

**DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE**

February 25, 2016

9:30am – 3:00pm

MEETING SUMMARY

Attendance

Members Attending In Person: Bill Barcellona, CA Association of Physician Groups; Kirsten Barlow, County Behavioral Health Directors Association of California; Richard Chinnock, MD, Children's Specialty Care Coalition; Sarah DeGuia, CA Pan-Ethnic Health Network; Anne Donnelly, Project Inform; Michelle Gibbons, County Health Executives Association of CA; Bradley Gilbert, MD, Inland Empire Health Plan; Carrie Gordon, CA Dental Association; Marilyn Holle, Disability Rights CA; Elizabeth Landsberg, Western Center on Law and Poverty; Sherreta Lane, District Hospital Leadership Forum; Kim Lewis, National Health Law Program; Marty Lynch, LifeLong Medical Care and California Primary Care Association; Farrah McDaid Ting, County Supervisors Association of CA; Steve Melody, Anthem Blue Cross; Erica Murray, CA Association of Public Hospitals and Health Systems; Gary Passmore, CA Congress of Seniors; Chris Perrone, California HealthCare Foundation; Brenda Premo, Harris Family Center for Disability and Health Policy; Rusty Selix, CA Council of Community Mental Health Agencies; Cathy Senderling, County Welfare Directors Association; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center; Kristen Golden Testa, The Children's Partnership/100% Campaign; Richard Thomason, Blue Shield of California Foundation; Bill Walker, MD, Contra Costa Health Services; Anthony Wright, Health Access California.

Members Attending by Phone: Stephanie Lee, Neighborhood Legal Services of Los Angeles County.

Members Not Attending: Lisa Davies, Chapa-de Indian Health Program; Michael Humphrey, Sonoma County IHSS Public Authority; Bob Freeman, CenCal Health; Sandra Naylor Goodwin, CA Institute for Behavioral Health Solutions; Herrmann Spetzler, Open Door Health Centers; Lishaun Francis, CA Medical Association.

DHCS Attending: Jennifer Kent, Mari Cantwell, Rene Mollow, Sandra Williams, Sarah Brooks, Brian Hansen, Adam Weintraub, Alani Jackson and Lindy Harrington.

Public in Attendance: 30 members of the public attended.

**Welcome, Purpose of SAC and Today's Meeting and Introductions of New SAC Members
Jennifer Kent, DHCS Director**

Director Kent thanked Blue Shield of California Foundation and California HealthCare Foundation for their support to convene the stakeholder meetings.

Director Kent noted that this is the first time that the SAC has reconvened since the completion of the 1115 waiver renewal. She thanked all those that participated in moving it forward. She also noted that there are seven new members of the SAC.

Follow-Up Issues from Previous Meetings and Key Updates

Adam Weintraub reported that most DHCS follow up items are included in the scheduled presentations. Other updates will be reported in future dates; they are not yet ready to report back on.

DHCS FY State 2017 Budget Proposal

Jennifer Kent and Mari Cantwell, DHCS

- **Summary of Key Drivers of Medi-Cal Budget**
- **MCO Tax**
- **CCI**
- **CCS**

Jennifer Kent reported that the budget proposal is very positive given that a few years ago there were reductions. Other items to note are that the budget includes continuation of the Coordinated Care Initiative (CCI). The budget is predicated on successful passage of the MCO tax. Medi-Cal enrollment continues to increase and is expected to exceed 13+ million. DHCS is working on the May budget revision. She also thanked the plans and other stakeholders working to secure support for the MCO tax. The plans' support has been instrumental in working to secure the necessary 2/3 vote.

Mari Cantwell added that budget numbers reflecting a decrease is reflective of the cash budget (e.g. repayments from prior years; overpayments on managed care; recasting for CCI) and is not reflective of decreasing caseload or other cost reductions.

Questions and Comments

Elizabeth Landsberg, Western Center on Law and Poverty: I have heard different numbers in the budget and related to the MCO tax. Some refer to additional funding?

Mari Cantwell, DHCS: The Governor's budget assumed that the MCO tax would continue but the Medi-Cal budget did not assume the funds. That is where some confusion and questions have come up that should be clearer in May.

Anthony Wright, Health Access: What does the MCO tax bring in net?

Jennifer Kent, DHCS: The gross is \$2.4 billion and net is \$1.27 billion.

Gary Passmore, Congress of CA Seniors: My understanding is that the budget continued the CCI for one more year and Mari noted that it was tied to the reformed MCO tax. Is there a time where the CCI is not going to be threatened, questioned? Will the end of the 3-year pilot make it permanent?

Mari Cantwell, DHCS: The way it works is that every January, the Department of Finance makes a cost analysis. We didn't make a cost assessment this January, therefore CCI will go through January 2017. This is the sunset end date of Cal MediConnect because of the CMS contract. The other components of CCI do not have an end date. We expect that part of our discussion for next January's budget will be if there is an extension of Cal MediConnect.

Anthony Wright, Health Access: Are the estimates of the deferred action new Medi-Cal enrollment included in the budget?

Mari Cantwell, DHCS: It was not included for the simple reason that it we did not think it would impact this fiscal year. It does not indicate a change in the state's position or perspective.

1115 Waiver Renewal Application: Medi-Cal 2020

Mari Cantwell, DHCS

- **Review of STCs and Key Components of Waiver Renewal**
- **Timeline for Implementation**

Presentation slides are available at:

http://www.dhcs.ca.gov/Documents/SAC_Waiver_022516.pdf

Ms. Cantwell highlighted key components of the waiver and provided an overview of programs and time lines for each component. Total initial federal funding is \$6.2B. There are four main programs: 1) Public Hospital Redesign and Incentives in Medi-Cal (PRIME); 2) Global Payment Program (GPP); 3) Dental Transformation Initiative; and, 4) Whole Person Care (WPC).

Reviewing the details of PRIME, there are three domains under PRIME: Outpatient Delivery System Transformation; Targeted High-Risk or High-Cost Populations; and Resource Utilization Efficiency. This is the new version of the previous DSRIP component of the waiver. PRIME requirements: There was a desire by CMS to see Alternative Payment Methodology (APM) included and DHCS and hospitals also have had a longstanding interest in moving toward value-based payments and away from fee for service (FFS). As part of this, there are requirements for the public hospitals in the aggregate to meet certain targets over five years for their primary care patients. We are on board for a February 29 approval to finalize the PRIME attachments, metrics and funding. Five-year project plans are due within 30 days with another 60 days for approval by DHCS. There will be two public meetings during this period.

