

**DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
Thursday, May 30, 2013
10:00AM – 3:00PM
MEETING SUMMARY**

Attendance

Members Attending: Bill Barcelona, CA Assoc. of Physician Groups; Katie Murphy, Neighborhood Legal Services- Los Angeles and Health Consumer Alliance; Anthony Wright, Health Access California; Kim Lewis, National Health Law Program; Marty Lynch, Lifelong Medical Care and California Primary Care Association; Elizabeth Landsberg, Western Center on Law and Poverty; Anne Donnelly, Project Inform; Marilyn Holle, Disability Rights CA; Rusty Selix, CA Council of Community Mental Health Agencies; Melissa Stafford Jones, CA Association of Public Hospitals and Health Systems; Ellen Wu, CA Pan-Ethnic Health Network; Stuart Siegel, Children's Specialty Care Coalition; Herrmann Spetzler, Open Door Health Centers; Brenda Premo, Harris Family Center for Disability and Health Policy; Ingrid Lamirault, Alameda Alliance for Health; Chris Perrone, California HealthCare Foundation; Richard Thorp, MD, CA Medical Association; Richard Thomason, Blue Shield of California Foundation; Michael Humphrey, Sonoma County IHSS Public Authority; Sandra Goodwin, CA Institute for Mental Health; Suzie Shupe, CA Coverage & Health Initiatives; Gary Passmore, CA Congress of Seniors; Michelle Cabrera, Service Employees International Union; Cathy Senderling, County Welfare Directors Association

Members Attending by phone: Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center; Kristen Golden Testa, The Children's Partnership/100% Campaign

Members Not Attending: Marvin Southard, LA County Department of Mental Health; Jim Gomez, CA Association of Health Facilities; Bob Freeman, CenCal Health; Mitch Katz, MD, LA County Department of Health Services; Kelly Brooks, CA State Association of Counties; Judith Reigel, County Health Executives Association of California; Teresa Favuzzi, CA Foundation for Independent Living Centers; Steve Melody, Anthem Blue Cross/ WellPoint; Anne McLeod, California Hospital Association; Lee Kemper, County Medical Services Program

Others Attending: Toby Douglas, DHCS; Brian Hansen, DHCS; Len Finocchio, DHCS; Jane Ogle, DHCS; Tara Naisbitt, DHCS; Karen Ruiz, CalHEERS; Neal Kohatsu, MD, DHCS; Laurie Weaver, DHCS; Rollin Ives, DHCS; Benjamin McGowan, DHCS; Carene Carolan, Covered CA; Allan Roush, DHCS Consultant, Steve Ruhnau, DHCS Consultant

Public in Attendance: 14 members of the public were in attendance

The meeting was called to order at 10:00 am

Meeting materials: <http://www.dhcs.ca.gov/Pages/May30,2013SACMeeting.aspx>

Welcome, Purpose of Stakeholder Advisory Committee, Introduction of Members and Review Today's Agenda

Toby Douglas, Director, DHCS

Douglas welcomed everyone and introduced new SAC members Michelle Cabrera and Gary Passmore. SAC members, including members attending by phone, and DHCS staff introduced themselves.

Douglas thanked the Blue Shield of California Foundation and the California HealthCare Foundation for all of their support including their input to the agendas and the meetings.

Douglas reviewed the day's agenda.

**May Revise Comments and Discussion
Heading to 2014 and Implementation of ACA**

Toby Douglas, Director, DHCS

Primary care Increase: An important part of the ACA is the 2013 and 2014 increase in primary care provider payments to 100% of MediCare rates. We are working on a state plan amendment and methodology for managed care health plans to increase payments. The state is on track to put in place a self attestation system by providers in July for providers to qualify for payments. In late summer/early fall we will distribute increased rates to health plans to start releasing those payments to providers. Bulletins to providers and plans will be sent over the summer. We hope this increases provider participation in the program and access to primary care services for beneficiaries.

DRG's: July 1st, we will implement Diagnostic Related Groups for all private hospital payments. We are moving away from daily rate payments and selective contracts to a system based on outcomes and cost to create a more transparent and efficient system.

We are completing the transition of Alcohol and Drug Programs to DHCS. We may return to this when we discuss strengthening substance use services later today.

Rate Reduction: The Ninth Circuit Court ruled to allow state to move forward on the 10% reduction for Medi-Cal provider payments. Once the final ruling is issued, we will move forward on the recoupment and 10% reduction. We will monitor access and are working to preserve access to services at this critical time.

Elizabeth Landsberg, Western Center on Law and Poverty: On the 10% rate cut, how will state monitor access on the fee for service (FFS) side since there is nowhere for FFS beneficiaries to call?

Douglas: There is an 800 number for beneficiaries to call with problems run through ACS Xerox fiscal intermediary. That is one way. We also have a monitoring plan that is

not real time but is a part of the information; we rely on information from stakeholder groups and we will be looking at utilization and provider claims.

Elizabeth Landsberg, Western Center on Law and Poverty: How did you notify beneficiaries?

Douglas: We will check how notification was sent.

Katie Murphy, Neighborhood Legal Services- Los Angeles: Beyond the phone number, are there ways we can elevate the stories we receive about problems? Stakeholder groups often see balance billing and other problems when there is a change of this kind. Who should stakeholder groups speak to about problems? Where do we report them?

Douglas: We need to identify a point person for you to bring issues forward.

Kim Lewis, National Health Law Program: Does the number provide referrals if a beneficiary is having trouble finding a provider?

Douglas: The fee for service system does not have that kind of structure. We don't have information about providers participating in the program with access for new patients. We are proponents for managed care because we do have this structure for managed care.

Marilyn Holle, Disability Rights CA: There is supposed to be a number for families and children to help them link up to services.

