

**SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER  
HEALTH CARE COVERAGE INITIATIVE (HCCI) TECHNICAL WORKGROUP  
Meeting #4 – Thursday, April 29, 2010  
10:00am – 2:30pm  
CPCA, 1231 I Street, 4<sup>th</sup> Floor**

The meeting convened at 10:00 AM.

Attendance

*Technical Workgroup members attending:* Jennifer Abraham, Kern County; Tangerine Brigham, City and County of San Francisco Department of Public Health; Kelly Brooks, California State Association of Counties; Sandy Damiano, Department of Health and Human Services, Sacramento County; Irene Dyer, Los Angeles County Department of Health Services; Len Finocchio, California HealthCare Foundation; Bob Gates, Orange County Medical Services Initiative; Nancy Kaatz, Santa Clara Valley Health and Hospital System; Elizabeth Landsberg, Western Center on Law and Poverty; Louise McCarthy, Community Clinic Association of LA County; Anne McLeod, California Hospital Association, Erica Murray, California Association of Public Hospitals and Health Systems; Judith Reigel, County Health Executives Association of California; Cathy Senderling, County Welfare Directors Association; William Walker, Contra Costa Health Services; Anthony Wright, Health Access California; Ellen Wu, California Pan-Ethnic Health Network.

*Others attending:* David Maxwell-Jolly, Director, DHCS; Gregory Franklin, Director of Medi-Cal Operations and Project Director, 1115 Demonstration Waiver Project, DHCS; Jalyne Callori, DHCS; Caroline Davis, Health Management Associates; Bobbie Wunsch, Pacific Health Consulting Group.

*Public in Attendance:* 8 individuals attended in person, and 6 people called in on the listen-only telephone line.

Welcome and Introductions

*Bobbie Wunsch, Pacific Health Consulting Group* welcomed the group and provided an overview of the agenda.

The Stakeholder Advisory Committee (SAC) will meet on May 13<sup>th</sup> at the Sacramento Convention Center.

Proposed Approach to HCCI

*David Maxwell-Jolly, Director, DHCS*, presented DHCS' current thinking on the future of HCCIs and the waiver. DHCS was initially cautious about the prospects for HCCI expansion, but the passage of federal Health Care Reform legislation (HCR) offers new opportunities, and DHCS hopes to take advantage of them. DHCS now proposes to build on the 10 existing HCCIs, and to offer all additional counties the opportunity to participate in what he hopes will be a significant statewide expansion.

Income eligibility criteria for persons not otherwise eligible for Medi-Cal would be maintained at up to 200% FPL, as in the current HCCIs. Enrollees would primarily be adults who are not categorically eligible, as in most current HCCIs.

The proposed HCCI expansion would rely on counties to provide their local indigent care expenditures as the nonfederal share for federal reimbursement and would grow to the extent that those funds are available. DHCS has heard from a number of counties that they have unmatched indigent care dollars to allow for growth: in some counties, HCCI expansion can happen quickly, while in others it will take longer. One caution is that the HCCIs cannot make commitments beyond the funding that the county actually has. That will be frustrating for many but is a real constraint.

The proposed expansion is explicitly designed to allow seamless enrollment in full coverage either through the expanded Medicaid option (up to 133% FPL) available beginning in January 2014, or in subsidized coverage through the insurance exchange at the point that it is initiated in conformity with HCR.

To make HCCI expansion work, DHCS believes that the following features are needed:

- *Standardized enrollment processes:* The HCCIs should have clear and fairly consistent processes across all counties with respect to documentation and processing. Well-documented eligibility is critical to get to seamless enrollment in 2014. HCCI enrollment must be incorporated into existing enrollment recording systems to a greater extent than in the existing HCCIs. Currently, participants are required to go through the DRA process, and one advantage of using existing systems will be the ability to simplify that process. DHCS is engaged in active conversations in other forums about eligibility assistance, and how to operate it in the long run. DHCS wants to assure that the HCCIs are an integral part of that process.
- *Benefit package:* There is a tradeoff between breadth and depth: an expansive benefit package versus expanding eligibility to more people. The pool of local dollars is not unlimited. Congress was clear in the HCR legislation that the eventual benefit package should have certain components, not all of which are included in the current HCCIs. Over time, the goal for the HCCIs will be to get to the benchmark plan, however that is defined. Counties will be encouraged to establish mental health (MH) and care management (CM) components, as many existing HCCI counties have already done. Many in the HCCI population have serious behavioral issues, and it will take more than a passive approach to manage their care. DHCS' goal is to grow the benefit package to be more comprehensive, remaining mindful of where the state is going in the long run.
- *Provider network:* Counties will be responsible for establishing a provider network, and would have the authority to determine the network construct through which services are provided. However, DHCS will expect counties to make an effort to engage a broader spectrum of the provider community than existing HCCIs have done. In non-public hospital counties, HCCIs already rely on private hospitals. Going

forward, HCCIs in public hospital counties will be expected to engage private providers more than they have in the past. DHCS expects a substantial expansion of the provider network for HCCIs.

