March 12, 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: CalAIMECMILOS@dhcs.ca.gov

RE: Public Comment regarding Draft ECM and ILOS Documents

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 draft Enhanced Care Management (ECM) and In-Lieu-of-Services (ILOS) requirements, released for public comment on February 16, 2021. CHA supports DHCS' goals of the California Advancing and Innovating Medi-Cal (CalAIM) initiatives and recognizes that both ECM and ILOS are foundational components.

California has committed to Medi-Cal managed care as the delivery system of choice, and now projects enrollment to surpass 13 million around the time CalAIM will begin to implement starting January 2022. CHA appreciates DHCS's recognition of the need for increased care coordination and care management, as evident by the proposed new statewide ECM benefit. Many Medi-Cal beneficiaries with complex physical or behavioral health conditions are unable to navigate our complex health care system on their own. Moreover, depending on their specific medical, behavioral, and social needs, beneficiaries may require services from multiple delivery systems and already receive some level of care coordination. Medi-Cal managed care plans'(MCPs) ability to implement effective, person-centered coordination of care, and home and community-based services and supports will be critical to the overall success of CalAIM.

In reviewing the draft ECM and ILOS documents, we are struck by the complexity and significance of the changes — as well as the expanded role and responsibility that Medi-Cal MCPs will be faced with beginning on January 1, 2022. Even though the comment period was less than 30 days, we appreciate DHCS' willingness to consider additional feedback and have compiled a robust set of comments for your review and consideration. Included below are a few general areas of concern, and beginning on page 4, you will find feedback that is specific to the individual documents.

First, since the release of CalAIM back in 2019, DHCS has messaged to the provider community that a guiding principle for the Administration and CalAIM was to standardize the Medi-Cal program (benefits, enrollment, administration, etc.). ***However, DHCS' proposed implementation of both ECM and ILOS, eliminates any expectation of a standardized Medi-Cal managed care benefit throughout the state.*** We understand there are additional federal requirements when implementing the ILOS option for Medi-Cal MCPs. However, DHCS' proposed contract provides Medi-Cal MCPs and their Subcontractors

considerable flexibility to implement the benefit, along with the ability to make programmatic changes every six months. This will undoubtedly generate confusion within the provider community and create unnecessary disruption in Medi-Cal beneficiaries' ability to access vital services. Unfortunately, this flexibility included in the proposed contract for Medi-Cal MCPs related to ILOS is also included when implementing the ECM benefit.

The proposed contract does not provide sufficient detail or criteria to ensure consistency of application across Medi-Cal MCPs, a shortcoming that is particularly troublesome in the context of DHCS's description of the seven mandatory ECM "target populations." As proposed, CalAIM will require Medi-Cal MCPs to proactively identify members who meet the target population criteria and offer them ECM services. While DHCS has provided descriptions for each of these beneficiary categories, the descriptions do not provide adequate detail. CHA is concerned that such poorly defined criteria will be applied inconsistently among and between providers and Medi-Cal MCPs, leading to differences in access, as well as in utilization, costs, and DHCS' assessment of plan performance. For example, the target population definition of "*high utilizers*" includes several quantitative and qualitative descriptions that are open to wide differences in interpretation: "High utilizers are Members with *multiple* hospital admission OR *multiple* short-term skilled nursing facility stays, OR *multiple* emergency room visits that could be avoided."

Based on this definition, one Medi-Cal MCP could determine that a member is considered a high utilizer if they are admitted to the hospital or seen in the emergency department three times in a six-month period, and another Medi-Cal MCP may decide that the threshold is five. Such differences in threshold criteria will lead to unacceptable differences in access and outcomes. Similarly, DHCS's current descriptions include several other provisions that are open to interpretation, including "individuals that have *impactable* conditions" or "*significant* functional limitations." Terms like "*impactable*" and "*significant*" are subjective and may lead to unintended consequences in the department's pursuit of equity in access and patient outcomes. DHCS should take steps to further define its expectations and provide clear criteria for each of the target populations.

Additionally, included in the proposed contract is considerable flexibility for Medi-Cal MCP's to define "*adequate*" staffing levels and appropriate "*capacity*." As is the case with providing clarity around the definitions mentioned above, so is the importance for DHCS to implement minimum network adequacy standards for these benefits especially as Medi-Cal MCPs begin to build their ECM and ILOS provider networks. Without additional guidance from DHCS, each Medi-Cal MCP may implement their own version of network adequacy standards, and again, it may lead to unintended consequences where Medi-Cal beneficiaries will experience wide variations throughout the state while attempting to access these important services. In summary, additional specificity is needed to ensure that all Medi-Cal managed care beneficiaries who qualify can access the services they need and that Medi-Cal MCPs are meeting their contractual responsibilities.

