

**SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER  
STAKEHOLDER ADVISORY COMMITTEE (SAC)**

**Meeting #11 – Monday, April 23, 2012**

**10:00am – 3:30pm**

The meeting was convened at 10:00 AM.

**Attendance**

Members attending:

Bill Barcelona, California Association of Physician Groups; Kelly Brooks, California State Association of Counties; Anne Donnelly, Project Inform; Bob Freeman, CenCal Health; Kristen Golden Testa, The Children's Partnership/100% Campaign; James Gomez, California Association of Health Facilities; Sandra Goodwin, California Institute for Mental Health; Michael Humphrey, Sonoma County IHSS Public Authority; Mitch Katz, MD, LA County Department of Health Services; Lee Kemper, County Medical Services Program; Ingrid Lamirault, Alameda Alliance for Health; Elizabeth Landsberg, Western Center on Law & Poverty; Marty Lynch, LifeLong Medical Care; Anne McLeod, California Hospital Association; Steve Melody, Anthem Blue Cross/WellPoint; Katie Murphy, Neighborhood Legal Services- Los Angeles; Sara Nichols, Service Employees International Union; Brenda Premo, Center for Disability Issues and the Health Professions; Judith Reigel, County Health Executives Association of California; Rusty Selix, California Council of Community Mental Health Agencies; Cathy Senderling, County Welfare Directors Association; Suzie Shupe, California Coverage & Health Initiatives; Stuart Siegel, MD, Children's Hospital Los Angeles; Marvin Southard, LA County Department of Mental Health; Melissa Stafford Jones, California Association of Public Hospitals; Richard Thomason, Blue Shield of California Foundation; Anthony Wright, Health Access; Ellen Wu, California Pan-Ethnic Health Network  
Casey Young, AARP California

Members attending on phone:

Marilyn Holle, Disability Rights California

Teresa Favuzzi, California Foundation for Independent Living Centers

Members not attending: Al Senella, California Association of Alcohol and Drug Program; Executives/Tarzana Treatment Center; Herrmann Spetzler, Open Door Health Centers  
Richard Thorp, California Medical Association

State Staff: Toby Douglas, Director, DHCS; Jane Ogle, DHCS; Len Finocchio, DHCS; Luis Rico, DHCS; Brian Hansen, DHCS; Jalyne Callori, DHCS; Bob Diamond CCS

Peter Lee, Executive Director, California Health Benefit Exchange attended as a guest; 34 members of the public attended the meeting.

The meeting was called to order at 10:00 am.

Welcome, Introductions and Purpose of Stakeholder Advisory Committee (SAC)  
*Toby Douglas, Director, DHCS*

*Toby Douglas* welcomed everyone and thanked Blue Shield of California Foundation for their support of the continuation of the Stakeholder Advisory Committee (SAC) He reviewed the purpose of the SAC in this continuation phase, reporting that the SAC is to consider both the experience under the waiver as well as related efforts to implement the Affordable Care Act (ACA) such as better organized systems of care for dual eligible populations, childless adults, behavioral health and working with the California Health Benefit Exchange. This is a more holistic purview than the original SAC purpose which focused on the waiver only. This purpose created a need for changes to membership of the SAC and he offered thanks to members who have completed their service and welcomed new members to the newly configured SAC. New members include Anne Donnelly, Bob Freeman, Casey Young, Cathy Senderling, Ellen Wu, Jim Gomez, Katie Murphy, Kristen Golden Testa, Lee Kemper, Mitch Katz, Sara Nichols, and Suzie Shupe. There will be three meetings of the SAC in 2012, today, July 23 and November 19. He then reviewed the agenda and mentioned that Public Comment would be at the end of the agenda.

SAC members and DHCS staff introduced themselves, including two SAC members attending by phone.

#### **UPDATE OF KEY COMPONENTS OF THE WAIVER**

Douglas introduced Dr Bob Diamond to provide an update on CCS pilots. This presentation is available as a powerpoint at:

<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

*SAC Member:* What is the timeline for implementation?

*Diamond and Douglas:* The Medi-Cal Managed Care pilot is implementing first, probably the PCCM in Alameda will be second, and it is unknown what model will implement next.

*Marilyn Holle, Disability Rights California:* is there is a plan to expand specialty care centers, such as some of the genetic disability areas?

Diamond said this not part of the 1115 waiver. Expansion is something that we would do outside of the waiver process.

*Katie Murphy, Neighborhood Legal Services:* What is the plan for ramping up Health Care Options?

*Diamond and Douglas:* San Mateo is the first plan to implement and as a COHS, the CCS children are already enrolled in the plan. Family engagement is a key piece but The next model, Alameda PCCM, will be run by County CCS and will not use the

MediCal HCO broker. *Luis Rico* added that the HCO will not be used for the CCS project. Enrollment will continue to be done by local CCS Program. .

*Katie Murphy Neighborhood Legal Services*: Nevertheless, it will be important for the HCO to be kept up-to-date because of later transition issues and questions from beneficiaries..

Toby Douglas introduced Jalyne Callori to provide an update on LIHP implementation. Her presentation is available at:

<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

*Anne McLeod, CHA*: Remind us what was anticipated enrollment?