Douglas: The plans are responsible for this in managed care, but I will get back to you about how we are complying with this overall.

Bill Barcelona, CA Assoc. of Physician Groups: Thank you for choosing option two for implementation of the rate increase, with pre payment plus backend true-up. We are hearing awkward information that plans decoupling payments to capitated groups so that the plan pays directly to downstream providers. That is not going to work well. Can we have a meeting about this prior to implementation?

Douglas: I don't have information about this but we will get back to you.

Richard Thorp, MD, CA Medical Association: Access is a huge issue for CMA and we are concerned that with a rate cut, access will not be sufficient given the increase in enrollment. We want to see increased provider enrollment. There are a number of FFS specialists who will not receive the increase in payments but will be impacted by the 10% cut. We need ways to enhance provider enrollment because once they disenroll, it is not easy to re-enroll as a provider. What is the department's plan long term? The concern we have is that the increase in payments may go away. It is difficult to engage primary care providers and increase provider enrollment when the primary care bump might end in 1-2 yrs. On the cut, this is clearly a bad time to be cutting specialty care.

Douglas: I appreciate that. First, we are moving to an automated provider enrollment system for fee for service system. We are moving to more and more managed care and the focus will be enrollment in managed care, but the plans do often require enrollment in FFS. We need to streamline this process. On the future of the bump, this gets to many unknowns. We need to restructure the state-county relationship. We need to

continue to examine our capacity 2014 and beyond to monitor how plans preserve access. We did exempt primary and specialty providers for kids from the 10% cut but it will impact adults.

Stuart Siegel, Children's Specialty Care Coalition: Does the SPA for payment reform need to be approved before can move ahead with primary care provider bump?

Douglas: Yes, it needs to be approved and CMS is aware of the timeline. We think it is going to be approved soon.

Gary Passmore, CA Congress of Seniors: What is the effective date for the cut? Will you generate a report for the public and legislature on the impact to providers of the cut? Is there a process for plans to report network adequacy?

Douglas: We will recoup payments back to 6/20/11. Method will be by withholding from future payments. As to a report, we are required through CMS to report and monitor rates and participation on regular basis.

Ogle: Yes, plans report quarterly to DMHC and we review changes.

Anne Donnelly, Project Inform: From the HIV and AIDS perspective, the 10% cut is disastrous. The transition is already causing providers to contemplate stopping HIV services because they can't provide services financially.

Marilyn Holle, Disability Rights CA: Since the cut impacts Medi-Cal only and not Dual Eligibles, will you separate the monitoring?

Douglas: We look at each group separately for monitoring, including Duals, children, geography.

Suzie Shupe, CA Coverage & Health Initiatives: To follow up on Katie Murphy's comment, it is a good suggestion to have dedicated staff to address emerging access issues. As we have collected stories during the Healthy Families Program transition, it has been difficult to ensure we get the issue to the right person at DHCS and see that the systemic issues are dealt with.

Anthony Wright, Health Access California: There is a retroactive payment on the increase to primary care and retroactive recoupment on the 10% cut. How will this be scheduled and coordinated?

Douglas: The recoupment of the cut is over a two year period. For primary care providers, there is no cut and no cut for children's services. The primary care bump will be implemented as fast as possible.

Anthony Wright, Health Access California: What thinking and analysis has DHCS done about the impact of immigration reform on emergency Medi-Cal and county and state programs?

Douglas: On Emergency Medi-Cal, since they are eligible today, we don't expect any change. Assuming they will not be eligible for full scope benefits in Medi-Cal, then the main question is the interaction with county 17000 responsibility. Before we take savings at the state, funding would be retained at the county if there is increased

demand. The overall structure we are working on with counties takes this dynamic into account.

Melissa Stafford Jones, CA Association of Public Hospitals and Health Systems: There are a number of assumed components that are in the negotiations. Some elements being debated around immigration reform could be greater than what we are discussing.

Suzie Shupe, CA Coverage & Health Initiatives: Where is DHCS on the offer from The California Endowment to expand enrollment?

Douglas: This is now part of the budget process. The item is in both senate/assembly budget language. We are working hand in hand with Covered CA and this would fit into that structure. On the CBO part of the proposal, we have concerns about building expectations for funding that won't continue and CBO's can't count on. It also presumes an internal capacity to target different populations than Covered CA and DHCS is not set up for this.

Suzie Shupe, CA Coverage & Health Initiatives: You are saying that you are working to make it work?

Douglas: I can't tell you what will happen to budget process. If it is passed, we will make it work. The language targets different organizations and a different population than Covered CA. Whoever does this work would have to start over from scratch.

Katie Murphy, Neighborhood Legal Services- Los Angeles: The way this is playing out locally is that there is concern that without this effort to focus on Medi-Cal populations, enrollment will be disjointed. We understand it is a new system for DHCS but we encourage the department to work this out because there is a hole without this funding. We have a collaborative in LA to think through these very issues and this fragmentation of what Covered CA is funding and the fragmentation for Medi-Cal is one of the biggest challenges.

Medi-Cal Expansion Key Components and Milestones Len Finocchio, DHCS and Jane Ogle, DHCS

Timeline for Key Transition Activities: slides available:

<http://www.dhcs.ca.gov/Documents/SACKeyMilestonesTimeline3.pdf>

Jane Ogle, DHCS

Coordinated Care Initiative (CCI)

We finalized the MOU and have received a draft contract from CMS for the CCI. NORC, the contractor for plan readiness, is working with plans and solving any deficiencies. We are talking with CBO's about an ombudsman program It will be similar to the one operated by DMHC where they take complaints and try to solve these on behalf of beneficiaries. We will contract with DMHC to expand the structure so there is one in each county. Recently, we put out information for comment on Dual Eligible Special Needs Plans (SNP). The SNP's that exist will remain until 2014. The goal is to have people move into managed care but if they are in a SNP and want to remain, they

can stay enrolled in the SNP. What they can't do is hop between different SNP's. We will roll out soon a draft enrollment policy for LA. CMS and the State agreed to a 3 month delay for passive enrollment to begin, then passive enrollment probably by birth date. There is a cap on enrollment of 200,000 for LA County. There are 270,000 total eligible. We will be posting drafts of notices of enrollment and we will take comments on notices. We want to move through this on a timeline so we can be on time with notices.