Questions and Comments

Gary Passmore, Congress of CA Seniors: Will hospitals be applying with a grant proposal? How will financing work?

Mari Cantwell, DHCS: Public hospitals will submit plans to DHCS based on what is laid out in the terms-and-conditions attachments being finalized now. Allocations will be delineated in the attachments.

Kirsten Barlow, CA Behavioral Health Directors Association: For domain two, will the hospitals identify for themselves who are high risk/cost or will the state define this?

Mari Cantwell, DHCS: The attachment guidance lays out the criteria and the measures for identifying the populations. Data from individual systems will inform the size of the population.

Bradley Gilbert, MD, Inland Empire Health Plan: Most of the data will come from the plans because there is not a lot of data available from the hospitals. I think this is one of those partnership areas where the plans can be real partners.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: How does this APM in the public hospital world, which includes public clinics, relate to APM for FQHCs, which also includes a number of public clinics? How do I think about the two together?

Mari Cantwell, DHCS: A public hospital clinic participating in the FQHC APM would help support achievement of the target in the waiver APM.

Steve Melody, Anthem Blue Cross/WellPoint: Would DRGs qualify as a value-based payment?

Mari Cantwell, DHCS: We haven't figured out what fits in the fourth category although it may fit. We are working with CMS to see if that can qualify.

Anthony Wright, Health Access California: CMS has a broad goal of value-based payments. Do they consider capitation within the value-based payment method?

Mari Cantwell, DHCS: Yes, they do.

Anthony Wright, Health Access California: How do you do capitation for the remaining uninsured?

Mari Cantwell, DHCS: With respect to this requirement, only Medi-Cal managed care members that are their responsibility for primary care are included. The remaining uninsured are in a different part of the waiver.

Bill Barcellona, CA Association of Physician Groups: How many individuals will be covered by the PRIME program?

Mari Cantwell, DHCS: We don't know that yet. Erica Murray and CAPH are working to get those numbers.

Anthony Wright, Health Access California: With regard to the public meetings, will every local institution have a public input process?

Mari Cantwell, DHCS: There is no requirement, but we imagine that each participant will have some sort of input process.

Erica Murray, CA Association of Public Hospitals and Health Systems: Yes, members are creating "public integration teams" to include local input.

Mari Cantwell then discussed the Global Payment Program. The goal for the whole waiver process to move away from cost based, hospital-centric payments to shift care based on patient needs. The former Safety Net Care Pool and DSH funding are being pooled in a GPP. The goal is to allow for more of a focus on primary and preventive services and innovation and less on hospital services. We are looking to develop a threshold of value of services for each public hospital program based on their historical costs serving the uninsured. The categories for determining value are: Traditional provider-based, face-to-face outpatient encounters; other non-traditional provider, groups, prevention/wellness, face-to-face; technology-based outpatient; and, Inpatient facility. The program has been carefully designed to ensure that improvements occur over time.

Questions and Comments

Gary Passmore, CA Congress of Seniors: Does the 2014-15 baseline remain the same through the 5-year waiver or does it change?

Mari Cantwell, DHCS: In terms of developing the service thresholds, we rely on 2014-15 as a base year. Looking at future years, this baseline will only change to the degree the funding in the program changes. If the funding were to decrease or increase by a certain percentage, then the thresholds would change as well.

Marilyn Holle, Disability Rights CA: The FFS Medi-Cal rates in primary care at clinics are usually higher than at a stand-alone doctor. How is that addressed? I was also perplexed that the definition of a safety-net hospital in the 1115 waiver was limited to inpatient?

Mari Cantwell, DHCS: I am not aware of where that is. Could you forward that information? Because this is only uninsured, the Medi-Cal rates don't apply here.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Can a public entity contract with non-profit health centers to fulfill these goals? Can undocumented residents count toward the goals?

Mari Cantwell, DHCS: Counties can define their systems as both their providers and their contracted providers. Yes, all uninsured are included.

Chris Perrone, California HealthCare Foundation: Can something like a telehealth visit be valued at the same level to an e-consult or are there wide ranges of values?

Mari Cantwell, DHCS: They are valued differently. The encounters are valued on the intensity of the effort compared to face-to-face. A telehealth visit might be 90; a regular visit is 100; less intensive is valued less.

Chris Perrone, California HealthCare Foundation: Do you anticipate a similar approach to managed care rate setting?

Mari Cantwell, DHCS: That is something we are certainly looking at now -- how we can, within our current constraints, allow managed care plans to adopt similar approaches.

Anthony Wright, Health Access California: The Safety Net Care Pool is \$236M in year one, is that the same in future years?

Mari Cantwell, DHCS: It is unknown what CMS will do. We had proposed a phased-down amount, but we don't know what CMS will do in the future.

Anthony Wright, Health Access California: So even though we talk about this \$6.2M with an asterisk, we think it will be more but don't know, correct?

Mari Cantwell, DHCS: Yes.

Anthony Wright, Health Access California: To clarify on the DSH side, what are the non-federal funds?

Mari Cantwell, DHCS: It is IGTs (intergovernmental transfers). Only county systems are eligible to receive DSH.

Gary Passmore, CA Congress of Seniors: Are other states undertaking similar efforts in relation to the 1115 waiver?

Mari Cantwell, DHCS: We are the first. Other states may be interested if they see success here.

Mari Cantwell then discussed the dental transformation initiative. The focus here is on increasing use of preventive care and access among children. It is structured as an incentive program that has particular projects and metrics that need to be met in order to take advantage of the incentives. The program is open to all dental providers, both FFS and contracted dental providers and includes FQHCs providing dental services. There is \$750M total funding over 5 years that is available. There are four domain areas: Increase Preventive Services Utilization for Children; Caries Risk Assessment and Disease Management; Increase Continuity of Care; and, Local Dental Pilot Programs. The local dental pilot projects, maximum of 15, will be capped at 25% of total funding available for this component of the waiver.

Questions and Comments

Carrie Gordon, CA Dental Association: How will the state capture data on dental emergency room visits since coding doesn't distinguish dental?

