

**DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
October 14, 2015
9:30am – 3:00pm**

MEETING SUMMARY

Attendance

Members Attending In Person: Kelly Brooks Lindsey, CA State Association of Counties; Michelle Cabrera, Service Employees International Union; Lisa Davies, Chapa-de Indian Health Program; Sarah DeGuia, CPEHN; Anne Donnelly, Project Inform; Lishaun Francis, CA Medical Association; Bob Freeman, CenCal Health; Bradley Gilbert, IEHP; Sandra Naylor Goodwin, CA Institute for Behavioral Health; Marilyn Holle, Disability Rights CA; Michael Humphrey, Sonoma County IHSS Public Authority; Amber Kemp, California Hospital Association; Elizabeth Landsberg, Western Center on Law and Poverty; Stephanie Lee, Neighborhood Legal Services of Los Angeles County; Kim Lewis, National Health Law Program; Marty Lynch, Lifelong Medical Care and California Primary Care Association; Steve Melody, Anthem Blue Cross/WellPoint; Erica Murray, CA Association of Public Hospitals and Health Systems; Gary Passmore, CA Congress of Seniors; Brenda Premo, Harris Family Center for Disability and Health Policy; Judith Reigel, County Health Executives Association of California; Rusty Selix, CA Council of Community Mental Health Agencies; Kristen Golden Testa, The Children's Partnership/100% Campaign; Richard Thomason, Blue Shield of California Foundation; Anthony Wright, Health Access California.

Members Attending By Phone: Herrmann Spetzler, Open Door Health Centers; Chris Perrone, California HealthCare Foundation

Members Not Attending: Bill Barcellona, CA Association of Physician Groups; Cathy Senderling, County Welfare Directors Association; Stuart Siegel, Children's Specialty Care Coalition; Mitch Katz, MD, LA County Department of Health Services; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center; Marvin Southard, LA County Department of Mental Health.

DHCS Attending: Jennifer Kent, Mari Cantwell, Hannah Katch, Sarah Brooks, Marlies Perez, Jim Watkins, Adam Weintraub, Anastasia Dodson and Lindy Harrington.

Public in Attendance: 54 members of the public attended.

**Welcome, Purpose of Today's Meeting, Discuss Future of Stakeholder Advisory Committee, and Introductions
Jennifer Kent, DHCS Director**

Ms. Kent thanked Blue Shield of California Foundation and California HealthCare Foundation for their support to convene the stakeholder meetings. She introduced two new members, Lisa Davies from Chapa-de Indian Health Program and Stephanie Lee from Neighborhood Legal Services of Los Angeles. This is also the last meeting for Judith Reigel, County Health Executives Association, who will retire at the end of the year. Lindy Harrington was recently announced to replace Pilar Williams leading the Health Care Finance Division.

Follow-Up Issues from Previous Meetings and Key Updates

Update on MCO Tax – Jennifer Kent, DHCS

Ms. Kent provided an update on the \$1 billion managed care organization (MCO) tax that was pending at the last meeting. DHCS proposed a new model for the MCO tax and worked with the legislature and health plans to approve this prior to the end of the legislative session, however, we do not yet have an agreement. This is a significant budget revenue source for the general fund and we continue to believe we can get to an agreement. It will require legislative approval when they return in January.

Gary Passmore, CA Congress of Seniors: Are you continuing to work on the last public proposal or are there new concepts proposed? There are other states with this same issue – are there proposals from other states to consider?

Jennifer Kent, DHCS: We are not starting over although to the extent that others have a model that meets the requirements, we will consider it. As to other states, they are asking for our ideas and looking to California.

Elizabeth Landsberg, Western Center on Law and Poverty: We find taxes interesting because they support safety net and low-income programs. We are supportive of an MCO tax. We were disappointed to have important Medi-Cal bills that were negotiated in good faith vetoed by the Governor over the last few days. They were apparently a reflection of the lack of an MCO tax and its revenue. We stand ready to do anything we can and hope this is resolved before January. The vetoes may be an indication of further cuts in the future if this is not resolved.

Follow-Up Issues: Adam Weintraub, DHCS

Adam Weintraub presented [details of follow up](#) based on the matrix in the meeting materials.

1115 Waiver Renewal Application: Medi-Cal 2020 Status of Waiver Renewal Proposal, CMS Discussions and Timeline for Next Steps

Mari Cantwell, DHCS

Mari Cantwell reported that as of the meeting date there is no final agreement or even clarity over what would be included in the waiver renewal, although the existing waiver is set to expire in 18 days. As was shared in September, CMS has indicated the federal-state shared savings financing approach will not be included, although other elements of the proposal remain under discussion, including whole-person care, global payment reform, maternity and dental. Part of the delay and difficulty has been a need to educate CMS about California's Medi-Cal program and a back and forth about why proposals from other states do not make sense for California. In addition, California's financing is very complicated and this hampers our ability to advance certain ideas. There is CMS interest in standardizing Medicaid across the country. California's position is that each state and each program is different, Medicaid is a state-federal partnership and proposals from other states don't make sense for California.

Once shared savings was dropped, we worked to identify other non-federal sources to finance the various waiver concepts. In partnership with CMS, we looked at Designated State Health Programs (DSHP) -- programs that finance care for the uninsured -- as match. This has been done in other states and had potential to fund incentives and programs such as whole-person care, maternity and dental. Previously, there was \$400M available that would have financed \$800 million total. However, due to the declining number of uninsured, the actual amount now available in DSHP is only \$150 million. It became clear that CMS did not view this as viable and this leaves us without significant sources of non-federal share to match some elements of the waiver proposal. The focus turned to maintaining the core services financed through the waiver

and some smaller elements of projects originally proposed. A final package is before CMS for review that includes five key components. The overall managed care program and the Substance Use Disorders Services waiver will continue and are not part of the description below:

- Delivery system transformation incentive program for Designated Public Hospitals (DPHs) and district/municipal hospitals (DMPH), known as PRIME (Public hospital Redesign and Incentives in Medi-Cal). It includes financing for various elements of transformation for both designated public hospitals and district/municipal hospitals.
- Global Payment Program: Services to the uninsured in designated public hospital systems that combines Disproportionate Share Hospital (DSH) financing and the Safety Net Care Pool (SNCP) to move toward primary care and prevention;
- Dental transformation incentive program: The dental program will be based on DSHP financing.
- Whole Person Care Pilot: This will include housing supports proposed previously and will operate through a voluntary county/regional program. The concept is similar to the 2005 waiver Coverage Initiative Program with a pot of money that relies on county funding and an intergovernmental transfer (IGT) mechanism with a competitive process to choose local projects.
- Independent assessment of access to care and network adequacy for Medi-Cal managed care beneficiaries and independent studies of uncompensated care and hospital financing. This element will look at compliance with access standards such as time/distance and grievance/appeals. There is a newly formed advisory committee to provide input on the assessment.

The programmatic elements listed above total \$7.25 billion total. The original proposal for this waiver was \$17 billion so it is significantly lower. It is also lower than the previous waiver, which was \$10B.