- *Outreach:* The state's goal is to maximize enrollment to the extent that county funds are available. To the extent that enrollment does not keep up with capacity, outreach will be required.
- *Data infrastructure:* HCCIs should take full advantage of HIT developments. Over the next four years, the state will be investing a great deal of work in data systems at the care delivery level, and DHCS wants that development effort to be incorporated in the HCCIs.

DHCS has begun discussing this approach with CMS, and will report more on those discussions over the coming months. DHCS believes that an HCCI expansion is the best way for California to implement HCR early, and hopes that everyone will join in making the argument that this is the best way to build to transition in 2014. The current fiscal situation precludes a statewide expansion using state General Fund, but the proposed approach allows for significant advances in providing services to a population that has not received what they need. The state needs support from CMS to waive statewideness and the requirement for a benchmark benefits plan for the Medicaid expansion population.

Regarding benefits, David Maxwell-Jolly said that discussion in the BHI TWG had encouraged him to think about the benefits of combining behavioral health (BH) and medical funding in order to best deliver integrated services to this population, which has significant BH as well as medical needs. In the areas of mental health and substance abuse (SA), there are concerns that the overall level of funding is not as great as it should be. However, the case can be made that early intervention in BH saves money on the medical side in the long run, and therefore it may make sense to invest in BH services early on. The HCCIs offer an opportunity to test that proposition: a county could use its HCCI to provide a broader array of BH services, and analyze whether it reaps benefits on the medical side in the form of cost savings. In other words, there may be an opportunity for unified funding for services, most of which are the responsibility of the county in the first place.

*Anne McLeod, CHA*, asked what DHCS estimated statewide county indigent funding to be, and whether down the line there might be enhanced match. David Maxwell-Jolly said that DHCS expects the match for HCCIs to be the regular (50%) FMAP rate. He also hopes that the HCCI funds (up to 133% FPL) will not count against the funding available via the Safety Net Care Pool. In 2007, the state estimated county indigent funding at \$1 billion, but that was four years ago and the number may be out of date. DHCS has had specific proposals from some counties and hopes for more.

David Maxwell-Jolly said that DHCS is hoping to make the case that the federal allocation for HCCI enrollees with incomes up to 133% FPL can be relatively open-ended, as opposed to fixed. The waiver argument would be that these expansions could have been done absent a waiver, and thus the expenditures for that category would not count toward the cost-neutrality ceiling. Anne McLeod asked whether under this thinking the HCCI expansion would be considered uninsured coverage through HCCIs, rather than an expansion of

Medicaid, and David Maxwell-Jolly said it would be a program established through the waiver.

*Judith Reigel, CHEAC*, welcomed the state's proposal. She cautioned, however, that the county money going to indigent health is not sufficient to transition what the counties do with episodic care into standardized benefit package for current indigents, particularly since counties will still have Section 17000 obligations. Thus, the idea of a standardized benefit package raises concerns. David Maxwell-Jolly said that this will be an important point of discussion with CMS, and that the state may have opinions too. There will be trade-offs: to the extent that there is a particular set of benefits required of every county, enrollment will be necessarily limited. While this goes against the objective of having the maximum number of people ready to transition to Medi-Cal in 2014, DHCS does expect to develop an expanded benefit package that is standardized across the counties as part of the lead-up to 2014.

*Tangerine Brigham, San Francisco*, also applauded the idea of expanding HCCIs as a vehicle to prepare for HCR. She emphasized that indigent care dollars at the local level are for HCCI-eligible people and for non-eligible people, for whom counties have some responsibility to continue care. She asked about DHCS' thinking concerning counties' ongoing obligations to people who will not be eligible for HCCIs or, over the longer term, for the Medi-Cal expansion. David Maxwell-Jolly said that it is counties' responsibility to balance their desire to grow or establish HCCIs against their residual obligation to care for people who are not enrolled. Some of the existing HCCIs were cautious in establishing their programs, due to concerns about ongoing obligations. HCR has altered the game, and planning parameters may be different as a result. DHCS will rely on counties' analyses regarding balancing their commitments.

*Louise McCarthy, CCALAC*, raised several questions related to potential tensions between what the federal government would like to see and what California can do. 1) DHCS' policies are that counties should use a wider variety of providers in their HCCI networks, but also that counties determine the network construct. Are there requirements in HCR related to provider networks that the HCCIs should incorporate? 2) Regarding the inclusion of BH services and encouragement of BH integration in HCCIs, would this be entirely at county discretion or might there be financial incentives to do that? 3) Is there an expectation that HCCIs sunset in 2014 or at some later date related to Medi-Cal expansion?

