# DEPARTMENT OF HEALTH CARE SERVICES
# STAKEHOLDER ADVISORY COMMITTEE
# Wednesday May 7, 2014
# 9:30AM – 3:00PM

## MEETING SUMMARY

### Attendance

*Members Attending:*
Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance; Anthony Wright, Health Access California; Elizabeth Landsberg, Western Center on Law and Poverty; Richard Thomason, Blue Shield of California Foundation; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center; Erica Murray, CA Association of Public Hospitals and Health Systems; Lishaun Francis, CMA; Gary Passmore, CA Congress of Seniors; Sandra Naylor Goodwin, CA Institute for Mental Health; Chris Perrone, California HealthCare Foundation; Herrmann Spetzler, Open Door Health Centers; Marty Lynch, Lifelong Medical Care and California Primary Care Association; Judith Reigel, County Health Executives Association of California; Kim Lewis, National Health Law Program; Stuart Siegel, Children's Specialty Care Coalition; Marvin Southard, LA County Department of Mental Health; Kelly Brooks Lindsey, CA State Association of Counties; Amber Kemp, California Hospital Association; Cary Sanders, CPEHN; Lee Kemper, County Medical Services Program; Marilyn Holle, Disability Rights CA; Anne Donnelly, Project Inform; Bob Freeman, CenCal Health; Rusty Selix, CA Council of Community Mental Health Agencies; Bill Barcelona, CA Assoc of Physician Groups; Mitch Katz, MD, LA County Department of Health Services; Michael Humphrey, Sonoma County IHSS Public Authority.

*Members Attending by Phone:*
Frank Mecca, County Welfare Directors Association; Suzie Shupe, CA Coverage & Health Initiatives.

*Members Not Attending:* Michelle Cabrera, Service Employees International Union; Jim Gomez, CA Association of Health Facilities; Teresa Favuzzi, CA Foundation for Independent Living Centers; Brenda Premo, Harris Family Center for Disability and Health Policy; Steve Melody, Anthem Blue Cross/ WellPoint; Kristen Golden Testa, The Children's Partnership/100% Campaign

*Others Attending:* DHCS staff: Toby Douglas, Anastasia Dodson, Karen Baylor, Marlies Perez

*Public in Attendance:* 19 public members attended.

**Welcome, Purpose of Today's Meeting and Introduction of Members**
*Toby Douglas, Director, DHCS*

*Douglas* welcomed everyone. Thank you to the California HealthCare Foundation and Blue Shield of California Foundation for their support of the stakeholder process.

I had the opportunity to speak at Assembly Health Committee with Peter Lee. A brief re-cap is that we have had success with ACA implementation and enrolling 1.9M. There is more to do. There are approximately 900,000 pending Medi-Cal applications; there is work to do on CalHEERS; and we are continuing to provide guidance to county workers. In short, we have had much success so far, and it is still a work in progress.

CCS may be an issue some want to discuss, and I would like to include this topic later in the agenda. There was a big milestone on May 1st to restore dental benefits.

One announcement to make here on an action yesterday by the administration: DMHC put a conservator into Alameda Alliance to ensure continued services to beneficiaries. Our goal is to ensure strong financial standing and turn this back to local control as quickly as possible but we must ensure access to services for beneficiaries in the meantime. We will work closely with members of the board.

*Chris Perrone, California HealthCare Foundation*: Do you see this as an isolated incident or are there other plans close to the edge as well.
*Douglas*: This is isolated. There are plans that have financial difficulties but not at the level of Alameda Alliance.

**Update on SUDS Waiver**
*Karen Baylor and Marlies Perez, DHCS*

- Purpose of the SUDS Waiver
- Stakeholder involvement/process for waiver and program planning
- Critical issues for consideration
- Timeline moving ahead

Presentation Slides posted at:
**http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx**
Meeting notes from SUD Waiver Advisory Group meetings in April 2014 posted as well.

*Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center*: This presentation was a good overview of the work done in the advisory group. A few other issues I want to mention. While the Continuum of Care chart is a good one, it is missing medical detox. The Inpatient Mental Diseases issue needs to be addressed and tied together. On financing, there is tremendous concern for the rate structure and its inadequacy for the services we want to provide. Many providers are refusing to participate in the current program because of the rates and this causes capacity issues. Through the waiver, we should tackle this and come up with

new approaches. On staffing: everything is physician driven; approving medical necessity, extended treatment and other services. In the stakeholder meetings, everyone generally agreed we need to change this to include other experts to make these decisions. Case management was mentioned but care coordination is not supported in the system. With the substance use benefit, there is no responsibility or resource to support care coordination – and we see this in the early months. It can't just be on a piece of paper – everyone needs to have skin in the game to make it work and resources need to be available. Health homes were discussed as a model to include here. New initiatives on this are moving forward for primary care and other integration through health homes, and we should dovetail this with those upcoming efforts. Finally, we need to see the draft proposal ASAP. There is concern about what is actually being included in the proposal from all the recommendations that have been offered. There are stakeholders who have major concerns about what is being proposed, for example, selective contracting, guaranteed access to care at all levels and how many counties will opt in to this. It is unfortunate this is not statewide.