Questions and Comments

Kristen Golden Testa, The Children's Partnership/100% Campaign: Can you describe the process going forward? You submitted the proposal; is the next step for CMS to accept the proposal and then turn to the terms and conditions? Will there be an extension of the current waiver?

Mari Cantwell, DHCS: Yes, since there had been extensive discussion already about the various elements, we submitted a one-page revision document that relies on details in the original proposal. Once that is accepted, we will move to terms and conditions. If we reach an understanding and need more time, a short extension to work through details is fine; however, we need clarity about where we will land.

Michael Humphrey, Sonoma County IHSS Public Authority: What are key elements in the original proposal that are not included?

Mari Cantwell, DHCS: This proposal does not include the value-based payments with Medi-Cal managed care plans with a focus on behavioral health integration; maternity care changes; or work force training. Behavioral health is still an element of the public hospital incentive program but it is not as broad as previously.

Kim Lewis, National Health Law Program: If you get agreement on these five concepts, what is the impact of the changes compared to the current waiver? What are the primary changes that will happen immediately without approval of a new waiver?

Mari Cantwell, DHCS: If the final package is approved, nothing is lost except for General Fund offset that was in the DSHP. Nothing would be taken away. The state budget agreed to in June did not assume the DSHP was included.

Lishaun Francis, CA Medical Association: Can you discuss why CMS did not approve?

Mari Cantwell, DHCS: There was an early premise that the overall funding would be lower so some of our proposal could not move forward based on a lower number assumed by CMS. Another issue was that they did not think we needed a waiver to do some of the projects. We will continue to move toward value-based contracts but it will not be as rapid. CMS has issues with the workforce proposal as to whether it was appropriate to use Medicaid funding to finance this because bulking up workforce is not exclusive to Medicaid. They were supportive of the goals and of the other pieces but there was not enough money on the table to do them.

Mari Cantwell, DHCS then reviewed each waiver element in detail.

1. **Public Hospital Incentive Program:** There are two components for public hospitals. It maintains the level of funding from the last two years of the current waiver with the designated hospitals maintaining \$700 million annually in federal funds; the domains included for redesign are similar to the workgroup discussion of this waiver concept. Domain 1: integration of behavioral health and physical health (required); Domain 2: includes complex care management for targeted high-cost populations (required); integrated health homes for foster children; improved perinatal care; and, transitions to integrated care, in particular for post-incarceration populations. These two domains will have higher funding over time in the waiver with 50% of the funding after year two focused on these areas. Domain 3: outpatient transformation and prevention including redesign of ambulatory care (required); optional projects such as the Million Hearts Campaign are also included. Domain 4: includes resource utilization efficiency such as high-cost imaging and antibiotic use. For non-public hospitals: The proposal includes \$100 million annually for federal funding to district/municipal hospitals, funded with their IGTs. This will be optional participation in at least one project or could include more if they choose.

Questions and Comments:

Michelle Cabrera, Service Employees International Union: Earlier we heard CMS wanted the waiver to drive to statewide metrics. Can you offer what those might be?

Mari Cantwell, DHCS: Yes, that was in the context of the full proposal. We had discussed the percent of payments in value-based purchasing; increasing the number of individuals with MD visits; decreasing emergency room utilization. We remain willing to track those items, however waiver funding is not linked to those metrics given we don't have the broader incentive program. We aren't sure it makes sense to link achievement of these metrics in this new context.

Bradley Gilbert, IEHP: Given the expansion of Medi-Cal populations and given the ongoing work between plans and public hospitals on the issues such as high-cost populations and behavioral health integration, it is unfortunate not to have the plan incentives. These efforts all have to be in sync between safety net providers and the Medi-Cal managed care plans. If we are

successful working with public hospitals in doing these things, it will be so unfortunate that as we gain efficiencies, rates may be cut. Two things to emphasize: 1) the need to go forward with plans, public hospitals and district hospitals together; 2) how do we deal with retaining savings to invest in additional things the waiver doesn't include?

Mari Cantwell, DHCS: Excellent points. We are discussing this and how we can sustain the work and the integration between hospitals and plans. Retaining savings is something we want to work toward. It will be harder without a demonstration project of the savings that would have allowed us to move quickly. However, we are discussing how we can move along separate from the waiver although at a slower pace.

Bradley Gilbert, IEHP: We are moving along on these concepts such as behavioral health with major investments but that is in peril.

Mari Cantwell, DHCS: We understand and we are philosophically on the same page.

2: Global Payment Program: This is similar to the original proposal to combine the SNCP and DSH payments for care to the remaining uninsured in the designated public hospitals. CMS is philosophically supportive but they have questions. The issues for CMS may be due to work in other states that have uncompensated care pools, which have been and remain very different from California's proposal. Our proposal doesn't fit the mold of other states and we are struggling to move forward given CMS interest in standardized approaches across states. We have worked to convince CMS that our proposal fits the guidance they provided. The principles from CMS include: coverage is best; no backfilling of Medi-Cal payments; SNCP should not interfere with managed care. We think California's program has always and continues to be in line with this guidance and supports the right care at the right time for remaining uninsured. CMS proposed an analysis of what uncompensated care includes in order to agree to a five-year program. However, this is infeasible to manage and it is critical for us to know what funding will be available. Therefore, we agreed to a declining amount in this element of the waiver in order not to be dependent on a "wait and see" status. The uninsured have declined and the current level of this funding is \$236 million. We propose to begin with \$236 million for year one based on current levels and decline to \$160 million in the last year. This is the compromise proposal but the final agreement remains unclear. There are questions and concern about this not being a cost-based proposal.

Questions and Comments:

Kristen Golden Testa, The Children's Partnership/100% Campaign: To confirm my understanding, CMS says they need to assess the cost or set a base of what cost would be in order to establish a ceiling for a budget. We are saying, each year it will not be that cost because we are changing.

Mari Cantwell, DHCS: It is unclear if actual costs should be the driver, which discourages driving cost down. Also, they want to assess costs prior to setting what the cost is over 5 years. The decreases in the uninsured have significantly lowered the overall size of this element.

Anthony Wright, Health Access California: Are the numbers of the \$236 million to \$160 million only from the SNCP side?

Mari Cantwell, DHCS: Yes.

Anthony Wright, Health Access California: Is there a change in its target of the remaining uninsured and beyond the four walls of the hospital?

Mari Cantwell, DHCS: No, it is the same

Anthony Wright, Health Access California: We are very excited about this particular proposal and have advocated for this based on our unique demographics. We also have heard the issue of consistency, and in particular, comparison with Florida and Texas.

Mari Cantwell, DHCS: We have done Medi-Cal expansion and Florida/Texas have not. Our remaining uninsured are truly uninsured. The Florida IGT is unrelated to actual experience of uncompensated care of the entity putting up the IGT. It was not linked to the actual uninsured. We talked to CMS about the fact that our proposal includes actual experience and is auditable. Our proposal is also linked to higher use of primary and preventive care. The dollar amount of our proposal is also smaller than other states.

Anthony Wright, Health Access California: CMS has been receptive to information about counties doing innovative things. I agree there is a learning curve about California's safety net.