*Callori* said about 500,000 by 2014 so we are currently at higher level for where we expected since we are in early stage.

*Marilyn Holle, Disability Rights California*: What is break-out of enrollment levels for counties covering 100% vs 133%?

*Callori*: We don't have this information here today but I can get you the information.

*Mitch Katz, LA County*: commented that he knew the counties have appreciated the work on HIV waiver. This issue was unexpected for all concerned and consumed a lot of time. You mentioned that CMS has approved in concept, how do you see this playing out.

*Callori*: DHCS will submit an expanded proposal to CMS to show how the pilots are transformational CMS will then form a federal workgroup to include CMS and HRSA that will work with a state workgroup, including State Office of AIDS, DHCS and other stakeholders to develop metrics associated with the projects. Once the metrics are approved, we will get the official approval by CMS and we will circulate out to counties so that they can develop the projects. CMS is working cooperatively with us, but this is not approved yet.

*Mitch Katz, LA County*: asked about whether jail population can be covered in LIHP for overnight hospital stay; whether it is limited to overnight stays? Would chronic medications be covered? Would an outpatient CT scan or other complex diagnostics be covered?

*Callori*: State and County inmates are eligible for LIHP for inpatient stay and only if it is for an overnight stay. CMS approval requires they are "outside walls of jail facility". Diagnostic-only would not be covered. We have developed a policy letter and it is being reviewed internally. We will convene a stakeholder call with counties to go over the letter once review is complete.

*Marilyn Holle, Disability Rights California*: asked about residents of IMDs – are they covered?

*Callori and Douglas*: No, it is not allowed in the waiver. We are working with Contra Costa and Sacramento on a demonstration pilot under ACA for stabilization of IMD that would result in this population being covered.

*Mitch Katz, LA County:* I thought that complex procedures for IMD's, like an angioplasty would be covered.

*Douglas:* No, this is not reimbursable. It is a longstanding policy from CMS that IMD is not covered for this type of procedure.

*Anthony Wright, Health Access:* asked about the data presented. The data was for legacy counties only. Are there any trends with newer counties that reflect different demographics in terms of age and gender? Are there themes for counties slower to implement that they have raised?

*Callori:* Some counties have had difficulty contracting with providers for a network and negotiating terms. This is first time entering into this type of provider and other contracts for some counties. Previously they may have had only informal arrangements for county indigent patients.

*Douglas* asked Lee Kemper about demographics in CMSP counties. Lee commented that they accomplished enrollment through auto conversion so most of previously enrolled consumers are transitioned. They are primarily white, English speaking with some Latino. He expects this to be consistent in the LIHP going forward. Age is evenly distributed with one third each older, middle age and younger age. Caseload has been relatively flat since CMSP went live with the waiver program

*Anthony Wright, Health Access:* If the Supreme Court strikes down parts or all of ACA, how does this impact the LIHP? Would it go away immediately? It is a waiver but authorized by the ACA.

*Douglas:* The way the waiver is constructed, this is a Medicaid expansion that is allowed as a state option pre-2014. It is unknown exactly how the court ruling will impact the LIHP.

*Rusty Selix, Council of Community Mental Health Agencies:* is there any data on specific populations enrolled such as prison, homeless, emergency department or others with high mental health needs?

*Callori* responded that DHCS will track inpatient and some of those mentioned, such as Emergency Department services, but not the other populations mentioned.

*Anne Donnelly from Project Inform:* offered thanks for all the work on HIV waiver and the collaboration between DHCS and DPH. We are still concerned about the individuals transition of people with HIV moving into LIHP. We don't think the grace period is long enough to ensure that individuals get into care and get medications. We think the timeline needs to be longer to move into LIHP. A suggestion is that counties arrange for transitional pharmacy pick-up for one month before going to full LIHP practices for pharmacy.

*Lee Kemper, CMSP:* commented on the Supreme Court ruling impact on the waiver to encourage DHCS to do worst-case scenario analysis to determine what happens if waiver is tossed based on ruling. CMSP is currently serving many times the number of

beneficiaries with the waiver than we would have funding to serve without the waiver. Waiver programs that are up and running need a heads up about consequences.

*Marv Southard, LA County:* commented that he wanted to encourage planning on the assumption that all goes well for ACA implementation under the court ruling. He wants to begin planning efforts for substance abuse benefits under ACA. To make the program work from a cost and clinical perspective, the substance abuse benefits need to be considered in an integrated way. For a number of reasons, this has not been looked at systemically.

*Douglas and Hansen:* responded that the behavioral health assessment in the waiver was completed in March and a plan is due in October to CMS. The assessment looked at capacity of the system, benefits, best practices, integration efforts and outreach and enrollment. The plan itself includes models California may want to use for behavioral health integration, benefits under benchmark plans and also best practices on workforce and integration issues. We hope to have time for feedback prior to submission of the plan to CMS. DHCS will really need feedback, especially from the Counties, on the benefit package as it relates to the expansion population and how the benefit package in the plan lines up to the existing benefit package for mental health. Should there be Differences? What makes the most sense cost-wise and care-wise.

*Lee Kemper, CMSP:* asked is there any distinction between categorically linked Medi-Cal eligible and MAGI eligible for behavioral health benefits?