*Douglas*: That is great feedback. On the issue of opting in, it is our intention that this be statewide, and we will work with our county partners. There is an important intersection with realignment and populations transitioning from prison to counties creating interest on the county side. The focus of this demonstration is to decrease emergency room/inpatient care. We know where this responsibility sits – with plans. Bob, when you have someone with substance use in your system, is there a financial incentive as well as the overall health concern?

*Bob Freeman, CenCal Health*: in the global sense, we are trying to coordinate their wellbeing and substance use impacts overall health. We coordinate whenever we can with county health departments for financial reasons and for overall health.

*Douglas*: we should look at the waiver to see where we can create intersections with plans and substance use providers to focus efforts to make this happen.

*Bill Barcelona, CA Assoc of Physician Groups*: The state needs to figure out the financing mechanism upfront so it works with the business structure of coordinated care groups. There are ways to build the BH integration into a coordinated care model with global capitation. It has been carved out for a long time. Mostly plans are working to identify mental health conditions. We could figure out a business model to work with behavioral health providers.

*Sandra Naylor Goodwin, CA Institute for Mental Health*: Al's comments covered a lot of terrain. It is important to remember we didn't have the expanded benefits a year ago, and I want to commend the department for the benefits, however, the rates remain an issue. My conversations with some large groups indicate they won't participate because of the rates. Our care coordination collaborative, under contract with DHCS, is working out the care coordination on the ground. Given there is no funding, we are working creatively to figure this out. At a recent meeting, a pilot surfaced that will identify those with the ten most complex conditions shared across systems to understand how to do

care coordination and substance use is one of the conditions, so we will learn from this. On the rehab option, they need services outside the clinic – in the street, home or where they are - because it is difficult to get them in. On residential rates, if they have to do under 16 beds, it is not financially feasible. Other states have made this work, so we need to find a way to do away with the IMD exclusion at least for this pilot project because this will help us find providers.

*Marvin Southard, LA County Department of Mental Health*: It is wonderful to have these benefits. The timeline is difficult because we need this worked out now – and that is difficult for the state. On the Los Angeles context, the board of supervisors approved a new jail yesterday with lots of discussion about co-occurring conditions. We don't have a structure to provide co occurring substance use services partly because this waiver isn't clear yet. Second, in LA, Health Neighborhoods are being implemented with federal grant support for 18 sites to test the model. On the substance use side, we have willingness but lack knowledge of exactly what benefit is to be integrated. For us, the discussion of templates is helpful so we can work to implement the health neighborhoods with this in mind. Third, LA was successful in getting SB82 (grants to build infrastructure for crisis residential and training triage workers), but the urgent care can't work unless it is embedded in a system of mental health and substance use community services. You can only stay 23 hours, so it must be linked to other services like the substance use residential programs – maybe even sharing facilities. I applaud the work done by the state. The presentation shows the complexity, and I am also saying we need all that complexity in a timely way. This is the key to making jail diversion, integrated care and SB82 work - this is the missing piece. On certification of providers, LA county is willing to assist in the process. One suggestion from the COJAC committee is that it might be useful to have advance standing for certain providers, in particular current Short-Doyle providers since they meet the Medi-Cal standards. This could be included to accelerate the integration of Mental Health and Substance Use.

*Douglas*: We are working closely with CMS to get this approved, especially the residential care issues. This has not yet been approved in other states. CMS visited us with San Mateo and San Francisco and we have pressed the urgency with them.

*Marvin Southard, LA County Department of Mental Health*: The rehab option gives some work arounds to the IMD exclusion on the mental health side that are not available on the substance use side.

*Rusty Selix, CA Council of Community Mental Health Agencies*: I want to reinforce a few points. About 80-90% of providers provide substance use services but only 10-20% participate in the Medi-Cal program because of the certification process. They are Short-Doyle providers. We are supportive of the waiver and would like it to look as much like mental health as possible. Co-occurring disorders should be viewed as the norm not the exception, and every service provider should provide both substance use and mental health service.

*Kim Lewis, National Health Law Program*: Do you have a specific timeline for approval of the waiver?
*Douglas*: There are two tracks here. We are waiting for CMS and the federal administration to give us information about the residential care exclusion. Regardless, we see the value of moving forward with an organized care system. It won't be as effective without all the benefits. However, either way we are moving forward.

*Elizabeth Landsberg, Western Center on Law and Poverty*: It sounds like lots of ideas have come forward, have the policy decisions been made?
*Douglas*: We are putting a draft together that will go out for comment.

*Kim Lewis, National Health Law Program*: It would be important to include consumer advocates involved and send the draft out broadly. I want to underscore comments about how the rehab option is the basis for care coordination. This should not be isolated in the medical model, but allow the provider to address related life needs to get them to health in a holistic way.
*Douglas*: The calendar of all meetings is on the website. It is in the stakeholder updates, and we try to alert you about the many things going on.

*Richard Thomason, Blue Shield of California Foundation*: Many of us support the themes of integration and coordination coming forward. What is the department's vision of how this discussion fits in the upcoming waiver? How do you see this informing the discussion of the next waiver?
*Douglas*: I see them as complementary but separate. We don't know exactly what might be in the next waiver – there will be focus on payment reform across the broad delivery system. This can be seen as a building block. We will be looking to gather ideas for the waiver on physical and mental health coordination.

