July 14, 2020

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Director
California Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

SUBJECT: Medi-Cal Long-Term Care at Home Benefit Design

Via e-mail: Will.Lightbourne@dhcs.ca.gov

Dear Director Lightbourne:

On behalf of our 24 member Medi-Cal managed care plans (MCPs) that arrange for the care of approximately 10.8 million Medi-Cal members, the California Association of Health Plans (CAHP) appreciates the opportunity to provide recommendations to the California Department of Health Care Services (DHCS) on the *Draft Medi-Cal Long-Term Care at Home Benefit Design Proposal,* that DHCS and the California Department of Aging (CDA) released on June 24. The proposal provides an overview of a potential new Long-Term Care at Home (LTCH) benefit. CAHP looks forward to participating in the ongoing LTCH stakeholder engagement effort, and we offer the initial comments below to be incorporated into DHCS' stakeholder engagement process.

First and foremost, CAHP members appreciate DHCS' leadership in developing a proposal for a statewide benefit that would provide increased access to long-term services and supports (LTSS) in the community and increase nursing facility capacity. While we support the effort to create a new LTCH benefit, we are concerned that the current proposal does not have sufficient details about the structure of this benefit. CAHP recognizes that there is an immediate need to provide increased access to LTSS and to ensure that nursing homes have capacity, and we support efforts to design this LTCH benefit to meet this demand. However, the current timeline is not realistic given that very few program details appear to be worked out including who is eligible, what the scope of the benefits will be, how the provider networks will be developed, how the benefit will be financed to be cost neutral to the State General Fund, the time it will take to receive Centers for Medicare & Medicaid Services (CMS) approval, and how the program will interact with currently operating programs that serve the targeted population. In addition, current medical and community-based providers are consumed with efforts to care for Medi-Cal members and mitigate impacts of the COVID-19 pandemic as much as possible. Given all of these outstanding questions – and considering that the health care community is currently mobilizing efforts around the COVID-19 pandemic – CAHP requests that DHCS consider a delay of the implementation of this benefit to allow for the significant opportunity to further develop and refine the proposal with MCP partners, providers, and stakeholders through an enhanced and extended stakeholder engagement process.

Detailed comments below – informed by the experience of CAHP members – are organized as follows: 1) DHCS' key goals, 2) target populations, 3) model of care, 4) LTCH agency licensing, 5) financing and cost, and 6) stakeholder engagement and timeline.

I. Key Goals

CAHP members are supportive of DHCS' stated goals. However, CAHP request that DHCS refines these goals through the lens of DHCS' California Advancing and Innovating Medi-Cal (CalAIM) initiative 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 and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

Filtering the LTCH benefit goals through the lens of DHCS' CalAIM goals and ensuring stakeholders have a deep understanding of how the LTCH benefit not only addresses the shortcomings of currently available services and systems that were identified throughout the CalAIM stakeholder engagement process – but also how this proposal fits within the larger CalAIM initiative – is an important first step.

CAHP encourages DHCS to not lose sight of our CalAIM learnings, in which DHCS, MCPs, providers, and other stakeholders identified barriers within the current health care delivery system that need to be addressed to ultimately improve health outcomes and the patient care experience for the Medi-Cal members we serve. Examples of these barriers include, but are not limited to, the following:

- **Coordination of multiple different systems.** There are multiple delivery systems, payors, and agencies that coordinate care, with a very real opportunity to better coordinate medical, behavioral health and substance use disorder pharmacy services. MCPs are concerned that with the LTCH benefit, as currently proposed, there will be an overlap of services and difficulty coordinating amongst multiple benefits. MCPs offer that one possible solution is to have a centralized database that tracks all services provided to a member. This would facilitate data integration and ensure all of the member's needs are being addressed, without duplicating services. Additionally, MCPs recommend that all members' services should be authorized by a single entity.

- **Lack of wraparound services due to limitations**. Examples of current limitations of wraparound services include: a cap on the maximum number of In-Home Supportive Services (IHSS) hours a member can receive, Medi-Cal funds not being able to be used for non–medical services like home health aid/companion care on long-term basis, and home modifications to keep individuals in the home (e.g., ramps, stair lifts, medical alert systems). CAHP requests that DHCS address these limitations in its proposal.

- **Lack of provider network.** MCPs report the main reason that more Medi-Cal members do not receive home health post-discharge is often related to lack of available providers in a service area. In addition, the ability of MCPs to attract providers largely comes down to rates. MCPs continue to report having providers who don't want to take on Medi-Cal-only business because of low Medi-Cal rates, but these providers will contract with MCPs for Cal MediConnect (CMC) for the Medicare piece. DHCS' proposal must include steps to ensure a robust provider network is available for this benefit.

CAHP and its members welcome the opportunity to partner with DHCS to address these identified limitations before potentially adding further complexity to our health care delivery system.

