Proposal: Medi-Cal 2020. We were very involved in California's 2010 "Bridge to Reform" Waiver which played a key role in California's success in implementing the Affordable Care Act, particularly through the Low-Income Health Program (LIHP) which enabled the day-one enrollment of some 650,000 people into the Medicaid expansion group.

Managed Care Systems Transformation & Improvement Programs (Section 4.1)

The proposed waiver includes a plan to implement a pay-for-performance program based on quality and resource utilization and a shared saving model between providers, plans and the state to lower costs. The shared savings incentive program is generally described as a proposal where MCOs can receive an incentive payment for lowering the cost of care while meeting set outcome and quality targets. While the idea of improving quality and outcomes at a lower cost is difficult to argue with, we look forward to working to develop more specific outcomes and quality targets and evaluation measures.

Similarly, the pay-for-performance (PAP) strategy for MCOs to implement with providers is generally a good idea and needs additional details as to what elements the PAP program will be required to have, what metrics will be allowed, and how plans will be able to be compared if they use different or variable measures. Finally, the waiver proposes the strategy of integrating behavioral health and physical health at the plan /county and provider levels. One model proposed is better coordination between the health plans and the mental health plans. This is critical as the arrangement of mental health carve-out has existed for many years

and coordination has been a continuous challenge, even with required MOUs in place between the health and mental health plans. Unfortunately there have been fiscal disincentives to make this work effectively, since plans do not pay for care if the care is another plan's responsibility. As a result, clients have had to navigate these systems on their own, and general ineffectively. The state describes the use of incentive payments to change the plans' behavior and further details are needed regarding how this will work and what performance measures or quality metrics will be used.

Fee-For-Service System Transformation & Improvement Program (Section 4.2)

We support the overall goal of improving access to dental and maternity care in the fee-for service system. Any incentives to increase payments to providers who serve Medi-Cal patients are critical, given the extremely low reimbursement rates under Medi-Cal. Again, more details will need to be developed such as how DHCS attract dentists in the necessary geographic areas and how the hospital incentives program will meet the needs of the state's large pregnancy population.

Public Safety Net System Transformation & Improvement Program (4.3)

We support the overall goal of using the waiver as a vehicle to improve health quality and population health. As Medi-Cal enrollment continues to grow, it is important for the state to use Medicaid dollars to ensure that the safety net provides services that ensure quality and are aimed at improving the health of the population as a whole.

In domain one, we particularly support the goal of funding projects that integrate behavioral health and primary care services. Now that Medi-Cal Managed Care Plans are tasked with providing behavioral health services for mild to moderate conditions, better coordination and integration is needed to ensure that the safety net provides full access to needed behavioral health services.

In domain two, we strongly support the goal of using "team-based approaches to care and better use of front-line workers in care navigation, and in offering culturally and linguistically competent care." We note that the safety net sometimes lacks robust resources in terms of specialty care, and in order to ensure full coordination, relationships with specialists must be strengthened.

In domain four, we support elimination of services which are truly ineffective or harmful. However, we want to ensure that the goal to "apply value-based principles and drive shared decision-making to move pharmaceutical use to higher levels of cost-effectiveness" does not result in inappropriate limits on access to high cost, but medically appropriate and effective drugs. Already in Medi-Cal managed care plans, access to the new Hepatitis C treatments is reaching a crisis point, as Medi-Cal plans have adopted various criteria to limit access to drugs that cure Hepatitis C due to

their cost. While we appreciate DHCS's goal of providing good stewardship of taxpayer dollars, the goal of cutting costs must be balanced against the need for low-income Californians to access medically necessary care.

We support the goal of ensuring that projects developed under this program are subjected to a "robust and rigorous evaluation" to ensure that they are meeting the overall waiver goals as well as the goals of this program.

Increased Access to Housing and Supportive Services Program and Regional Integrated Whole-Person Care Pilots (Sections 4.5 and 4.6)

We fully support the state's proposals to improve the health of homeless and other high-need Medi-Cal enrollees through tenancy support services; intensive care coordination; and data-sharing among plans, counties and community partners toward a whole-person and patient-centered care model, as described in Sections 4.5 and 4.6 of California's renewal concept paper.

We are particularly supportive of the state's interest in targeted services specifically for homeless Medi-Cal enrollees (Section 4.5), which reflects an increased awareness that housing stability is intimately connected with health outcomes and the cost of healthcare. Studies show that persons who experience homelessness are some of the costliest users of health care services, and yet continue to have poor health.[1] One study of the homeless in Los Angeles found that 10 percent of the homeless with the highest public costs accounted for $58,962 a year in health care costs, or $4,914 per month.[2]

Because of this discrepancy between the health outcomes of homeless persons and the costs of care, it is appropriate that the state's target population for these services are persons who are homeless or will be homeless upon discharge from a health facility or incarceration, and who have a) repeated emergency department admissions, inpatient stays or nursing facility placements, or b) two or more chronic conditions, or c) mental health or substance use disorders.