Rene Mollow, DHCS: This is one of the measures that CMS is asking us to work on to see what we can capture. If it is not feasible, we will talk again with CMS to modify this element.

Carrie Gordon, CA Dental Association: We have a new State Dental Director and we see this as a great opportunity to partner with the dental director to move this project forward.

Rene Mollow, DHCS: We are working very closely with him on this and overall.

Kim Lewis, National Health Law Program: This is supposed to be based on statewide improvement, yet it is voluntary. If you don't have representation from certain parts of the state, is that adequate to show improvement?

Mari Cantwell, DHCS: We are hopeful that providers will want to participate in the program to earn individual incentives and funding. We don't anticipate that no one will want to participate.

Rene Mollow, DHCS: This is a demonstration model to test whether it works and we want to think through the concerns about the financing of the program.

Kim Lewis, National Health Law Program: Is the dental home idea simply about continuity of care? Is part of this looking at the experience of consumers with their dental care?

Rene Mollow, DHCS: The goal is to keep patients with the same dental provider. We had not considered a consumer experience piece, but it is important and we can take it under consideration.

Elizabeth Landsberg, Western Center on Law and Poverty: Can you give us a sense of the dollar figures? I am looking for a sense of what the individual incentives would look like for providers and for the GMC plans?

Mari Cantwell, DHCS: All payments will be made to the individual providers, even for providers in a plan. It will not flow through the plans.

Alani Jackson, DHCS: In terms of the values, we are still working to model that. But, for preventive services, the amount would be 75% above the schedule of maximum allowances (SMA). .

Elizabeth Landsberg, Western Center on Law and Poverty: Are we tracking progress by county? That could allow us to compare GMC vs FFS?

Alani Jackson, DHCS: The first domain will be statewide. The second and third domains are pilots and are county specific.

Gary Passmore, CA Congress of Seniors: I appreciate the focus on dental. I have a concern that state policy seems to be premised on the assumption that teeth stay healthy after age 18. Will the state bring this kind of attention to adult dental care?

Mari Cantwell, DHCS: For the purpose of this waiver it is focused on children, however, certainly this could be something to think about in the future.

Anthony Wright, Health Access California: Is there any way that this could have linkage or impact on adult dental?

Mari Cantwell, DHCS: The waiver will inform the broad dental program.

Marilyn Holle, Disability Rights CA: Is there any way to capture data to see how dental care translates into improved health and thus additional savings?

Mari Cantwell, DHCS: This is something we struggle with to connect data when people are receiving care in different systems.

Kim Lewis, National Health Law Program: Managed care plans are already being paid capitation rates to provide these services. How is this going to impact that practice and how is this going to be monitored to ensure that they are providing this service?

Mari Cantwell, DHCS: We do track dental metrics quarterly from managed care plans. That is a factor in going directly to the providers with payments. What ends up happening and its impact in the overall program is something we will look at going forward.

Kim Lewis, National Health Law Program: The provider will be getting the regular payment from the plans and enhanced payments from the state?

Mari Cantwell, DHCS: Yes, if they meet certain metrics.

Sarah DeGuia, CA Pan-Ethnic Health Network: How will you work with beneficiaries and community organizations to let them know about these goals and that these options are available?

Rene Mollow, DHCS: A component of the waiver requires that we do outreach to beneficiaries and providers. We will be working on this and coordinating with key stakeholders and local entities such as First 5.

Sarah Brooks, DHCS discussed the Whole Person Care pilots, for which \$300M has been set aside. Multiple lead agencies are eligible to participate if they are able to provide the non-federal

share for the program. This is the first time that we are looking more broadly at the social determinants of health and health, behavioral health and social services. The overall goal is to provide care coordination for individuals that are frequently and inappropriately utilizing these systems. The target population is up to the local pilot within the general guidelines specified such as homeless. She noted that one optional component is the inclusion of housing and supportive services. Through this option, they can provide a housing pool, tenancy-based care management services, etc. Some examples of tenancy-based services include housing transition programs, housing related collaborative activities and other support. Dollars cannot be used to pay for rent but the pilots can create housing pools created by savings used to provide other care for these services, as well as savings from reduced ER/other high cost services. DHCS will issue the application sometime in May. Also, DHCS will issue an FAQ, timeline, LOI (letter of intent) and a document clarifying the differences and opportunities for coordination between this and the Health Home Initiative. The number of approved pilots is not specified in the waiver terms. Metrics are being finalized that will be required for reporting by all pilots.

Questions and Comments

Gary Passmore, CA Congress of Seniors: Are the WP Care pilots not restricted to the CCI counties?

Sarah Brooks, DHCS: It is available to all counties or could also be a region.

Kristin Golden Testa, The Children's Partnership: Will you be sharing information about entities who are interested in applying? Can you clarify who is developing the universal metrics?

Sarah Brooks, DHCS: The intent of collecting the LOI information is to make that available for local coordination. CMS is the partner on the metrics.

Rusty Selix, CA Council of Community Mental Health Agencies: Can there be more than one project per county?

Sarah Brooks, DHCS: There is nothing that precludes that. We would like to see geographic diversity across the state.

Jennifer Kent, DHCS: These are funded by IGTs, so the lead entity needs to be able to put forward the non-federal share. If we received multiple LOIs from the same geography, we would likely be in touch to encourage local coordination. It is unlikely we will fund multiple pilots in a single geography.

Rusty Selix, CA Council of Community Mental Health Agencies: This advisory group reviewed data indicating that the small percentage of patients accounting for the vast majority of cost have mental illness. I have been told that two-thirds of these people are not in the county mental health system – their only contact with mental health system may be inpatient. Is there a way that we can produce a break-down on the data and share who these clients are so we can work locally to understand the population?

Sarah Brooks, DHCS: We expect local entities to have conversations about these topics and we can look to see how we can support the discussion from the state level. There are privacy considerations but we will look at it.

Kim Lewis, National Health Law Program: The \$300M doesn't go very far statewide, especially considering housing. You might find that there is a lot more demand than funding available. How will you address that? What criteria will you use?

Sarah Brooks, DHCS: That is a great question. DHCS is working on selection criteria and we will share it for a quick comment period. We do want a diverse group of pilots.

Bill Walker, MD, Contra Costa Health Services: Is there a projected number of pilots you expect to fund?

Sarah Brooks, DHCS: No.