CHA urges DHCS to look at ways to help standardize the definitions, criteria, reporting requirements and network adequacy requirements for Medi-Cal MCPs as they implement this new ECM and ILOS benefit.

Second, while DHCS will require Medi-Cal MCPs (and their Subcontractors) to engage with ECM and ILOS providers to meet the needs of Medi-Cal managed care beneficiaries, the level of reporting described in

the proposed contract template is not sufficiently comprehensive nor detailed enough to provide meaningful oversight. Descriptions of ECM and ILOS oversight and reporting provisions are incomplete and limited to just two broad and poorly defined items: 1) encounter data "using national standard specifications and code sets to be defined by DHCS", and 2) supplemental reports "on a schedule and in a format to be defined by DHCS categories."

CHA's view of this issue is informed by our previous experience with Medi-Cal MCPs, including in the context of CalMediConnect (CMC). Hospitals continue to report significant issues with access to post-hospital care, such as delays or denials of post-hospital services, including skilled-nursing care, medically necessary post-acute care, psychiatric lower levels of community-based care, and home and community-based services. Without clearer reporting requirements or expectations outlined, Medi-Cal managed care beneficiaries will continue to experience delays in accessing care and connecting to services.

CHA urges DHCS to increase oversight of the Medi-Cal MCPs and their Subcontractors to ensure that not only are basic obligations being met, but that the additional layers of benefits and requirements contained in the California Advancing and Innovating Medi-Cal are being achieved.

Finally, the proposed contract includes the wide scope of specific requirements for ECM and ILOS; however, fails to fully address the Medi-Cal managed care financial obligations associated with the expanded responsibility. Included in the proposed contract, is a section that highlights the Medi-Cal MCP's responsibility for payment of services to ECM and ILOS providers. However, the proposed contract does not include any specifics pertaining to the Governor's $300 million investment in incentive payments which are:

> *"focused on building a pathway for Medi-Cal MCPs and providers to invest in the necessary delivery and systems infrastructure, build appropriate and sustainable care management and ILOS capacity, and achieve improvements in quality performance that can inform future policy decisions to align with the goal of managed long-term services and supports by 2026."*
> *(PC 225; Medi-Cal Estimate)*

Without including specific requirements for the incentive payments in the proposed contract, DHCS' requirements of the temporary funding source for Medi-Cal MCPs will be unknown. This will lead to questions about how Medi-Cal MCPs are able to expend these limited resources and whether they are accountable to the department's clear expectations. Will they be required to build out capacity and system infrastructure as the budget states? What happens if they don't spend it all? Since the funding is time-limited (through June 30, 2024), it is important that contractual requirements be included upfront and not be subject to subsequent DHCS guidance or all plan letters (APL)—as we have seen in the past, APLs tend to be released in a retroactive manner (e.g., hospital directed payments APL).

Additionally, pursuant to Senate Bill (SB) 171 (Chapter 768, Statutes of 2017), effective in rating periods beginning on July 1, 2023, Medi-Cal MCPs will be required to remit payments back to the State should they fail to meet the 85% Medical Loss Ratio (MLR). Given CMS' flexibility included in the 2016 CMS Final Rule which includes legal clarity on the ability to include ILOS in the numerator of the MLR calculations, CHA believes the proposed contract with the Medi-Cal MCPs should include a more detailed description than the single reference in the ILOS definition section. Understanding the broad definition of allowable

incurred claims will be important as Medi-Cal MCPs look to align incentives and establish provider networks.

CHA urges DHCS to include additional financial oversight within the proposed contract for Medi-Cal MCPs. This should include requirements for incentive payments, as well as, expectations for how ECM and ILOS will impact the Medi-Cal MCP's MLR requirements.