II. Target Populations

Special Considerations for Dual Eligible Individuals
CAHP requests that dual eligible individuals be eligible for this benefit and looks forward to partnering with DHCS on special considerations for the dual eligible population. Further, CAHP requests that DHCS clarify how this benefit will work for the different categories of duals: Medi-Cal only full duals, Medi-Cal only partial duals, and CMC. CAHP recommends that dual eligible individuals enrolled in CMC be eligible for all services under the benefit, and that dual eligible individuals outside of CMC be eligible for the skilled nursing facility (SNF)-to-Community category. For the focus of this benefit to extend beyond the Medicare allowed services (nursing, physical therapy/occupational therapy (PT/OT)) a clearly defined set of Medi-Cal services will need to be identified, such as socialization, personal care attendant, and care coordination. Return to hospital or long-term stays in custodial settings are often not due to the lack of skilled care, but due to other factors required for independent living. The proposal as currently written has a focus on the skilled services.

CAHP acknowledges there will be some challenges in coordinating Medicare benefits for dual eligible individuals. For example, MCPs will need more information regarding the coordination of care of dual eligible members who only have Medi-Cal with MCPs (and Medicare via fee-for-service (FFS) or another entity). Care management for these members would be extremely challenging given the limited data sharing. CAHP recommends that DHCS have processes in place to avoid duplicative services (i.e., since Medicare is primary, to ensure that these services are not being provided on the Medicare side).

Primary Categories of Skilled Nursing or Skilled Therapy Care
CAHP provides the following recommendations related to the three primary categories of skilled nursing or skilled therapy care that may be provided at home through this new benefit:

- **Short-term skilled nursing:** CAHP members are concerned that for members with high acuity, services cannot be rendered at home due to clinical condition, safety, requirement for monitoring or frequency of the skilled need (hourly or multiple times a day).

- **Long-term skilled nursing:** CAHP notes this appears very similar to Home and Community-Based (HCBA) waiver services. Typically, home health services are intermittent skilled visits, not continuous nursing care which is private duty nursing (22 CCR § 51124(b) Skilled Nursing Facility Level of Care). Lastly, many members who can safely transition home are still pending waiver/housing slots.

- **Low-acuity skilled nursing:** CAHP notes that this is similar to intermediate care services criteria (22 CCR § 51120. Intermediate Care Services). In addition, members coming from an acute setting are still at risk. With no support or safe discharge plan, institutionalization is the best/safer option for those who need the 24/7 monitoring. CAHP requests that DHCS provide concrete details on how members will be successfully transitioned out of the hospital or nursing home, including discharge criteria, which is notably missing from the proposal. CAHP requests that DHCS also include graduation criteria and requirements, especially for members with a short-term need. Lastly, CAHP would like to point out the confusion that arises for some as these three primary categories of skilled nursing or skilled therapy care are aligned with an institutional level of care.

Congregate Living Health Facilities
The draft benefit design currently excludes transition to residential care facilities for the elderly and "room and board" facilities. In assessing where to transfer members based on their level of acuity, and given the focus on having members in a safe environment (which their actual home may not be for various reasons), CAHP requests DHCS include transfer to congregate living health facilities ("CLHFs") in the scope of this benefit, particularly for members who need short-term skilled nursing or lower-acuity skilled nursing. Because CLHFs are licensed to provide skilled levels of care, but the services are not currently covered absent a wavier, they could be safe alternative to a member's home under this benefit.

Additional Clarification Needed Regarding Definition of "Home"
DHCS indicates that Medi-Cal beneficiaries who receive this benefit will be able to transfer from a hospital to their home, transfer from a SNF to their home, or potentially avoid a SNF stay altogether. CAHP requests that DHCS clearly define "home," as Medi-Cal members would only be eligible for this benefit if they are transferring home. CAHP recommends that the definition of "home" also include independent living facilities, single room occupancy, etc. or limited definitions of this. CAHP members are deeply concerned that there is no strategy for homeless or poorly housed people in this proposed benefit. As written, the benefit requires a home for the member to go to, and someone in the home able to provide at least monitoring and support. The current members in long-term custodial care oftentimes do not have a home, oftentimes do not have a family member willing to provide care, and require a lot of care every day (tube feedings, ventilator management, dementia management). CAHP requests that DHCS clarify how this benefit will address these circumstances. In addition, MCPs note that a major barrier is limited housing resources outside of board and care (not a covered benefit). In short, the exclusion of other discharge settings provides limited or no alternative for members with no other social supports or housing and this will make operationalizing this benefit a challenge. CAHP requests that DHCS address this in future iterations of its proposal.

Eligibility Exclusions
DHCS indicates that, for various reasons, not all Medi-Cal beneficiaries who require long-term care (LTC) services will be eligible for this benefit. CAHP members agree that irrespective of acuity, MCPs and their contracted LTCH agencies must retain the ability to not offer this benefit to members that 1) do not have a safe home environment, and/or 2) that do not have willing, able, and capable caregivers to help support them at home.