*Mitch Katz, MD, LA County Department of Health Services*: It would be positive if the waiver included services for SUD in supported housing for those not in treatment. It will be easier to get them into treatment once they are in housing. The continuum implies the consumer wants sobriety and that is not the reality for some. Supportive housing is cheaper than residential treatment and can be the door into treatment. It shouldn't be one or the other. CMS rejected NY's attempt to pay for housing, but I think we should make another go at getting this in the next waiver.
*Baylor*: Yes, that is part of looking at the rehab option. SAMHSA is interested in how block grants could fill in gaps in the continuum of care to support some of these issues.

*Mitch Katz, MD, LA County Department of Health Services*: There is strong support in the literature for housing as an intervention for behavioral health. We can end up spending lots more money on SUD services that fail because they are living under the freeway. The exclusion has not been about serving them at housing – it is about the rent.

*Marilyn Holle, Disability Rights CA*: I want to emphasize the importance of the rehab option in terms of incorporating medical necessity options.

*Cary Sanders, CPEHN*: I want to comment on stakeholder meetings. I appreciate you posting the information, but we need more notice of the dates and that makes it difficult to staff them.
*Douglas*: Good feedback. I will have notes from the meetings sent out to this group. We can look at a separate call for input for those who were not able to participate.

*Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center*: A point of clarification. You mentioned the relationship of this discussion and the later waiver discussion. Is the Drug Medi-Cal waiver a separate stand alone or will it be incorporated?
*Douglas*: This will be an amendment to the current waiver and will be in included in the new waiver.

*Herrmann Spetzler, Open Door Health Centers*: I was pleased to see flexibility on work force, but there was nothing on work force development. For rural to succeed with this, we need to educate our providers in a way that is not reflected here.
*Douglas*: There is a lot of work force training and certification happening. We did try to tackle work force in the last waiver and we can include that going forward.
*Herrmann Spetzler, Open Door Health Centers*: We need to continue to bring this up with CMS. We are using the same work force for all the new approaches. We need to reiterate that we need new work force to deal with all the issues.

**Medi-Cal Outreach and Enrollment**
*Rene Mollow and Anastasia Dodson, DHCS*

- Enrollment numbers
- Update on CalHEERS applications
- Outreach Efforts
- Retention and Renewal Strategies

Slides available:
**http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx**

*Marty Lynch, Lifelong Medical Care and California Primary Care Association*: Is there a way to move a type of presumptive eligibility to get the hundreds of thousands of pending applications approved?
*Dodson*: On the backlog, we are assessing the problems from every angle and possible solution. There are many symptoms underlying the problems that we are diagnosing. For example, there are automation issues; policy and training issues; there are new processes for consumers to enter their own information. The more automated batches we employ, the more we may exacerbate some of the underlying issues such as duplicate applications.

*Mollow*: Following up on that. The more we try to do automated batches the more we create confusion in the provider community with new aid codes and notices. We are

trying to balance the solutions so we mitigate the confusion. We want to get people into the right aid code and complete the process. We hope to touch the case no more than twice. It requires both county-state and automation solutions. We are looking at a multitude of solutions for this backlog.

*Gary Passmore, CA Congress of Seniors*: My understanding is that this data describes people already in your system. What is happening for people who moved into the system in January and February? I assume they are moving into managed care and there are timeliness requirements about seeing a physician, etc. Do you have information, even anecdotal, on care rather than enrollment? If not now, when might we have this?
*Douglas*: Anecdotally, plans report they are able to handle enrollments and care requirements. It takes several months for actual data to move from plans to state and for us to report.

*Bob Freeman, CenCal Health*: We spent much of 2013 ramping up to identify patients who were in care as private pay patients. We have had no spikes in grievances or other indication of care issues.

*Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance*: We do appreciate how much the state is doing to solve the backlog. As the contractor for the ombuds program, I have information to share on this. About 25% of the data indicate problems due to CalHEERS. There are five major problems analyzed on the handout we passed out:

1. Existing cases terminated and with increasing frequency.
2. Getting the wrong share of cost
3. Problems with the transition from CovCA and Medi-Cal
4. Incorrect information related to MAGI
5. Backlog of pending applications

While the backlog is very important, some of the other issues may be even more important. We need a plan right now for all the people losing coverage and care. We so appreciate the work you are doing and want to work with you to deal with these urgently.

*Dodson*: I hope that we can get information on specific cases to solve this.
*Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance*: Yes. And, I understand that the magnitude of issues is huge. It seems there are not even sufficient staff authorized and trained to solve this.
*Douglas*: CalHEERS has many problems, but let's clarify what it does or does not do. It can't produce share of cost – that is happening in another system. We need to understand the cases to know where the problem is. Medically needy is a different eligibility process with different documentation.
*Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance*: My understanding is that when CalHEERS fails, it triggers the SOC process. I understand that you hear me and we can follow up with you.

*Frank Mecca, County Welfare Directors Association*: I want to underscore that the issue is that CalHEERS produces the underlying answer that is wrong and this is causing the SAWS error.