CHA appreciates the opportunity to comment on the proposed draft documents for ECM and ILOS. 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, Healthcare Financing Initiatives

CHA specific comments regarding the "ECM and ILOS Standard Provider Terms and Conditions" document:

Reference; Page #	Proposed	CHA Comments
ECM 1 b.; Page 1	**ECM Provider**: a Provider of ECM. ECM Providers are community-based entities, with experience and expertise providing intensive, in-person care management services to individuals in one (1) or more of the target populations for ECM.	CHA urges DHCS to clarify the scope of eligible ECM Providers are not limited to only public providers. There are several successful examples where a private hospital and/or health system participated in the Health Homes Program.
ECM 2 g.; Page 1	ECM Provider ***shall have agreements*** and processes in place to engage and cooperate with area hospitals, Primary Care Providers, behavioral health Providers, Specialists, and other entities, including ILOS Providers, to coordinate care as appropriate to each Member; and	CHA requests for DHCS to define the expectations of what constitutes an agreement. Will they be subject to the network provider requirements (APL 19-001; Attachment A)? Will a Letter of Agreement (LOA) suffice?
ECM 4 b.; Page 2	ECM Provider ***shall immediately*** accept all Members assigned by MCP for ECM, with the exception that an ECM Provider shall be permitted to decline a Member assignment if ECM Provider is at its pre-determined capacity.	CHA understands default assignment for ECM Providers. Will DHCS communicate the expectations for what the Medi-Cal MCP default algorithm will be? Or will MCPs have the options to define independently? How will MCPs take into consideration when an ECM Provider is

		part of a health system, where the provider has multiple providers types (hospital, outpatient clinics, FQHCs or RHCs)?
ECM 4 b(i).; Page 2	ECM Provider shall immediately alert MCP if it does not have the ***capacity*** to accept a Member assignment.	In alignment with our broader comments, without defining capacity or the specific expectations of what network adequacy will be defined as, each ECM Provider could define "capacity" differently. CHA urges DHCS to standardize the network adequacy requirements for ECM.
ECM 5 a.; Page 2	At all times, ECM Provider shall have ***adequate*** staff to ensure its ability to carry out responsibilities for each assigned Member consistent with this Contract and any other related DHCS guidance.	CHA urges DHCS to standardize the network adequacy requirements for ECM.
ECM 10 a., Page 5	MCP will provide to ECM Provider the following data at the time of assignment and periodically thereafter	CHA urges DHCS to define "periodically thereafter." Additionally, along with the initial data provided at the time of assignment, DHCS should also include a requirement for the MCP to provide any known "Comprehensive Assessment and Care Management Plan" previously established for the member. This will occur where a member switches plans within a county, or in situations where they relocate to another county. To account for these situations, DHCS should establish a requirement for data sharing between MCPs when a member switches plans.
ECM 11 a.; Page 7	ECM Provider shall submit claims for the provision of ECM-related services to MCP using the national standard specifications and code sets to be defined by DHCS.	CHA urges DHCS to define a reasonable timeline for ECM Providers to submit claims/encounters.
ECM 13 d.; Page 7	MCP shall pay 90% of all clean claims from practitioners who are individual or group practices or who practice in shared health facilities within 30 days of date of receipt and 99% of all clean claims within 90 days. The date of receipt shall be the date MCP receives the claim, as indicated by its date stamp on the claim. The date of payment shall	CHA urges DHCS to define "clean claims." Additionally, CHA urges DHCS to clarify by adding in "MCP**, or their Subcontractor,** shall pay…" In instances where the Medi-Cal MCP has delegated the responsibility to a Subcontractor, the same timely payment requirements should still apply.

	be the date on the check or other form of payment.	
ILOS 1b.; Page 8	**ILOS Provider:** a contracted Provider of DHCS-authorized ILOS. ILOS Providers are community-based entities with experience and expertise providing one (1) or more of the ILOS authorized by DHCS to individuals with complex physical, behavioral, developmental and social needs	CHA urges DHCS to clarify the scope of eligible ILOS Providers are not limited to only public providers. There are several successful examples where a private hospital and/or health system participated in the Health Homes Program.
ILOS 3 b(i).; Page 9	Experience and Expertise i. The ILOS Provider shall have ***sufficient experience*** and expertise in the provision of the ILOS being offered.	CHA requests DHCS define "sufficient experience." Without a required certification or license for these ILOS Providers, the definition of sufficient experience if undefined will vary between Medi-Cal MCPs.
ILOS 5 a.; Page 10	ILOS Provider shall record, generate, and send a claim or invoice to MCP for ILOS rendered.	CHA urges DHCS to release template claims or sample invoices for non-traditional services (i.e., housing deposits) which are not transferrable into the national standards or code sets. Additionally, the format released by DHCS should also be required by all MCPs, which will standardize encounter reporting and assist them in their timely payment requirements.