David Maxwell-Jolly responded that HCCI would sunset when the federal government begins paying 100% of Medi-Cal costs for the expansion population (January 2014). The state has no intention of requiring county match when the federal government is covering all costs of the expansion. The transition to Medi-Cal will require a lot of planning, but is a great opportunity to cover as much of the indigent care responsibilities as possible, since there will be remaining county responsibilities that won't be covered. In terms of BHI, one potential incentive could be the HCR option that provides 90% FMAP for services to people with multiple chronic conditions or mental illness who are managed through medical homes. It is possible that in the HCCI context, if care management costs were segregated, that these funds could be available. It would be challenging for counties, potentially, but worth looking at. The question of whether there could be an incentive to bring counties to table

around BHI is interesting. There is already a lot of creative thinking on this point at the local level, and counties already have some financial incentive there to invest in BH services in order to reduce medical costs.

*Bill Walker, Contra Costa*, asked whether DHCS had analyzed the relative impact of HCCI expansion as proposed, versus moving more of the HCCI population to Medi-Cal sooner and potentially drawing down more DSH and FQHC funds that way. David Maxwell-Jolly reminded the TWG that California currently spends all of its DSH allotment. While he would be interested in hearing more about leveraging FQHCs, he was concerned about the amount of local funds that may be available for the non-federal. He said that DHCS would consider pilots along these lines that enhance federal funding in the context of the waiver.

*Anne McLeod, CHA*, said that large cuts are expected in Medicaid and Medicare DSH in 2014. The Secretary of Health and Human Services will develop criteria for how these cuts are implemented, but they are supposed to be based on states' most current uninsured rates. As a result, covering more people potentially puts the state at risk for even greater cuts to DSH funding. She asked DHCS to work on protecting the HCCI enrollment ramp-up from the DSH calculation. David Maxwell-Jolly said that DHCS is aware of the DSH reduction mechanism and will be mindful of it going forward.

*Irene Dyer, Los Angeles County*, asked whether the state has considered changing the HCCI reimbursement mechanism to counties under the waiver, from FFS to capitation or a global payment of some kind. David Maxwell-Jolly agreed that this could be advantageous for counties, and said that DHCS is exploring some options for an HCCI component that would be along the lines of a capitated arrangement. It is complicated but not out of the realm of possibility.

*Cathy Senderling, CWDA*, asked about plans for involving county associations going forward, and whether DHCS has anything in writing on the plans for HCCI. David Maxwell-Jolly did not have any written documents to distribute but said that HCCI expansion will be included in the draft implementation plan that DHCS will release in the next few weeks. There will be continuing discussion of the implementation plan and HCCI as part of the SAC process, where several county associations are represented, and with the associations in other forums as well.

*Anthony Wright, Health Access*, said he appreciated DHCS' embrace of the HCR opportunities, and asked specifically what the state is asking CMS to waive. David Maxwell-Jolly said that early enrollment in Medi-Cal would require the state to have open-ended eligibility, a benchmark benefit package that includes BH among other things, and to deliver services through the full array of Medi-Cal providers. These are the primary areas in which early Medi-Cal expansion is at variance with the HCCI structure as it exists, and all would have to be waived. The HCCI expansion proposed is not full-scale Medi-Cal eligibility, but can still do a lot of good.

*Elizabeth Landsberg, WCLP*, echoed comments in support of the HCCI expansion, and asked whether DHCS had analyzed the difference between a benchmark package and the proposed standardized HCCI package. The state *could* make the policy decision to make

full-scope Medi-Cal the benefit package for childless adults. David Maxwell-Jolly replied that DHCS has not yet done a full analysis of the issue. There is a lot still to learn about what will be acceptable as a benchmark plan: currently, it is the benchmarks in a state plus whatever the Secretary agrees to. However, benchmark plans will allow cost-sharing and include mental health benefits, both of which are major additions. To say that there's an HCCI benefit package is a stretch, since there isn't a single consistent one. Standardization will be challenging, since there are some counties, not currently operating HCCIs, who have modest commitments to their indigent populations and who will be hard-pressed to provide any benefit package at all. In the case of CMSP, requiring parity will put a tremendous strain on those counties.