*Anthony Wright, Health Access California*: On the chart of enrollment, does it include those who leave Medi-Cal?
*Dodson*: The charts include our best estimation, including the lag in enrollment due to issues such as retroactivity.
*Anthony Wright, Health Access California*: How many of enrollees are enrolled in a plan?
*Dodson*: We can report on that later. I don't have that now.
*Anthony Wright, Health Access California*: What is the status of notifying pending application folks about their status?
*Dodson*: We are focused on diagnosing the problem and executing solutions. We have talked about sending those notices but given our need to focus staff time on is not currently our priority. We know that about half of pending applications are in the last 45 days and they have the initial notice. The second notice is starting to go out.

*Suzie Shupe, CA Coverage & Health Initiatives*: I want to follow up on accelerated enrollment for children. With the backlog, there is anecdotal information that kids are not receiving accelerated enrollment. We have asked for data on this. During this period of backlogs, we suggest that kids get accelerated enrollment from all entry points, even those coming in through the county.
*Dodson*: We understand the importance and should have the data later this week. We have looked at the flow and ascertained that most children with accelerated enrollment aid code in CalHEERS have gotten through. There is a process to move kids into MEDS and we are looking to see what cases did not go through and why.
*Mollow*: As we look at accelerated enrollment, not all children receive AE. If they have coverage already, they do not receive AE.
*Douglas*: We are focused on fixing the problems we have now, not implementing new solutions.

*Anne Donnelly, Project Inform*: Thanks to Health Consumer Alliance for bringing forward a clear indication of the problems. Can all of us continue to be in the loop about the communication, so we can get the information out to our network? If we have a better understanding of the problems and timeline for solutions, it will help us sort through the interaction with ADAP and Medi-Cal.

*Lishaun Francis, CMA*: We don't expect a letter to all patients who are pending, but it would be useful to notify physicians and physician advocacy organizations so they can help communicate to patients. There is a need for more communication about what to say to patients and to understand the FAQ on the website better.
*Mollow*: Thank you. Jane Ogle and I participated in webinars with CMA and physician networks and we are happy to do that again. We welcome the opportunity to communicate with physicians and welcome input to make communications effective.

*Kim Lewis, National Health Law Program*: I appreciate the process of diagnosing and fixing the right problem. CalHEERS is complex system and we must prioritize getting it right. You have suspended residency verifications and negative action notices in CalHEERS. I would ask that you ensure the negative actions going out are accurate so that people get the right decisions. I also want to emphasize a point from another meeting that the goal is to have a real time eligibility system. I want to be sure that people are not having to provide unnecessary information because of the problems. I hear that some are asked for everything to cover all bases.
*Dodson*: On the issue of verification, we are looking specifically at who is being verified and at what point in the process are the applications stuck.
*Mollow*: Also, the site visits are helping us get feedback to understand the point of view from county workers to help assess and provide guidance that is targeted and specific so they are clear and are not asking for everything due to uncertainty.

*Richard Thomason, Blue Shield of California Foundation*: Following up on the enrollment numbers, the budget estimate was for 10 million enrollees. Will the May revise have new estimates?
*Douglas*: It is reasonable to assume revisions but we must wait for the official May revise.

*Marty Lynch, Lifelong Medical Care and California Primary Care Association*: I appreciate that we are trying to be efficient. Is there a way to make a value statement that we will hold consumers/patients harmless while we solve the problems?
*Dodson*: Our intentions are fully aligned, it is just that the combination of issues is overwhelming.

*Mitch Katz, MD, LA County Department of Health Services*: I want to thank Rene for her work to solve a particular problem we had with Healthy Way LA patients transitioning to Medi-Cal who were in care and we greatly appreciate it.

*Cary Sanders, CPEHN*: Are you going through the pending cases chronologically?
*Dodson*: There was a batch process in December to 180,000 individuals. Some people fell out of the batch process and some people applied after that and people are coming in person to a county office and some people entered in March/April. We give counties general guidance to solve older cases first, but when someone comes in person, they are helped. It is difficult to adhere strictly to a chronological order.
*Douglas:* I want to emphasize the dedication of the staff to solving these issues and even when we are not able to implement some of your suggestions, it is not due to a lack of attention or commitment to get the issues solved.

*Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance*: There was confusion in our county about the CalFresh process – that there was one batch check and that also there would be an ongoing way to catch people.

*Mollow*: We issued guidance on that to counties. There are some who make an application for CalFresh and are found ineligible, then the county will undertake a MAGI application. We are continuing to work through whether there are other issues.
*Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance*: Is there an effort to have dual agency notification between health and social services. The difference in instruction between social services and health has led to confusion.
*Mollow:* I see. I understand.

*Mitch Katz, MD, LA County Department of Health Services*: In general, the hospital PE process is a success – has been very positive. Our understanding is that CMS could extend this to outpatient settings. What would the process be for allowing government outpatient clinics to use PE including those not on the hospital license?
*Mollow*: If a hospital has outpatient clinics on the hospital license, we consider those to be part of PE. We can follow up on the non-hospital aspect of PE.

*Marvin Southard, LA County Department of Mental Health*: What is the difference between patients "rejected" and "denied" on the slides?
*Mollow*: Those listed as "rejected" includes those where the process was not completed. Denied includes those who didn't respond to something or are already on PE or have Medi-Cal or their income too high. We have an updated list of providers enrolled in the PE program. They must execute a contract and then get workers trained. We are working to ensure guidance is clear for hospitals who are working through a vendor that the hospital is responsible – it cannot be delegated to a vendor.

