CALIFORNIA MEDICAL ASSOCIATION

December 16, 2019

Richard Figueroa, Acting Director
California Department of Health Care Services
1501 Capitol Avenue, MS 0000
Sacramento, California 95814

Via email at CalAIM@dhcs.ca.gov

Re: Comments on California Advancing and Innovating Medi-Cal (CalAIM)

Dear Acting Director Figueroa:

On behalf of more than 45,000 physician members and medical students of the California Medical Association (CMA), we would like to thank you for considering stakeholder input on the Department of Health Care Services' (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Proposal. Through a comprehensive program of legislative, legal, regulatory, economic and social advocacy, CMA promotes the science and art of medicine, the care and well-being of patients, the protection of the public health, and the betterment of the medical profession. CMA's physicians are committed to working to improve the Medi-Cal program and to ensure that patients have access to care. As we continue to participate in the various CalAIM stakeholder groups and as the proposal evolves or changes, we will provide additional suggestions, feedback and comments as appropriate. We appreciate CMA's inclusion on some of the key workgroups and continue to seek opportunities to help develop this proposal in a way that supports physicians and their patients.

IDENTIFYING AND MANAGING MEMBER RISK

2.1 Population Health Management Program

CMA supports the requirement that all Medi-Cal managed care plans (MCPs) maintain a population health management program that improves the ability of physicians and other health care providers to identify social factors and needs that impact health. We believe that a more comprehensive strategy that accounts for screenings, health assessments, case management, data collection and monitoring and risk stratification is a fundamental and much-needed improvement to the overall managed care plan responsibility. However, the plans should not develop these population health management programs in isolation. We would recommend that the plans be required to include practicing physicians from the plans' geographic service areas in the development and operationalization of their program. This local input will ensure that plans receive feedback directly from practicing physicians on the most effective ways to improve care coordination, communication and data sharing.

Initial Risk Assessment

One of the challenges in managing high-risk populations is the inability to share appropriate levels of data with providers in a meaningful and timely way. The Department is correct in seeking to separate risk assessments from clinical screenings. However, it's important that the results of the member-contact screening also be shared with assigned primary care physicians or specialists and not just between the plan and the Department of Health Care Services (DHCS). Physicians and patients would greatly benefit from additional information about a patient's social needs, including their access to food, clothing, household goods and transportation. If a health plan is obtaining this information through its assessment, CMA would recommend that a mechanism be developed to appropriately and legally share this patient information with the physicians that are caring for the patients directly. This information should also be available electronically, integrated with the patient's existing health records, and updated in a timely fashion.

The data should also be collected in such a way so that it can be easily transmitted in a usable format and incorporated into the risk stratification process. We recommend that initial risk assessment be standardized to the extent that DHCS is able to compare data across plans and develop methods to evaluate the success of their population health management programs. Additionally, to the extent that member-contact screening requirements are passed down to physicians, DHCS should make sure there is adequate reimbursement for such screenings. Screening tools should be separate from screenings used for clinical screenings, cost-effective, and not negatively impact medical care or create additional burden for physicians. DHCS should also implement enhanced education on effective screening practices.

Risk Stratification

The CalAIM proposal requires Medi-Cal managed care plans to risk stratify the population to determine the level of intervention that members require based on all available data sources, as well as the results of the member-contact screening. CMA urges the department to ensure that it implements efforts to identify and address bias in the use of these risk stratification algorithms and to avoid introducing or exacerbating health care disparities in connection with the use of these tools, particularly since they will be used for vulnerable populations. While recognizing there is some proprietary intellectual property in the development of risk stratification algorithms, we would also encourage greater transparency about how these tools are being deployed as well as the underlying data being used to generate any outputs. Any algorithms used by plans should be validated nationally and required to use as complete a set of data as possible.