Eligibility Exclusions Based on Access to Other Services, Enrollment in Other Programs
DHCS indicates that since many of the long-term care services provided under this benefit may be available through other avenues and/or programs, DHCS will also evaluate and provide clear written policy guidance as to when it may exclude Medi-Cal beneficiaries. CAHP requests that DHCS also develop a list of all duplicative programs, including in which counties these programs are offered, to inform future stakeholder discussion on this benefit. All stakeholders must have a common understanding regarding the population of individuals who would qualify for this benefit, the differences between current MCP benefits, current waiver programs, and interaction of this benefit.

Special Considerations for County Organized Health Systems
CAHP cautions that for MCPs that currently do not have any LTC benefits beyond month of and month after, it would be extremely challenging to create a relationship with an LTCH provider, only to have that no longer be in place after disenrollment. There is currently no incentive or rate structure to support MCPs who currently do not have the LTC benefit to provide the LTCH benefit. CAHP requests that DHCS

clarify if the intent with LTCH is to have these members stay in managed care or to have their LTCH benefit provided via FFS?

Special Considerations for Rural Areas
MCPs are particularly concerned there are not enough available providers/resources in rural areas of the state. Some MCPs report that even if they were to contract with LTCH providers to provide wraparound services via this benefit, they don't believe these providers would necessarily have the bandwidth to keep up with the demand of member needs. CAHP recommends that DHCS address how it will increase available resources in these regions before launching this benefit.

Refinement of Target Population
CAHP and our members look forward to participating in the identified stakeholder process to refine the target populations of this new benefit. MCPs note there are many additional considerations that must be considered, including but not limited to, the following:

- Will DHCS expect MCPs to attempt to transition members who have been in a LTC facility prior to the initiation of this benefit, or will this benefit be offered only for prospective members?
- If a beneficiary admits to the hospital/SNF from home when on the LTCH benefit, at what point do they need to reapply or restart the program? MCPs request that DHCS develop a workflow to address.
- Will MCPs receive a target member list or clearer eligibility criteria?
- Will DHCS have discussions with hospital facilities, as the discharge plans and communication to members within the hospital will require coordination with LTCH providers. Will use of this benefit delay hospital discharge?
- Will DHCS consider a workgroup with the hospitals to design a workflow that incorporates LTCH into the discharge planning process? Would these hospitals want to be LTCH providers for the MCPs?
- MCPs would like confirmation that children under age 21 are not currently in scope for this benefit.
- MCPs would like confirmation as to whether share of cost beneficiaries are in scope for this benefit.
- Will MCPs receive an identifier in the 834, or some other report to indicate when a member is enrolled in a waiver or other exclusionary program?
- Can members on the LTCH benefit also be on an assisted living waiver waitlist?
- Some members will be actively enrolled in palliative care or have interest in accessing palliative care. Will home-based palliative care be considered a duplicative service or will members be allowed to receive both?
- How long can a beneficiary use the LTCH benefit (i.e., is there a maximum number of days, maximum amount per year)?

CAHP and our members look forward to partnering with DHCS to address these additional considerations.

III. Model of Care

DHCS notes it conceptualizes this benefit as an analogous comparison to the bundled payment and service structure of Medi-Cal's existing hospice benefit, minus the end of life component, whereby the

state-licensed agency performs an assessment of the medical and psychosocial needs of the individual (including family members), and arranges for and/or directly provides skilled nursing care and related therapies as part of a suite of services. In terms of messaging, CAHP requests that DHCS not publicly compare this benefit to hospice, and that DHCS not reference hospice during stakeholder communications. MCPs are deeply concerned that this messaging is problematic as Medi-Cal members will not want to associate returning to their homes with hospice; MCPs do not anticipate that most members will be facing end of life at the time the benefit is utilized.

New Distinct Licensure Process for Provider Agencies
CAHP appreciates that the agencies will need to be contracted with MCPs as this will mitigate siloed and duplicative efforts to support beneficiaries. With respect to the new and distinct CDPH licensure process for agencies that seek to enroll with Medi-Cal to provide this benefit, CAHP members are concerned that the additional step of CDPH certifying the vendors to provide this care may significantly limit MCPs' ability to complete contracts in a timely manner. MCPs will likely need to seek to add an amendment to existing home health or hospice or palliative care agencies to provide this case management support and additional in home care – but the requirement to use CDPH-certified vendors changes this – and does not allow MCPs to get started on these contracts.

CAHP requests that DHCS allow for additional organizations to be considered as LTCH agencies. For example, CAHP requests that DHCS clarify if these agencies could be Multipurpose Senior Services Program (MSSP) sites, and if MSSP waiver beneficiaries could be transitioned into this this program. CAHP requests that DHCS provide clarity regarding the interaction of MSSP and this benefit.

CAHP members have expressed concern that most home health skilled nursing agencies do not have the capacity, staff, nor structure to operationalize skilled nursing services at a comparable level to inpatient skilled nursing. For example, coordinating twice daily antibiotics, twice daily therapies at home would be cost prohibitive given the need for these providers to travel, etc. CAHP requests more information from DHCS regarding how it would ensure that these agencies have the appropriate capacity, staff, and structure to operationalize this benefit. With CDPH licensure, will CDPH be providing oversight of these LTCH vendors? If so, will this oversight ensure the capacity to provide significant in-home support under this benefit?