Katie Murphy, Neighborhood Legal Services- Los Angeles: Is the handbook going to be up for comment?

Ogle: Yes

Gary Passmore, CA Congress of Seniors: As the State originally presented the CCI, it was for 58 counties. We now have eight under some type of demonstration but some large counties like Sacramento are not being discussed. I would like your comments on those counties. It would be good for us to understand your thinking.

Douglas: Some of this is for the afternoon conversation. Our vision has not changed around CCI, that it is eventually statewide. The timing has changed. It will not be in year 1 or 2 but we will evaluate and continue to discuss.

Jane Ogle, DHCS:
Rural Expansion

The state is expanding Medi-Cal Managed Care to 28 rural counties. In 18 counties, Centene and Anthem Blue Cross health plans will implement beginning in Sept 2013. Partnership Health Plan will expand the County Organized Health System (COHS) model in 8 counties with strong support from those counties. In Imperial and San Benito Counties, we are working to determine the plans and the models that will be best and we are trying to finalize that soon.

Kim Lewis, National Health Law Program: Is it one plan or two in San Benito and Imperial?

Ogle: We are still working on this –don't know if 1 or 2 plans. A COHS plan was looking into going into San Benito but elected not to.

LIHP Transition Plans

Allan Roush, DHCS Consultant

Slides available: <http://www.dhcs.ca.gov/Documents/SACLIHPpresentation-2013-05-30-Final.pdf>

Marty Lynch, Lifelong Medical Care and California Primary Care Association: On the plan and primary care assignment, do you have data on enrollment by county?

Roush: Yes, this is presented on a slide

Gary Passmore, CA Congress of Seniors: If the legislature and Governor decide to offer the adult dental benefit, are you prepared to offer that in welcome packet or will you have to go out with another announcement.

Douglas; There are two issues here. The timeline for the optional managed care expansion is January 1st, so we have time to accommodate changes from legislation. For the currently enrolled, we will be planning when we can get that in place – if it happens.

Katie Murphy, Neighborhood Legal Services- Los Angeles: I don't have information on the webinar you mentioned about communications and outreach.

Hansen: We sent the information to 250 on a list serve. We will expand to the broad DHCS list.

Elizabeth Landsberg, Western Center on Law and Poverty: Is this the only venue for this information?

Hansen: The overall plan includes: 1) have a technical workgroup offer input; 2) make revisions; 3) use the webinar to announce changes; 4) provide feedback to stakeholders after the webinar, 5) complete the final plan and notices. Notices will be available for the webinar or as soon as possible for review. There will be review and feedback on each of the following elements: the communications and outreach plan, continuity of care, and the next iteration of the transition plan. There will be time after the webinar for individuals to provide feedback.

Anne Donnelly: Will you be able to link primary care providers for the HCCI group?

Hansen: No, only for the MCE group.

Brenda Premo, Harris Family Center for Disability and Health Policy: How will beneficiaries know about the administrative move from the LIHP to Medi-Cal?

Hansen: That is the focus of the communication and outreach plan document. Several notices will go out. First, a general notice will go out, then later in the year a specific notice of what plan they will go to, followed by welcome packets and BIC cards, and finally, information from the managed care plans.

Kim Lewis, National Health Law Program: Who is being moved automatically? All people now in the MCE? What about the MAGI discussion from the previous SAC meeting?

Hansen: We are still working through the technicalities but yes, all beneficiaries with incomes at 133% and below will go into Medi-Cal. Anyone eligible for regular Medi-Cal will be sent to eligibility to make a formal determination.

Kim Lewis, National Health Law Program: For the counties who have a LIHP income eligibility under 133% poverty and have identified individuals over their eligibility limit, will they have the opportunity to move those individuals administratively as well?

Hansen: We will take that back to think it through.

Anne Donnelly, Project Inform: The LIHP networks are not the same as the Ryan White networks. Has there been discussion with Office of AIDS about this population?

Hansen: Yes we are in touch with Office of AIDS.

Anthony Wright, Health Access California: What counties have you heard might be raising eligibility thresholds?

Roushu: We will follow up

Katie Murphy, Neighborhood Legal Services- Los Angeles: I am concerned that we get the message right. Eligibility is not changing but coverage is changing dramatically. Any language about ending, stopping, closing, etc will disrupt care. We need to use language of transition or merging.

Rusty Selix, CA Council of Community Mental Health Agencies: How will this work in the transition with mental health? In the LIHP, there were caps for mental health services but there are not caps under Medi-Cal. Have you thought about the folks who will hit the cap under LIHP but not under Medi-Cal?

Ogle: One thought is that beneficiaries are required to have an assessment when they come into care and mental health needs could be identified.

Rusty Selix, CA Council of Community Mental Health Agencies: Is that really a comprehensive mental health assessment?

Ogle: No, it isn't. We need to follow up about other ways to identify them.

Marilyn Holle, Disability Rights CA: Will anyone who is on the LIHP waiting list be considered LIHP for transition to Medi-Cal?

Hansen/Ogle: I am not familiar with waiting lists. I think the plans set up the ability to have a waiting list but I am not sure there is anyone on the lists. We can follow up.