Anne Donnelly, Project Inform: The pilots are exciting. To the degree these are intended to move to the triple aim, we are disappointed there is no mention of communicable, infectious disease management, an issue for many of the likely target patients you mention. We understand the design of whole pilot can't be focused on this, however, we are wondering if we can work with you going forward to consider language about screening or how this project may have some focus being on infectious disease. And, just to be clear I am not saying the whole pilot should be focused on this but some area of focus on communicable disease.

Sarah Brooks, DHCS: The target populations listed do not limit the populations and there is no reason this could not be a focus.

Marty Lynch, LifeLong Medical Care and California Primary Care Association; The sooner you can get out the information on the interaction of this and the Health Home project would be extremely helpful.

Sarah Brooks, DHCS: Yes, we agree. The FAQ will address this and we will have a webinar on this topic.

Anthony Wright, Health Access California: Is the applying county required to have a stakeholder input process?

Sarah Brooks, DHCS: It is up to the lead entity. There is a requirement that the specialty mental health plan, two community organizations and one managed care plan participate. We will be looking for indications of community support in the applications through letters of support.

Bradley Gilbert, MD, Inland Empire Health Plan: It's pretty clear to me that for the success of PRIME, WPP and Health Homes, there is a common thread of complex care management. We don't want a PRIME care manager and a WPC care manager. IEHP is going to invest in Riverside County care managers/management programs and this is a natural for a WPC, but we want to see this as a coordinated effort with multiple funding streams. Jennifer Clancy put together a great side-by-side analysis that emphasizes this onsite, point of care management, which I can forward. I think making this clear is really important -- that the work is across the continuum with multiple funding streams. Otherwise, people will be stumbling over each other.

Sarah Brooks, DHCS: Brilliant as usual. The intent is not to create siloes but coordination across the continuum.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Is it feasible for the health plans to put up the county investment?

Mari Cantwell, DHCS: No, that would be permissible.

Bradley Gilbert, MD, Inland Empire Health Plan: We see this as providing seed money to help the counties develop core staffing and infrastructure.

Gary Passmore, CA Congress of Seniors: I second Brad's comments.

Sarah DeGuia, CA Pan-Ethnic Health Network: Is there just one application process at the beginning, with the award stretching over five years?

Sarah Brooks, DHCS: Yes, unless there was additional funding, which would enable a second round of funding.

Sarah DeGuia, CA Pan-Ethnic Health Network: How are you thinking about sharing best practices and lessons learned? What are the data specifics? Will data be shared?

Sarah Brooks, DHCS: That is a great question. Pilots will report semi-annually and we will bring that information forward. There will be a reporting template online and we do plan to share information although at this point we don't know precisely what will be shared.

Mari Cantwell, DHCS: There is also a requirement for pilots to participate in a learning collaborative. We also will likely convene them.

Cathy Senderling, County Welfare Directors Association: In identifying the target population, we may find that they are all different in the end, but it has to be a data-driven process in order to have a strong basis for selecting the target population. Even if there are 3-4 different target populations among the pilots, how can we share best practices that are not so specific to the population but allow for lessons to be applied across the state? The collaborative information sharing will be a critical part of this learning across the state.

Chris Perrone, California HealthCare Foundation: I'm often reminded as we do pilots that we should have brought evaluators in earlier. Do you have an evaluator selected?

Sarah Brooks, DHCS: The evaluator is not chosen but we agree with you about the need to bring them in early. There are specifics in the terms and conditions that require an evaluation.

Stephanie Lee, Neighborhood Legal Services of Los Angeles County: Will DHCS connect applicants with similar projects or target populations in the interest of information sharing? Also, how does WPC and Health Homes overlap with CCI case management?

Mari Cantwell, DHCS: Depending on the LOI information, if we see applications that can benefit from information in another county's application or could be a regional approach, we will try to connect them.

Sarah Brooks, DHCS: We are looking at how WPC Pilots, CCI and Health Homes Initiative overlap and how they can be coordinated. CMS has engaged in this discussion as well.

Mari Cantwell briefly discussed background and specific programs included under the Designated State Health Programs (DSHP) part of the waiver. Ms. Cantwell reviewed budget neutrality and she noted that a major issue was how the budget neutrality would be structured in

the new waiver. We were able to reach a compromise for the waiver agreement that includes an “over-time” adjustment to savings from the transition to managed care. It will reduce over time eventually to 23%. That agreement did significantly reduce the savings but we still have a large amount of savings. The other change is that the trend rates are the President’s trend rates, which are lower. Overall, budget neutrality is a lower amount of savings but still includes enough to support the programs discussed, with a cushion. The additional piece is that CMS is allowing us to use funds in the new waiver that are unused in the current waiver to achieve budget neutrality. We will continue to monitor this but do not expect any budget neutrality issues.

Questions and Comments

Elizabeth Landsberg, Western Center on Law and Poverty: Are you saying we can use unused neutrality dollars from the last waiver and apply them here?

Mari Cantwell, DHCS: Yes. We haven’t been able to finalize the numbers but we feel confident there are significant savings, potentially billions.

Anthony Wright, Health Access California: What are your concerns about what could go wrong with budget neutrality?

Mari Cantwell, DHCS: Mainly, it is if managed care PMPM (per-member per-month) costs went up faster than we projected. Also, if lower enrollment in some populations happened where we expect savings, we could have losses that could affect budget neutrality.

Gary Passmore, CA Congress of Seniors: Do you have any data on which populations those are?

Mari Cantwell, DHCS: Yes, the eligibility groups are listed in attachment C.

Marilyn Holle, Disability Rights CA: I know that with the Medicaid expansion, there are more people with disabilities in that group than there were previously. Is there any way you can determine that?

Mari Cantwell, DHCS: For the Seniors and People with Disabilities population, we actually do accrue savings. The expansion group itself is not part of budget neutrality and we cannot accrue savings from them.

Marilyn Holle, Disability Rights CA: What about other high costs like Hep C drugs?

Mari Cantwell, DHCS: Yes, that is where some of our risk is and we cannot control it.

Anthony Wright, Health Access California: Can you clarify the numbers in the SNCP line – the \$472M? Are those total funds? What is the \$236M number listed previously?

Mari Cantwell, DHCS: The total funding number is \$472M and the \$236M is 50% of the total.