*Amber Kemp, California Hospital Association*: Thank you for partnering with us. It is a concern that only 20% of those submitting applications are approved. Also, we are concerned that the number of applications denied may point to a system problem.
*Mollow*: Some reasons for denial are that information is not clear or not verified. We would like to work with the association to clarify guidance and improve understanding.

*Erica Murray, CA Association of Public Hospitals and Health Systems*: PE has turned out to a critical part of expanding enrollment. Almost all public hospitals are approved and those receiving TA are going full throttle. There are others who need more training and TA to use the system to maximum extent. When used well, there are dramatic enrollment results. We would love to partner with you to improve results for all hospitals.
*Mollow*: Thank you.

*Cary Sanders, CPEHN*: Thank you for posting the County/CBO partnership information. In looking at the list, some counties have not specified the partnership information.
*Mollow*: Yes, some counties are going through their procurement process and Board of Supervisor approval. As soon as this is complete, we will update the information.
*Cary Sanders, CPEHN*: There was confusion with assistors receiving payments for CovCA and not for other cases in Medi-Cal. Is there any communication other than the FAQ on the website covering the reimbursement issues from Medi-Cal to assistors?

*Mollow*: We have to verify that there was not coverage within the past 12 months. We can put out some additional information and work with advocates to communicate with assistors.

*Anthony Wright, Health Access*: Can you clarify the LIHP numbers from the slides vs. last report?
*Douglas*: I believe the previous numbers were cumulative but I will follow up with you. The numbers will change over time as people move to different aid codes or make other changes.

*Anne Donnelly, Project Inform*: Could we talk off line about the implications of newly recognized same sex marriages on Medi-Cal?
*Mollow*: Great

*Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance*: Do you know how many counties are holding renewals until the negative action issues are fixed? Do you know the status of forms going out in non-English languages?
*Dodson*: We have not polled counties on who is holding renewals. On language access, we are exploring options so we don't send so many different instructions to counties.
*Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance*: You have heard this before from us, but for patients to be held harmless, we request that no forms should be sent out.
*Mollow*: No negative actions are taking place right now. The system functionality is not in place to send the notices.

*Elizabeth Landsberg, Western Center on Law and Poverty*: We appreciate working on the 2015 renewal form. Is there an estimated timing on the 2014 renewal form?
*Dodson*: No, it is unknown at this point.

*Cary Sanders, CPEHN*: What type of information about language access is available if people are receiving notices that is not in their primary language? Are counties trained to respond to this issue? What is the guidance?
*Mollow*: We don't translate all forms into all languages, but there is a form included in packet that provides a phone line for additional languages. The counties are prepared to assist.

*Marty Lynch, Lifelong Medical Care and California Primary Care Association*: Since we have a large pending application problem, we should not add renewals. We should extend renewals until the pending applications are cleared. Is there timing for this?
*Mollow*: We have extended the renewal policy by five months. As we look at solutions and timing, we will take all options into consideration. There is not a set timetable for decisions.

**1115 Waiver Process: 2014-2015**
*Toby Douglas, DHCS*

- Purpose of 1115 Waiver
- Components of 1115 Waiver Planning Process
- Overall Timeline for Planning

Slides available:
**http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx**

*Cary Sanders, CPEHN*: A general comment from the consumer perspective. We want to ensure that quality is considered, not just cost. We need to look at the data and what the needs of the populations are. We want quality to be a criteria for consideration under the waiver.
*Douglas*: We agree. Payment reform is about quality

*Erica Murray, CA Association of Public Hospitals and Health Systems*: The existing waiver is a success. I am interested in the approval timeline with CMS. As successful as the current waiver has been, there was a six month lag, and we want to be sure we can hit the ground running with a seamless transition between this waiver and the next. We are also wrestling with the political considerations post-election that may change the focus of CMS to a defense position. I am curious about the relationship between the waiver and the State Innovation Model application that also focuses on payment reform?
*Douglas*: Where CalSIM is similar, in driving systems to quality outcomes at lower cost, there will be an interaction. In terms of budget neutrality, there is less overlap.

*Anthony Wright, Health Access*: Looking at the six goals in the past waiver, I don't want to lose the focus on extending coverage and access as we go forward. These goals are valid to continue into the future. The feds have a stake going forward especially with the expansion on ER Medi-Cal. We could add prevention and primary care to save money on what is spent on ER Medi-Cal costs. It would be a mistake to retract from traditional focus on access and coverage and safety net.

*Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance*: You spoke about the stakeholder process generally. What will the role of this group on providing input?
*Douglas*: We are thinking it through what the role of this advisory group will be.

*Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance*: I agree with Anthony. Does the delivery system piece mean looking at utilization issues?
*Douglas*: yes, generally I think so.

*Kim Lewis, National Health Law Program*: it would be helpful to know if you have bullet points about what the "must haves" are in the new waiver.
*Douglas*: I don't have more to say now. I welcome input on how we create the right coordination and incentives.