Gary Passmore, CA Congress of Seniors: Are we better off because we are different?

Mari Cantwell, DHCS: It can be helpful sometimes, but not always. My sense is that driving toward Medicaid consistency is difficult in each of the state discussions. Every state would say; we aren't like other states. And, if this continues, it may make it harder for California going forward.

Gary Passmore, CA Congress of Seniors: Compared to the cost structure in other states, California Medicaid is a bargain. It seems CMS would want to encourage continuing advancement on the path we are on.

Jennifer Kent, DHCS: Yes, we may be penalized for being farther ahead. For example, New York is just starting managed care and that is considered value-based care. In California, plans are all capitated and many providers are capitated as well. We want to go forward from that. It is disturbing to be told we have to do what every other state is doing when we are farther ahead.

Stephanie Lee, Neighborhood Legal Services of Los Angeles County: In some ways, Los Angeles mirrors the way California is seen nationally. Are there other outlier states?

Mari Cantwell, DHCS: We are not the only; other states have issues along the same lines. The way we have done managed care and the level of delegation and capitation is very, very different than other states. We are not the only outlier, although we may have bigger differences compared to other states.

Jennifer Kent, DHCS: The new CMS managed care regulations are a good example of how they are standardizing state Medicaid processes. Many states were concerned with medical loss ratios in the regs and we have already moved past this. The concerns from other states in some cases don't trouble us because we have already implemented.

Bradley Gilbert, IEHP: I understand the advantage of standardization from the point of view of CMS. What about the politics? They needed us in 2010 and there was a willingness to entertain innovative elements related to ACA success. Is the tone different because the ACA is past us?

Mari Cantwell, DHCS: That has not been said but I think it is playing into this. There is nothing in ACA we have not at least tried to do.

Jennifer Kent, DHCS: In fairness to CMS, the current waiver was approved in a different political environment. Congress has changed significantly and they have a tough time defending unique situations or unique arrangements for an individual state.

Mari Cantwell, DHCS: For 5 years, the total funding for uncompensated care component is \$1 billion. DSH is not included.

Anne Donnelly, Project Inform: I am left with impression that CMS is willing to look at cost containment strategies to improve Medicaid but not interested in value proposals that require investment?

Mari Cantwell, DHCS: No, they want value-based payments as you see with Medicare although that is a largely fee-for-service environment. There was interest in our proposal. As we began to have issues with nonfederal share, it changed the discussion. There is also an issue of cost related to the public entities. We see a resurgence of concepts related to lowering costs that were proposed by previous administrations and deleted by Congress.

Anthony Wright, Health Access California: On messaging related to global payment, it would be helpful to understand whether to emphasize how we are similar to others like Florida and fit the criteria vs how we are different and here are the reasons why we are different.

Mari Cantwell, DHCS: It is a combined message. We are trying to move away from cost because that is not value; not about lowering hospitalization. Public systems want to move to value but have to retain the money in the system to serve existing patients as they improve care. Although CMS understands that, it comes back to cost and a concern about overpayment.

3. Dental transformation incentive program: The dental program will be based on DSHP financing. We are proposing \$150 million annually; \$750 million over 5 years. This uses \$75 million of DSHP to draw down an additional \$75 million for \$150 million total annual amount. There are three project areas: incentive payments to increase services for children compared to a baseline year; utilizing a prevention and risk assessment model to prevent childhood caries (CAMBRA) by paying bundled payments if a provider is using this risk-assessment approach; incentives for continuity of care for annual services to same beneficiaries focused on both children and adults.

Questions and Comments:

Marty Lynch, Lifelong Medical Care and California Primary Care Association: Integrating dental care and primary care is essential to improve diabetes management and other health care conditions.

Mari Cantwell, DHCS: Those are the kinds of things we wanted to do but there was not sufficient funding overall.

Kim Lewis, National Health Law Program: Is there an aspect of the proposal to deal with geographic variation in utilization and access?

Mari Cantwell, DHCS: Yes, that is the goal of the first element. Incentive payments are earned if you see more children in the program. It is not geographically focused but we do want to improve the variation.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Is the CAMBRA model a value-based approach?

Mari Cantwell, DHCS: Initially there will be an incentive payment to adopt the approach. The goal is to demonstrate the benefit of the CAMBRA model and move to bundled payments.

Elizabeth Landsberg, Western Center on Law and Poverty: It is great to have dental as a priority, is this fee-for-service only or across dental managed care as well?

Mari Cantwell, DHCS: It is across both managed care and fee-for-service.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: Is there anything specific to FQHC providers in the dental proposal?

Mari Cantwell, DHCS: We see the FQHC providers as significant dental providers and we hope there is participation.

Anthony Wright, Health Access California: What has been the feedback from CMS?

Mari Cantwell, DHCS: Only that dental is good; no specific back and forth on details.

4. Whole Person Pilot: This has been an area of great interest in California from many stakeholders and policy makers. There is the challenge of finding the non-federal funding and identifying a source of IGTs. The concept is similar to 2005 with a set amount of \$300 million annually (\$1.5 billion over 5 years) and we assume there will need to be a limit on the number of programs as we will only be able to fund 5-10 projects. Local applicants with a source of IGT will propose their project based on a set of required elements. This would include a focus on a high risk, high utilizing population and support from community partners, private and public providers. The applicant would propose how the services would work; how financing would flow; how supportive housing would work. Funding plans should include necessary infrastructure such as data, services that are not currently available and outcomes that produce savings for reinvestment, such as reductions in emergency/hospital utilization. We are still working on how the proposal will work and have not received specific feedback on this element from CMS.

Questions and Comments:

Gary Passmore, CA Congress of Seniors: On the flow of dollars, each county would have to provide public dollars to draw down the funding for a model of care to include housing but not pay for housing, right?

Jennifer Kent, DHCS: In the example of the Coverage Initiative in 2005, another parameter in the implementation was a cap on the amount a single county could receive so that there will be funding for multiple projects.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Is this for the Medi-Cal population only? Does it include the managed care plans?

Mari Cantwell, DHCS: Yes. A robust application would need to include all partners, including health plans and behavioral health collaboration, and explain how this would wrap around existing services.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Can a locality choose several target populations, like asthma in kids?

Mari Cantwell, DHCS: Sure.

Kristen Golden Testa, The Children's Partnership/100% Campaign: How will the waived services work? Will there be a blanket waiver or specific waivers for the types of projects you expect to be proposed?

Mari Cantwell, DHCS: We will have to have broad expenditure authority. We have an idea of how this will work based on work current plans are doing but the applicant will go through approval with us.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: My understanding is this is support for housing placement and retention but no actual money for housing?

Mari Cantwell, DHCS: There could be a savings pool concept developed among partners where funding is produced from savings on health care to pay for other things. Another thought is that since some portion of the money will be linked to outcomes and if there is a need to spend money on housing to achieve the outcome, it would indirectly provide funding.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: This is an IGT mechanism and I am not sure how that works but if a county or plan is above the plan's "rate room" or ceiling, can they participate?

Mari Cantwell, DHCS: Yes, this is a separate waiver pot of money to be allocated and not part of a plan's rates.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: Is this parallel to MCE population within plans where we are not spending up to allowable costs?