Michelle Gibbons, County Health Executives Association of CA: I don’t see a line item for the Drug Medi-Cal waiver in budget neutrality.

Mari Cantwell, DHCS: It is included in the budget neutrality, but it is actually treated as a wash and actual expenses are just passed through.

Mari Cantwell then discussed the evaluation and managed care assessments. We committed to producing an access assessment that will compare the Medi-Cal line of business to other lines of business as well as network adequacy, the degree to which Knox Keene requirements are being met and other topics. DHCS will have an advisory committee to look at the assessments and we are beginning the process of developing that committee. The access assessment itself won't take place until we have the final waiver statute in place.

Questions and Comments

Carrie Gordon, CA Dental Association: Are specialty plans, such as dental, included as well? Is there something to be done to include them?

Mari Cantwell, DHCS: No, they are not included. We can certainly look at this topic, but the difficult component is funding.

Brenda Premo, Harris Family Center for Disability and Health Policy: Access is an interesting word. The department has done some great things to expand the definition of access, such as, 'once you get there you have to get in the building,' but there are still some things to be done. There are now programs in managed care that are totally about the disabled. Access has to do with anything that will prohibit the patient from being able to participate in care. We need to go beyond time and distance. What we are really talking about is total ability to benefit equitably from the services provided. What can we do to ensure that we are defining and measuring access more broadly? Where does the equipment exist and how long does it take to get there? I hope we can talk about how to integrate the needs of the disabled into the overall approach.

Mari Cantwell, DHCS: That really is the goal of having the committee - to inform what we need to look at. We appreciate this kind of input.

Bill Barcellona, CA Association of Physician Groups: I agree with Brenda. I commented on the federal Medicaid access standards last year that their national access standards are really just the 30-year-old standard of time and distance. If we just rely on the CMS, we may be limited to a 30-year old standard.

Mari Cantwell, DHCS: The federal requirements are the minimum and many areas of California exceed those minimums already. Nothing prohibits us from doing more.

Bradley Gilbert, MD, Inland Empire Health Plan: I think we need to be sensitive to what Brenda is saying but we know there are levels. If we have one orthopedic surgeon and they are not in a very good building, then we have to balance access issues overall. Do we prevent them from being in the network? We need to pick standards that make sense and perhaps look qualitatively at other topics.

Marilyn Holle, Disability Rights CA: For someone with a low incidence disability, access can include having access to someone who has expertise in your particular disability. It can also mean access to someone who can deal with your conditions in one place. The experience of CCS is that this is the way to avoid hospitalizations.

Mari Cantwell then discussed the Uncompensated Care Assessment. She said there are two reports that have to be completed by independent parties. The first report, due May 15, is on the designated public hospitals to determine the amount of uncompensated care (\$236M). CMS will then make a determination on funding levels for the uncompensated care pool. The second report will expand to include all hospitals in California. It will incorporate the information from the

designated public hospitals, and will add all other hospitals to look at how uncompensated care has changed given expansion. Thanks to BSCF for its support in funding the first study.

Questions and Comments

Richard Thomason, Blue Shield of California Foundation: We have chosen Navigant Consulting to carry out the first study. He thanked The California Endowment for helping to fund this study. Mari Cantwell discussed the Global Payment Program evaluations. There will be two evaluations of provider expenditures and activities, one at the mid-point of the demonstration and one in year four. For PRIME there are two evaluations to review impact of the program. The first report is due after the fourth year and the second after the last year. Lastly, the waiver continues several existing authorities, such as Medi-Cal managed care, the Community Based Adult Services (CBAS), CCI, Drug Medi-Cal and others. We will be working with evaluators to develop the specifics on these requirements.

Questions and Comments

Rusty Selix, CA Council of Community Mental Health Agencies: There are a couple of sentences in the Drug Medi-Cal terms and conditions, there is reference to integrated behavioral and medical care with implementation dates. Can you speak to that?

Jennifer Kent, DHCS: This relates to an integration plan that is being approved for release in draft form for comment.

Mari Cantwell, DHCS: New information and documents will be posted on the waiver website and we will continue to monitor it and respond.

Michelle Gibbons, County Health Executives Association of CA: When are the access reports due?

Mari Cantwell, DHCS: The timing is linked to when we get the contracts.

Sarah Brooks, DHCS: We will be working on a timeline for that based on the terms and conditions and we will share it publicly.

Kim Lewis, National Health Law Program: Are there any updates on enrollment numbers and pending Medi-Cal applications? Are you going to present on this information?

Rene Morrow, DHCS: DHCS is tracking the 45-day enrollment timeline and those applications that are in excess of 45 days. We are letting those applicants know that their application has not been acted on within the required timeline and that they can file for a hearing related to that. We are tracking and reporting to CMS. There have been 1.4M applications that came in during open enrollment and of the total applications, about 21,000 (2%) statewide that are in excess of the timeline requirement. In doing this report, we look at posting of the determination in MEDS. We do not know the details behind this – for example, has the county reached out for additional information; which applications were approved on day 46; what programs the applications fit under? It is purely applications received that were not determined by day 45.

Kim Lewis, National Health Law Program: Thank you for the information. CMS said they encourage states to post this information online. Will you be doing this? Is there a way to find out from counties what is the reason behind the lack of a determination?

Rene Mollow, DHCS: We will share out the information and will post it on the Consumer-Focused (Stakeholder Workgroup) web site. There is no way to find out the more detailed information or to track the details.

Kristen Golden Testa, The Children's Partnership/100% Campaign: How often are the reports submitted? Is this total counts from CalHEERS, phone, online? Is there a breakdown of kids?

Rene Mollow, DHCS: The reports are weekly and do include all sources of applications. I will try to get information on kids, but my suspicion is that they would represent a low number because of the opportunity for kids to have accelerated enrollment through CalHEERS.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center: Another item not yet discussed or on the agenda is the Drug Medi-Cal organized delivery system, a system that maybe no one knew how enormous the interest in it would become. It dovetails or needs to dovetail directly with the WPC Pilot and the Health Home initiative moving forward. It's important to keep it at the forefront to know where it stands.

Jennifer Kent, DHCS: Marlene has presented on it several times to the SAC. It is not on the agenda today because there are not major updates since the last presentation. We have received five implementation plans from counties and they are with CMS. There are no county approvals and no services being provided yet. We will keep it on the agenda as progress is made.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center I recognize that and I see that lack of approval as a problem. Counties are moving too slowly.