Streamlined, Expedited Process for Enrollment
CAHP suggests that DHCS create a streamlined/expedited process for enrollment of LTCH providers. The current processing times for enrollment do not seem feasible with an early 2021 start date. MCPs note that the timing of the licensure process – coupled with DHCS' ambitious proposed implementation date – create the possibility that there would be a waitlist to get a beneficiary connected to an approved provider to access the benefit, which is concerning in terms ensuring Medi-Cal members have timely access to care.

Coordination and Alignment with the California Department of Managed Health Care
Has DHCS consulted the California Department of Managed Health Care (DMHC) on development of this benefit? CAHP recommends that DHCS engage DMHC in development of this benefit, as MCPs will have network adequacy requirements; oversight/audit requirements; and utilization management appeal processes, including appeal rights, for DMHC independent medical review or state fair hearing.

Primary Components of Model of Care

DHCS indicates the LTCH agency will be responsible for providing and coordinating all components of the benefit through interdisciplinary care teams that work directly with qualifying Medi-Cal beneficiaries, and their families, caregivers, and primary care physicians (PCPs). CAHP requests that DHCS clarify the role of MCPs given this proposed structure. It appears that the current proposal places MCPs in the role of just passing through dollars. The current model does not help MCPs with ensuring care coordination for their members, if they are simply a pass-through between DHCS and the LTCH agency. The current proposal severely limits plans' ability to administer the benefit by requiring MCPs to contract with an LTCH agency, or a licensed hospice or Home Health Agency (HHA) approved to provide these services. The current model **does not** allow MCPs the flexibility to contract and coordinate with a variety of providers and community-based organizations (CBOs) – in addition to the licensed LTCH agency, or licensed hospice or HHA – to ensure the benefit is offered to eligible members.

CAHP requests that DHCS permit MCPs to administer the benefit in a way that best fits their local community and provider capacity. Reasons for this requested flexibility include, but are not limited to, the following:

- MCPs are already responsible for – and skilled at – managing the care of their members and providing required health care services.
- There may not be a "one stop" provider in a community who is currently able to offer all of these services on their own. There may be services that an HHA doesn't offer that will need to be supplemented by other entities.
- This benefit is going to be a huge undertaking and difficult benefit to manage in some markets already; more restriction is going to make this an even more difficult benefit to manage.
- MCPs will need flexibility in choosing which agencies/organizations would provide this benefit as MCPs may have different types of entities that can already do this work.
- MCPs indicate that being able to negotiate rates, shared savings, or pay-for-performance options would be preferable.

Many MCPs report having an infrastructure in place that can be scaled up to provide these services. Many MCPs have existing relationships with CBOs and health care providers to be able to offer these services. Regarding care coordination staff, MCPs could either hire or contract this to provide the coordination services for the new benefit. However, MCPs note that a major concern will be the clinical services — getting doctors and nurses to go into the home. It is challenging to hire and manage staff that are willing to go into a member's home to provide services.

In terms of certifying that MCPs could do all of the things required of a LTCH agency, DHCS could create a readiness review and checklist similar to other new benefit implementations. This could include network information, staffing ratios, policies and procedures, model of care, reporting, etc.

MCPs look forward to discussing CAHP's recommended approach with DHCS and to addressing these initial questions:

- Will members who are enrolled with Plan A for Medi-Cal and enrolled with Plan B for Medicare be eligible for the LTCH benefit?
    - If so, which of the two plans would be responsible for administering the benefit?
    - Would plans have access to the other plan's member information?
    - How would services be coordinated?

- DHCS previously mentioned it hopes for a go-live date of early next year. How soon would MCPs be expected to begin administering the benefit?
- How would MCPs be assessed or monitored in their administration of this benefit?
- MCPs that are National Committee for Quality Assurance (NCQA) accredited have requirements to perform complex case management or to have a delegate meet all required standards for complex case management. Will this benefit create a situation where there are two case management entities managing the same member at the same time if the LTCH is not required to meet the NCQA standards?

CAPH provides the feedback below related to the four primary components of the LTCH benefit: 1) individual, person-centered assessment; 2) transition service; 3) care coordination; and 4) medical and home and community-based services (HCBS).

Individual, Person-Centered Assessment
CAHP members are pleased that the individual, person-centered assessments will be conducted through standardized tools to ensure appropriate utilization of the benefit. CAHP requests that DHCS include more information in its proposal related to the screening and referral process.