Mari Cantwell, DHCS: No, these pilots could demonstrate savings and support the way health plan reimbursement could work differently, but this would be separate for now. The money for other services would continue to flow as it does today.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: How does this work with 2703 Health Homes?

Mari Cantwell, DHCS: To the degree that a Health Home project is in the same locality, we do expect them to work together to implement.

Sarah DeGuia, CPEHN: Are there counties expressing interest?

Mari Cantwell, DHCS: Yes, the concept has changed somewhat but in the last 12 months we have talked to counties about similar concepts. I anticipate there will be interest.

Sarah DeGuia, CPEHN: Is there a risk you wouldn't spend the annual amount? Can it flex over the 5 years?

Mari Cantwell, DHCS: It's a good question. We don't know the answer, but if we are in that situation in year one, we would have a conversation with CMS. We need people ready to go in year one.

Jennifer Kent, DHCS: There was a roll-over mechanism in past coverage initiative project where money was reallocated if unused.

Sarah DeGuia, CPEHN: There are foundations and others interested in these pilot concepts; is there any difficulty with their participation?

Mari Cantwell, DHCS: Foundations can't be the source of the match.

Anthony Wright, Health Access California: You are seeking approval based on some of the Health Care Coverage Initiative provisions. Why is there a \$300 million limit since this is based on what counties can match?

Mari Cantwell, DHCS: This must be included in the total ceiling for the waiver so this is the amount we think is possible given the overall limitations on the size of the waiver from CMS.

Brenda Premo, Harris Family Center for Disability and Health Policy: The housing proposal is interesting. There is HUD and there are CDBG funds locally to fund housing issues and access, such as grab bars. The need for health services is great and the need for serving baby boomers is huge. Has there been a conversation about using all the dollars from the various sources including HUD to create integrated the multiple needs and the financing?

Mari Cantwell, DHCS: The original concept included plans to bring in entities, such as HUD with other sources of complementary funding. We have not had the opportunity to pursue these discussions but we hope they will happen at the local level.

Brenda Premo, Harris Family Center for Disability and Health Policy: Community level discussion is good, but I think the state needs to be involved to bring HUD to the table so we retain health care dollars for health services. If we are going to solve housing, we need housing partners at the table.

Kim Lewis, National Health Law Program: Can you review the total federal match funding available?

Mari Cantwell, DHCS: It is the \$7.25B amount that is federal funding.

Stephanie Lee, Neighborhood Legal Services of Los Angeles County: I suspect LA would have the non-federal share to participate in this project. Do you plan to specify the cap ahead of time or wait to see the applications before deciding?

Mari Cantwell, DHCS: Last time we set the cap prior to applications, but we haven't made a decision.

Michelle Cabrera, Service Employees International Union: Thank you to you, Mari for understanding the need for infrastructure, such as workforce and your advocacy for DSHP to

retain the workforce investment. California has been in a leadership position on some of these discussions in the past, where CMS has not been supportive of a concept that later becomes possible. For the moment, the training pieces are off the table with CMS, but can you comment on whether front line workers such as promotoras could be part of this project under services not currently provided? Or could we include new workforce in global payment incentives?

Mari Cantwell, DHCS: Yes, in both global payment and in the whole person pilot, we are seeking flexibility on workforce. We think that should be an option if communities propose that.

Bradley Gilbert, IEHP: I was not understanding this – now it sounds broader to me. Can this be for anything related to specific populations? Is this a mechanism to extend the complementary pieces with the public hospitals that relates to services for similar populations and integration?

Mari Cantwell, DHCS: Yes.

Elizabeth Landsberg, Western Center on Law and Poverty: Thank you for your efforts. Is there willingness to increase the pot of money if many counties come forward?

Mari Cantwell, DHCS: That will be difficult based on the set waiver amount and budget neutrality.

Gary Passmore, CA Congress of Seniors: Would you consider ramping this piece up over time rather than having it set at \$300M annually? So we can build this into the 2020 waiver?

Mari Cantwell, DHCS: I don't think CMS will be interested in that because they are ramping down on waivers - to be done in 2020.

Gary Passmore, CA Congress of Seniors: Our thanks. On workforce, when you have a waiver agreement, can we go back and look at the proposal to see how to accomplish the proposal with other means?

Erica Murray, CA Association of Public Hospitals and Health Systems: I echo my thanks to the team. This has been an endurance test. It is so important for my colleagues to urge CMS approval and urge your elected representatives to call CMS for approval. Nothing is approved and we only have 17 days. There is lots of work on the details and the Special Terms and Conditions. Also, to the need to message – the whole process has been a need to appreciate the limited scope of what we can accomplish over the next five years. Although it is disappointing to have a narrower scope, I want this stakeholder advisory committee to realize that we will accomplish a lot. First, we will have a value based DSH; we have the first whole person care pilots; and other structures that are more ambitious than many other states. We remain leaders and should be excited about our progress.

5. Independent assessment of access to care and network adequacy: In the terms and conditions of the waiver, we propose to enter into an agreement with an independent contractor to assess primary, core specialty and facility access to care for managed care beneficiaries based on the timely access and geographic standards and also fair hearing, grievances and appeals as well as other factors to be identified by a stakeholder committee to be established. We propose using the same contractor that is currently the External Quality Review Organization for DHCS. Beginning in 2016, the contractor will convene an advisory committee to offer input to the assessment including metrics. This will include associations, health plans, providers, legislative staff, advocates and consumer groups and they will also look at an initial

draft of the assessment report. This will look at Medi-Cal plans with a comparison to other lines of business in the geographic area. Health Services Advisory Group is the contractor.

Questions and Comments:

Marilyn Holle, Disability Rights CA: How will non-medical transportation figure into the assessment?

Mari Cantwell, DHCS: We don't have a proposal on that. It will be part of what contractor looks at as they develop this.

Kim Lewis, National Health Law Program: Will there be a single evaluation over life of waiver?

Mari Cantwell, DHCS: This is a single assessment completed in first couple years of the waiver. There is no plan for ongoing assessment.

Chris Perrone, California HealthCare Foundation: What is the size of the investment you are proposing?

Mari Cantwell, DHCS: There is not a dollar amount yet. It will depend on the contractor's proposal for the scope of work.

Kim Lewis, National Health Law Program: Will this include carve-outs?

Mari Cantwell, DHCS: The focus is the 22 Medi-Cal managed care plans – the Knox-Keene and COHS.

Amber Kemp, California Hospital Association: Is this something DHCS proposed or did it come from CMS?

Mari Cantwell, DHCS: CMS is very interested in access and this is something we have had many conversations with CMS about. There was not deep understanding that Medi-Cal plans have the same requirements as commercial plans through Department of Managed Health Care (DMHC). It came about as part of those conversations.

Anthony Wright, Health Access California: I understand there will be an initial and final report. Is there anything in the waiver tied to that?

:

Mari Cantwell, DHCS: There is no specific link to anything else. We are looking for recommendations as part of the assessment report and once we have that, we will consider what the next steps are.