Bradley Gilbert, MD, Inland Empire Health Plan: I agree this is important for us to talk about taking care of people comprehensively. A major barrier is the federal regulations preventing the sharing of data. There is an absolute block on sharing data on the substance use side. I read the new regs and they are not doing much to fundamentally change the law. It is an old school decision of thinking substance use treatment is different than behavioral health. IEHP will send a comment letter but whatever the state or anyone can do to say that you have to change this fundamentally. You can't have a separate law barring transmission of information dealing with this one person. Don't tweak it, make it consistent with HIPAA.

Implementation of SB75 – Coverage for All Children

Rene Mollow, DHCS

Presentation slides available at:

<http://www.dhcs.ca.gov/Documents/SB75SACpresentation022016.pdf>

Rene Mollow provided an update on SB 75. She said that an upcoming Eligibility and Enrollment Plan has been distributed for stakeholder feedback and will be finalized soon. A webinar will be scheduled once the eligibility and enrollment plan is final. DHCS has made a decision that this population will be treated like other newly eligible populations and will go through the health plan choice process. Kids currently covered through local programs will need to complete a Medi-Cal application to become eligible. We are working with foundations and local program partners to develop the right messages and communication to avoid confusion. She also said that they are not looking for children in restricted scope Medi-Cal to have to take any action to receive full-scope coverage. She presented a timeline of the key milestones, reviewed proposed notices and discussed system readiness. Currently, the tentative plan projects system readiness on May 16th. Once the system becomes operational, the effective

date for eligibility will be back to the first day of that existing month (e.g. May 16 would retroactive to May 1). DHCS currently estimates up to 170,000 currently uninsured or in restricted benefits will become eligible.

Questions and Comments

Bradley Gilbert, MD, Inland Empire Health Plan: I understand that you need to use the regular program. We have a Catch 22 that I am concerned about. Our network does not take FFS Medi-Cal so I am planning to pay for bridge coverage during the FFS period as long as they stay with IEHP. We will end coverage if they choose Molina during this time. You mentioned they would not go into managed care if they have other coverage.

Rene Mollow, DHCS: Generally, other coverage is private insurance. I don't think we would recognize local programs as coverage or pick this up.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Thank you for all the work on this. Is Kaiser included in the plans that DHCS is talking with and how this will affect them?

Rene Mollow, DHCS: Yes, we are talking with them and the same rules will apply. They need to apply for Medi-Cal and they can choose Kaiser.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Can you talk more about what outreach/education for the families would include?

Rene Mollow, DHCS: That is the work that we've been speaking with the foundations about. What are the messaging points that they should be addressing with populations they are covering? Most important is that they will have to apply for Medi-Cal and they would have to tell us about immigration status. It is still a choice for the families to come forward and apply.

Kristen Golden Testa, The Children's Partnership/100% Campaign: We have had sobering conversations with counties about if the May 16th goal of the linkage with SAWS would also happen at that time. Some counties have said they haven't gotten the appropriate information to do programming.

Rene Mollow, DHCS: I don't feel this is the case with counties we are working with. We are planning for contingencies very closely with counties.

Kristen Golden Testa, The Children's Partnership/100% Campaign: We have heard from some counties that they haven't received guidance in the form of an All County Welfare Directors letter. We are 60 days out – when do you think this will go out?

Rene Mollow, DHCS: There will be policy guidance that will go out, but I am not sure when. It is on fast track.

Kristen Golden Testa, The Children's Partnership/100% Campaign: It would be really helpful to have the privacy rules for Medi-Cal clearly posted because not everyone in the community understands how information will be used.

Jennifer Kent, DHCS: Medi-Cal will only share the information for the purposes of determining eligibility.

Rene Mollow, DHCS: The immigration information goes to the Department of Homeland Security; they have said they will not use it for anything other than verifying. This is written up in the Rights and Responsibilities document. It speaks to this already.

Brenda Premo, Harris Family Center for Disability and Health Policy: A lot of people are not going to read eight-page notices and they are not going to trust that the federal government will not use this information. The key is trust and how we communicate and reach out through promotoras or others they trust. There has to be personal contact to explain how it will be done. I know you care about getting them into the program.

Rene Mollow, DHCS: We agree and that is why we are looking to local programs and residents to use those trusted networks to get that message across. That's why we are working with the foundations to develop tools to get that message across.

Rusty Selix, CA Council of Community Mental Health Agencies: How does the financing of mental health work given that it is realigned?

Jennifer Kent, DHCS: We accounted for it. It will be a responsibility of counties once they receive full-scope coverage.

Mari Cantwell, DHCS: We may have built in General Fund consideration for the cost of mental health under the program.

Kim Lewis, National Health Law Program: The transition of children is tricky because they are in so many different programs. Is there a way for plans and beneficiaries to help inform them about the process for expedited enrollment into managed care, especially if they need to get on/stay on more quickly?

Rene Morrow, DHCS: We will need to get back to you.

Kim Lewis, National Health Law Program: Assuming that it will take a couple of months for the enrollment process, there could be delays in getting full scope. Would counties be doing prep prior to May 16th?

Rene Morrow, DHCS: Yes, the expectation of when it goes online and is live, the transition kids' coverage would be effectuated retroactive to the first day of the month. There may be individual cases that need follow up but not the majority.

Anthony Wright, Health Access California: A comment on communication of information about what immigration information will/will not be used for: I assume the information will be highlighted given its importance. It's not just about immigration enforcement but also about this community's concern about public charge – does it impact their ability to take advantage of other options in the future? That is crucial to highlight as well. Also, is there a timeline of when the enrollment plan will come out?

Rene Morrow, DHCS: Yes, staff is finalizing so we can hold a webinar to take final comments. It will be very soon.

Elizabeth Landsberg, Western Center on Law and Poverty: We also support both choice and continuity of care and urge the department to please send the choice packet earlier.

Sarah Brooks, DHCS: We can't send it out early because the applicants would not be able to select a plan given they wouldn't be in the system.