*Elizabeth Landsberg, WCLP*, said that she was interested in DHCS' proposal to expand HCCI eligibility to 200% FPL everywhere, as all the current HCCIs with the exception of Los Angeles currently do. She asked whether the state's thinking is that for people up to 133% FPL (138% FPL with the 5% disregard) HCCI enrollment could be considered early enrollment and not count against the state in the cost-neutrality calculation. David Maxwell-Jolly said that DHCS wants to make the best use of all the money. There will be a fixed-pot approach to individuals from 133-200% FPL -- a constrained amount will be shared among counties. DHCS will need to figure out how to distribute these funds after they know how much will be available. *Elizabeth Landsberg* also commented that counties have a continuing Section 17000 obligation, and that advocates want to make sure the remaining group of uninsured have access to a strong safety net.

*Bob Gates, Orange County*, said that existing HCCI counties are currently working on their budgets for 2010-11 and are questioning whether the program will be extended. He asked when counties would receive some kind of guarantee about continuation. David Maxwell-Jolly said that DHCS is committed to continued availability of federal money for existing HCCIs under the waiver, and that the budget construct as reflected in the May revise will include the waiver. Continued funding for existing HCCIs is an important component of HCR planning. Bob Gates commented that different counties may require different levels of proof. *Jennifer Abraham, Kern County*, said that she is concerned that if her county does not receive something in writing very soon, they will lose their HCCI infrastructure and have to start all over again. Counties are looking at cuts everywhere, and it would be very easy to cut HCCI absent written confirmation that it will continue.

*Jennifer Abraham, Kern County*, said that the ideas regarding BH integration make sense to her as a provider. Of 8 patients she admitted the previous week, 2 were there for physical needs related to their MH issues. There are many opportunities for cost containment. Regarding funding structures for HCCIs, the FFS requirements of time studies and service levels are convoluted, time-consuming and costly. Case management has been very successful for Kern County, with a 32% decrease in ED use for patients receiving care management. However, since they have to take the Coverage Initiative Percentage (CIP) for case management, they are paid for only 61% (FMAP) of 52% (CIP) of those costs. David Maxwell-Jolly replied that the only ray of hope he sees in this regard is the state plan option under which the federal government pays 90% for people enrolled in a medical home. He agreed that the current structure presents significant impediments to managing care well and said that DHCS will look at available opportunities. The BHI Workgroup has

discussed the difficulty of the medical and BH sides working together, but some counties have been doing it successfully.

*Erica Murray, CAPH*, asked about DHCS' proposed process for bringing in new counties. David Maxwell-Jolly said that, as opposed to the first round which was competitive, this time the state will lay out certain requirements and certain goals for new counties. If counties cannot commit to certain levels of participation in terms of the HCCI construction and operation, however, they may be denied. He reiterated that DHCS wants to make it possible for all counties to participate, even if they must develop their structures over time.

*Kelly Brooks, CSAC*, asked whether DHCS had a ballpark estimate of the federal funding required to open the HCCI process up to all counties. David Maxwell-Jolly said that the defining number is the amount of funding that counties are spending on indigent health care, minus the residual funding that they need to retain for non-HCCI eligible care. He said that he thought the state could commit to that amount. Kelly Brooks asked whether, if the federal government caps the amount they will match, there is a threshold at which the state would limit participation. David Maxwell-Jolly said he did not want to hypothesize a scenario where the federal match for coverage of people to 133% FPL was capped.

*Ellen Wu, CPEHN*, commented that given the diversity of the population, and the importance of cultural competency as part of the definition of medical home, outreach must be culturally and linguistically appropriate.

*Sandy Damiano, Sacramento County*, said that she appreciated the broad strokes of the vision, but expressed concerns given the hard times counties are facing. David Maxwell-Jolly said that he had heard HCCI expansion described as a ray of hope in an otherwise desolate landscape, and said that DHCS is excited about the ability to do a little more with this proposal.

*Nancy Kaatz, SCVHHS*, said that she is working on additional county funding to expand their MH model to more clinic sites, and asked for any additional detail on the medical home/90% option. David Maxwell-Jolly said that there is nothing more than the paragraph in the law, and that CMS guidance either through letters or possibly regulations will be required to figure it out.

*Nancy Kaatz, SCVHHS*, asked about the state's plans to standardize eligibility and enrollment, and what counties should know before they invest in additional technologies. David Maxwell-Jolly replied that there are ongoing discussions about California's welfare eligibility systems, addressing front-end systems such as One-e-App as well as consortia systems and MEDS. DHCS' initial thinking is that front-end, web-based applications and other portals should be leveraged into this. Only a few current HCCI counties have made their HCCI eligibility systems compatible with other county systems, and DHCS' view is that HCCI enrollees should all be incorporated into existing county automated eligibility systems, so that conversion to Medi-Cal does not require a whole new application process.