CHA specific comments regarding the "DHCS MCP ECM and ILOS Contract Template Provisions" document:

Reference; Page #	Proposed	Question/Comments
ECM 1 a (ii); Page 2	Contractor shall ensure it has ***contracts*** in place to ensure its ECM Provider capacity meets the needs of all ECM target populations in a setting consistent with all the requirements in this Contract amendment, as described in ECM Section 4: ECM Provider Capacity.	CHA requests for DHCS to define the expectations of what constitutes an agreement. Will the contracts be subject to the network provider requirements (APL 19-001; Attachment A)? Will a Letter of Agreement (LOA) suffice?
ECM 2 c; Page 3	Contractor may identify additional unique target populations that may benefit from ECM, subject to DHCS' prior approval within the process	In alignment with our broader comments, providing the MCP the opportunity to identity target populations, or expand into unique target populations, will undoubtedly lead to differences depending

	described in ECM Section 5: Model of Care.	on which MCP is available for the Medi-Cal beneficiary. CHA urges DHCS to standardize the specific criteria for target populations across the state for Medi-Cal MCPs.
ECM 3c (vi.); Page 4	Hospitals or hospital-based Physician groups or clinics (including public hospitals and district and/or municipal public hospitals)	CHA urges to clarify that private hospitals are eligible to participate as ECM Providers as well. Suggested edit: “**Public and private** Hospitals**,** ~~or~~ hospital-based Physician groups, **and/**or clinics ~~(including public hospitals and district and/or municipal public hospitals)~~”
ECM 4 b; Page 6	Contractor shall ensure ***sufficient*** ECM Provider capacity to meet the needs of all ECM target populations [See ECM Section 2: Target Populations for ECM].	In alignment with our broader comments, without defining capacity or the specific expectations of what network adequacy will be defined as, each ECM Provider could define “capacity” differently. CHA urges DHCS to standardize the network adequacy requirements for ECM.
ECM 4 d(ii); Page 6	Contractor shall report 60 days in advance on its ECM Provider capacity whenever there are significant changes, pursuant to DHCS reporting requirements.	CHA urges DHCS to define “significant.” Each MCP will interpret significant differently, which will reduce DHCS’ ability to monitor changes in real-time. As providers continue to deal with the impacts from COVID, and begin to shift to the long road of recovery, DHCS’ ability to determine real-time assessments of community resources should be required. Just in one county alone, 20 FQHCs and RHCs that a single hospital system has historically partnered with have either closed their doors or significantly reduced their hours. The resources that were available at the start of 2020 in this community are drastically different today.
ECM 4 e; Page 6	If Contractor is unable to provide ***sufficient capacity*** to meet the needs of all ECM target populations in a community-based manner through Contracts with ECM Providers, Contractor may request written	CHA urges DHCS to define “sufficient capacity.” If DHCS is not standardizing the network adequacy requirements for Medi-Cal MCPs, there will be too much room for interpretation.

	approval for an exception to the ECM Provider contracting requirement from DHCS that authorizes Contractor to use Contractor's own staff for ECM.	
ECM 7 c; Page 8	Contractor shall identify Members for ECM through the following pathways: i. Analysis of Contractor's own enrollment, claims, and other relevant data and available information. Contractor shall use data analytics to identify Members who can benefit from ECM and who meet the ECM target population criteria.	In alignment with our broader comments, providing the MCP the opportunity to identity target populations, or expand into unique target populations, will undoubtedly lead to differences depending on which MCP is available for the Medi-Cal beneficiary. CHA urges DHCS to standardize the specific criteria for target populations across the state for MCPs.
ECM 16 c; Page 15	Contractor is ***encouraged*** to collaborate with its Subcontractors on the approach to ECM to minimize divergence in how ECM will be implemented between Contractor and its Subcontractor(s) and/or across multiple Subcontractors and ensure a streamlined, seamless experience for ECM Providers and Members.	CHA urges DHCS to standardize the requirements across the state. However, if DHCS disagrees with our request, at the very least DHCS should require consistency within the Contractor and Subcontractors. ECM Providers should know if the Medi-Cal beneficiary is a LA Care member, regardless of their plan partner, the benefit structure is the same.
ECM 17 a; Page 15	Contractor shall pay contracted ECM Providers for the provision of ECM.	CHA urges the inclusion of "Subcontractor" in this section. Suggested edits: "Contractor, **and Subcontractor(s),** shall pay…"
ECM 18 c; Page 16	In the event of ***underperformance*** by Contractor in relation to its administration of ECM, DHCS may administer sanctions as described in Exhibit E, Attachment 2, Provision 16, Sanctions	While Exhibit E, Attachment 2, Provision 16 provide the Department with the authority to issue sanctions, the provision does not define "***underperformance***." CHA urges DHCS to define underperformance.
ILOS 1 e; Page 18	If Contractor elects to offer one (1) or more DHCS-authorized ILOS, it need not offer the ILOS in each County it serves. Contractor shall report to DHCS the	CHA urges DHCS to clarify for instances where a Medi-Cal MCP is responsible for a region of Counties, are ILOS required in all Counties under the specific contract?