*Chris Perrone, California HealthCare Foundation:* There were a few defining characteristics of the current waiver: CMS approved the use of savings from past managed care expansions to invest in other things; and, the state put up very few of its own dollars. Can you offer thoughts about whether this approach will continue for the future?
*Douglas*: The expectation is that the framework of budget neutrality will continue, meaning we will project forward the budget neutrality margin. The big challenge is the non-federal share and how do we claim for what is essential. The question will be whether the state puts up general funds to draw down or are there other options? We will all have to work together to figure this out. What might we do under a waiver we couldn't do under the State Plan?

*Marilyn Holle, Disability Rights CA*: On Anthony's point, it seems we could look at the financial experience in San Mateo to see if we can understand what the savings might be and what to cover. I want to emphasize the issue of quality and the extent to which we can cover paraprofessionals, telephonic services and ways to ensure access to specialists including access in rural areas. We should look at CCS and other systems for what the standards of care should be.

*Stuart Siegel, Children's Specialty Care Coalition*: Care coordination has come up in a number of ways and this is important to consider in novel ways. There should be some attempt to look proactively at financial data that will be needed.

*Michael Humphrey, Sonoma County IHSS Public Authority*: I want to ask about potential expansion of CCI and whether it will fit into the next waiver?

*Amber Kemp, California Hospital Association*: I want to include the potential for all hospitals to be included.

*Bill Barcelona, CA Assoc of Physician Groups*: My perspective is that we are not knocking down siloes with specialty providers in the general Medi-Cal population. How can we find the right financial models so that all providers are working on cost and quality goals? Across the country, the 160 CapG groups have two thirds involved in Medi-Cal and one third of groups are very experienced through Medicare Advantage. We are not tapping this MA potential. There is the opportunity to build a greater coordinated care system.

*Marty Lynch, Lifelong Medical Care and California Primary Care Association:* Any creativity to get remaining uninsured covered including undocumented is important. We have been limited by current definitions in CCI and related programs; we need more flexibility to keep people in community.

*Marvin Southard, LA County Department of Mental Health*: It may be useful to tie in some concepts we are testing with UCLA and RAND on health neighborhoods. It is testing payment models that may be useful to consider for the new waiver.

*Anne Donnelly, Project Inform*: I echo coverage for uninsured and the comments on quality of care. I want to look at rational drug purchasing system that would allow use of block buster high cost drugs even though cost/cure is less.

**CCS Discussion**

*Stuart Siegel, Children's Specialty Care Coalition*: The CCS carve out is due to sunset in 16 months. In the current waiver, we hoped that pilots would assess how CCS would run in the future. The problem is that only one pilot is underway. The pilots in the most populous counties are not functioning and so there are no pilots available to assess. This raises the question of what will happen when the carve-out sunsets. My understanding is that financial data is unavailable and is holding up pilots being implemented. What is the thinking about the sunset timeline? If the problem is data, can we consider working with providers and other groups to hold them financially harmless but implement and collect data? It seems the other alternative is to renew the carve-out. *Douglas*: San Mateo pilot is running. Data is only one of the issues holding up the other pilots (others are size, local issues, and County CCS role). We are back to square one, realizing that testing via a pilot is an unknown. As to timing for the carve out, we will be sure that if any transition occurs, we address readiness. We should consider whether to continue this into the next waiver or is it fine to leave the current CCS system as is?

*Marilyn Holle, Disability Rights CA*: I want to address CCS coordination of care and access to services. The current waiver includes outpatient clinics providing coordinated care and one stop care to keep people out of the hospital. There is a nurse liaison knowledgeable about when to bring people in. When they pass age 21, services are fragmented and they are required to go here and there for service. They are not in a setting that addresses the interaction of needs to stay out of the hospital. Another problem is that when a clinic is housed in a Hill Burton hospital, CMS is not enforcing the ongoing obligation to serve Medi-Cal recipients. Part of looking at CCS is considering what is working to keep people out of the hospital.

*Stuart Siegel, Children's Specialty Care Coalition*: There is concern about the many stakeholder groups and different discussions looking at CCS issues. There is a need to bring this input together into consolidated input.

*Amber Kemp, California Hospital Association*: Given that the pilots have not been implemented, we would hope that the department will allow for a longer timeframe to evaluate the options.

**Public Comment**

Corilee Racela, Neighborhood Legal Services: I appreciate the opportunity to speak to you about enrollment. We are seeing a problem among continuing Medi-Cal cases

highlighted in our written comments. There are many odd results such as receiving SOC higher than their income. We ask you to view these as system wide failures that are impacting care. We want to engage in a process to address this.

Ann Kuhns: CA Children's Hospital Association: We are encouraged by discussion on CCS. Our major concern is that CCS works well for a large number of people. It is a small population overall but their needs are profound and the system is working well for them. Any change to this system will have a detrimental impact on the system and the families. We want to remain a part of stakeholder process going forward to solve this problem.

**Update on Coordinated Care Initiative/CalMediConnect**
*Margaret Tatar, DHCS*
*Ed Long, DHCS*

- Counties that started voluntary enrollment; passive enrollment
- Status of new plans in Los Angeles County
- MLTSS Status
- New Information and Processes

Slides available:
**http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx**

*Anne Donnelly, Project Inform*: People with HIV were supposed to be able to opt out of managed care and I have seen nothing about a process for this to happen. I can talk offline but want to say it is serious.
*Tatar*: We want to follow up with you.