The reliance of risk stratification algorithms on inputted data can lead to certain associated risks. These algorithms require access to large quantities of high-quality data during training and validation. Without accurate and meaningful data, algorithms may not be correct or may not be applicable to different populations. The source of the data used during training will impact the algorithm significantly, and models must be tested on a variety of data sets for validation purposes in order to create an algorithm that works accurately across patient populations. Otherwise, an algorithm may be trained and validated, only to produce inaccurate results when used with a population that varies based on race, gender, or socioeconomic background, medical history, hospital setting, or geographic location.[1]

Furthermore, the biases of training data can risk exacerbating existing health disparities. If models only reflect the limited populations on which they are trained, they will be less accurate for minority groups, and majority groups will have better access to accurate algorithms and thus superior health care.[2] In addition to training and validating across broad populations, MCPs should work towards increased transparency in order to provide opportunities to disclose and address system bias. Understanding data provenance, including key attributes of the training data population, is necessary to evaluating the accuracy of the risk stratification algorithms and the risks of applying the system to a different population.[3]

Provider Referrals

CMA supports the establishment of a process for providers to refer patients for case management, including a toll-free line for both primary care and specialists to seek technical and referral assistance when a patient requires additional evaluation and treatment. Physicians would greatly benefit from guidance on how to best assist a patient needing additional services that are beyond the physician's capacity to address, so CMA would request that plans provide physicians with specific information on how they can access this service on behalf of their patients. The information should be shared prominently rather than simply posting on a website and including it in provider materials where it may not be readily available or known about. Additionally, DHCS and MCPs should facilitate processes to guarantee a warm handoff between physicians and social service providers so that patients are able to easily access additional services that will support their health.

CMA also supports the provision of a 24-hour/7-day a week toll-free nurse advice line for members seeking assistance for physical, oral and behavioral health services. While this is a current service requirement for plans licensed under the Knox-Keene Act (28 CCR 1300.67.2.2(c)(8)), CMA is aware that some plans simply delegate this requirement to contracting physicians, with no reimbursement for providing the service. CMA would urge the Department to not permit plan delegation of this function to a contracting physician

---

[1] See Jennifer Bresnick, *Unleashing the Value of Health Data in the Era of Artificial Intelligence*. HEALTH IT ANALYTICS, *available at* https://healthitanalytics.com/features/unleashing-the-value-of-health-data-in-the-era-of-artificial-intelligence.

[2] American Medical Association Policy H-480.940; *Report 41 of the Board of Trustees (A-18) Augmented Intelligence (AI) in Health Care*, American Medical Association (2018), *available at* https://www.ama-assn.org/system/files/2019-12/a18-bot-reports.pdf.

[3] *Report 21 of the Board of Trustees (A-19): Augmented Intelligence (AI) in Health Care*, American Medical Association (2019), *available at* https://www.ama-assn.org/system/files/2019-04/a19-bot21.pdf..

practice unless there is a mutually agreed upon contract and reimbursement rate between the plan and its contracting physician practice for this specific service.

Health Information Technology to Support Integrated Care and Care Coordination

CMA supports the proposal to require MCPs to implement health information technology (HIT) to support population health principles, integrated care and care coordination across the delivery system. We believe the development and funding of this HIT infrastructure is key to the success of the CalAIM proposal, and would request that DHCS provide more specific information in future stakeholder meetings and written documents as to how it will be build and fund interoperable health information technology and health information exchange infrastructure. We would also request more details as to the data exchange protocols MCPs will be required to develop in order to ensure care coordination with their physicians as well as between physicians and other health care providers including behavioral health specialists.

In order to personalize health care and improve health outcomes the healthcare industry must share and effectively use health data. While we have the technical and operational ability to do this today, we lack the willingness of all the participants in the system to enable effective data exchange and use. For instance, currently electronic health record (EHR) vendors lack the market imperative to ensure interoperability, partly because providers bear most of the costs of integrating these devices and because there is an absence of an aligned demand to drive change in the technology ecosystem. Some larger health care providers achieve some level of medical device integration, particularly to support data to EHR integration. However, in the perceived absence of a prominent value proposition, many devices are not integrated with other technologies at all.