*Elizabeth Landsberg, WCLP*, commented that changes also will be needed to make the current enrollment systems work with the Exchange as well as with Medi-Cal. David

Maxwell-Jolly agreed, and said that MEDS is the only unified statewide system, and it is old and incompatible with newer interfaces. *Cathy Senderling, CWDA*, said that HCR also contains elements related to enrollment systems, including linkages with DMV and tax systems. Linkage architecture is promising and might allow the state to avoid ripping everything down and starting from scratch. David Maxwell-Jolly said that the overall trajectory of systems development is one of increasing standardization and unification in terms of the underlying database.

*Len Finocchio, CHCF*, suggested defining what is needed in various areas of program development by 2014, and working back from there, establishing benchmarks in the various areas of benefit packages, enrollment, BH integration, etc. for each year between now and then. He asked about the state's role in technical assistance. David Maxwell-Jolly said that the small group discussion (on the agenda for the TWG meeting) asked exactly those questions, and said that DHCS needs to hear from stakeholders in order to present a consensus view to CMS.

### Expansion County Readiness: Break-Out Sessions

*Bobbie Wunsch, PHCG*, introduced the break-out session agenda. The Workgroup divided into three smaller groups, all of which discussed the issues new counties would need to confront as they prepare to implement HCCI, and identified best practices from the current HCCI counties that new counties may find helpful.

### **Expansion Counties**

- How can DHCS encourage and motivate new counties to join HCCI?

#### Group 1

- (Mainly talking about non-CMSP, non CI counties.)
- Are counties concerned that applying might change Section 17000 to require undocumented coverage? Assurances about this would be important.
- The federal match is counties' primary incentive: they are spending something now that they could receive match for.
- Long-term incentive: HCR will move HCCI individuals to Medi-Cal, and payments for providers will be higher (up to Medicare rate).
- DHCS should publicize the experience of current CI counties to show others. Evidence of decreased ED utilization and any other metrics from UCLA would be good.
- Informal discussions between current CI counties and potential expansion counties could be helpful.

## Group 2

- **Financing issues:** In first round, non-applicants were concerned about MOE, concerned they couldn't sustain funding.
- Sustainability is less of a long-term concern with HCR, but may still be a barrier to participation. If a county doesn't have the CPEs, they still can't do it (absent some arrangement with donor and recipient counties)
- Moving to IGTs would allow more flexibility – counties could use foundation dollars or other sources for match.
- Cash flow is a bigger issue in smaller counties: the state should guarantee the payments, whether through advances and reconciliation or some other mechanism.
- Counties are going to cut their budgets to the bone just before this becomes available – timing is critical.
- **Infrastructure issues:** Most of the Phase 1 counties built on managed care – without that, a county faces building a quasi-managed care arrangement from the ground up. Infrastructure issues are most significant for non-CMSP counties, which would have to create new billing structures.
- Orange County has contracted these tasks out, but have others? LA HCCI more typical: uses LA Care for its call center, ID cards, etc.

## Group 3

- Clarify that what they're signing on for isn't biting off more than they can chew and ensures sufficient resources for Section 17000 responsibilities.
- Would be good to tap into 90% match for beneficiaries with chronic conditions/SMI.
- Ensure that counties will be paid on time.
- Ensure sufficient staffing and support at DHCS.
- Involve counties in planning.
- Counties will need flexibility in terms of their provider networks.
- Application process geared toward 2014, taking advantage of SSA DRA flexibility via link to automated match.
- Hard to know exactly what new counties will need without details about HCCI's revised framework (benefits, enrollment, etc.).

## **Readiness Requirements**

- What readiness standards should DHCS use to determine whether a new county would be allowed to implement HCCI?
- What elements of the current criteria should be retained? Which should be changed?

## Group 1

- Maintain the original standards, minus sustainability.
- Demonstrate a robust provider network.
- Demonstrate movement toward uniform eligibility processes.

- Should be able to track the number of individuals eligible for HCR Medi-Cal during course of HCCI and be ready to flip a switch for HCR.
- Enrollment: should be able to ramp up numbers over time.
- Principles of medical home should be required, but need to be careful that these don't impede access. An organization/clinic should be able to serve as the medical home.
- Clarify the definition of the single medical record.

### Group 2

- Existing criteria should apply: they are all needed (pretty basic) and it's unrealistic to add more.

### Group 3

- Demonstrate how to streamline application to take advantage of automated process in human services.
- Ability to provide care management/medical home models.
- Demonstrate how they will be ready for conversion in 2014, including both flipping the switch for newly Medi-Cal eligible, and being prepared to serve residually uninsured. This will be key to the ongoing viability of safety net.
- Ability to ramp up to benchmark plan.
- Requirement that the county be a Medi-Cal provider should be dropped for the next round of HCCI. Long-term financial sustainability of the HCCI also is no longer germane.