*Douglas, DHCS:* responded that the new federal Medicaid rules will mean that a determination will occur first under MAGI. There will be four different categories (parent/caretaker, children, childless adults, and disabled populations). Unless someone wants to be determined as disabled, they will come in under MAGI. The new benefit package will be primarily for childless adult population. If we choose as a state, the childless adult population will receive a different benefit package from those eligible as disabled populations. .

*Elizabeth Landsberg, Western Center:* commented that, we shouldn't rule out that we can use the same benefit package for both MAGI and nonMAGI groups. We shouldn't rule out a full scope benefit package for both. There is a lot to sort out on benefits.

*Douglas:* Right, no decisions have been made.

*Katie Murphy, Neighborhood Legal Services:* commented that she encourages a focus on the transition plan on the laboratory aspect of the current LIHP endeavor and learn about how counties have experienced challenges? We need to draw out the lessons so that we know the issues for ACA implementation. By looking at what LIHP's are struggling with, we can learn about what the transition to Medi-Cal in 2014. July may be too soon to know these lessons but I encourage that we gather information as far as possible.

*Douglas:* It makes a lot of sense to incorporate lessons learned.

*Anne Donnelly, Project Inform:* commented that this approach is also useful for transition in the Health Benefit Exchange for persons with HIV.

*Toby Douglas* introduced Jane Ogle, DHCS to provide an update on the transition of Seniors and Persons with Disabilities into managed care. Slides from this presentation are available at:

<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

*Anne McLeod, California Hospital Association:* What was the expected number of enrollees – 400,000? How are we doing with savings in waiver? What are implications of not meeting savings in budget neutrality?

*Douglas:* We are working with CMS to make some changes in how we categorize numbers but we still have room within budget neutrality. There are savings based on what we are seeing in the waiver over would have been expected.

*Marty Lynch CPCA/Lifelong:* Was there a strategy outside of telephone to reach hard to reach populations and get their feedback e.g. homeless, supportive housing?

*Ogle:* No, the survey was intended to be quick and easy to understand the issues.

*Rusty Selix, California Council of Community Mental Health:* On the problem of pharmacy refills, my organization has heard concerns about problems with extra cost and hoops to work through the plans is causing difficulty in keeping patients on some mental health medications. Can you survey County Mental Health Programs to better document what the concerns are? As a second point, I want to emphasize that there are major opportunities to document improvements in physical health for those with mental health problems now that they will have a medical home.

*Jim Gomez, California Association of Health Facilities:* When will the study being funded by California HealthCare Foundation be finished?

*Ogle and Douglas:* UCB doing the study. It will be complete in Fall 2012 and it will help inform future transitions with dual eligibles and Medi-Cal expansion in 2014 with lessons learned.

*Casey Young, AARP:* I am concerned about the wording on the work with providers and beneficiaries. The issue is beyond education - it will require one on one work and counseling – especially with the dual eligibles. The issues can't be solved with more written materials.

*Ogle:* Yes, there will be multiple ways of informing dual eligible beneficiaries, such as using HICAP and other trusted advisors.

*Steve Melody, Anthem:* It is great you are using a lessons learned approach. In terms of the telephone survey: Were you able to see county level data? Any differences between voluntary enrollees vs transitioned enrollees?

*Ogle:* I will see if we can get this data.

*Katie Murphy, Neighborhood Legal Services:* We would like to see some investigation of what is happening for those who are struggling – even if it is a small number. We are glad that 87% are ok but what are the issues for those who have problems. There are a

number of topics we need more information about: Do you have information about how MER requests can trigger a continuity of care request with plan? How many days did people go without care? We need more information about navigation problems and navigation systems that are needed.

*Ogle and Douglas:* I don't have information about the MER and Continuity of Care issue. DHCS will let the health plans know about the individuals who have filed a MER and ask that they can provide information back to DHCS.

*Elizabeth Landsberg, Western Center:* Can you offer an update on the MER backlog?  
*Ogle:* There are about 1,500 pending MERs.

*Elizabeth Landsberg, Western Center Law and Poverty:* We are concerned about the assertion that DHCS is making clinical decision and interpretation that is overriding the physician recommendation who we think knows the patient best.

*Anne McLeod, California Hospital Association:* Can you clarify the denials of MERs and Continuity of Care request loop?

*Ogle:* Two denial groups exist: One group is denied clinically by a physician at DHCS. The second group has insufficient information. DHCS sends the request back to the applicant to ask for more information and if they don't respond, the MER is then denied. An MER is approved when the clinical judgment is that the individual will be at risk by transitioning care.

*Ogle:* To explain Continuity of Care: this pertains to a patient inside the managed care plan. Continuity Of Care is triggered when patient says they want to stay with provider who is not contracted to the plan and the plan contracts with the provider for out of network services. For out of network providers, especially primary care providers, we are telling the plans that they should continue to pay the provider for one year.

Medical Exemption Request: keeps the person out of managed care. The MER is approved when clinical judgement is that someone would at risk medically if they are transitioned into the managed care plan. There are links to information about these topics on the DHCS website.