Jennifer Kent, DHCS: My personal kudos to Mari and this team. We have a small but mighty team working on this and they have been tireless. We are disappointed not to have final answers but my thanks to their hard work.

**Update on Drug Medi-Cal Waiver Approval, Implementation and Financing Issues
Marlies Perez, DHCS**

Presentation slides are available at:

http://www.dhcs.ca.gov/Documents/Update_on_Drug_Medi-Cal_Waiver_Implementation.pdf

Jennifer Kent, DHCS introduced Marlies Perez. This is a positive development in the waiver. California is a leader and is looked to by other states on the Drug Medi-Cal waiver. Ms. Perez reported that the waiver was approved August 2015 and it will carry over into the 2020 waiver. DHCS is hosting a webinar Oct 22 at 1 pm to discuss the specific terms. Ms. Perez reviewed slides detailing implementation phases, formation of learning collaboratives and engagement in training and technical assistance. County implementation and rate development was discussed. There will be a stakeholder advisory group as implementation moves beyond phase one. Results of a baseline survey that is part of a UCLA evaluation were presented. The majority of counties are expected to opt-in to the waiver. Counties report that residential services will be most difficult to implement. Ms. Perez also reported on fiscal provisions of the waiver. The waiver allows counties to pilot alternative payment mechanisms.

Questions and Comments

Kelly Brooks Lindsey, CA State Association of Counties: Do counties need to propose alternative payment up front in the application or can they come back later when they have more experience?

Marlies Perez, DHCS: There is no time limit, although any changes to the implementation plan require approval.

Sarah DeGuia, CPEHN: What goes into the county implementation plan? How will it include consumer engagement?

Marlies Perez, DHCS: Implementation plan details are included in the Special Terms and Conditions on the DHCS web site. The plan must explain how the county will ensure the continuum of care, what MOUs are in place; how they will guarantee access; expand medication-assisted treatment and others. One element of the plan is assurance to the state that the county has engaged with stakeholders and described how they have engaged.

Bradley Gilbert, IEHP: It is great to see the information about creating the MOUs between plans. The finding in the slides that 17% of county mental health and substance use providers have agreements is surprising. Is it part of the waiver for them have more formal MOUs?

Marlies Perez, DHCS: There are a few issues as part of that. Part of it is that we are in a different position at the county level because most counties are behavioral health counties, so some of that is happening at the county level. Second, as part of the waiver, by 2017 DHCS is required to put forward an integration plan and that includes mental health as well.

Bradley Gilbert, IEHP: It would make sense for plans to have a single MOU with that integrated system so there is a spectrum of services for our members, rather than separate agreements with mental health plan and substance use.

Marlies Perez, DHCS: That is something we can look into. This was a baseline survey of counties. UCLA wants to survey managed care plans as well to get baseline information. This is an areas we see a lot of growth and that way we can highlight that change as we go through this.

Richard Thomason, Blue Shield of California Foundation: Can you offer a ballpark estimate of funds that will flow through the waiver?

Marlies Perez, DHCS: it is challenging to answer that because we are working with so many systems that feed into this. We are expanding the modalities of service and availability while we are expanding who is eligible. For example, there are a significant number of beneficiaries from the Department of Corrections because parolees are now eligible for Medi-Cal and they will be new in the system. It is difficult to estimate the amount of the waiver.

Jennifer Kent, DHCS: I am not sure of the amount, but I think it is in the ballpark of \$60 million. We are adding the full continuum for the first time. Also, we didn't talk about the tribal system as part of this. In any case, it is not billions, it is millions.

Kelly Brooks Lindsey, CA State Association of Counties: To the extent the state has an integration plan, will it change how counties operate and will they need to conform to that plan or is it about the state's integration?

Marlies Perez, DHCS: We are looking at the SAMHSA integration model and do not have details yet. We will be developing a more detailed plan and as part of the process will consult with stakeholders.

Kim Lewis, National Health Law Program: There is no limit on the number of counties that can opt in? Will the evaluation compare access in counties that do not opt-in?

Marlies Perez, DHCS: We submitted the evaluation plan recently to CMS and we will look at the counties that do not opt-in. More importantly, we will look at the phases as key to the evaluation to highlight the change over time. We can see the impact from this waiver by using the change in the phases. Because most counties will likely opt in, the only counties that are unlikely to opt-in are very small. The comparison would not be as useful.

Kelly Brooks Lindsey, CA State Association of Counties: Essentially, counties are creating a new treatment system and organizing managed care plans. This is a heavy lift and a big transformation. Counties will be at risk and are putting up the non-federal share. So some caution is needed about how this will play out. It vastly expands the population and services but we don't know how this impacts rates.

Jennifer Kent, DHCS: I was in a small, 12,000-population county recently that was talking about not opting-in. For them, it doesn't make sense unless they can participate in a regional or CMSP-like approach.

Implementation of SB75 – Coverage for All Children

Jennifer Kent, DHCS

Presentation slides available at:

http://www.dhcs.ca.gov/Documents/Draft_SB%2075_Presentation_Oct_2015_100815.pdf and <http://www.dhcs.ca.gov/Pages/October14MeetingMaterials.aspx>

Jennifer Kent provided an update on the timeline and implementation of full scope Medi-Cal coverage for all children, regardless of documentation status, beginning May 2016. She presented a timeline, including the availability of webinars to report on implementation as it proceeds. Stakeholder input has been through the immigration subgroup of the AB 1296 workgroup. Ms. Kent provided numbers of children previously known to the system by county and aid code. There is interest in working with foundations and stakeholders to increase outreach efforts to promote enrollment.

Questions and Comments

Gary Passmore, CA Congress of Seniors: How do we grapple with the children not known to the state already? Is there a ballpark number?

Mari Cantwell, DHCS: We think it is an additional 50,000 - 70,000.

Anthony Wright, Health Access California: Thank you to the administration for signing SB 4. The presidential debates referenced this issue with support for states on this track. Are we on track for May 1st? Is there more information on the enrollment plan on the website?

Jennifer Kent, DHCS: The specifics are under final review and will be posted soon.

Elizabeth Landsberg, Western Center on Law and Poverty: Can you clarify, will notices be translated into all threshold languages?

Jennifer Kent, DHCS: Yes.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Who is the team leading this?

Jennifer Kent, DHCS: This is through the Eligibility Division; Rene Mollow is leading. There are others involved for CalHEERS, choice packets, etc.

Kristen Golden Testa, The Children's Partnership/100% Campaign: On outreach, will there be efforts to reach out to partner organizations like WIC or CHDP?

Jennifer Kent, DHCS: CHDP kids are included in the group that is known to the system. I am not sure about WIC. We are having conversations with foundations about strategies to reach out.

Bradley Gilbert, IEHP: There are kids already in organized systems of care, like Kaiser, and IEHP has 1000 children already enrolled in the plan. We need to figure out how to identify them so they don't move through fee-for-service and back into plans.

Jennifer Kent, DHCS: They have to apply and then they can make a choice of plan. We have been in conversation with Kaiser and other plans, but they need to go through application.