### Technical Assistance Needs

- What kinds of assistance will new counties require to successfully implement HCCI (e.g., assistance to determine amount of available non-federal dollars , assessing provider capacity, HIT needs, etc.)?
- What are some best practices from the current HCCI counties?

### Group 1

- Counties need sufficient time for the HCCI application. They also need help with the application and with system requirements:
  - Resource list of people who were helpful in preparing applications in the first round.
  - Foundations or state to help pay that assistance.
  - At minimum, hold forums/workshops for application.
- Create a briefing paper/case study document based on existing county experience that sets out how to accomplish each of the requirements and addresses operational pitfalls, etc.
- Fast reimbursement for administration.

- Counties will need assistance to develop/expand provider network: TA for contracting, HIT, enrollment systems, data warehouse functions.
- Single medical record definitions/practices should be shared and discussed.
- Working with Local Initiatives has pros and cons – some felt it is a best practice and for others it would have caused new barriers.
- Education on MAA/TCM.

#### Group 2

- Counties – especially those without public hospitals – will need help with administrative structure: how to bill, how to contract, etc.
- DRA, income verification requirements were challenging in some places, but many counties already have some kind of structure in place for MIA/Section 17000 programs.
- TA on practice redesign may be needed.
- HIT (and staff to do it) on a centralized level (enrollment, utilization, outcomes) but also on provider side.

#### Group 3

- New counties will need help with network capacity, identifying amount of available county funds, and HIT.

### **Evaluation Criteria**

- How should DHCS measure the success of the expansion counties?

#### Group 1

- Keep the current evaluation criteria – enrollment and quality.
- Full utilization of federal allotment (134-200% FPL) and meeting enrollment goals (up to 133% FPL) should be criteria for success.
- Measure how ready the county is to flip the switch to HCR based on established benchmarks set up ahead of time.

#### Group 2

- Evaluate on same basis as existing HCCIs.
- Additional criteria for initial 10 counties.
- Measure percentage of population that is teed up for 2014.
- Chronic care measures/hospitalization/ED visits.
- Measure infrastructure: waiting times, other access measures.
- Don't build anything that won't be required in 2014.

### Group 3

- Evaluation measures will depend on the focus of HCCI – expanding enrollment or providing better care.
- Counties should be measured on their ability to “flip the switch” in 2014 and move enrollees into Medi-Cal and the exchange.
- Evaluation should focus on how well the county infrastructure is prepared for 2014 (eligibility and enrollment systems, provider networks, etc.).
- Rather than conduct a formal evaluation, evaluation should be a policy and monitoring tool that reflects the steps that are necessary to ensure a smooth transition in 2014.

### Challenges Facing Current HCCI Counties

*Bobbie Wunsch, PHCG*, said that the morning discussion had highlighted current HCCI counties' need to receive official word, soon, regarding continuation of current HCCI funding, so that counties can plan to sustain their efforts. She asked the Workgroup to identify additional needs of current HCCI counties.

*Bob Gates, Orange County*, said that his program is planning to incorporate MH and SA services. A match of the HCCI database against the BH database found that, of 35,000 individuals enrolled in the HCCI, 1,100 are clients of the specialty mental health system. Another 5,000 people would likely qualify for SMH. The challenge is to identify and enroll those individuals. The benefit package will mimic the SMH services that the county provides, so that what the county currently spends becomes part of the CPEs that can be reimbursed under HCCI. The eligibility criteria for SMH are stringent, and typically require a diagnosis of severe mental illness (SMI) – Orange County would like to offer a more expansive BH package, but are not sure yet how to do this. Bob said that their success was a result of strong leadership, and that it helped to have a unified county health care agency.

San Mateo is planning something similar, using unmatched MHSA and county mental health dollars to enhance BH services in the next round of HCCI.

*Bill Walker, Contra Costa*, said that his HCCI is working around the edges of BH/physical health integration, bringing more psychiatrists into clinics to interface with primary care for those who don't qualify for SMH. They are also working to bring more onsite primary care to their mental health clinics, and are using FQHC funding to build a PC clinic on the second story of one of the BH clinics. Contra Costa has not figured out how to integrate the main drivers of mental health funding – even in a county structure, it is difficult to deal with the silos.

*Louise McCarthy, CCALAC*, noted that LAC's DMH participates in the SAC. At this point, there is no significant BH integration under the waiver. The county DMH is issuing RFPs for integrated pilots, but without connection to primary care funding streams. Louise said that these efforts center on new individuals getting services, rather than on expanding the benefits package for existing users. There has not been any meaningful dialogue about unifying payment systems to serve this population.