*Katie Murphy, Neighborhood Legal Services:* The plan must contract under Continuity Of Care if patient requests and the provider is willing. We want DHCS to go further so that the MER requests go to the managed care plan – not just as fyi – but to trigger a continuity of care request.

*Douglas:* The plans often say providers don't want to contract. How will sending the MER requests help?

*Katie Murphy, Neighborhood Legal Services:* This would not be asking them to join the plan, just to contract for one patient.

*Ingrid Lamirault, Alameda Alliance for Health:* We need to frame this discussion of SPDs as "continuous improvement". Patients who need high touch navigation now probably needed it in Fee For Service and were even less likely to get that in FFS.

*Ogle:* Yes, but they were free to choose and change in FFS.

*Marilyn Holle, Disability Rights California:* In Continuity Of Care, how does the health plan get information on existing TARs? The plans don't seem to have access to TARs to know about previously approved medications and other services. Patients are having to start over with approvals they already have.

*Douglas:* We give member specific data to plans. In terms of prescriptions, this was a major area of concern noted in the telephone survey. You are suggesting that Medi-Cal should hand over information on existing TARs?

*Marilyn Holle, Disability Rights California:* Yes, it is a quality issue. It causes risk to have the patient not getting the right medication for very serious illnesses.

*Douglas:* Good feedback. I want to take this offline to get into the details.

*Mitch Katz, LA County:* A big issue in Los Angeles relates to the big number of auto assignments into the county provider under LA Care. After auto assignment, beneficiaries realize they need to choose and they finally make a choice that is out of the network. Makes everyone unhappy – beneficiaries were happy and have been changed; and we become a claims processor for people who don't want to be with us. Opting in and out causes administrative burden. I don't have the answer to this issue but I wanted to raise it. A second issue is that we want people to see providers they like, but what if a specific provider doesn't have good outcomes? I don't have the answer – what is the responsibility of the plan to be inclusive of providers who don't have highest quality? This will be a big issue with dual eligibles.

*Douglas:* Yes, the choice rate has only been at 30% and we need to do a better job informing beneficiaries so they choose positively. There is a tension in maintaining choice and achieving outcomes.

*Brenda Premo, Harris Center for Disability Issues:* My role is to remind everyone that access issues are biggest for those least likely to participate in a phone survey – those who can't see, can't hear, those who are homeless, etc. First, the people who would be most likely to have difficulty with access are the least likely to be able to participate in the phone survey. A second issue I want to raise is, How is the HCO broker doing on issues related to disabilities? There has been a blatant disregard for those with disabilities. Alternative formats must be in place or DHCS should use a different vendor for the dual eligibles.

*Ogle:* We are pursuing the issue of the alternative formats.

*Anne Donnelly, Project Inform:* I am pushing on systemic issues because the level of questions among the experts here is illustrative of the confusion. With patients, the burden is so much more. I want to emphasize, that, within the HIV community, we don't understand the criteria or the protocol for MER. In one example, a physician agreed to care for one of five patients in his practice because he felt that one patient was the most complex. This patient's MER was denied. Another patient who the physician did not believe was as complex was approved. This is why the MER protocol should be disseminated, so we can understand when patients' qualify. Also, can we look into the 7,500 requests with insufficient information to see what is actually going on with those?

*Mike Humphrey, Sonoma County Public Authority:* How much time will it now take to get through the 1,500 MERs backlog?

*Ogle and Douglas:* I don't have the timeline. Those who complete a MER are staying in FFS for now.

*Katie Murphy, Neighborhood Legal Services:* I am glad that is the policy but there is a problem. HCO is saying FFS is not available. There is patchy implementation.

*Mike Humphrey, Sonoma County Public Authority:* Back to the point about TARs that are approved in FFS before moving to managed care, I am concerned about this information not moving to the health plan. This should be rectified quickly.

*Jim Gomez, California Association of Health Facilities:* We need performance criteria to hold people accountable - both DHCS and HCO broker for how the MER process will work. Is the timeline for the MER process two weeks, 30 days? As we move to larger populations, it will be critical to have criteria for performance and hold DHCS and contractors accountable.

*Stuart Siegel, LA Children's Hospital:* Patients in Genetically Handicapped Persons Program (GHPP) discovered that MERs requests to stay in the Centers of Excellence were denied. But there is no one else who can do primary care for this population with quality. This relates to patients with Sickle Cell disease and other complex diseases. Medical exemption must be an option because managed care is not an option unless services and providers are connected to a Center of Excellence. We may be able to improve care if we include Centers of Excellence, but this was not arranged ahead of time. There is also an opportunity to find those in FFS using the Emergency Room and move them into managed care to improve their outcomes.

*Douglas:* Why are these providers not being included?

*Siegle:* It was not done proactively but it can be fixed.

*Mitch Katz, LA County:* This is controversial, but my goal is that there are no TARs, no MERs. We should work to get advocates and providers to agree on reasonable objective criteria so that individual doctors and nurses are not making decisions for the TAR or MER on a case by case basis.

*Marilyn Holle, Disability Rights California:* Speaking to issue of the Specialty Care Centers, treating physicians in the community may not understand the issues with low incidence, complex issues that need to be handled in the Specialty Care Centers by physicians who are involved in and up to date on current recommendations.