Elizabeth Landsberg, Western Center on Law and Poverty: Does DHCS have information on the match between the LIHP provider network and Medi-Cal managed care network? This is important in order to know how big the change is for people and it will be important for messaging. It is also important to let people know they have a choice under Medi-Cal.

Hansen: We have done some initial work and are still waiting for additional information to complete this. The initial information looks pretty good as to the match.

Katie Murphy, Neighborhood Legal Services- Los Angeles: It is very important to let people know that their primary care provider maybe in both plans and that they will have a choice.

Gary Passmore, CA Congress of Seniors: You are looking at a separate rate component for those new MCE moving into managed care, is that right?

Douglas: Yes, this MCE group will have its own rate.

Anne Donnelly, Project Inform: In addition to letting people know that they have a choice, we need to let them know why it is important that they make a choice – that they are in a network.

Anthony Wright, Health Access California: First, I want to acknowledge that this is a great development, that it is possible to administratively move 600,000 enrollees into

Medi-Cal on Day 1. We hope that we can encourage counties to use LIHP to enroll more people while the federal share is 100%. Also, I am curious to know what lessons have been learned that will continue after Jan 2014 with regard to LIHP at the State and County level? Programs have lessons on coordinating care, mental health integration and other things. To have that infrastructure disappear without capturing the lessons would be too bad. If we don't institutionalize lessons, we could go backwards.

Finocchio: The last paper by UCLA will be about the LIHP transition. Perhaps our foundation partners will want to continue beyond that.

Douglas: We need to remember that these are delivery systems and the changes will remain. LIHP as program goes away, but delivery system changes of integration, medical home, working with mental health system will continue under managed care framework.

Katie Murphy, Neighborhood Legal Services- Los Angeles: In addition to delivery system, there are lots of lessons learned on eligibility and enrollment. There is more coordination among those systems in LA than ever before. We all hope this remains but I echo that there are implications for referral and connections that could be captured.

Managed Care Monitoring

Jane Ogle, DHCS

Slides available:

<http://www.dhcs.ca.gov/Documents/MMCDSACMay2013Dashboard.pdf>

Michelle Cabrera, Service Employees International Union: Can you share who is participating on the advisory group?

Ogle: I can share the list with you.

Stuart Siegel, Children's Specialty Care Coalition: Will the dashboard include considerations of patients about access to specialty and coordinated care.

Ogle: Patient satisfaction surveys are not part of the measures at this point. We hope to add this in the future.

Marilyn Holle, Disability Rights CA: Will you include information about inappropriate referrals in the dashboard? For example, multiple referrals that don't actually work for the person's need.

Ogle: That is not a measure we are capturing.

Katie Murphy, Neighborhood Legal Services- Los Angeles: This would have to be captured by looking at the times that multiple referrals are required for the same condition. We see this problem a lot.

Anne Donnelly, Project Inform: Timely access to specialty care is not a patient satisfaction issue and it is a big problem.

Chris Perrone, California HealthCare Foundation: CHCF conducted a survey that asked about access to specialty care. This information could be included in dashboard but the

survey is not ongoing or standardized. One of the challenges is the lack of national standards on access to specialty care. We have launched work on access to specialty care with Robert Wood Johnson Foundation. CAPS does ask this information. CHCF will produce a one-time snapshot on program and we may be able to include CAPS information if it is not part of the dashboard.

Marilyn Holle, Disability Rights CA: It is critically important to track access to specialty care. The low-incidence disability needs for specialists are very important because care patterns may be disrupted in managed care. We would also like the state to reinforce access to Hill-Burton outpatient clinics for those in managed care. There is good access for FFS, but there is no ability to enforce this through managed care.

Brenda Premo, Harris Family Center for Disability and Health Policy: One of the needs for data is to identify delay and/or inappropriate referrals because this information will help to demonstrate where we have shortages for health care professionals.

Rusty Selix, CA Council of Community Mental Health Agencies: There is an issue for those in psychiatric health care. Physical health care must be brought to the place where consumers get mental health care. We can't easily get them to go to physical health care. As we look at the dashboard, I hope we can capture information about their physical health care.

Herrmann Spetzler, Open Door Health Centers: There is great complexity to get this to work overall and I am wondering if we need a rural dashboard because the issues are different. We may need special data consideration due to small numbers.

Douglas: This data will include a drill down by plan, by county, by region. It is not aggregate data.

Stuart Siegel, Children's Specialty Care Coalition: The state is changing the system and this puts you in a role as the client on behalf of patients. This is a philosophical view of the dashboard.

Douglas: The important theme here is that we know we have lots to do to become data driven and increase our understanding of what is happening. This will take time to develop and we appreciate the input as we build this over time.

Gary Passmore, CA Congress of Seniors: I suggest that we carve out time at a future meeting to present more than the conceptual description. How will you use this information; how can advocates use the data; how can the legislature use the data. I don't mean presenting actual data, but looking at the system more specifically.

Douglas, definitely – good follow up

Benefit Package for Newly Eligible

Brian Hansen, DHCS; Laurie Weaver, Rollin Ives, and Ben McGowan joined from state

Slides available: <http://www.dhcs.ca.gov/Documents/SACBenefitsSlides52913.pdf>

Ellen Wu, CA Pan: I am confused by the 100-200% poverty level.

Douglas: The optional expansion benefit does not include pregnancy benefits. If you are between 100-138% income, you have the option to get tax credits below 138%.

Katie Murphy, Neighborhood Legal Services- Los Angeles: How do you envision the wrap working? Folks would be enrolled in an Exchange plan with Medi-Cal as secondary coverage?