*Jennifer Abraham, Kern County*, said that the silos are hard to work with in Kern County, where MH does not use the county lab or pharmacy. She has had patients in clinic with hallucinations, but had no way to get them into the SMH system. They have negotiated some access to their MH residency clinics, but only for a small number of patients.

*Tangerine Brigham, San Francisco*, said that SF's HCCI is the only one that claims for substance abuse services. This was not a problem as far as the state, but CMS was unfamiliar with block-grant funding for SU and it took several conversations to convince them that the SF HCCI was not double-dipping. She suggested that counties that are interested in SA allot significant time for planning.

*Kelly Brooks, CSAC*, asked about the status of blended funding pilots in BH. *Bobbie Wunsch* replied that these weren't included among the final pilots proposed by the BHI Workgroup. Instead, the pilot proposals are focused on embedding BH services either for the SPD population or in the HCCIs. The goal is to bring unmatched CPEs to the table to expand BH services and to encourage the HCCIs to do more in the area of BH.

*Bill Walker, Contra Costa*, said that it's difficult to separate the HCCI challenges from all the others facing the counties. The main challenge is insufficient funding, and secondly the challenge of gearing up for enrollment of SPDs in Medi-Cal managed care, which will require a whole new provider network, with new specialists and the inclusion of clients' established medical homes.

*Irene Dyer, LAC*, said that Los Angeles has room under their existing CPEs to enroll significantly more people than they have now, but not the 570,000 eligible uninsured people that UCLA estimates are resident in the county.

*Bob Gates, Orange County*, said that to date the enrollment process has been challenging but manageable – they have 35,000 enrolled of an estimated eligible population of 106,00. However, recruitment may become an issue going forward.

*Bobbie Wunsch* asked whether anyone had cautions or concerns about the standardization of eligibility or benefits in HCCIs leading up to 2014. *Bob Gates* said that standards *per se* are not a problem – they are not so far from the Medi-Cal benefits package – but that standardizing eligibility procedures poses more of a challenge.

*Tangerine Brigham, San Francisco*, said that the challenge in standardizing enrollment is that this function rests with county DSS. She asked whether the state would consider relaxing the rules on who does it – could Local Initiatives be involved? Currently, CBOs can take the information and store it, but cannot make the final determination. As much as possible, there should be a one-stop approach as opposed to a two-step process. As far as the benefit package, she raised concerns about the state defining the BH package in terms of number of visits or levels of service, given that it is the county that must provide the care. *Bobbie Wunsch* pointed out that this issue may be even more problematic in expansion counties. Overall, *Tangerine* noted that more detailed standards in terms of required benefits would be a concern.

*Bill Walker, Contra Costa*, said he had no argument with the standardization of benefits. Enrollment currently goes through the health department's own financial counselors, who then send Medi-Cal eligible individuals to the Department of Human Services (DHS). In Contra Costa, DHS has been hit hard by budget cuts, so it would be problematic to ask DHS staff to conduct HCCI eligibility and enrollment. Accordingly, he would like to keep enrollment within the health department as long as possible.

*Bob Gates, Orange County*, said that the ability to use co-pays in the HCCI is an important part of the cost-control system and that he would not want to lose it. *Tangerine Brigham, San Francisco*, agreed, and mentioned concerns about San Francisco's ability to expand the provider network for HCCI beyond the county delivery systems.

*Bob Gates, Orange County*, offered a caution from past experience: as the HCCI population becomes eligible for Medi-Cal, the counties and the state may lose incentive to enroll them in disability programs such as SSI. *Elizabeth Landsberg, WCLP*, agreed, saying that to the extent that people are not on SSI they miss out on cash aid and potentially full-scope Medi-Cal and Medicare.

*Bob Gates, Orange County*, said that it is time to start talking to current *and* expansion counties about what they actually have in the way of unmatched CPEs.

#### Reflections on the HCCI Technical Workgroup

*Bobbie Wunsch, PHCG*, recognized the support of The California Endowment and the California HealthCare Foundation, and thanked state staff for their efforts. She noted that the HCCI expansion will be the hallmark piece of the waiver, and an enormous step in preparing for Medi-Cal expansion in 2014. She asked each Workgroup member for a final comment on the Workgroup process and issues related to HCCI.

*Ellen Wu, CPEHN*, asked about the waiver timeline and expressed concerns about accomplishing everything in time.

*Erica Murray, CAPH*, said that public hospitals see the next coverage expansion as a crucial means by which California can demonstrate an accelerated move toward HCR. The next few years should be used to strengthen county structures so that by 2014 the state has a more robust safety net. Issues requiring ongoing attention include the implications of Medicaid expansion and how to bridge the gaps between HCCLs and Medicaid. From the public hospital perspective, it is critical to think about HCCI expansion as one piece of an overall waiver that includes the enrollment of SPDs in managed care and stabilizing public hospitals to serve undocumented people and other uninsured individuals.