*Douglas:* The Specialty Care Centers' value is not up for debate. The difficulty is getting them into the managed care system. As a Department, we have many more MER's than expected. We are working to address the MER process and to deal with COC.

*Anne Donnelly, Project Inform:* commented that the issue of clinical judgment in the MER request is important.

Update on Dual Eligibles Pilot Demonstration Projects  
*Jane Ogle, Deputy Director for Health Care Delivery Systems, DHCS*

The presentation is available at  
<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

*Anne McLeod, California Hospital Association:* California has some ACOs that have been approved and they overlap with the dual demonstration sites. What will happen – are they not excluded?

*Ogle:* It would be up to the individual dual eligible beneficiary to opt out if they are in an ACO.

*Anne Donnelly, Project Inform:* We don't agree with passive enrollment. The AIDS Healthcare Foundation is exempted from passive enrollment. There are many beneficiaries with HIV/AIDS who are anticipated to be enrolled, what would be the distinction between who is enrolled and who is exempted.

*Ogle and Douglas:* Two provider groups were exempted; PACE and AIDS Healthcare Foundation. Most of HIV services that are medical are MediCare and they will continue to receive these services. The plans will be required for six months to provide continuity of care if they are passively enrolled.

*Anne Donnelly, Project Inform:* A second concern is MediCal AIDS Health Home Waiver needs to be carved out of requirement for managed care. It should be a demonstration

*Douglas:* The CMS dual eligibles demonstration is about integrating all care. We can carve out populations not services. All services must be included. We can talk offline about this because it is complicated.

*Marty Lynch, CPCA, Lifelong:* Advocates are confused about what can be done under Medi-Cal vs Medicare in the pilots and it is a reminder about how difficult it is going to be to get this right with beneficiaries. What about ability of plans to continue dental as part of the pilot? With savings, do you have any idea of whether plans will continue to offer this service?

*Ogle:* We will put in the proposal to CMS that dental and vision services is a requirement.

*Marty Lynch, CPCA, Lifelong:* What is the timeline of ruling about the carved out Mental Health/Behavioral Health being incorporated?

*Douglas:* We want to talk this through with our partners given realignment. We are looking at different models: e.g. County might fully integrate; might create a performance pool between the county and plan; there can be different approaches to coordinate and align incentives to get to cost savings.

*Marty Lynch, CPCA, Lifelong:* Is there a plan to fully integrate?

*Douglas:* No.

*Jim Gomez, California Association Health Facilities:* There are issues of patient protection and provider protection that weren't resolved in California's initial legislation. Do you expect to revise trailer budget language?

*Douglas:* DHCS is seeking input to the trailer bill language. We are reviewing and will make changes before the May revise. We have received comments from many of you. We have not received overall comments from others and welcome feedback on language on beneficiary and provider protections.

*Jim Gomez, California Association Health Facilities:* What happens with the managed care provider tax?

*Douglas:* Projections do show increased revenue that will result in increased taxes and they will go to the General Fund. This is preventing other reductions elsewhere.

*Jim Gomez, California Association Health Facilities:* It is a concern to move 400,000 dual eligibles in Los Angeles all at once and then to think of moving dual eligibles in six more counties continues to feel too fast. Other states are pushing to later timelines. Will California consider going slower?

*Casey Young, AARP:* I second the last comment about Los Angeles. What is the timeline for getting standards about network adequacy out to plans?

*Ogle and Douglas:* This will happen over the next 2 months. The workgroup will review, then one month later we will finalize. Over the first year, there will be no changes with IHSS. Nursing facilities are not expected to be excluded from the provider network.

The group adjourned briefly for lunch and reconvened at 1 pm.

Moving from the waiver to other topics in health care reform, Toby Douglas introduced the next session: Presentation on Eligibility Expansion and Enrollment: AB 1296

*Len Finocchio, Associate Director, DHCS*

*Elizabeth Landsberg, Western Center on Law and Poverty*

The presentation slides are available at

<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

The following link offers additional information

<http://www.dhcs.ca.gov/Pages/AB1296EligibilityExpansion.aspx>.

*Cathy Senderling, CWDA:* The process for implementing AB1296 has really worked. SEIU and CWDA attended with "on the ground" eligibility workers so the workgroup could hear how the system really works. The sessions are very useful and I encourage others to participate. If you can't come to the whole day, you can give comments to Elizabeth or me to give input.

*Suzie Shupe, CCHI:* How will the work this group is doing will be incorporated into the CalHEERS system with the vendor.

*Landsberg and Finocchio:* Exchange staff has been involved. Once the CalHEERS vendor is announced we hope that they will attend the AB1296 meetings.

*Douglas:* AB1296 is a huge change in the way eligibility is done by simplifying systems and process. It will impact transitions and continuity of care if we don't get this right.

*Kristen Golden Testa, The Children's Partnership/100% Campaign:* AT the first 1296 workgroup, we discussed that the benefit package will have a big impact on the enrollment system. I am not clear what the process is for working on the cost analysis.  
*Finocchio and Landsberg:* It will probably come farther down the road. Manatt is going to help with the cost analysis. Another issue in this category is horizontal integration for how we use health information or connect them to other public programs.