*Marty Lynch, Lifelong Medical Care and California Primary Care Association*: I have feedback that there is confusion on when the SPD roll-out is happening?
*Tatar*: For those in managed care plans, the benefit is turned on already and is receiving MLTSS already through their plans. The Medi-Cal only populations will come in July 2014. There is a monthly stakeholder call to update anyone who wants to join.

*Chris Perrone, California HealthCare Foundation*: Does the information about the Alameda Alliance conservatorship affect the timing for this roll-out?
*Tatar*: No plan will start until readiness is established. Alameda was scheduled to begin Jan 2015 or later. We are confident the conservator will address issues there and hope the plan can remain on that calendar, but it is too early to know.

*Marty Lynch, Lifelong Medical Care and California Primary Care Association*: Is there a way to track how many enrollees are getting care coordination. We have defined benefits, but it is unclear how well the plans will be able to address the care coordination needs.

*Bill Barcelona, CA Assoc of Physician Groups*: In some readiness reviews, there have been compliance issues getting all Duals into a care management plan. The groups were given about 90 days, and they put Duals into four levels of acuity to stage the work; however, CMS required 100% compliance. We are back to the beginning, working to accomplish this.
*Tatar*: We will monitor this closely and CMS is as well.

*Marty Lynch, Lifelong Medical Care and California Primary Care Association*: Does the monitoring include LTSS and MSSP?
*Tatar*: The current program builds on existing programs, including MSSP, IHSS and CBAS, and incorporates all the protections in those programs. We will be looking at the plans to see how well they are coordinating services and develop policies and procedures to ensure coordinated services. We recently published a managed care plan dashboard, with support from the foundations, and we hope to track these topics through that tool.
*Marty Lynch, Lifelong Medical Care and California Primary Care Association*: CBAS and MSSP are limited in number and not universally available as to the beneficiaries they serve, so it is important that the health plan have services on top of the small number of people.
*Tatar*: We agree and are working with CDA on this

*Marilyn Holle, Disability Rights CA*: I encourage DHCS and the plans to draft regulations, so that the IHSS could be temporarily increased during a transition home from inpatient care, so they don't need to go to a SNF.
*Tatar*: Plans are focused on care transitions.

*Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center*: How do you monitor that this is actually being carried out around SUD and MH? I recognize that plans develop policy, but how do you monitor they are being carried out? The plans are mostly invisible to the provider.
*Tatar*: Larger than CCI, SBIRT is required for the plans. We issued guidance about referrals and follow up as well as training to plans. We anticipate we will need to do more as time goes forward. The plans have specific reporting requirement for CalMediConnect on referrals and follow up. I can bring information back to a future meeting.

*Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center*: It might be helpful to capture feedback from providers as part of monitoring – not just counties and plans. Second, we only adopted SBIRT for alcohol so this remains a broken system.

*Michael Humphrey, Sonoma County IHSS Public Authority*: One of the concepts behind this is that plans will be able to provide MSSP or MSSP-like services to those not getting these services. Do you see that happening?
*Tatar*: It is too early for data but the promise and benefit of CalMediConnect is the care plan optional services. It can be discussed at an upcoming meeting.

*Michael Humphrey, Sonoma County IHSS Public Authority*: A comment on the alternative format materials, it is important for materials and plan materials, like the provider handbook to be available.
*Tatar*: I can follow up on the plan information. I was speaking to the state notices.

*Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance*: I was asked to offer an update on LA County. We subcontract for the state ombuds grant and have a grant from LA Care to do training.

- There seem to be high volume of calls from people with complex and multiple conditions. It seems far beyond what happened in the SPD transition.
- Non-English notices: there seem to be many translation issues with notices so we are analyzing the translation packets.
- Many calls from people who don't understand what choice means. The instruction does not say you can opt out of CalMediConnect and no space on the form to opt out. We are glad you are making improvements.
- Major challenge with provider education. People are calling saying, my provider says I can't stay with them; my provider doesn't understand the form.
- Providers are concerned about auto-cross over billing and this is a big issue in our trainings. We are not sure about this obstacle and are looking into it.
- Every call includes some discussion of concerns I will lose access to my provider, to provider, to SNF. Do I have to go back to my provider to tell them the correct information?
- Calls are increasing: there are more each day than the day before.

*Anne Donnelly, Project Inform*: How do HIV patients opt out of CalMediConnect? It says on the DHCS website that a medical necessity is required? I am hoping that can be removed
*Tatar:* We will follow up.

*Kim Lewis, National Health Law Program*: It's good you are collecting feedback and information from people on the ground. Are you reporting these issues?
*Tatar*: We are looking for those topics that will be on the dashboard. Also, there will be a complaint tracking and resolution module on the web site. All complaints and resolutions will be populated and posted. We will make sure you get information on this.

*Lishaun Francis, CMA*: With the secret shopping you are doing, is this happening in non-English language?
*Tatar*: I will follow up to let you know.