*Bill Walker, Contra Costa*, echoed the public hospital concerns, and said that if the Workgroup process had any relationship to the Governor's letter, which included so many important issues, then it has been successful.

*Judith Reigel, CHEAC*, said the Workgroup discussions had been a great opportunity, and that more work remains on defining what it means to be ready for 2014: how can we meld the goals of enrolling large numbers and better serving difficult populations?

*Nancy Kaatz, SCVHHS*, also echoed public hospital concerns. She said that it is challenging from a public hospital perspective to figure out the impact of HCCI on revenues, when they are so dependent on matching their costs. She said she is looking forward to additional funding.

*Elizabeth Landsberg, WCLP*, said that while advocates would love to see full Medi-Cal expansion right away, they recognize that the General Fund dollars are not available and are willing to be flexible. The extent of that flexibility depends, to some extent, on the end game: if the Medicaid expansion population will receive the Medi-Cal benefits package in 2014, advocates will be more flexible about statewideness and other requirements. The question of whether to expand to 200% FPL in the HCCIs or to focus more on lower-income/higher need groups remains an issue. In the areas of eligibility and enrollment, WCLP looks forward to continuing to work on preparing counties for a major transition. She reminded the group of the residual county Section 17000 obligation.

*Bob Gates, Orange County*, asked about the relationship of the waiver to the legislative process. David Maxwell-Jolly said that in the past, DHCS and CMS negotiated the waiver and then went to the legislature for bills that redefined hospital financing and defined HCCI. This time, given the compressed time frame, the state may want to have a legislative framework in place before a final agreement with CMS is completed. Typically, states get conceptual agreement from CMS, but the Special Terms and Conditions (STCs) lag behind, and the legislation may have to be passed in that interim period. The existing HCCI is defined in statute, and that would probably have to be amended to move onto phase 2. *Elizabeth Landsberg, WCLP*, asked whether ABx4 6 requires legislation 60 days prior to submission of the implementation plan. David Maxwell-Jolly said that DHCS and the Legislature would work together to get enough in place simultaneously. He said that DHCS believes that it can be done and is essential for the sake of the of health delivery system.

*Bob Gates, Orange County*, said that counties need to be cautious as they develop programs. Orange County's HCCI offered dental care at the Denti-Cal level, first through community clinics and then through community dentists, but program demand exploded and they have had to shut it down. (The budget was \$1.4 million, and in 2 months they had spent \$3 million.) He suggested the need for a further process with counties on some of these points – the state is knowledgeable, but county people know even more.

*Irene Dyer, LAC*, said she was optimistic about what can be achieved.

*Louise McCarthy, CCALAC*, said she was thinking about how the state can incentivize counties to do things, such as integration of BH and PC, and provider participation. She said there are a number of counties that have not included community clinics in their HCCIs, and suggested modeling essential community provider language for HCCIs on similar language in federal HCR. She suggested more discussion of what to do in non-managed care environments, and in communities that do not have the capability to build capacity.

*Jennifer Abraham, Kern County*, reiterated that the state urgently needs to give counties guidance on the continuation of HCCIs. Contracts with providers, staff positions, and new enrollment will all end on August 31 absent something in writing, even regarding an extension.

*Kelly Brooks, CSAC*, suggested convening the current 10 counties to present the lessons learned to the other 48 counties. She noted that new counties will be making decisions about their budgets in June and July that will affect their ability to make HCCI decisions. Depending on the timing, potential HCCI CPEs may be cut in the new budget year. She said she is interested to see how HCCIs inform the delivery of care to the SPD population and BH integration.

*Tangerine Brigham, San Francisco*, said she hopes for ongoing communication with the Workgroup in some form. The HCCI is San Francisco's bridge to 2014. It is important to manage expectations, and to create some breathing room to accomplish goals. Given how challenging reimbursement and funding have been for HCCI counties, development of different reimbursement mechanisms should be a priority.

*Len Finocchio, CHCF*, said that the Workgroup has been helpful in thinking through the Foundation's role in this area.

*Sandy Damiano, Sacramento County*, thanked the HCCIs for blazing a trail for expansion counties. She also expressed interest in any attempts to capture the lessons learned by the current 10 HCCI counties so new counties can avoid "reinventing the wheel."

*David Maxwell-Jolly, DHCS*, reported on Governor Schwarzenegger's speech in at UC-Davis, which had just concluded. The Governor used the speech to announce his commitment to HCR and to state that California would work aggressively to take advantage of early opportunities.

*Bobbie Wunsch, PHCG*, thanked the group for near-perfect attendance, and thanked CPCA for hosting the meeting.

The meeting was adjourned at 2:05.