*Katie Murphy, Neighborhood Legal Services:* To go back to the doomsday scenario of the ACA Supreme Court ruling. How do you take the essence of this great work and makes sure we take it into a California plan if ACA goes down.

*Finocchio:* If the ACA is reversed, there is great work that can be incorporated into policy bills. What exactly can be accomplished, I don't know but there is interest and motivation so to continue. On the issue of LIHP transition, it is likely we will have a second AB1296 eligibility meeting and that might be the best place to have the conversation about how to do an eligibility transfer from LIHP to Medi-Cal or the Exchange.

*Lee Kemper, CMSP:* Question about timing, process and products that will move from the workgroup to DHCS. DHCS will put together an implementation plan for changes to the automated welfare system? When will they go live?

*Finocchio:* The changes will go into legislation this session to articulate changes in the eligibility rules. In the fall, the changes to the respective rules engine would be developed. So, the timeline is Fall 2012 – June 2013 timeline to be completed.

**Members moved to Focused Feedback Session small group discussions. Notes are included at the end of the document.**

The group reconvened at 2:50.

### **Health Benefit Exchange and DHCS Working Together**

*Toby Douglas* introduced the Peter Lee, Executive Director, Health Benefit Exchange and commented on the close coordination between DHCS and the Health Benefit Exchange already occurring on many issues.

*Peter Lee, Executive Director, California Health Benefit Exchange* The ACA is not only about expanding coverage, but also about changing the whole dynamic of health insurance in America. It is not about risk avoidance any more but about high quality care. DHCS and the Exchange have been and will continue to work closely together. They have looked at issues together, commented together to the CMS, are looking jointly at the CALHEERS system and making efforts to align enrollment, making it

consumer friendly and seamless, focusing on continuity of care and provider networks being aligned as much as possible. The system should be one touch and no wrong door. We are looking jointly at how to best accomplish outreach between MRMIB, DHCS and the Exchange. We are working informally on issues including plan selection, how to deal with differences in payment rates.

*Kristen Golden Testa, The Children's Partnership, 100% Campaign* : Thanks for working closely together. It seems there is a fundamental difference in payment rates: Medi-Cal is a matching program with the federal government and Exchange subsidies are not and that will have an impact on decision-making. Have you made a decision on how you will work this out? It is difficult when decisions and rules are made from separate entities. We want this to be as smooth as possible.

*Lee*: We want to maximize resources and authority given to each of us. We want to be clear about where we draw the lines through an interagency agreement.

*Marv Southard, LA County*: What about substance abuse and mental health parity issues?

*Lee*: We in California will define (likely in the Legislature) how to handle this in the future. This is an issue for the whole system, not just for the Exchange. How do we make sure that parity rises to the level of standards.

*Anthony Wright, Health Access*: How will the Exchange supervise multiple consultants?

*Lee*: Let's not overstate the role of the consultants. There is a huge amount of input from stakeholders and others. Consultants are staff support but no consultants are making recommendations. They are developing options for the staff and Exchange Board to consider.

*Katie Murphy, Neighborhood Legal Services*: There are many moving parts for consumers, especially dual eligibles. Can you speak to the role of navigators? What is the best way to structure navigators with so much complexity?

*Lee*: There will be discussion about navigators at the June 12 meeting of the Exchange Board. We have lots of input and we are sorting through that now.

*Jim Gomez, California Association of Health Facilities*: What happens in California if the Supreme Court rules to reverse ACA. What is Exchange assuming for rate increases? Managed care premium rates are currently increasing 8-10% What are you seeing in the future for rate increases?

*Lee*: It seems unlikely that the Supreme Court will rule for full reversal, but regardless of the Supreme Court, the Exchange is moving full steam ahead. Financial resources are necessary but the expansion of Medicaid is not being seriously questioned. We are looking at changing the entire underlying care delivery system. On the issue of cost and rates, we are spending time talking about this with the health plans. In the end, we need to have delivery system reform. The Exchange is looking at how do we build an element of delivery system reform to encourage cost control and quality.

*Douglas*: As the Secretary of HHS recently noted, we will need to move ahead with what we can implement in the ACA. To rate increases, adding two million lives to Medi-

Cal is going to have potential implication on rates. We have to figure out how to expand access, make the system efficient and get costs under control. We hope our Medi-Cal rates increases of only 3-4% continue.

*Marty Lynch, CPCA/LifeLong:* Clinics do a good job of quality care but we are worried about clients moving away from traditional providers through the Exchange only to move back to them when their income drops and they are back on Medi-Cal. What about the difficulty of continuity of care as people go back and forth between Medi-Cal and the Exchange.

*Lee:* The Exchange wants consumer driven continuity of care but is still working out how to make that happen. Allowing consumers to understand that if you have a medical home and you want to maintain that relationship, we want you to be able to do that.

*Douglas:* Using lessons learned in the SPD transition to managed care will be helpful. What do we do with plans to ensure continuity of care and bring providers into their networks over time.

*Lee:* Plans will determine their interest in the Exchange. We will do what we can to ensure that plans with significant Medi-Cal populations will be interested.

### **Public Comment**

No Public Comment.