We note that this population of homeless persons may significantly overlap with the target population described in Section 4.6 for "Regional Integrated Whole-Person

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[1] *See, e.g.,* DANIEL FLAMING ET. AL., GETTING HOME: OUTCOMES FROM HOUSING HIGH COST HOMELESS HOSPITAL PATIENTS, Economic Roundtable (2013), *available at* http://www.csh.org/wp-content/uploads/2013/09/Getting_Home_2013.pdf; DANIEL FLAMING, PATRICK BURNS & MICHAEL MATSUNAGA, WHERE WE SLEEP: COSTS WHEN HOMELESS & HOUSED IN LOS ANGELES, Economic Roundtable (2009), *available at* http://economicrt.org/publication/where-we-sleep/; Mary Larimer & Daniel Malone, *Health Care and Public Services Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems*, 301 JAMA no. 13, 2009 at 1349.
[2] D. FLAMING ET. AL., GETTING HOME: OUTCOMES FROM HOUSING HIGH COST HOMELESS HOSPITAL PATIENTS, Economic Roundtable, at p.31.

Care Pilots." These whole-person care pilots will target "high-need patients," who are part of the top 1% of emergency/inpatient users, or at least 50 Medi-Cal patients.

DHCS intends the whole-person care pilots described in Section 4.6 to be implemented via regional partnerships among managed care plans, counties and local partners, while the increased access to housing and supportive services of Section 4.5 will be available statewide to Medi-Cal enrollees through a new set of tenancy-based services paid through the plans. Despite the regional versus statewide implementation of these two proposals, we see significant overlap between the two. Both target high-need persons who are high-utilizers of Medi-Cal services. And both describe the need for services to address the whole-person, such as integrated care coordination among physical and behavioral health systems, hospitals, and existing community supports to provide housing and other supportive services; and the need for strong collaboration among health plans, county mental health plans, local governments, and community-based agencies to coordinate services and share data.

We fully support these concepts and look forward to working with the state to implement these services to assist the most vulnerable Medi-Cal beneficiaries in securing and maintaining housing through tenancy support services, as well as whole-person care that integrates the physical and behavioral health services commonly needed by this population.

Public Safety Net System Global Payment for the Remaining Uninsured (Section 5)

We applaud DHCS's recognition that directing safety net resources to ensure care for California's remaining uninsured is key to meeting the goal of improving population health.

We agree that payments to safety net providers to serve remaining uninsured Californians should move from a cost-based to value-based system to incentivize more coordinated and effective care. We are heartened that DHCS has identified timeliness, access, and improved health status, as priority areas. To that end, we encourage DHCS to adopt additional metrics that measure timeliness and access, including time from referral to specialty care appointment, and distance to specialists from primary care. We support the inclusion of non-traditional services such as health coaches, patient support & disease management groups, and telephone and email consultations.

Public Notice and Comment Process (Section 9)

The Affordable Care Act requires opportunity for public comment and greater transparency of the section 1115 demonstration projects. The final rule, effective on April 27, 2012, established a process for ensuring public input into the development

and approval of new section 1115 demonstrations as well as extensions of existing demonstrations. We greatly appreciate the fact that stakeholder groups were convened on the key topics in the waiver. We also appreciate that DHCS held a broad stakeholder session on the waiver in January, 2015 to solicit feedback on the strategies. All of these processes have helped to ensure the process has been transparent and open. That said, the state has not committed to any additional stakeholder meetings and none are planned to discuss the March 2015 Waiver Renewal proposal or any specifics about the waiver proposal. We know that a lot can and will change between the time the Waiver Renewal concept paper is submitted and the final waiver is approval by CMS. We therefore urge CMS to require continued active engagement, including sharing draft Special Terms of Conditions with stakeholders with an opportunity for input and feedback.

Medi-Cal 2020 Evaluation Design (Section 10)

Section 1115 authority is only permissible for an "experimental, pilot, or demonstration project," meaning a state must be using the authority to test some hypothesis.[3] A state cannot, under the law, simply enact a permanent change to its Medicaid program through section 1115 or use section 1115 to save money. Evaluation projects validate the research and demonstration findings and help CMS monitor the effectiveness of the waiver. Additional details should be developed about the evaluation for this waiver.

We look forward to continuing to work with the state, our California partners, and CMS toward the successful implementation of the Affordable Care Act. We appreciate the opportunity to share our feedback on the Waiver Renewal proposal.

Sincerely,

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Cc: Vicki Wachino, CMS
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[3] 42 U.S.C. § 1315(a).