Kim Lewis, National Health Law Program: On continuity of coverage, many kids are with Kaiser. Could there be an effort to reach out through the coverage program they are already in? Could notices go out sooner to allow them to choose to stay in their existing plan so there is no break in their care? It seems there is time to coordinate this effort.

Jennifer Kent, DHCS: We are having those conversations and they aren't completed yet. The children do have to apply so how we get them to apply is what we are working on. We have to find them eligible through the system. If they are in restricted Medi-Cal now, they do not need to apply.

Sarah DeGuia, CPEHN: We have worked with you in other instances to review notices and other materials going out and hope there will be an opportunity to review these as well. Who is the audience for the webinar?

Jennifer Kent, DHCS: The webinars are open to the public but geared to advocates and stakeholder organizations. The information will be nuts and bolts of how enrollment will work.

Sarah Brooks, DHCS: We are considering having a provider webinar as part of a strategy to reach families.

Jennifer Kent, DHCS: The notices are coming through the AB 1296 stakeholder group.

Stephanie Lee, Neighborhood Legal Services of Los Angeles County: It would seem useful to have counties work with school districts to find families and that will help with establishing a trusted enrollment site.

Kristen Golden Testa, The Children's Partnership/100% Campaign: In addition to review of the notices, will we also be able to review modifications to the application?

Jennifer Kent, DHCS: I don't think there are modifications to the application.

Kristen Golden Testa, The Children's Partnership/100% Campaign: We heard about different verifications being required and I am glad to hear there are none.

Chris Perrone, California HealthCare Foundation: Gene Lewis is looking at this issue of the transition of kids not known to the system. There is a report on this topic due out in November.

CCI/CMC Update

Sarah Brooks/Hannah Katch, DHCS

Presentation slides available at:

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

Sarah Brooks provided an update on the Coordinated Care Initiative. She offered an enrollment update by county (total enrolled 125,000) and opt-out data (46% overall). There is a high opt-out rate in Orange County, the newest county to enroll, and analysis of this is pending. There is a different enrollment process in Orange County for those in skilled nursing facilities and the timeline for this is posted on the website. Details on opt-out data were presented based on various analyses such as IHSS specifics, ethnicity/race break-outs, language and age. There will be additional analysis of providers and evaluation results from SCAN Foundation in the coming months. There is high satisfaction for beneficiaries enrolled in the program, so while there is high opt-out prior to enrollment, beneficiaries have high satisfaction once enrolled. There are some issues around notices and communications reported. A new dashboard of Health Risk Assessments is posted.

Hannah Katch spoke to the Multipurpose Senior Services Program Transition. The date for transition has changed to 2017. Focus groups are occurring to learn about the roll out. She reported on the updated Resource Guide and Choice Book that grew out of stakeholder suggestions. In addition, she reported on work to develop a new beneficiary toolkit, population-specific and provider outreach materials as well as case management tools.

Questions and Comments

Lishaun Francis, CA Medical Association: Can you speak more about the extension for the CCI pilot?

Sarah Brooks, DHCS: California submitted a nonbinding letter of interest to continue CCI.

Mari Cantwell, DHCS: As required by statute, there is an analysis of the demonstration that needs to be completed. This is underway and will be part of the January budget. There is no specific timeline for next steps.

Gary Passmore, CA Congress of Seniors: For the most part, we have moved from passive to active enrollment. Are you rethinking the firewall to allow plans to be involved in enrollment? I think it was a huge mistake of CMS to require this and I think plans could have done a better job of enrollment than having it at the state level. COHSs were allowed to be involved and have markedly better enrollment.

Sarah Brooks, DHCS: Plans can talk with beneficiaries about options under marketing rules. I think you are referring to streamlined enrollment options. We are having conversations with plans about that and will come back to the stakeholder group before moving forward.

Gary Passmore, CA Congress of Seniors: As part of this, are you assessing the efficacy of the HCO role in this process?

Sarah Brooks, DHCS: Yes, we are also looking at how different structures complement each other.

Marilyn Holle, Disability Rights CA: For counties that transition out of MSSP, what will happen to institutional deeming rules? Under MSSP, there is an option to quality under deeming rules. What about using that now as counties transition?

Sarah Brooks, DHCS: We haven't looked at that and can circle back on that.

Rusty Selix, CA Council of Community Mental Health Agencies: CCI includes a behavioral health integration similar to the 1115 waiver. Do we have data on how that is working?

Sarah Brooks, DHCS: There is data being reviewed so we can present it in a standardized manner. There is a dashboard being developed and that will be released soon.

Michael Humphrey, Sonoma County IHSS Public Authority: My understanding is that financial analysis on the continuation of the CCI will come out with Governor's budget?

Mari Cantwell, DHCS: Correct

Michael Humphrey, Sonoma County IHSS Public Authority: I thought there was a large opt out in the Vietnamese population in Orange County. Is part of the reason a lack of plans reaching out to providers serving those populations?

Sarah Brooks, DHCS: This is an excellent question and we have this same question. We are looking to identify specific providers; assess whether there was outreach; what is the feedback from them.

Michael Humphrey, Sonoma County IHSS Public Authority: Since Orange is a COHS county, should there be a lower opt out rate similar to San Mateo? I was surprised by that.

Sarah Brooks, DHCS: Yes, we are as well.

Stephanie Lee, Neighborhood Legal Services of Los Angeles County: Thank you for releasing consumer materials for comment and for incorporating suggestions made to reduce confusion. One key issue is that beneficiaries do have provider loyalty and this is a big reason for opt out. Have plans recruited the providers with these consumers to join their network? Have plans looked at specific chronic conditions to assess whether they have sufficient providers in the area?

Director Kent asked the health plans to comment.

Steve Melody, Anthem Blue Cross/WellPoint: We do look at the specifics including the mix of patients. For us, in LA, we have Care More which is already an integrated system so it is slightly different than in other places.

Bradley Gilbert, IEHP: IEHP has a lower opt-out rate. We did a major expansion of the network and created relationships with IPAs and providers who are Medicare providers and that brought in a large number of primary care providers. The issue we have is that we have providers who do not belong to any organized system of care and have no managed care contracts. There is no interest among this group to join any managed care system. If they have patients, there is not much we can do. It does vary by physician and specific ethnic background. I am struck by the patterns here today and will go back to look at this internally and see if they are willing to join our plan. If they are Medicare fee-for-service only, there is not much we can do.

Sarah Brooks, DHCS: We continue to work on making beneficiaries and providers aware of continuity of care rights. We are drafting a continuity of care document that will go to all providers to educate them. We welcome feedback on this document.

Steve Melody, Anthem Blue Cross/WellPoint: In Santa Clara, the network is customized and aligned with the expectations of the program to avoid situations where a provider participates in Medi-Cal and wouldn't participate in CCI. There are some nuances between the traditional Medi-Cal network and the network we see in CCI.

Gary Passmore, CA Congress of Seniors: The data show a high level of satisfaction for those who have signed up. It is important to understand that the opt-out rates are a missed opportunity for improved care and improved satisfaction.

Bradley Gilbert, IEHP: We did focus groups that indicated people did not understand the benefits of joining – like dental and vision. Now that we have time to explain the full information to the member and make sure their physician is in the network, we are seeing good results. They didn't get this information during passive enrollment - there was a lot to understand.