Meeting adjourned at approximately 3:20 pm. People who wanted to be added to the various workgroups related to AB1296, please inform Toby Douglas. The next Stakeholder Advisory Group meetings will be held on Monday, July 23, 2012 and Monday, November 19, 2012.

## **Focused Feedback Session Notes**

### **Presumptive Eligibility and Provider Gateways Session**

*Rene Mollow, DHCS,* opened the session by providing background on the issues before the workgroup today. DHCS would like to discuss the role Presumptive Eligibility should have once health care reform is fully implemented, especially since full enrollment will be simplified. Currently, Presumptive Eligibility is an optional service for pregnant woman (pregnancy related care only) and children (full scope) in Medi-Cal, and patients in the Breast and Cervical Cancer Program and for FamilyPACT recipients for family planning services. Children who apply under the Single Point of Entry get Presumptive Eligibility and those “bridging” from Healthy Families to Medi-Cal get a month of fee for service Medi-Cal. Presumptive Eligibility means that people who “seem likely to be eligible for MediCal” can get services for up to two months or until a final determination is made (whichever comes first). Presumptive Eligibility is based on a simplified application, manually on a paper application for pregnant women and electronically for

others. The concept of “bridging”, receiving a month of Medi-Cal when transitioning from Healthy Families to Medi-Cal, is not Presumptive Eligibility but it is based on it. Rene Mollow, DHCS, pointed out that ACA simplifies enrollment (eliminating assets test for most groups, MAGI, etc.) Does this lessen the need for Presumptive Eligibility?

*Kristen Golden Testa, The Children’s Partnership/100% Campaign:* Keeping Presumptive Eligibility is to maintain what we have. We do not want to close any existing doors.

*Cathy Senderling, CWDA:* We agree that we should not close any current doors, and if we can, we should have a form of PE accessible from CALHEERS. (*Kristen Testa* agreed with this.) Some CWDA members have reported that sometimes it is quicker to get to full eligibility and that in certain cases PE slows things down. Therefore, CWDA wants to note that if you can get to full enrollment, don’t encourage people to stop at PE. On the other hand, you want people to know they can use PE to get to the doctor immediately. One suggestion is to start with MAGI eligible using the FamilyPACT Model, which is simple and works well. Then, use lessons learned to inform the procedures for the rest of the recipients. There was a discussion about including the Exchange in some sort of Presumptive Eligibility process.

*Kristen Golden Testa, The Children’s Partnership/100% Campaign:* pointed out that her organization hasn’t figured out how to incorporate Presumptive Eligibility into the Exchange because of need in the Exchange to select a plan and use a sliding scale. These items are “not a yes or no question” like Medi-Cal eligibility. Group agreed.

*Don Novo, CMS* brought up need for program integrity to ensure that uninsured are not gaming the eligibility system to get services covered.

*Rene Mollow:* DHCS is very conscious of cost. PE is not currently expensive because it is mainly for children and they are generally healthy; adults will be different. There was discussion of a “bridge” from the Exchange to Medi-Cal? How would the care be provided?

*Rene Mollow. DHCS:* Not sure how the finances would work.

*Suzie Shupe, CCHI* offered feedback from one CCHI member (large COHS county) – they stated it was important for all providers to have access to PE because most Medi-Cal recipients are found that way. Also, behavioral health providers should also have access. The application should be the similar to the SAWS 1 (a short form for Medi-Cal).

*Rene Mollow, DHCS* discussed the difference between Presumptive Eligibility and Pre-Enrollment. Difference is that ‘re-enrollment’ is about getting ready (filling out income information, selecting a health plan) for Medi-Cal or Exchange coverage as of January 1, 2014 and Presumptive Eligibility is for services now. Pre enrollment means you get all the enrollment information and do plan selection so that on day one individuals are ready for full enrollment.

In terms of next steps, *Kristen Golden Testa* told the group that the 100% Campaign has a paper on this topic coming out with a paper.

*Rene Mollow*: DHCS is waiting for federal guidance to answer a bunch of questions. It is on the AB1296 list of “other” issues to deal with.

*Finnocchio*: May 22 AB1296 will cover this issue among others.

## **LIHP Transition Breakout Session**

Power Point presentation link:

[http://www.dhcs.ca.gov/Documents/LIHP%20Transition%20small%20group%20overview%20\(final\).pdf](http://www.dhcs.ca.gov/Documents/LIHP%20Transition%20small%20group%20overview%20(final).pdf)

*Dylan Roby*: *UCLA Center for Health Policy Research*, with assistance from the UC Berkeley Labor Center and the California Medicaid Research Institute (CaMRI), are contracted by the Blue Shield of California Foundation to assist the Department of Health Care Services (DHCS) in the development of a transition plan to coordinate the transition of Low Income Health Program (LIHP) enrollees to Affordable Care Act (ACA) coverage options (Medi-Cal or the Exchange) “without interruption in coverage to the maximum extent possible” as part of the 1115 “Bridge To Reform” Waiver. The Special Terms and Conditions (STCs) of the waiver call for an initial transition plan to be submitted to the Centers for Medicare and Medicaid Services (CMS) by July 1, 2012. The process could last into the summer if there are comments by CMS that need to be addressed. UCLA/UCB are also working on two policy briefs that discuss how the State will transition individuals to Medi-Cal (due November 2012) and the Exchange (due January 2013). Several of the transition issues identified so far involve information technology, legal questions (consent), coordination of care, eligibility and enrollment, provider network adequacy and coordination with the AB 1296 effort.