A report published by the West Health Institute in 2013 estimated that wide-spread medical device interoperability could eliminate at least $36 billion of waste in inpatient settings alone (West Health Institute, 2013). It was estimated that functional interoperability leads to increased efficiency, lower costs, and better quality of care through four primary drivers: reducing adverse events because of safety interlocks ($1.9 billion); reducing redundant testing ($1.5 billion); reducing clinician time spent manually entering information ($12 billion); and shortening length of stay through more timely transmission of critical information such as lab results ($18 billion).Technologically and financially, physician practices, hospitals, and clinics in California range from large and sophisticated systems to small, strained offices and facilities. Under any statewide policy requiring stakeholders to meaningfully share health information, it is reasonable for certain providers with limited infrastructure and means—such as independent physicians, rural hospitals, and safety-net clinics—to expect public subsidies and incentives to help defray the costs of participation. Moreover, other states' efforts to advance health information sharing through both strong requirements *and* funding have seen success.[4] We would recommend that DHCS consider incentive payments to physicians for adoption of new technology, and that DHCS offer electronic equipment, as well as technical support, to ensure that every provider can participate in meaningful data exchange and a patient's health record is truly comprehensive.

Additionally, we ask that DHCS take this opportunity to create the position of state "coordinator for connected care," or its equivalent. This coordinator position would oversee all health IT efforts, including general health IT coordination among payers and providers, health IT upgrades for county mental health billing, consistency in telehealth offerings across programs, MCP and provider participation in HIE, and the promotion of interoperability among health IT systems, especially EHRs. In past experiences such as the creation of the position of deputy secretary of health information technology within CHHS, the state was able to play a critical role in facilitating the policy, statutory, and regulatory changes needed to advance electronic health record adoption and health information exchange.

While DHCS currently has the Information Management Division, there is no individual who is tasked with such coordination efforts, especially to provide guidance to payers and providers on how to navigate the myriad billing, health records and other IT systems that are in place among and often within organizations. While we thank DHCS for expanding the breadth of telehealth-enabled services now reimbursed by the Medi-Cal program, we note that these impediments to better care coordination are likely to continue and compound for physicians serving the Medi-Cal population and DHCS as well, particularly since most Medi-Cal beneficiaries receive their services in multi-payer environments where payers may use different technology platforms with providers to provide services, and where physicians are utilizing different electronic health records vendors that make integration difficult.

2.2 Enhanced Care Management Benefit

CMA strongly supports the addition of this new benefit to the Medi-Cal program. As documented in several studies, including a recent Commonwealth Fund report,[5] five percent (5%) of the population accounts for fifty-percent of the health care costs. As noted in the report, identification of the high-risk population is not enough. There must be an overall effort to change the way care is delivered through innovative methods including alternative payment models, systemic change and supporting providers in changing their own organizations. CalAIM will not be successful if this approach is not supported with the right financing and programmatic flexibility.

---

[4] The state of Michigan helps fund its statewide health information-sharing platform, and as a result, providers receive daily ADT and emergency room notifications for more than 7 million patients (out of 10 million residents). See Michigan Health Information Technology Commission Update, May 2018; https://www.michigan.gov/documents/mdhhs/May_2018_HIT_Commission_Presentation_Final_Version_631723_7.pdf

[5] Kushal Kadakia et. Al, COMMONWEALTH FUND, ADAPTING PROMISING INNOVATIONS TO MEET THE NEEDS OF HIGH-NEED, HIGH-COST POPULATIONS (April 4, 2019), *available at* https://www.commonwealthfund.org/blog/2019/adapting-promising-innovations-meet-needs-high-need-high-cost-populations.

CMA supports efforts to promote well-coordinated and adequately funded case managers for people with complex medical and social needs. Many social and economic conditions often lead to health disparities, or differences in health outcomes, and vary by socioeconomic status, race/ethnicity, geographic location, educational attainment, sexual orientation, gender, and occupation. Strong evidence has accumulated over the last decade that links unmet social needs with poor health status.[6,7] A recent study found that when organizations had greater flexibility over spending, health care leaders made investments in a range of services to address housing, food, legal, and other social needs, as well as capacity-building interventions to strengthen health care and community-based organizations' ability to respond to these needs.[8]

We understand from the CalAIM proposal and from previous stakeholder meetings that the ECM benefit is designed to be provider-based and in-person, and that MCPs will contract out for these services. Additionally, we would ask DHCS to clarify in its written policies, that unlike the existing case management and complex case management benefits provided by the MCPs, ECM will be done at the provider level. We would encourage the utilization of existing provider relationships and networks, and for MCPs to continue to build on the success of existing programs like the Whole Person Care pilots. Additionally, we strongly support contracted models where MCPs will provide direct funding for physician practices to hire additional case managers who can provide this benefit to patients.