Douglas: We would have agreement with Covered CA to be sure that plans are paid for the difference between any cost sharing and the premium. If there are benefits in Medi-Cal that are not in the Exchange product, the patient would use their BIC card to receive fee for service from a provider. This is different than secondary coverage now because it will be clear that you receive certain services and benefits from certain providers. This is replicating what we currently do, it is similar to today.

Elizabeth Landsberg, Western Center on Law and Poverty: It is better to have the wrap than not, but this is confusing for consumers to have different cards for different services. You are outlining the administration's proposal, but this is in play still.

Kim Lewis, National Health Law Program: If you are not pregnant when you come into Medi-Cal and subsequently become pregnant, then how would benefits work? Do they stay on full scope benefits?

Douglas: Benefits would be reduced in that scenario.

Kim Lewis, National Health Law Program: It is not clear why the recommendation is to have the asset test apply for long term care services. The regulations say no assets are required for the expansion population – it's not service specific. Secondly, there are no fiscal implications because the services follow the person and the federal share is 100%

Douglas: First, the asset test: we will need federal approval for this. There would not be asset test to get into benefits, it would be a second step for those who want long term care. There is a concern the state will be paying 10% share in the future.

Sandra Goodwin, CA Institute for Mental Health: I want to offer a brief correction on the group therapy for seriously mentally ill. You have to have a diagnosis and meet medical necessity to get into the system. I want to understand the proposal for the optional county program. Counties must draw on local dollars?

Douglas: The state will redirect growth funding to counties who opt in.

Sandra Goodwin, CA Institute for Mental Health: The concern is that counties only serve about 50% of population that need service now so those funds are tapped out. It is hard to see how this can be operationalized. Given that this is a Medi-Cal benefit, can different counties implement differently?

Douglas: We will have to apply for a waiver.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center: Thank you for movement to respond to the input provided on substance use issues. Unfortunately, this proposal falls short in terms of the benefits. The notion that this be a county option is not going to work for people who need service.

We have seen this failure already under the LIHP – only a handful of counties at a modest level had any benefits.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: On the benefit for pregnant women: what is the interface between the Exchange benefit and CPSP and what are you thinking on the PPS.

Douglas: We might need to get back to you. How does PPS kick in and how does CPSP figure in?

Anne Donnelly, Project Inform: I want to understand new immigrant benefits for pregnant women.

Douglas: For newly eligible not on program today, they will be enrolled in Covered CA with the affordability wrap. For pregnant women, this starts at 100% because they don't receive a subsidy.

Anne Donnelly, Project Inform: On the issue of the two cards for the wrap benefits, can't you issue one card that includes the benefits for both sides of the wrap?

Finocchio: We are trying to operationalize this as one card for all the services but we can't get this done by Jan 1st.

Gary Passmore, CA Congress of Seniors: Is it your intention that you will have all issues resolved with CMS related to long term care to have services available by Jan?

Douglas: Absolutely.

Marilyn Holle, Disability Rights CA: I want to clarify – you are not proposing asset test for first 100 days of long term care, are you? Right now, if you go into a long term care facility and your disability is not expected to last a year, from the old MIA program, will there be a new category?

Douglas: We need to get back to you.

Elizabeth Landsberg, Western Center on Law and Poverty: Podiatry broadly is not covered by the Kaiser Small Group?

Hansen: I could not find evidence of broad podiatry coverage. The Kaiser Small Group shows coverage of some podiatric devices.

Elizabeth Landsberg, Western Center on Law and Poverty: We hope when you are with the Governor, you will urge him to restore dental benefits. This is important to their health. People are suffering.

Rusty Selix, CA Council of Community Mental Health Agencies: The SMI/SED is a big issue. Virtually all of them meet eligibility for Medi-Cal as disabled. Fee for service Medi-Cal is not covering a broad category – it is fairly narrow. Also providers are not available for this service which would be a bigger issue if it was a broad category. The Legislature has taken a different approach than the Administration to fold substance use disorders into plans. The Administration approach is counter intuitive. The savings are in physical health and inpatient care. It seems to me it makes sense to include a substance abuse

benefit with physical health since they will reap benefit as a system. Kaiser in Sacramento GMC covers this because their own data shows it pays for itself. The Administration's view just doesn't make sense.

Michelle Cabrera, Service Employees International Union: I am confused by you saying that the asset test would remain and you would get enhanced FFP, given that this scenario isn't contemplated for the MAGI eligible population. What happens if CMS does not approve the asset test for long term care services?

Hansen: The May revise says we will provide long term care services IF CMS approves using the asset test. There are conflicting rules that require asset look-backs for long term care services. How the look-back rules interact with MAGI is under review by CMS and is not settled.

Finocchio: In ACA, there is no asset for newly eligible beneficiaries. What CMS is looking into is in section 1917.

Anthony Wright, Health Access California: In Covered CA, will the wrap apply in any plan and any tier for pregnant women and immigrants? Can they choose any plan?

Finocchio: We are still sorting that out.

Kim Lewis, National Health Law Program: I echo the sentiments about dental coverage. In addition, we believe that ABA therapy for children is required in Medi-Cal. We believe ABA therapy is a rehabilitative service required under Medi-Cal. Litigation has been lost in other states and they reinstated this service.

Suzie Shupe, CA Coverage & Health Initiatives: We also feel strongly that ABA should be included as a benefit.

Eligibility and Enrollment in 2014
Len Finocchio, DHCS; Covered California staff
Policy updates
CalHEERS/ SAWS
Covered California Service Center
County Workgroup

Policy updates
Tara Naisbitt, DHCS

We have submitted a verification plan to CMS for how the state will verify data for the eligibility process. We have comments back from CMS that will be incorporated and then the plan will be shared with stakeholders. The Department of Social Services has developed a joint application and shared with CMS. This will also be shared with stakeholders once it is finalized. We have a Medi-Cal Eligibility Director Information Letter on ACA guidance including the single, streamlined application status and MAGI changes. There is also an uber letter being prepared that will provide overall policy guidance to counties and a link to a website with updates to information. We are working on trailer bill language on implementation of ACA.