CAHP requests that DHCS address the questions below related to the individual, person-centered assessment:

- Person-centered assessments are already being done throughout other Managed Medi-Cal Long-Term Supports and Services (MLTSS) programs. CAHP requests clarification on how this assessment will not duplicate efforts.
- Will the process for determining member eligibility include assessing the permanence of a member's housing?
- Will DHCS also pay an LTCH "assessment rate?" MCPs report that experience with palliative care assessments is that the assessments were very time consuming and oftentimes resulted in the benefit being not appropriate for the member for a variety of reasons. In this case, providers requested an "assessment rate." MCPs note this benefit would be different from hospice, where most referrals turn into the member enrolling in the program.

Transition Service
Related to the the proposed transition services, CAHP notes that these transition services sound similar the Care Plan Option (CPO) services for Cal MediConnect. CAHP request that DHCS clarify what the correlation will be to CPO, if any. In addition, MCPs request that DHCS clarify if "additional" in lieu of services (ILOS) may be added for transition members, as this seems like a more intuitive pathway for transitions from SNF to home for the low-acuity members. MCPs request that DHCS confirm it will allow the flexibility for providers to subcontract or to provide these services themselves. Lastly, MCPs would like clarification as to who is responsible for paying for the transition services, given they are not part of the LTCH agency's per diem rate. As the transition services will be billed separately from the per diem rate by the appropriate entity or provider, CAHP requests that DHCS clarify if it will be providing appropriate billing codes/rates for these services, and if these services will be subject to standard encounter reporting requirements.

Housing Assessments
DHCS notes in its proposal that transition services will not include monetary assistance to secure housing such as rent, security deposits, or the like. In addition, transition services will be billed

separately from the per diem rate by the appropriate entity or provider. CAHP cautions that without the flexibility to pay for housing-based services, agencies will be hindered in the ability to assist members who do not have a "home." This creates an unnecessary disparity that could be addressed with flexibility to cover these costs through an ILOS type of requirement. In addition, it is important to acknowledge that members would likely need basic furnishings such as a bed, stove, refrigerator, cooking utensils, etc.

CAHP requests that DHCS clarify if the LTCH agency will provide assistance when there is a need for housing. MCPs have expressed concern that many programs that offer permanent supportive housing currently have long waiting lists with no more slots available. CAHP members note that those coming from institutions are prioritized on existing waiver programs; however, if they have no housing and social supports, then disposition is not possible. MCPs would like to understand why these individuals would not be eligible for hospital to home discharges, and in the case of trying to keep members at home, rather than moving to a SNF. In both of these situations, the member's home must be assessed, suitable, and safe for the LTCH benefit.

Money Follows the Person/California Community Transitions Grant Program
DHCS indicates in its proposal that the agency will prioritize the coordination of transition services in accordance with the Money Follows the Person/California Community Transitions Grant (MFP/CCT) program for the higher reimbursement and services the MFP/CCT program can provide. CAHP members are concerned that these dual processes could be fairly duplicative and lead to confusion for the beneficiary. What guidance will be provided to ensure that the beneficiary has a clear understanding of the services being received?

CAHP requests that DHCS provide additional clarity on which services will be covered under MFP/CCT vs. the LTCH benefit. MCPs would like to note that if a member is lower acuity, then LTCH would seem more appropriate than the MFP/CCT program; if a member is higher acuity, more robust time and resources would be required so it would be more appropriate for the CCT program to be engaged as CCT will have more resources and flexibility than LTCH. Lastly, will MCPs be notified of which members are currently engaged in MFP/CCT? MCPs do not currently receive this data.

Care Coordination
DHCS' proposal notes that the LTCH agency will be responsible for the Medi-Cal beneficiary's care coordination. CAHP is incredibly concerned that the proposal appears to outsource all care coordination services to LTCH agencies, when MCPs are skilled at providing care coordination on behalf of their members. CAHP requests that DHCS allow for MCPs to provide some of the care coordination services, particularly in the event a local agency is unable to provide all the services.

CAHP requests that DHCS consider alternative models for the interdisciplinary care team (ICT) structure. The requirement that a physician is on staff limits providers that can participate, as many agencies that may be best suited for this work (i.e., CCT providers) may not have physicians on staff. MCPs note that there are a variety of organizations that already work as CCT provider ICTs.

Case Management
CAHP requests clarification that the LTCH benefit includes case management/enhanced care management (ECM) benefit type services, or if these need be coordinated with the MCP, Health Homes Program (HHP) provider, Whole Person Care (WPC) Pilot provider, etc. The proposal, as stated, looks very much like case management. If the intent is for the LTCH agency to provide case management

services, is enrollment in HHP, WPC, or any similar program considered duplicative and exclusionary? Further, CAHP requests that DHCS confirm if individuals enrolled in HHP, WPC, case management at the MCP level, MSSP, and other case management programs are eligible for LTCH and, if so, what the expectations are around care coordination between the LTCH provider and the other providers. MCPs are very concerned with overlapping efforts – multiple assessments, multiple care plans, multiple people trying to coordinate care. Again, CAHP requests that DHCS filter this proposal through the lens of the CalAIM goal of moving Medi-Cal to a more consistent and seamless system by reducing complexity. CAHP requests that DHCS ensure that Medi-Cal members, MCPs, providers, and other stakeholders have a common understanding of how these programs interact together, not in solos, so as not to create more confusion. Further, if agencies are providing all-inclusive services, CAHP requests that DHCS clarify the role of MCP (authorizations, assessments, care plan sharing, ICT, etc.).