*Cary Sanders, CPEHN*: Are you tracking issues related to language? How do you track the issues coming in about how to navigate the system?
*Tatar:* We are tracking any enrollment issues, and complaints are tracked but I am thinking of any way we capture any navigation issues.
Ed: One related issue is that we ask the HICAP via survey about any problems beneficiaries are having and we track follow up to those issues.

**Network Adequacy and Timely Access with Increased Enrollment**
*Margaret Tatar, DHCS and Health Plan Representatives*

Slides available:
**http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx**

*Elizabeth Landsberg, Western Center on Law and Poverty*: We have heard some concerns about specialty care, especially in rural areas. Are there time and distance requirements for specialty care?
*Tatar*: Yes, we are having a series of calls to address this. Please bring these issues to our attention. We are working with the plans to address this.
*Elizabeth Landsberg, Western Center on Law and Poverty*: One topic is that there is a lack of clarity about referrals.
*Tatar*: I will talk to you off line. This issue is one that was addressed on the first call.

*Kim Lewis, National Health Law Program*: I am glad to hear about the monitoring and think the monitoring web page is helpful. Have you drilled down when you get complaints over time about a topic?
*Tatar*: Generally, we get reports from the plans and monitoring information comes from grievances. When a system issue comes to our attention, we follow up. We may reissue guidance plan-wide, schedule calls to find out more and set work groups on occasion. We will stay involved to surface issues and resolve them. Often this process informs the audit tool to close the loop on the monitoring process.

*Anthony Wright, Health Access*: Many of the timeliness access standards were not mentioned. HEDIS does not monitor this. I am concerned it was not discussed. How do you go about monitoring?
*Tatar*: The monitoring process is the same and is based on reports. I will follow up.

*Bob Freeman, CenCal Health:* DHCS does a comprehensive job of monitoring health plans – financially, operationally, etc. We have been planning for Medi-Cal expansion for all of 2013. Generally access has not been a particular problem. Specialty care access was an issue previously and remains an issue. We have experience expanding provider networks, adding new geographies and are now very methodical about how to do this. There have not been issues that have come to our attention. We knew that 80% of the population was already being seen in an FQHC so, with the notice we had, the clinics were able to staff up and this has strengthened their reimbursement. This meant we could focus on the 20%. Timely access is a challenge – some providers are full and they may be the only provider in an area.

*Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance*: A comment about appeals and that you are not seeing those. We don't file them often. We have relationships with plans and we try to resolve things without an

appeal. I like the idea of a dashboard. Is there anything in a county with a delegated model like LA, what is going on at the IPA level?
*Tatar:* The performance dashboard current configuration does not go to a delegated level. It might be able to accommodate that – we are on the first version of the dashboard. It would take some time to think that through. I can follow up with you about how to approach that.

*Lee Kemper, County Medical Services Program*: I am interested in the rural transition. I have a series of questions to walk through and get more detail in an individual setting.
*Tatar*: I will follow up

*Chris Perrone, California HealthCare Foundation*: I am interested in all the issues being raised. I suggest these should be on the agenda next time rather than handling them separate from this process.
*Tatar*: We can work on how to bring the information back to these meetings

*Marilyn Holle, Disability Rights CA*: DMHC has a good system for complaints. There is no mechanism to identify Medi-Cal systemic issues for DHCS. We do solve things individually but lack a vehicle to know how many others have these problems? Another type of issue is people not understanding obligations, such as the Charpentier injunction, DME, and inappropriately using Medicare standards. How can you not hamper the helping hand and still do compliance?
*Tatar*: I will follow up on this and what you sent to Sarah Brooks.

*Stuart Siegel, Children's Specialty Care Coalition*: We mentioned the Genetically Handicap Persons being put into SPD transition that caused many problems. Did that issue get picked up through the monitoring process? What was done with this?
*Tatar*: We learned about that through informal and formal monitoring process. As a result, we have carved out the factor from the plans. We surveyed specialty centers about plan collaboration. I don't know that we provided guidance.
*Stuart Siegel, Children's Specialty Care Coalition*: I would like to talk to you offline. The bigger issue is the outcome of the care for the patients which goes beyond the factor.

*Amber Kemp, California Hospital Association*: Can the department provide a list of the exceptions that the department has made for the plans to the access standards?
*Tatar:* I can look into that.

*Lishaun Francis, CMA*: I suggest we do a deep dive on this whole topic in the next meeting.

*Kim Lewis, National Health Law Program*: We have quarterly meetings between DMHC and advocates and DHCS here. Can there be joint conversations on compliance?
*Tatar:* You are suggesting we have DMHC here?

*Bill Barcelona, CA Assoc of Physician Groups*: Did I understand that the plans file monthly network information to you?

*Tatar*: They file monthly updates on changes to the network.

Public Comment

Bob Achermann CA Association of Medical Product Suppliers: The AVS system does not currently reflect enrollment in CalMediConnect. We alerted DHCS and this will be fixed by June.

Beth Abbott, Health Access: I want to reiterate something that surfaced. Almost every state and federal agency attempts to resolve consumer complaints individually. It is incumbent on the state to use this information to identify system wide issues. CMS has not addressed patterns, what happens over time, what happens in geography? This needs to be a fulsome topic for a future meeting.

There are a number of follow up items from this agenda. DHCS will follow-up on these items.

Next Meeting – September 11, 2014.