While supporting the addition of this important benefit that holds a lot of promise for tackling the most high-cost and high-risk populations, physicians report to CMA that oftentimes when managed care plans are given additional requirements for enhanced care management that require high-touch, on the ground and face-to-face contact, either programmatic or data-related, that these requirements tend to be delegated downstream to treating physicians, often without discussion or additional financing to support the new requirements. Providers, both physical and behavioral health, will be key to successfully driving these changes with individual patients. However, in order to successfully implement this new benefit, plans cannot simply add additional unfunded contract requirements to provider contracts and expect this to be absorbed into practice flows. CMA would urge the Department to require plans to include any additional requirements and associated reimbursement for enhanced care management responsibilities in physician contracts.

Quality Metrics

We also understand from previous stakeholder meetings that funding for these benefits, and for incentive based-contracts with physicians, will be based on reporting on quality metrics.

---

[6] C. Mansfield and L. F. Novick, "Poverty and Health: Focus on North Carolina," North Carolina Medical Journal, Sept.-Oct. 2012 73(5):366–73.

[7] S. H. Woolf and P. Braveman, "Where Health Disparities Begin: The Role of Social and Economic Determinants—And Why Current Policies May Make Matters Worse," Health Affairs, Oct. 2011 30(10):1852–59.

[8] Hugh Alderwick, Carlyn M. Hood-Ronick, and Laura M. Gottlieb. Medicaid Investments To Address Social Needs In Oregon And California. *Health Affairs* 2019 38:5, 774-781.

We strongly encourage limiting the number of data points on which physicians need to report so that physicians can spend their time providing medical care instead of completing administrative tasks. We encourage DHCS to consider the following guiding principles for selecting incentive measures:

- The quality performance standards tied to value-based payment models must be physician specialty-validated clinical measures.
- Quality reporting measures should be consistent and aligned with other programs and payers. Developing mechanisms for sharing standardized quality measure data among different programs will reduce time and resources spent reporting duplicative or redundant measures.
- The development and revision of these measures should be an ongoing process that reflects new clinical evidence and quality data.
- When new quality measures are adopted, other measure should be reviewed and evaluated before being retained.

Minimizing additional administrative burdens on physicians should be a priority. Currently, physicians are required to report multiple quality measures in different ways to different entities. This imposes significant burdens on physician practices and impedes comprehensive improvement in overall quality of care. A recent study[9] indicates physicians and their staff can spend upwards of 15 hours per week dealing with various quality measures with different payors. The physician time alone spent dealing with quality programs is estimated to be enough time to care for approximately nine additional patients and the staff time spent is incredibly costly to practices.

We encourage DHCS to emphasize quality measures that can be assessed based on available data, and to use existing encounter data rather than requiring physicians to complete additional reporting. Ensuring these measures can be automatically extracted from encounter data would reduce the need for physicians and their staff to manually extract and manipulate data measures according to the individual specifications of each entity requiring quality data reporting.

CMA strongly supports using existing sources of data when evaluating physician participation in this program and that any assessment of the proposed measures be done through existing encounter data. CMA also strongly opposes any measures that require increased manual review of medical records by physicians, their staff, or external auditors.

---

[9] Lawrence P. Casalino, et al., *US Physician Practices Spend More Than $15.4 Billion Annually to Report Quality Measures,* Health Affairs (March 2016), *available at* https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1258.

Data Sharing for Care Coordination

Ensuring data sharing among physicians, behavioral health providers, and social service agencies will be necessary to ensure the success of the enhanced care management benefit. Physicians face a confusing maze of legal and regulatory requirements around state and federal privacy laws. The federal Health Insurance Portability and Accountability Act (HIPAA) regulates how physicians maintain records, the security and confidentiality of medical records, patient access to their records, how physicians use and disclose records, and what to do when there is a breach of security to medical information. In addition to HIPAA, California law also governs how medical records are kept pursuant to the Confidentiality of Medical Information Act (CMIA). Certain kinds of medical records, such as mental health records and substance abuse records are also subject to additional laws depending on the practice setting, who and how the information was gathered. Physicians also need to be mindful of federal and California law that governs how electronic consumer data is collected, stored, used and disclosed.