Elizabeth Landsberg, Western Center on Law and Poverty: We have an ongoing concern about electronic residency verification because there may not be sources available and we hope there will be self attestation if electronic methods are not available.

Finocchio: I haven't seen CMS feedback but we are working on this issue.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: Will you discuss the CMS guidance and flexibility around nutrition guidelines?

Naisbitt: We received guidance from CMS with guidance on rules in five areas. 1) Early MAGI rules during October – December 2013, 2) extending Medi-Cal eligibility in early 2014, 3) enrolling based on SNAP eligibility, 4) enrolling parents based on children's eligibility, 5) 12 month continuous eligibility for adults. DHCS is reviewing these for implementation recommendations.

Finocchio: There are policy, technical and fiscal issues that will be reviewed asap.

Elizabeth Landsberg, Western Center on Law and Poverty: You are revising the SAWS 2 so that applications for CalFresh, Medi-Cal and CalWORKS will be included and this will be the ongoing application to be used? You are adding MAGI questions to application?

Finocchio: Yes.

Kim Lewis, National Health Law Program: What is the feedback from CMS on the verification plan?

Finocchio: We will follow up, I haven't seen it.

CalHEERS/ SAWS

Karen Ruiz, CalHEERS

Slides available:

<http://www.dhcs.ca.gov/Documents/CalHEERSSACUpdate05302013.pdf>

Anthony Wright, Health Access California: When is the time for stakeholders to see the functioning consumer interface? You have free beta-testers here among this group.

Finocchio: We are thinking of having a walk-through by webinar.

Ruiz: We have worked with a wide group of consumers to try out the system for testing.

Finocchio: Yes, multiple groups of consumers have tested this at different stages.

Anthony Wright, Health Access California: It would be useful to have both consumers and those knowledgeable about a range of hypothetical situations try out the system.

Brenda Premo, Harris Family Center for Disability and Health Policy: Is it screen reader accessible? Are you telling people that it is available?

Ruiz: Yes, it is available. It is a good suggestion to tell people about that.

Katie Murphy, Neighborhood Legal Services- Los Angeles: Advocate or stakeholder testing should not replace consumers. An example how this helps from LA is that, on "Your Benefits Now" LA County allowed advocates to suggest how certain word usage would likely trigger mistakes. We have a unique perspective of knowing mistakes that

consumers tend to make based on design, language, etc. I am happy to follow-up to provide you the kind of comments we provided to LA.

Finocchio: It would be helpful to have those examples and we can consider small group work such as you suggest. There will be opportunities for input later as well.

Suzie Shupe, CA Coverage & Health Initiatives: In August, you are rolling out functions for assisters and navigators. Can you talk more about this? Are you getting help from them on design?

Ruiz: The August functions are specific assister entity functions and there will be training for assisters on this.

Suzie Shupe, CA Coverage & Health Initiatives: Are the functionalities exactly the same as consumers? We suggested there be differences for assisters and navigators to cut time and cost with some shortcuts.

Ruiz: I believe they are largely the same screens for assisters and consumers but I will get back to you on any differences or toolbars available to assisters/navigators.

Suzie Shupe, CA Coverage & Health Initiatives: How will the Medi-Cal part of CalHEERS work? When will this be available?

Finocchio: On October 1st, CalHEERS will be live for all insurance including Medi-Cal. If you are Medi-Cal during this open enrollment period, you will choose your health plan by mail. In January, the SAWS and CalHEERS interface will happen and in April health plan choice for Medi-Cal will be on line.

Kim Lewis, National Health Law Program: CMS has been involved in consumer testing and I wonder if you have participated in this? When you ran through the application functions, are there hints/content for “help” aspects?

Finocchio: It has been written but not tested yet and has not been through readability.

Covered California Service Center Carene Carolan, Covered CA

We are sprinting to put up three service centers, in Rancho Cordova, Fresno and Concord. We are working to hire and train 670 staff by October 1st. We are on track with build-out in Rancho Cordova and Concord. Rancho Cordova will house 500 people including staff for service, quality, appeals, health plan assistance, etc. In Fresno, we are still negotiating on occupancy.

We have had 4,500 people complete the state exam for hiring. We have received 1200 applications and we are now interviewing. We are continuing to test in Fresno for more applications there. We planned to hire and train in waves, however we are delayed pending statutory approval for fingerprints. The approval is moving forward but puts behind. Final job offers follow all approvals so we are not able to begin training. Most staff is scheduled to begin in early August and we are currently planning how to handle calls beginning on August 19th. We are still on track to open October 1st with adequate staff.

Brenda Premo, Harris Family Center for Disability and Health Policy: As part of training, have you considered the needs of cognitively disabled, deaf and other disabled such as allowing extra time for working with these callers?

Carolyn: There are no time limits on calls. Covered CA is dedicated to meeting consumer needs and service. The training contract is being finalized and I will let you know more information once the vendor chosen.

Herrmann Spetzler, Open Door Health Centers: Which call center will service the Far North and rural areas?

Carolyn: All calls come to command center and are routed to next available agent who could be anywhere.

Kim Lewis, National Health Law Program: Are you developing scripts and protocols for questions?

Carolyn: Yes, we will have scripts and we are developing a knowledge-base via technology based on key words to allow answers to specific questions. We are currently operating a mini call center through a vendor and we are using this experience to know the scripts we will need.