Workforce Considerations
CAHP requests that DHCS' proposal account for the current shortage of home health registered nurses, PT/OT, and an extreme shortage of private duty nursing available. MCPs have shared that getting home MD/NP visits is very expensive and inefficient for the provider. In addition, MCPs report that getting personal care attendants to augment IHSS hours, and private duty nursing in lieu of SNF/custodial care is very difficult and very expensive. These issues must be acknowledged in developing this benefit. MCPs also acknowledge that mental health concerns are often very much front and center for this population, and access to in-home social work, family counseling or therapy may need to be a component of the LTCH workforce.

Individualized, Person-Centered Care Plan
CAHP requests that DHCS clarify if the agency's individualized, person-centered care plan will be considered primary. There needs to be clear ownership to avoid duplication, multiple care plans and touch points, and to decrease administrative burden. In addition, CAHP requests that DHCS clarify how care plan information will be shared with the MCP who may also be coordinating other benefits. Many members who may qualify for this benefit are considered high risk in MCP care management models.

Medical and Home and Community-Based Services
With respect to the list of "Medical and HCBS Services," DHCS notes that the LTCH agencies must "coordinate" all of the services on the list. For each item, CAHP requests clarification as to what particular items are actually *covered* by the LTCH agency as part of their per diem rate, rather than only "coordinated." As the services outlined in the list are services that MCPs are responsible for providing, CAHP requests that DHCS clarify that, in arranging for these health care services, the LTCH agency will partner with the member's MCP in coordinating access to these services.

CAHP is concerned that the list is focused only on medical care, and needs to include medical care *and* services that aim to address the ongoing psychological and social needs of individuals. Many individuals that would qualify for this benefit are in need of these psycho-social services.

In addition, CAHP requests clarification as to the scope of all of these services. Some examples include:

- Will medical equipment and supplies be limited to what's permitted in the Medi-Cal Provider Manual, or will there be differences in scope for this benefit?
- What is the scope of physician services that must be coordinated ty the LTCH agency? Are physicians expected to provide services in the member's home? Does this include both PCPs and specialists?

- What is meant by providing "nutrition services"? Are the agencies expected to plan meals, purchase groceries, and prepare meals for members (given meals would be provided in a traditional SNF)?
- With the category of "Long-term Skilled Nursing" services, what are the maximum limits to the number of service hours that could be provided?

For all services, CAHP requests that DHCS permit the use of telehealth when it is clinically appropriate.

In addition, CAHP recommends that DHCS develop new codes for these LTCH services, so that they may stand alone from hospice or home health codes. CAHP also suggests that DHCS host a technical stakeholder workgroup to discuss coding considerations.

Lastly, CAHP notes that the current proposal lacks care coordination requirements similar to the ones included in the HHP (i.e., staffing ratios, key services, in-person requirements, number of touches per month, etc). As DHCS envisions an all-inclusive per-diem rate, there need to be service requirements; CAHP requests that this information be included in DHCS' proposal.

In-Home Supportive Services
DHCS indicates in its proposal that for individuals who qualify for IHSS, the IHSS provider hours will be coordinated with the LTCH benefit through the development of the person-centered care plan. CAHP requests that DHCS work with the California Department of Social Services to require business associate agreements or memoranda of understanding between IHSS and LTCH agencies to allow for easy data sharing and more efficient care coordination; it is essential that this coordination is enforced at the county level. MCPs indicate that they and their partners were initially able to coordinate with counties at this level under the Coordinated Care Initiative; however, MCPs report this coordination has been inconsistent since the carve-out of IHSS and some counties have not worked as collaboratively as others. MCPs are deeply concerned that this will present challenges for LTCH providers unless counties are given clear guidance on collaboration expectations. CAHP requests more clarity on the interaction of IHSS and the LTCH benefit (i.e., requirements, workflow, timelines).

In addition, MCPs note that IHSS delays of up to 2-3 months and limitations on hours that would otherwise allow members to stay in a home-like setting remain significant barriers. CAHP requests that DHCS address these challenges through its proposal. Absent addressing these issues, CAHP would like DHCS to clarify if LTCH Agencies or MCPs will be funded to cover personal attendant hours during the lag time/gap.

Interaction of Other Waiver Programs for Transitions
CAHP requests that DHCS clarify how the LTCH benefit impacts other commonly used waiver programs for transitions, including the Assisted Living Waiver, HCBA, and CCT. CAHP also requests that DHCS clarify how the LTCH benefit impacts other programs and previous transition plans, if at all (e.g., MSSP carve-out, LTC carve-in for intermediate care facility/developmentally disabled). The duplication of services and availability of similar services through existing programs has been duly noted by many.