Brenda Premo, Harris Family Center for Disability and Health Policy: In the 1970's, when Southeast Asian refugees were arriving, we discovered high rates of breast and cervical cancer. Male physicians were not doing screening exams because of cultural values. We worked to expand female practitioners and, although that took 7-8 years, the problem dropped significantly. We haven't talked enough about how to bring in more providers who feel familiar to every population. People want to talk to someone who looks like them and speaks their language.

ACA 2703 Health Homes
Hannah Katch, DHCS

Presentation slides are available at:

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

Hannah Katch provided an update on the Health Homes Program. There has been significant input from stakeholders to develop the State Plan Amendment. DHCS is amending the timeline to submit the State Plan Amendment in January 2016 with implementation to July 2016. There are changes in eligibility criteria also. There are FAQs on the DHCS web site. A request for interest was released to health plans to gauge interest and understand local capacity. DHCS will use this information to determine the initial implementation counties. The State Plan Amendment will follow the outline of a concept paper 3.0 to be released for comment in early December. Requests for applications from plans will be released at the end of December with a deadline of February 5th. Ms. Katch reviewed information for some common questions.

Questions and Comments

Gary Passmore, CA Congress of Seniors: There were problems under CCI with CMS in some counties. Do we need CMS with the same standards as we experienced with CCI? Is this a separate process?

Hannah Katch, DHCS: This is separate process.

Sandra Naylor Goodwin, CA Institute for Behavioral Health: Does the SPA allow a Behavioral Health Home?

Hannah Katch, DHCS: We expect that behavioral health services are provided in the way that works best for beneficiaries. As to a health home located in a behavioral health setting, we have not put out guidelines on that but we are happy to discuss this more.

Steve Melody, Anthem Blue Cross/WellPoint: Can you clarify, does the “all plans must participate and be ready” requirement also apply to GMC?

Hannah Katch, DHCS: Yes, it is a federal requirement.

CCS RSAB Workgroup Update

Anastasia Dodson, DHCS

Presentation slides available at:

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

The CCS Advisory Group meets quarterly. Ms. Dodson reviewed updates. There are six redesign goals and three technical workgroups: 1) care coordination, medical homes and provider access; 2) data and quality measures; and, 3) eligible conditions. At the upcoming Oct. 21st meeting, there will be discussion of LA County’s risk stratification model and transitions for youth. Ms. Dodson reviewed key features of the whole child model.

Questions and Comments

Marilyn Holle, Disability Rights CA: I’m glad to hear you are looking at youth transitions. I hope you look closely at this age group to anticipate problems. This will tell you about changes that need to be made; where are they linked for care; how they are linked to a provider who is

familiar with their disability, as they move into the regular Medi-Cal system and managed care. I hope you will look at the specialty care centers and preserving their role for coordinated care to reduce hospitalizations.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Are you starting to work on contracts with managed care plans?

Jennifer Kent, DHCS: We are not that far yet. We are working on readiness and transition but not drafting contracts.

Michelle Cabrera, Service Employees International Union: There are some parallels between this process and CCI. We expected one thing in Orange County and experienced something different. Is DHCS trying to learn from CCI for CCS? We have heard high levels of satisfaction from families in CCS because of the expertise. They talk about having a partnership. How will you transfer that knowledge and expertise to the plans in the COHS counties as you transition?

Jennifer Kent, DHCS: We will talk about this at the workgroup next week. We don't see it as helpful to have the state dictating a process so each plan is developing an individual process that will work for their plan and counties and will be reporting on this next week.

CalHEERS Update

Jennifer Kent, DHCS

Presentation slides available at: http://www.dhcs.ca.gov/Documents/CalHEERS_Update.pdf

Jennifer Kent provided specifics on the recent and upcoming CalHEERS functional releases. The timing of this release was key to open enrollment for Covered California. The next release is set for February and the April releases will take care of the coverage expansion to all children. Stakeholders tested the recent release through scenarios and provided feedback on any glitches. We have a set of priorities for each release scheduled in advance but sometimes this is revised in an iterative process of discussion with counties and stakeholders.

Questions and Comments

Elizabeth Landsberg, Western Center on Law and Poverty: We appreciate participating in the testing.

Anthony Wright, Health Access California: What was adopted over the weekend is set now through open enrollment?

Jennifer Kent, DHCS: Yes, there were several items critical to open enrollment rolled out.

Review of Medi-Cal Utilization Data on Children

Jim Watkins, DHCS

Presentation slides available at: http://www.dhcs.ca.gov/Documents/Medi-Cal_Utilization_Data_for_Children.pdf

Jim Watkins presented data analysis on children in Medi-Cal. Data sets are drawn from multiple sources to understand what is occurring and make informed decisions. Today's presentation is a panoramic view and includes 2011 data for children 1-18. Newborns are not included in

today's data but are on the website in a birth outcomes report. Mr. Watkins presented enrollment data since 1966, outlining major expansions on a timeline documenting the number of children enrolled at key expansion points. He reviewed the data sets included in the presentation statistics, such as Medi-Cal eligibility and claims/utilization data, Short-Doyle and Mental Health data, Office of Statewide Health Planning and Development (OSHPD), the California Health Information Survey (CHIS) and Agency for Healthcare Research and Quality (AHRQ). The data presented includes children in FFS (17%), FFS and managed care within the same year (19%) and children in managed care for the full year (65%). He reviewed a number of break-downs of beneficiaries such as geographic region, language, ethnicity, spending (\$9.9B total), PMPM costs (average \$240 PMPM) and a range of conditions among the population subcategories. He noted that looking at sub-populations reveals that high costs were associated with Short-Doyle due to mental health conditions. He also reviewed emergency utilization in sub-populations as well as other targeted inquiries among high cost sub-populations.

Questions and Comments

Rusty Selix, CA Council of Community Mental Health Agencies: The adult slides in the last meeting was familiar information. Yet this data shows similar trends among children which we did not expect. This is earth-shattering data for children's mental health providers that they have other high cost medical conditions. This will cause a revolution among mental health providers. We need to know more about this data and will want to follow up with you on the data to understand how the high costs correlate. In the past, a children's behavioral health home had not been a priority but may be much more important than we thought and there may be other things we should do.

Jim Watkins, DHCS: Yes, we are finding that there are a number of co-occurring disorders among children as we see with adults. We are working on new analyses related to mental health.

Kim Lewis, National Health Law Program: Is the data you are looking at overall in mental health on adults; specific to children? Does it include inpatient?

Jim Watkins, DHCS: It is both adults and children. We started with adults and noticed the data on children so we are drilling down on children now in addition. Yes, inpatient is in here.

Jim Watkins, DHCS: If you have an interest in a particular condition, please let us know. We would like input on mental health definitions and other issues in understanding the data.

Rusty Selix, CA Council of Community Mental Health Agencies: There are reporters looking for information on this data because they have noted the inpatient data is increasing. Why is it going up, no one seems to know?

Jim Watkins, DHCS: We have 7 years of longitudinal foster youth and some other high need populations to understand the inpatient issue.