Anthony Wright, Health Access California: Is Spanish language usability being tested and are you hiring in multiple language?

Carolyn: The goal is to have 40% of call center staff speak one of the top five threshold languages such as Spanish, Tagalong and Mandarin. We are also contracting with a language service line for other languages.

Anne Donnelly, Project Inform: Are you setting timeliness standards for wait time, etc?

Carolyn: There are service agreements with call center contractors with performance metrics. Employees are represented by SEIU so we notice and test before we finalize. We may not meet our metrics out of the gate.

County Workgroup

***Len Finocchio, DHCS, Cathy Senderling, County Welfare Directors Association
Steve Ruhnau, DHCS Consultant***

We are working with counties and a diverse group of representatives to outline the work flow for eligibility workers – work flow today, in October before electronic interface is absent and in January after electronic interface is live. It has been beneficial to see work flow now and the changes they will go through. Some areas have significant change – others do not. We are slated to be finished with work flows around June 14th. We are reaching out to a broad county group to validate the work flows. These are generalized versions that will be personalized by individual counties.

Cathy Senderling, County Welfare Directors Association: This process is dovetailing with other work groups in counties detailing all the implementation changes for ACA.

Ruhnau: We are trying to leverage all the different training curricula and organizational change management between CalHEERS and other environments. We are now trying to integrate eligibility worker training with those other elements to synchronize how business will work so we are all on the same page.

Katie Murphy, Neighborhood Legal Services- Los Angeles: There is a complementary element of training that those of us in the community who conduct consumer assistance services are working on for assisters in the field. Can we message similarly? Can we see your materials so we can understand how to coordinate training for lay advocates and others with the training the call center gets?

Finocchio: That is a good idea and we will follow up with you.

Suzie Shupe, CA Coverage & Health Initiatives: Much of the training eventually will be online for assister/navigators. We hope the training and materials will be available for others who want to help, but are not paid, official assisters.

Anne Donnelly, Project Inform: The national organization, Enroll America, put out navigator assister spreadsheet saying the Exchange should have this training for those who are not certified assisters. We haven't heard whether California will have anything like that.

Finocchio: These are good ideas.

Ruiz: It is part of the plan to make resources available for those beyond assisters and grant entities. I don't have any details yet.

Sandra Goodwin, CA Institute for Mental Health: The most difficult population to enroll is the Mental Health and Substance Use population. There are ways to reach the population and we would be happy to share ways to help reach them.

Finocchio: Great.

SAC Q&A re: DHCS Written Updates

DHCS Staff

Cal MediConnect: Duals Demonstration Project

Rural Medi-Cal Managed Care

CCS Pilot Projects

Healthy Families Transition

Behavioral Health Service Needs Plan

Section 2703 Health Home Option

Delivery System Reform Incentive Program (DSRIP)

Written Update available: <http://www.dhcs.ca.gov/Documents/DHCSProgramUpdates-SACMay302013.pdf>

General Questions on any of the updates provided:

Katie Murphy, Neighborhood Legal Services- Los Angeles: Can we have an additional meeting before October and again in December? Also, is there discussion about what happens longer term for this stakeholder group?

Finocchio: We are open to meeting in those timeframes. We will work with PCHG to identify how to do this.

Hansen: We are open to other formats such as a phone call.

Elizabeth Landsberg, Western Center on Law and Poverty: On the Medi-Cal Managed Care plan expansion, what is a one plan model?

Ogle: In rural counties, the director has the option to choose one plan because of the small populations. We are talking with CMS to clarify what is a rural county.

Elizabeth Landsberg, Western Center on Law and Poverty: Will this include families, children and newly eligible only? SPD's later?

Ogle: Yes families and children now with SPD's later and Duals only as voluntary enrollment.

Elizabeth Landsberg, Western Center on Law and Poverty: What is the plan in the 18 county expansion? What model is this? Will the voluntary populations get a packet?

Ogle: There will be a two-plan model, both commercial. We are treating them as one area and the plans must operate in all 18 counties. Kaiser has some presence in three counties and they will continue to operate in El Dorado, Placer and Amador (I believe).

Elizabeth Landsberg, Western Center on Law and Poverty: On CCI, in January, will you be moving most of the Duals?

Ogle: This has changed. Only the low income subsidy people who would have to change plans and end up paying a premium will be in January. This is about 50,000 people in the eight counties on January 1. In February, we will begin to roll out non-LA counties by birthday. San Mateo is a bit different and will happen in January. For LA, the enrollment strategy will be out in a few days.

Elizabeth Landsberg, Western Center on Law and Poverty: On the overlap with Rural Medi-Cal Expansion and Healthy Families transition, is the notion that this will happen on the same day so that people will not move twice? Are notices coordinated?

Ogle: That is the plan.

Gary Passmore, CA Congress of Seniors: On Cal MediConnect and Duals Demonstration: Jane referenced Dual Special Needs Plans (D-SNP) that have been in place for 7-8 years or more. Tens of thousands of people are enrolled in these Medicare Advantage Plans. They do an excellent job of coordinating care. In fact, one criteria for choosing counties for the Duals Demonstration was whether they had a functioning D-SNP plan. We have grave reservations about how the State is approaching this. The State is suggesting that D-SNP enrollees likely will be passively enrolled into managed care plans. They will have the opportunity to disenroll from managed care and re-enroll in D-SNP. This is a complex process for a frail population without any obvious gain. Why move from one coordinated care system to another? Perhaps it is to increase the number of enrollees in the Duals Demonstration? Our recommendation is that the State should continue D-SNP and not force those who can't get into managed care – especially in LA – to be forced into fee for service. The State is

delaying action on this issue and I urge you to contact legislative staff who will be working on this in trailer bill language. We want to move people from fee for service into managed care – not from one coordinated system to another.