Interaction of In Lieu of Services
CAHP notes that the LTCH benefit hints at certain ILOS being provided (housing services and home modifications among others). CAHP requests that DHCS elaborate on the role of ILOS in this program, status of ILOS, and the correlation to CalAIM, if any.

IV. Long-Term Care at Home Agency Licensing

DHCS indicates that LTCH services may be provided by a licensed LTCH agency, or by a licensed hospice or HHA approved to provide these services. CAHP believes that licensed hospitals or HHAs have the ability to provide these services within the scope of their existing licenses, so do not feel separate licensure is necessary (especially given the timeline). From a quality perspective, it is also preferable to use agencies that have home health and/or hospice experience, rather than brand new agencies with no existing experience with providing care in member's homes. CAHP cautions that MCPs have noted concerns about existing access issues with these providers. MCPs have also expressed concern that while there may be some overlaps in activities, Hospice agencies have no experience with the SNF to home transitions, a function that is more aligned with MFP/CCT providers.

CAHP believes DHCS' stated approach unnecessarily limits access to the myriad of current providers that have significant experience in providing LTSS across the continuum of care and life span. The proposed approach creates barriers to access rather than using this as an opportunity to build on the knowledge and expertise that exists in the community. To this point, CAHP recommends allowing non-licensed CBOs to also participate as LTCH providers.

CAHP is concerned that the licensure requirement may become a barrier to contracting with providers or, at the very minimum, cause delays in building a network. Regardless of if DHCS believes these entities already exist and there just needs to be a licensing/certification process set up for them, or if DHCS believes there will be new agencies set up to incorporate the services envisioned under DHCS' proposal, CAHP cautions that it will require an incredible amount of work to set up the licensing process and to get agencies licensed by early 2021.

Credentialing of Providers
CAHP requests more information regarding the timeline for credentialing providers, as well as more information regarding how MCPs will be notified of providers who are going through, or have completed the licensing process. MCPs will need several months to add the providers to their network, as this is a new provider type and will require additional configuration. CAHP requests that DHCS factor these steps into its timeline.

V. Financing and Cost

CAHP members are generally supportive of the LTCH benefit in concept, but feel adequate reimbursement rates are critical to whether any existing or new agencies will be willing to participate and offer the appropriate level of quality for LTCH benefits (especially in light of staffing challenges with COVID-19). With respect to capitating MCPs for this benefit, CAHP requests clarification as to what data and experience DHCS will be able to rely upon to create actuarially sound rates, especially within such a compressed timeline. It seems preferable that MCPs be paid a supplemental payment for each member receiving the LTCH benefit until DHCS and MCPs have more experience with the actual costs of these services. In addition, DHCS may need to consider separate per diem rates and coding for members that receive IHSS.

CAHP members have posed the additional questions and observations below related to financing and cost:

- What, if any, plan oversight and/or administrative components will be included in the plan rates for this benefit?

- Would DHCS confirm if this is a monthly FFS per diem rate, not a daily/weekly rate? Given the complexity of the program and scope of services, it will be easier for MCPs to manage a monthly payment.
- What will the expectation be for MCPs to align with the state's FFS model? When will DHCS be able to provide additional details regarding the FFS model? MCPs note that adequate FFS rates will be critical to ensure provider participation.
- MCPs struggle every day getting home health support for members due to the fee schedule; this will be amplified with this new benefit, and also in providing additional personal care attendants, where MCPs cannot contract for this service at Medi-Cal rates.
- MCPs find it difficult to see how this benefit will be equivalent or lower cost than custodial care. With private duty nursing, personal care attendants, case management fee, social services support, home modifications, home pharmacy support, the LTCH benefit could very quickly greatly exceed the roughly $10,000 a month currently provided to MCPs for a member in custodial LTC.
- DHCS will need to factor in these costs to MCP capitation rates, particularly for MCPs who would normally disenroll these members to FFS but may now be responsible for all of their ongoing medical expenses.
- Does DHCS envision a tiered rate structure for differing acuity of the LTCH services that are needed?
- How will the increased capitation/reimbursement be tied to the member, (i.e., by the aid code)?
- What guardrails will be in place to prevent fraud/abuse (double billing)?
- Will DHCS be providing appropriate billing codes/rates for these services? Will these services be subjected to standard encounter reporting requirements?

Timing of Rate Development
All of the questions above are questions that must be resolved and understood as soon as possible if early 2021 is the desired implementation date. It will be important for MCPs to understand the rate impact several months before implementation, as it will factor into their planning, contracting and network development efforts.

Utilization Management Criteria
DHCS indicates in its proposal that it considers clinically appropriate utilization management policies to be a critical component of this benefit, as a means to ensure qualifying Medi-Cal beneficiaries receive a level of care that is appropriate for their needs, dynamic to meet any changes in their condition, and cost-effective. CAHP requests that DHCS partner with MCPs to determine the clinically appropriate utilization management policies.