Kim Lewis, National Health Law Program: On the Short-Doyle, does it include all services? Is EPSDT included?

Jim Watkins, DHCS: Most are included – it is about a \$1 billion spend. We can break out the services in different ways. For some, like foster youth, the Short-Doyle spending is higher than physical health spending.

Sarah DeGuia, CPEHN: Thank you for this level of information. Some things that stood out: a number of the costly conditions are preventable, such as asthma, injuries. How can we look at the environmental conditions and other services to reduce the incidence?

Anne Donnelly, Project Inform: Are there plans to look at substance use disorder treatment data?

Jim Watkins, DHCS: We are looking at that. As you know, this drives inpatient data and high costs. Along with mental illness, we see injuries that are preventable for adults and children that end up in emergency visits.

Anthony Wright, Health Access California: Great information. Is there analysis of the recent spike that separates the Healthy Families vs the ACA changes?

Jim Watkins, DHCS: We are putting that together now. During the ACA, 239,000 children came on coverage. We can drill down to see specifics within that number – were they on the program 6 months ago; were the parents on the program; were they on at a prior time, etc.

Anthony Wright, Health Access California: I am curious about the denominator for undocumented children. Since they only have coverage for emergency services, we would expect higher costs but we saw low costs?

Jim Watkins, DHCS: The per-member-per-month for undocumented children is only \$31 per member per month because the episode is spread over the study period. We take the aggregate cost spread over the study period. The cost per user would be a different metric and we would see higher cost. Relative to other sub-groups, they have lower costs, better birth outcomes, etc.

Anthony Wright, Health Access California: The comparison is not apples to apples because they may have health needs and services that is a churn effect where we don't see ongoing costs because they were not on coverage.

Jim Watkins, DHCS: Some sub-groups have limited scope services like undocumented. Even if you risk-adjust, they are still lower costs.

Jennifer Kent, DHCS: They are in fee-for-service for a high cost event but there is no capitation payment ongoing. That may explain the lower cost.

Anthony Wright, Health Access California: It is important as we have conversations about access to have this understanding that consumers are in partial managed care and to see the depiction of how fee-for-service and managed care interplay. There is remainder fee-for-service in every part of the program. Is there data to tie to this interplay?

Jim Watkins, DHCS: That is a complex evaluation. If we move a population into managed care, costs may go up. It is also difficult because some of the numbers are quite small.

Brenda Premo, Harris Family Center for Disability and Health Policy: Thank you for the interesting data. I am pleased to hear you want to work with people with multiple disabilities. At a recent training, some providers thought dual diagnosis was alcohol and drug use. I mentioned that a blind person could have Alzheimer's, etc. The treatment for many disabilities is not there. The training is not there, to learn about how to ensure access in unique situations. As we explore this, there are unique aspects to the care in crossover situations.

Kim Lewis, National Health Law Program: It is interesting to note that the complexity in the fee for service and managed care and whether you can actually do cost/benefit if bringing them into managed care

Jim Watkins, DHCS: Even with a mandatory managed care population, at any point there are 13-18% in FFS. There is never 100% managed care – at least yet.

Sarah DeGuia, CPEHN: How is this informing future efforts?

Jennifer Kent, DHCS: In particular for the high cost utilization, the data has prompted discussion of the mental health issues and how to target the right individuals. It depends on the specific discussion but it is informing policy to refine or confirm decisions.

Jim Watkins, DHCS: In looking at emergency medical transport, we see sub-populations on the mental health side that can drive 2/3 of costs. Sometimes without the data, you can't see the magnitude.

Michelle Cabrera, Service Employees International Union: Is this data being used to drive policy making on the social services side, within foster youth?

Jennifer Kent, DHCS: We are starting those conversations with DSS especially with signing of 403. It has been part of discussions in data sharing agreements. I can't say the exact data set here has been the reason for discussions but it is informing existing discussions.

Kristen Golden Testa, The Children's Partnership/100% Campaign: On the comments about emergency department rates being higher in some geographies, do you think it is about health conditions, provider availability?

Jim Watkins, DHCS: It could be all of those. We have not done analysis to see which particular factor is the key driver.

Kim Lewis, National Health Law Program: Have you looked at dental data for kids?

Jim Watkins, DHCS: Dental data is included.

Jennifer Kent, DHCS: We released dental data last week that is not through Jim's division but on dental caries and other issues.

Public Comment

Kathy Arbanasin, consumer: I am a Medicaid patient. I have attended these meetings on and off since 2011. I have been on Medicaid as the result of late diagnosis of a rare cancer. I appreciated the care. Access to care is something I value very much. When I came to the first of these meetings, I learned about Medi-Cal managed care. Managed care is not the best solution

for every patient. We need a system where there is an option for not every patient to be in managed care. I think it would be good to have more of a patient voice. Everything is being said for patients; decided for patients. I appreciated what Sarah Brooks presented that when she saw people were not enrolling in care, she went out to find out why. My mother died last year and I was her caregiver. She had a PPO insurance plan and she couldn't get the care she needed. She felt providers were making decisions about her body without her involvement. This may be part of why people don't want to be in managed care. They want to go to the place where they feel they can get help. I was recently at Health Care 2.0 and they talked about the preventative things we can do in our lifestyle to remain healthy and that stress is a big factor. It is very stressful when it is a hard process to get the care you need. I think the idea that there may be help with housing is good to hear. I like the idea of block grants that was suggested but the county I live in uses it for sidewalks, not to really help people have independent lives.

Jena Jensen, CHOC Children's Hospital: I just want to share some information on children's mental health since there was a conversation on this topic. CHOC just launched a program for children with co-occurring complex/chronic physical and mental health conditions. These kids have 3-5 times higher occurrence of mental health conditions – those with epilepsy, diabetes are at high risk for anxiety and depression. We have a 3 year grant from the Mental Health Services Act to do something about this. Also, children with eating disorders is on the rise. We saw a threefold increase in medical rescues that we thought was a blip but it has continued. When we speak about hospitalizations for children, eating disorders is something we should pay careful attention to.

Next Steps and Next Meetings

Slides for this item are available at: http://www.dhcs.ca.gov/Documents/SAC_2016.pdf

Jennifer Kent spoke to the group about continuing the stakeholder advisory committee for another year. We have requests from several people that want to be added to the group although we are trying to keep the group as small as we can to allow for participation. We are looking for a broad range of perspectives and active participation.

Chris Perrone, California HealthCare Foundation: The presentation of data is new and clearly enjoyed by the group. I want to encourage more of this. Thank you for working on the legal barriers to sharing the data and making it possible to have these data presentations.

Jennifer Kent, DHCS: We do plan to keep Jim coming back and appreciate his work.

Herrmann Spetzler, Open Door Health Centers: This was an excellent meeting. I would like to have a discussion of rural emergency rooms to explain the data. Can we move to use technology where we can see each other for these meetings rather than be on the phone?

Jennifer Kent, DHCS: that is an excellent suggestion. I will follow up offline on the ER data as well.

Next meeting dates: February 25, 2016
May 16, 2016
August 11, 2016
October 24, 2016