	Counties in which it intends to offer the ILOS.	For example, in the Regional Model, would the MCP be allowed to provide ILOS to Medi-Cal beneficiaries that reside in Butte county and not in Plumas county?
ILOS 1 h; Page 18	Electing to offer one (1) or more ILOS shall not preclude Contractor from offering ***value-added services (VAS).***	CHA requests DHCS define value-added services (VAS). In other Medicaid programs throughout the country, they define "value-added services (VAS)" as extra benefits offered by managed care organizations (MCOs) beyond the Medicaid-covered services. VAS may include routine dental, vision, podiatry, and health and wellness services. Will DHCS providing the same ILOS flexibility to Medi-Cal MCPs to provide vision and dental services? Will there be recognition of VAS in the Medi-Cal MCPs rate development and MLR calculations?
ILOS 4 b; Page 20	Contractor shall ensure its contracted ILOS Providers have ***sufficient capacity*** to receive referrals for ILOS and provide the agreed upon ILOS to Members who are authorized for such services.	As with ECM, CHA urges DHCS to define "sufficient capacity" for ILOS. If DHCS is not standardizing the network adequacy requirements for Medi-Cal MCPs, there will be too much room for interpretation.

CHA specific comments regarding the "CalAIM ECM and ILOS Model of Care Template" document:

Reference; Page #	Proposed	CHA Comments
II. The ECM/ILOS MOC Page 11	In order to balance statewide consistency with the ability of MCPs to innovate in their design of ECM and any ILOS, DHCS is standardizing certain design aspects of ECM and ILOS, while allowing MCPs the flexibility to develop a plan that will best meet the needs of their Members and communities.	In alignment with our broader comments, providing the MCP the opportunity to identity target populations, or expand into unique target populations, will undoubtedly lead to differences depending on which MCP is available for the Medi-Cal beneficiary. CHA urges DHCS to standardize the specific criteria for target populations across the state for MCPs.
d. Identifying Members	Using Policies and Procedures, describe how the MCP will use available MCP data to identify Members for ECM,	CHA urges to establish requirements for Medi-Cal MCPs and their ECM Providers to share information or establish a process of

for ECM; Page 26	including explicit reference to each of the data sources listed in Section 7 of the ECM and ILOS Contract. Include the approach to identifying Members in each DHCS-defined ECM target population and how the approach may vary by target population. Include in your answer how frequently data will be refreshed to identify potentially newly eligible Members and **shared with Providers.**	notifying network providers when a beneficiary is receiving these ECM services. Today, hospitals struggle with knowing when a Medi-Cal MCP beneficiary arrives in their Emergency Room whether the Medi-Cal beneficiary has additional services provided through the Health Homes Program.
b. ILOS Selection; Page 51	Indicate which of the DHCS pre-approved ILOS listed below the MCP plans to provide, indicating which County or Counties for each. Note that the MCP will be required to submit more detailed information outside of the MOC Template, for future rate setting and other purposes.	This selection criteria is only for the 14-DHCS approved ILOS services. DHCS did not include an opportunity within the Model of Care for a Medi-Cal MCP to provide justification for the option to provide a non-DHCS approved ILOS. If DHCS is going to allow for a Medi-Cal MCP to provide an ILOS outside the 14-approved, then CHA urges DHCS to include in their Model of Care an opportunity for the Medi-Cal MCP to describe, provide support behind the cost-effectiveness alternative benefit, and request approval of the additional ILOS.