Funding Exclusions
DHCS reiterates in its proposal that the LTCH benefit and the per diem will not fund services that are not Medi-Cal benefits such as rent, room and board, etc. CAHP requests that DHCS include in its proposal special considerations related to housing instability and homelessness. CAHP encourages DHCS to acknowledge in its proposal the unique housing challenges of Medi-Cal members, most of whom are renters of apartments, not owners of homes. Medi-Cal members are often in Section 8 housing or other subsidized housing. When they are out of an apartment, due to tight finances for a period of time, most renters will sublet or give up the lease. Most subsidized housing requires the renter to be present, otherwise the voucher is no longer available. When members spend 30 to 60 days in a SNF, it is possible to return to an existing apartment, but beyond that, new housing would often have to be secured, unless the member's family provides the housing. In addition, CAHP requests that DHCS address in its

proposal if there will be special considerations for homeless members who transition to recuperative care or motels, or are these also excluded similar to the Community Care Licensed facilities. Housing will be a major barrier to successful implementation of this benefit and the proposal should acknowledge and account for this.

VI. Stakeholder Engagement and Timeline

Stakeholder Engagement
CAHP appreciates that DHCS has planned for a July 15 discussion with MCPs to solicit feedback on development of this benefit. In addition, CAHP appreciates that DHCS has invited CAHP to represent MCPs on the LTCH Stakeholder Workgroup for the July 17 Master Plan on Aging Long-Term Services and Supports Subcommittee meeting. There is great opportunity to further refine this proposal and CAHP and its member plans look forward to partnering with DHCS on this important initiative.

Request for Development of Small MCP LTCH Workgroup
CAHP requests that DHCS convene a Small MCP LTCH Workgroup to begin to immediately engage in structured discussions on development of this benefit. On June 15, CAHP provided DHCS with a list of MCP experts – clinical services leaders, social services directors, experts in the provision of LTC, provider network staff, individuals working on development of DHCS' ILOS proposal – all of whom are eager to partner with DHCS to refine this proposal through a Small MCP LTCH Workgroup process. MCPs are critical partners, particularly as they will be administering this benefit, and they are eager to offer recommendations to ensure successful program implementation on behalf of the Medi-Cal members they serve. CAHP recommends that DHCS convene two Small MCP LTCH Workgroups on the following issues: 1) benefit design, and 2) implementation. Further, CAHP recommends that DHCS convene MCP sub-workgroups on the following issues: 1) information technology (IT) and reporting, and 2) special considerations for the dual-eligible population.

Timeline
DHCS indicates it intends to finalize the LTCH policy by the end of the third quarter of 2020, and for LTCH to go live in early 2021. DHCS indicates that after go-live it will focus activities on increasing Medi-Cal's statewide network of licensed LTCH agencies. CAHP requests significantly more detail regarding DHCS' stated timeline. When, specifically, does DHCS intend to finalize all components of the benefit design? When, specifically, does DHCS intend to go live? MCPs will need clarity regarding DHCS' expectations and on final timing before they can begin to build their networks.

CAHP requests that DHCS extend its current timeframe to allow for meaningful policy development and to ensure successful implementation of this benefit. Early 2021 is a very aggressive timeline given all that must occur, and at a time when plans are focusing on ensuring member access to care, as well as managing the work from home transitions of their staff due to COVID-19. There are simply too many outstanding questions and concerns that remain about this benefit – as well as COVID-19 – to commit to an early 2021 implementation. Furthermore, it is unclear how a statewide benefit can go live before a network of agencies available to provide the benefit exists. With this in mind, CAHP also requests that DHCS allow for flexibility for MCPs with respect to network adequacy for this benefit, if implemented in early 2021 (e.g., "go live" in this context could mean that MCPs begin to make reasonable efforts to establish a network for this benefit). In addition, MCPs will need a significant amount of time to implement this benefit *after* the design has been finalized to allow for provider licensure, contracting, data sharing, etc.

Special Timing Considerations for Data Exchange
CAHP requests that DHCS build in time for the creation of data exchanges with LTCH providers, as MCPs will want to exchange data with providers. This would include both traditional encounters, and other health information like care plans and referrals to CBOs. MCPs will need very clear technical specifications related to any IT lift. MCP providers' own internal capabilities will dramatically impact MCP timing as well.

Special Timing Considerations Related to Reporting
In addition, CAHP members would like to partner with DHCS to develop program reporting requirements. MCPs would like to know of the reporting requirements sooner, rather than later. To ease administrative burden on MCPs and their providers, MCPs would like to partner with DHCS prior to the go-live date to develop and refine reporting requirements, as MCPs will need to build requirements into provider contracts.

CAHP appreciates the opportunity to provide these initial recommendations to DHCS on its draft policy. CAHP and our members looks forward to continued discussions with DHCS to refine this proposal to ensure successful program implementation on behalf of the Medi-Cal members we serve. If you have any questions, please feel free to contact me at (916) 802-4069.

Sincerely,

Amber Kemp
Vice President, State Medicaid Policy

cc:

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