Health Home Initiative Update

Brian Hansen, DHCS

Presentation slides available at:

http://www.dhcs.ca.gov/Documents/Health_Homes_Presentation.pdf

Brian Hansen reviewed the ACA Section 2703 Health Homes Program (HHP). The program is intended to serve a small subset of members that account for a high level of services/ cost and require intensive support. The program is structured as a network including members to serve as a care management team. DHCS released a RFI to managed care plans to assess interest in the HHP and most expressed interest and requested implication in January 2017. He summarized feedback from the health plans, including the need for sufficient time to build effective programs, among other feedback. The schedule for implementation has been divided into three groups, in January 2017, July 2017 and January 2018. The first implementation wave for each group will include those with mental health conditions with subsequent waves focused on clients with multiple chronic conditions. All of the groups will be high risk. The application for the first three plans will be released this month with a list of questions that will enable them to complete successful applications. DHCS is working with Pacific Business Group on Health to develop technical assistance for the plans and community providers.

Questions and Comments

Gary Passmore, CA Congress of Seniors: When these are complete, will the information be publicly available?

Brian Hansen, DHCS: The intention is that the RFAs and proposals will be publicly available. The outcome metrics will be available.

Jennifer Kent, DHCS: The only caveat on making them public is if the data sample size is smaller than the state requirements for what information can be released.

Elizabeth Landsberg, Western Center on Law and Poverty: In our comments with Corporation for Supportive Housing, we suggested moving some of the bigger counties to phase 1. Can you share your thinking on why you are not front-loading some of the bigger counties?

Brian Hansen, DHCS: The sense from plans about what it will take to do this work is that in some of our smaller counties, they were more prepared to start early where as some larger counties require more time.

Steve Melody, Anthem Blue Cross/WellPoint: What is the timeline for plans to respond and what exactly are you looking for? Will you expect a full network analysis or a plan to develop?

Brian Hansen, DHCS: We haven't nailed down the timing but expect it will be about 45-60 days. We are looking for a reasonable level of detail given how much information the plans have. We want a good sense the plan is heading in the right direction. We don't expect a full network review at this point.

Michelle Cabrera, Service Employees International Union: Are we still going to be able to take advantage of the 90/10 federal match?

Brian Hansen, DHCS: There are eight quarters of enhanced funding. Each geographic area or population starts an eight-quarter timeline.

Michelle Cabrera, Service Employees International Union: Can you talk more about the contractor selected for TA (technical assistance)?

Brian Hansen, DHCS: PBGH operated a very similar TA program for Center for Medicare and Medicaid Innovation for Medicare plans in California. We are translating the curriculum to this Health Homes Initiative and working to make it specific to this population.

Rusty Selix, CA Council of Community Mental Health Agencies: This is just about half the counties; what is the status of the other counties not listed here? Is there a deadline for them?

Brian Hansen, DHCS: There is no schedule for the most rural counties yet. In the larger counties that are not participating, we have not received interest from both plans. We are continuing to work with them.

Rusty Selix, CA Council of Community Mental Health Agencies: What is the message with folks that want their county to participate?

Jennifer Kent, DHCS: They should talk to their plans and develop a relationship.

Rusty Selix, CA Council of Community Mental Health Agencies: For those providers who have never been paid by the Medi-Cal plans, will they need to get a Medi-Cal provider number to be in this program? Are you looking at stratified rates?

Mari Cantwell, DHCS: Providers in managed care do not need to apply for a Medi-Cal number – only FFS. DHCS is developing rates for the plans and the plans will contract with the providers. We do expect that our rates will be stratified but it will be up to the plans to determine rates for the providers.

Rusty Selix, CA Council of Community Mental Health Agencies: Is DHCS reaching out to providers in my association? We can be helpful to facilitate the linkage. Currently, they only do business with county mental health and this is a foreign country.

Jennifer Kent, DHCS: The heart of this program is the plans.

Mari Cantwell, DHCS: We have talked about ways for the plans to go through the county to accomplish this.

Sarah Brooks, DHCS: We have regular calls with the plans and can include this in a future agenda to discuss with them.

Bradley Gilbert, MD, Inland Empire Health Plan: To Rusty's point, in order to do care management in a good way, we have to have a good relationship with our county mental health plan who has the relationship with the providers, and that may be where we have the case managers sit because that is the site of care. Our challenge is in being able to exchange data.

Sarah Brooks, DHCS: We give health plans data monthly on anti-psychotic and HIV drugs and we will open this up to include all FFS data to help with care coordination.

Brian Hansen, DHCS: We will develop a list of those eligible as well.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Will the RFI's and responses be publicly available?

Brian Hansen, DHCS: The survey is available but we need to check on responses.

Kim Lewis, National Health Law Program: How many children as opposed to adults do you expect in the target population? One of the reasons is that, especially under EPSDT and kids with mental health problems, much of the funding is provided by the rehab option and specialty mental health providers. We want to be sure there are not dual functions and overlapping or conflicting coordination programs.

Brian Hansen, DHCS: We are going to run the data over the next month but we expect kids will be very small.

Mari Cantwell, DHCS: We do not want duplication or confusion of multiple care managers.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: How locked in are these waves? What if a county came to you and said we want to go forward earlier?

Sarah Brooks, DHCS: The timing is fairly locked in with the first wave but there may be more flexibility in the second or third waves.

Bill Barcellona, CA Association of Physician Groups: What entities does the self-assessment tool go out to?

Brian Hansen, DHCS: The assessment is targeted for those entities that would be serving as the core provider of health home/care manager for the program. We are letting the plans identify who the assessment should go to and we will identify others as we are aware of them.

Anne Donnelly, Project Inform: I want to flag the potential for duplication for patients with HIV Ryan White (Care Act services). It is likely a small population, but those patients may already be receiving high level case management. It will be important that there is not duplication and that the level of expertise is comparable.

Chris Perrone, California HealthCare Foundation: Are CCS kids eligible?

Brian Hansen, DHCS: Yes.

Managed Care Update

Sarah Brooks, DHCS

Presentation slides available at:

<http://www.dhcs.ca.gov/Documents/CalMediconnect%20Presentation.pdf>

Sarah Brooks provided a managed care update. RTI International released a report on the duals demonstration in seven states. Initial results were positive and DHCS looks forward to future reports. The CCI evaluation funded by the SCAN Foundation by the Field Research Corporation released a second report in December 2015. It found that most enrollees in Cal MediConnect

were satisfied with their doctors and hospitals, said that providers worked together to provide services and that providers were spending enough time with them to solve their problems.