Ogle: There are about 150,000 in D-SNP. About 60,000 are in Kaiser and will be left there. There are about 35K in one large D-SNP and the population we are talking about is about 25-30K in smaller D-SNP's. Our concept is that people will receive notices at 90-60-30 days and they can stay where they are – they will not be transitioned. If they get passively enrolled, they can go back to the D-SNP they were in. They can't move from one D-SNP to another. This is important because there is no care coordination with their Medi-Cal benefits (IHSS, C-BASS, etc). and that is why we think the integrated system is a good move. We are not closing D-SNP during 2014.

Anne Donnelly, Project Inform: Why are PACE, the AIDS Healthcare Foundation and the D-SNP different?

Ogle: AIDS Healthcare Foundation and PACE are carved out.

Marilyn Holle, Disability Rights CA: I assume that CCS is carved out in the COHS?

Ogle: Yes

Marilyn Holle, Disability Rights CA: Under original legislation, there was a requirement to tell people how to use transportation to get to care. This is very important in rural counties. There should be money to the plans to help sort out transportation assistance. Something should be done generally to address this, especially in rural areas. The obligation for ensuring that transportation is available rests with the County but nothing is happening to make this work.

Ogle: Part of plan's contract is health education and this obligation includes rights and benefits under plan.

Suzie Shupe, CA Coverage & Health Initiatives: On the Healthy Families Program transition, the continuity of care rights are not fully addressed in the update. We are now moving into phase four of transition and particularly rights about mental health services and providers are unclear to consumers. Many of these issues came up in the SPD transition and it is now coming up in the Healthy Families transition. What is the plan?

Ogle: I don't have a final answer for you. We have been working on continuity of care plans. ABA services are not a Medi-Cal benefit. ABA is only available through regional centers.

Suzie Shupe, CA Coverage & Health Initiatives: There was a promise by the department that no child would lose benefits/services because of the transition. Now they are. What are the rights for other issues, beyond ABA?

Ogle: If they are receiving services, they have a right to continue.

Suzie Shupe, CA Coverage & Health Initiatives: Families don't seem to know that. Plans say they don't know. We were told a letter was to go out to plans. Can we see the letter?

Finocchio: We will follow up

Kim Lewis, National Health Law Program: We have raised this many times and talked to CMS. These are not options but are required in Knox Keene. The requirement should be clear to the plans. It should not be on the consumer level to make this happen.

Anne Donnelly, Project Inform: It is critically important that continuity of care protections get out to consumers. This is not happening and is not mentioned in the Rural Expansion either. This was raised in CHCF survey. General continuity of care rules and specifics around transitions should be communicated to consumers.

Finocchio: This is helpful.

Anthony Wright, Health Access California: I echo comments on DSRIP, are we done with categories 1 and 2 – are the categories like phases?

Neal Kohatsu: Yes, the basic structure is to finish category 1-2 in the early phase but there is overlap between categories. We are now beginning category 4.

Anthony Wright, Health Access California: Is there a write up about how hospitals are meeting the requirements for each phase? What are the modifications on category 4?

Neal Kohatsu: At the 6 month point and every year there is a report on milestones. If the milestone is met, it is paid. We are setting milestones on category 4 targets with CMS which are all inpatient metrics. We are still assessing baseline and setting benchmarks.

Anthony Wright, Health Access California: Are annual reports online?

Neal Kohatsu: Yes.

Anthony Wright, Health Access California: When we are renegotiating the waiver, what results will be available?

Neal Kohatsu: Clinical information in category 4 will be available in about a year. We hope to have it available, but it will be close. We are trying to get as much as possible available for policy.

Bill Barcelona, CA Assoc. of Physician Groups: On Healthy Families Program continuity of care, the issue of confusion was discussed on a call. Families get a paragraph from the plan. When they ask questions, plans can't answer them. Does the patient have to be in an active course of treatment to request continuity with their provider?

Ogle: I think the patient must have had two visits within the last year to establish a relationship.

Bill Barcelona, CA Assoc. of Physician Groups: Knox Keene regulation says the patient must be in an active course of treatment.

Katie Murphy, Neighborhood Legal Services- Los Angeles: There are two standards operating here. Knox Keene rules are about current course of treatment. The State continuity of care rules are based on "relationship" and complexity for those in SPD and Healthy Families transition. Health Consumer Alliance has an internal memo on this.

Ogle: This is correct. There are two standards.

Marilyn Holle, Disability Rights CA: For example, with ABA – even if Medi-Cal is not covering it, there has to be a transition and a plan.

Finocchio: This is complicated and we are not going to solve this. We need to do this in follow up.

Anne Donnelly, Project Inform: This speaks to the need for clarity for this and related topics in continuity of care, not just physician visits but other services such as auxiliary services.

Bill Barcelona, CA Assoc. of Physician Groups: My other question is whether existing D-SNP will not be passively enrolled but will be given a notice?

Ogle: Existing D-SNP will be treated like other Dual Eligibles. They will receive notices and may opt to remain in D-SNP.

Anne Donnelly, Project Inform: Will DSRIP category 5 funding end in 2014?

Neal Kohatsu: There is no change in ending of category 5 funding that I know of. They have just submitted the first semi-annual reports.

Public Comment

No Public Comment.

Next Steps, Future Meetings and Adjourn

We have a number of follow steps and comments. We will try to follow up by email on these issues. We will try to have another meeting this summer (may be on the phone) and again in December. We will also discuss meetings into 2014. We appreciate your input – the more we hear, the better. Thank you.

Next Meetings: August 5, 2013 and November 20, 2013 – 9:30 – 12:30
Possible Webinar: October 21, 2013 3:00 – 5:00pm