CMA would request clear guidance from DHCS to both plans and physicians on how to share data and structure data-sharing agreements in compliance with state and federal requirements. CMA supports efforts to research historic data and promote data-sharing among social service, physical health and behavioral health providers, and correctional facilities, consistent with state and federal privacy laws, in order to provide continuous and coordinated care for people with social needs that may impact their health. Finally, given the myriad of medical records laws and regulations, and lack of clarity about compliance, CMA supports further education for physicians on their legal obligations regarding these laws.

2.4 Shared Risk, Shared Savings and Incentive Payments

The key to successfully implementing a majority of the CalAIM proposal rests on the financing and alignment of incentives. As the Department develops the mechanisms for the financial incentive payments, CMA requests that it, along with other physician organizations, be given an opportunity to offer input at key points in the rate and incentive payment process. The reason for this is two-fold:

- The CalAIM initiative will place a number of additional requirements on contracting managed care plans, their delegated entities and ultimately, the treating physician. CMA would like to ensure that these requirements are not only appropriately delegated, but appropriately reimbursed (as noted above).

- According to the proposal, the incentive funds are intended to build capacity for both enhanced care management and in-lieu of services. We believe that there will be greater pressure on the plans to support and build the in-lieu infrastructure (i.e., build additional facilities, bed capacity) and this could occur to the detriment of supporting the enhanced care management benefit. The two must be equally supported and

CMA would like to ensure any such incentive structure recognizes and supports both appropriately.

Lastly, the CMA requests that the Department consider dedicating a portion of the incentive payments to some of the underlying fundamentals associated with the managed care delivery system. There are currently a very large number of plans subject to Corrective Action Plans (CAP) with 20 MCPs placed under a CAP in July 2019 for noncompliance with the Annual Network Certification requirements.[10] MCPs continue to rely heavily on alternative access standards, with approximately 6,500 requests being approved in most recent network certification process, down from around 10,000 the previous year.[11] To date, the state has never offered plans an incentive payment for achieving or exceeding network adequacy standards. Given the necessity of keeping an adequate network and meeting time-and-distance standards for all Medi-Cal beneficiaries, the CMA would suggest that a portion of the new incentive dollars be provided to plans that not only meet, but exceed their minimum requirements in these critical access measures.

MOVING MEDI-CAL TO A MORE CONSISTENT AND SEAMLESS SYSTEM BY REDUCING COMPLEXITY AND INCREASING FLEXIBILITY

3.3 Transition to Statewide Long-Term Services and Supports, Long-Term Care and Dual Eligible Special Needs Plans

CMA has serious concerns about DHCS's proposal to move some of California's most vulnerable patients into mandatory Medi-Cal managed care. CMA opposes any effort to mandate that dual eligibles be enrolled in managed care. If the state decides to move forward with this mandate by 2023 as proposed, then we recommend ensuring that all efforts are made to ensure continuity of care for these patients and to learn from the lessons of the Coordinated Care Initiative (CCI) to improve patient and physician outreach and education. DHCS must also ensure there is no disruption in care for beneficiaries during this transition, which did occur during CCI implementation. Additionally, DHCS and the MCPs must provide full and clear disclosure to beneficiaries of options and implications of managed care enrollment.

DHCS should ensure robust stakeholder engagement in this endeavor, and develop enrollment notices and educational materials for beneficiaries that are accurate, easy to understand, and ADA accessible. Outreach, enrollment and coordination of care must be culturally, linguistically competent and fair for California's diverse seniors, especially those who have Limited English Proficiency. Patients and physicians must be properly educated

---

[10] Department of Health Care Services, July 2019 Annual Network Certification Corrective Action Plan Report, https://www.dhcs.ca.gov/formsandpubs/Documents/2019-July-Corrective-Action-Plan-Findings.pdf

[11] Department of Health Care Services, 2019 Approved Alternative Access Standards Report (Jan. 30, 2019), https://www.dhcs.ca.gov/formsandpubs/Documents/AB_205_AAS_Report_2019.pdf.

about this plan and its implications for coverage and access to care. DHCS should provide training and materials to physicians on billing, continuity of care, and plan enrollment, which should be available well in advance of the transition in 2023. Physicians should have the resources to make an educated decision about changing their participation status in MCPs or Dual Eligible Special Needs Plans (DSNPs) and to share information about the program with their patients.