UCB/UCSF CCI evaluation findings showed that most beneficiaries that opted out did so because they were happy with their current providers and didn't want to lose that provider. Many were also unfamiliar with the benefits and range of services, highlighting the need for more education. Enrollment is about 125,000, the largest in the country. The 2016 CCI activities include beneficiary outreach/education, projects to increase transparency (quality dashboard, evaluation, SCAN reports) and outreach with providers, especially where there is high opt out.

Questions and Comments

Gary Passmore, CA Congress of Seniors: As the administration evaluates the desirability of continuing the CCI, how does DHCS see the evaluation playing into that assessment and the Department of Finance information assessing the program?

Sarah Brooks, DHCS: The findings and evaluation helps tell the story of beneficiaries and it can also help to spread the word about the program to more individuals.

Mari Cantwell, DHCS: We feel this is a good program and think the program is helping people. Obviously, we have to think about the statutory and fiscal issues to continue the program.

Gary Passmore, CA Congress of Seniors: I am not sure everyone appreciates the fact that with the Medi-Cal expansion, there are a lot of boomers aged 55-65 who will approach the decision about CCI, but are already in managed care – so the issue of losing your provider is less of an issue.

Mari Cantwell, DHCS: That is absolutely one of the groups we are looking at – how do we do help with that transition, target them and help them enroll.

Michelle Cabrera, Service Employees International Union: Given that we've moved from passive to active enrollment, does DHCS have a plan for increasing enrollment?

Sarah Brooks, DHCS: We are discussing strategies to build enrollment and learn from program lessons thus far.

Sarah Brooks then provided a brief update on the CCS program. There have been ongoing discussions with a CCS advisory group about how to implement the whole child model. We anticipate a phased rollout. In the near term, DHCS will reach out to plans to begin discussing interest and readiness. We are also working on a draft transition plan.

Jennifer Kent added that in conversations with counties, DHCS has been asked to help develop a timeline and set of expectations for the plan and counties to help guide their discussions about when we want to see agreements or how to handle the transition. San Mateo transition has gone well but that may not be the right way to implement in every plan and county. We are also encouraging local creativity and problem solving and don't want to pre-suppose the conversation before it happens.

Marilyn Holle, Disability Rights CA: Has there been conversation about how to support children that age out of CCS and are eligible for Medi-Cal? One of the problems with continuity of care is that with the managed care plan – they get to see their doctor, but they don't have access to the lab or hospital where the provider who knows them is. For example, kids who age out of CCS

with significant conditions, one hospital may be very good at it and there is a problem when the program divorces from the hospital where there are admitting privileges.

Jennifer Kent, DHCS: Great question. In addition to the whole child model, there are changes related to all managed care plans and having agreements in place for continuity of care. When children turn 22, they fall off CCS and have nothing. We have been working with Medi-Cal plans to have a hand-off during the transition to keep their provider or have a plan in place.

Bradley Gilbert, MD, Inland Empire Health Plan: Here is a really good example. For our patients with hemophilia, Cedar Sinai won't contract with us. I agree with you, Marilyn that the best scenario is that you continue that care as-is. The other problem you have is that as the kids start getting older and older the physicians may not want to continue the care.

Marilyn Holle, Disability Rights CA: Cedars is a Hill Burton hospital with an obligation to continue services. They tend to forget the obligation when they are not providing money to patients. CMS has not pressed this obligation.

Jennifer Kent, DHCS: We have been deliberate in our CCS conversations thus far that we want to encourage contracting between hospitals and plans as a normalized way to interact. We are trying not to tip the balance where the plans are held hostage by hospitals that do not want to contract with them.

Michelle Cabrera, Service Employees International Union: In the proposed bill language DHCS released last year there were sections that dealt with continuity of care, plan readiness, but CCS is not the typical FFS program in that there is a whole infrastructure built around care coordination and other services. Has DHCS considered how those standards will be reflected in the transition and ensure that those protections will be carried forward?

Jennifer Kent, DHCS: If there are things that you want to bring to us please do. Each county operates differently. We want all of the counties to contemplate how the program is handed over to the plans. In the transition plans, we want to see a recognition of the fact that there is an intensive level of coordination that is needed with the family and providers.

Marilyn Holle, Disability Rights CA: They are RN/public health nursing case managers with 75/25 federal match for those services that should be kept in mind.

Jennifer Kent, DHCS: Public health nurses do have a 75% match. The whole child model is being implemented in four places. Other counties remain the same. Each county is going to have a very different scenario depending on the nature of their county system.

Marilyn Holle, Disability Rights CA: The RN case managers have an information and knowledge base that can't be replicated. CCS is frozen in time and we haven't developed new specialty care centers. CCS has always operated as the step-child. There really has been a neglect of resources of developing specialty care centers which defines community standards for all children with disabilities.

Jennifer Kent, DHCS: Expanding specialty care centers has nothing to do with the whole child model proposal. There is a data work group that will look at improving data quality measures; an adult transition group. In relation to the CCS/whole child model, we have been very clear that we are not touching the clinical quality requirements so the infrastructure stays in place. There

is no proposal to add General Fund resources so we are trying to do is something within the confines of existing resources in a way that is budget neutral.

Brenda Premo, Harris Family Center for Disability and Health Policy: I believe that we need specialists trained to support disability issues for adults. When you become an adult you deal with adult concerns such as, I want to have children, I want to have an adult chair. We have to look at it from two perspectives, the transition itself and how to offer services to the child who grows into an adult with a disability. Part of this is the condition and how we get resources and provide transitions, the other part is that we are dealing with a human being and they don't want to be viewed only through their condition. We need to think differently about how we train providers/specialists to deal with specialty areas and care for the whole person throughout their lifespan and transition from child to adult. We need to go beyond just CCS.

Jennifer Kent, DHCS: I agree. People come to us integrated as a whole person and we need to stop breaking them apart into distinct parts.

Chris Perrone, California HealthCare Foundation: There is a 50th anniversary of Medi-Cal coming up?

Jennifer Kent, DHCS: On May 24th, there will be a celebration of Medi-Cal. We will have a panel of spokespeople, beneficiaries and other activities. We are excited to celebrate this anniversary.

Public Comment

There was no public comment

Next Steps and Next Meetings

Next meeting dates:

May 16, 2016

August 11, 2016

October 24, 2016