As MCPs begin to operate DSNPs, they should work to maintain the same provider networks that exist in Cal MediConnect. DHCS should make sure that all Medicare Advantage Network Adequacy requirements are enforced, and encourage DSNP plans to contract fairly with physicians and to reimburse physicians at the Medicare Fee Schedule or higher. CMA strongly opposes any passive or default enrollment into DSNP for patients. Additionally, patients who do to choose to enroll should be permitted to disenroll after 30 days. Beneficiaries should have clear notice rights that they are not required to enroll in a DSNP and clear instructions about how to opt out.

3.4 Annual Medi-Cal Managed Care Plan Open Enrollment

Given the number of changes that CalAIM proposes to make in terms of greater standardization of managed care benefits (including the addition of enhanced care management and in-lieu of services) and the emphasis that the Department is making on care coordination for all populations in Medi-Cal, the CMA is supportive of the concept of annual open enrollment. This concept, if implemented and enforced appropriately, will allow plans and their network providers to invest the necessary time and resources in patient care coordination. It is difficult, and almost impossible, to coordinate complex patient care if the patient is changing their plan multiple times in a year, especially if the changes are because of administrative burden or access issues. CMA's support of this particular CalAIM concept is based on the consumer-friendly exemption process as currently proposed, especially as it allows a patient to keep their primary care physician or specialist if a physician contract has been terminated with an existing Medi-Cal managed care plan as long as the physician is contracting with a different network/plan in the same region.

3.6 Regional Managed Care Capitation Rates

Since the passage of Proposition 56 in 2016, the Department of Health Care Services and CMA have worked closely to design and implement the supplemental payments for physicians. This collaboration has been both productive and instructive in how these supplemental payments can be targeted to incentivize certain services (i.e., preventive screenings) as well as provide necessary funding to support existing Medi-Cal providers and the work they do in stabilizing our safety net. The CMA supports the important work done by the Department when it comes to rate-setting and overseeing the supplemental payments directed through the managed care plans. As the state moves to regional rate setting, the CMA understands that this will dramatically reduce the number of rates that must be developed by the department and approved by the federal government. While we are pleased that the State has increased the availability of supplemental Medi-Cal payments for certain services, this should not be viewed as a reason for plans to reduce base Medi-Cal rates. As the Department begins to implement these regional rates, CMA would urge caution as the potential downward pressure on capitated rates that some plans may experience because of this shift to regional rates may result in downward pressure in physician contracted rates. Physicians already struggle to participate in the Medi-Cal program due to low reimbursements, and further reductions in already low rates could have serious negative consequences for network adequacy and access to care.

3.15 Improving Beneficiary Contact and Demographic Information

The CMA is strongly supportive of efforts to improve beneficiary contact and demographic information, especially as it pertains to the increasing emphasis on care coordination and face-to-face interactions for the highest cost/highest complexity patients in Medi-Cal. CMA supports efforts to improve the Medi-Cal enrollment process to require as few client contacts and follow-ups as possible, and to expedite and simplify inter-county transfers. Additionally, CMA supports allowing eligible uninsured patients to enroll in Medi-Cal and other publicly funded health care programs at the time that they receive care. Historically, the beneficiary information has been inaccurate and is a significant factor in preventing a provider from contacting a patient for follow-up care or referral information. CMA would be pleased to participate in such a workgroup as discussed in the CalAIM proposal and looks forward into how this approach is implemented.

CONCLUSION

Thank you in advance for your consideration of our comments on DHCS's CalAIM proposal. California's physicians look forward to working with you to develop strategies and recommendation that improve quality care for Medi-Cal beneficiaries. We hope this letter will serve as guidance as this proposal is developed and implemented. If you have additional questions, please contact Jessica Rubenstein, Associate Director of Health Policy, at jrubenstein@cmadocs.org.

Sincerely,

Peter Bretan

Peter N. Bretan, Jr., M.D.
President
California Medical Association