*Ken Jacobs, UCB*: raised the question, what is the best way to gain consent.

*Mitch Katz, LA County*: asked the reason for the consent since LIHP is a program under the Medi-Cal waiver and should be treated as if this group is already in Medi-Cal. Whatever information collected now should be shared among the programs to “grandfather” them into Medi-Cal.

*Lee Kemper, CMSP*: If the LIHP is operating under the Medicaid waiver, shouldn't it be treated as another Medicaid program? CMSP case information is already in SAWS and they are ready to flip the switch.

*Mitch Katz, LA County*: If LIHP and ACA Medi-Cal Expansion eligibility requirements differ, what is the advantage of transferring the LIHP information. He is in favor of not asking for more information from enrollees until after January 2014.

*Dylan Roby, UCLA:* Information is available but is not necessarily in MEDS; some information is housed in the three SAWS systems. With that information, it may be possible to place them under presumptive eligibility until the next renewal.

*Elizabeth Landsberg, Western Center Law and Poverty:* noted that there is some relevant data, such as DRA information, but we should not ask enrollees to provide it twice. She also likes the idea of sending the LIHP enrollees a form, pre-populated with known data, along with a notice explaining the transition and asking for more information (i.e. household composition), if necessary.

*Ken Jacobs, UCB:* Should the State use the “opt in” or “opt out” approach to transfer enrollee data to Medi-Cal or the Exchange?

*Ellen Wu, CPEHN* would like the “opt out” option with automatic enrollment in Medi-Cal. *Melissa Stafford Jones, CAPH:* Transferring the LIHP population in its totality would be the easiest option. Since coverage is coverage, the State should take whatever information is available to transfer individuals to the appropriate program.

*Judith Reigel, CHEAC* suggested the notice indicate that the LIHP program will no longer exist in 2014 so beneficiaries will have to change to the new program. She stated that we should think of LIHP and Medi-Cal as the same program for consent purposes.

*Elizabeth Landsberg, Western Center Law and Poverty:* Consumers must be engaged in this process early on and that they need to know what is happening to them. She also favors the “opt in” option.

*Mitch Katz, LA County:* asked if there are differences between current and future definitions of family/household income in two person families.

*Dylan Roby, UCLA:* There could be differences related to divorce or custody.

*Ellen Wu, CPEHN:* Exceptions need to be taken into consideration but the bulk of enrollees need to be dealt with quickly. If there were a group less likely to change eligibility under the new guidelines, it would be less work to do the same thing for all.

*Lee Kemper, CMSP* stated there would likely be a “rippling” in eligibility for group below 133% of the Federal Poverty Level (FPL). This will be a special case of people on the bubble who will need “hand holding” – such as the group whose circumstances change month to month. He suggested looking at specific LIHP Aid Codes to identify the population for the transition.

*Alice Mak, DHCS* replied there are designated aid codes to track LIHP enrollees but not all counties are reporting them to MEDS. Also, MEDS does not collect income information. *Lee Kemper CMSP* suggested picking a FPL threshold and moving everyone under that threshold over to Medi-Cal “as-is” while keeping the enrollment terms the same. Then figure out a practical way to move those on the bubble. He also

suggested moving them over in a staggered fashion over time to reduce the workload on the counties.

*Ken Jacobs, UCB* noted that since all enrollees will have to undergo redetermination in 2013, it might be feasible for the counties to get consent at LIHP renewal.

*Melissa Stafford Jones, CAPH:* The process should begin as early as January 2013 by having the information collected and give them Medi-Cal under presumptive eligibility.  
*Elizabeth Landsberg, Western Center Law and Poverty:* noted the beneficiaries would need to be contacted any way for plan selection.

*Lee Kemper, CMSP:* stated that CMSP does redeterminations at 6 months while other counties perform them at 12 months. When CMSP was converting their caseload, they put everyone who would be eligible into the specific aid code and flipped the switch in January 2012. Asking for consent would be a perfunctory part of the renewal.

*Ken Jacobs, UCB:* Do the counties tell enrollees the LIHP is a transitional program?  
*Anthony Wright, Health Access and Lee Kemper, CMSP* responded they do tell enrollees that LIHP is a transitional program.

*Dylan Roby, UCLA* asked when it would be appropriate to ask for new information from the enrollees and is it easy to store new data.

*Lee Kemper, CMSP:* replied C-IV and CalWIN can save information into the case file but is not sure if the data is saved to the system. The SAWS probably have a lot of information and system level programming can be done during the year to capture new information. Once the Aid Codes are entered, the information is transferred to MEDS. Counties not using either CalWIN or C-IV will need to reconfigure their systems.

*Judith Reigel, CHEAC* noted most of the Legacy counties would have the biggest problem moving information to MEDS.

*Elizabeth Landsberg, Western Center Law and Poverty:* inquired if there was a required timeline for transferring data from the counties to MEDS.

*Alice Mak, DHCS* replied there is not a State deadline and this requirement is not in the STC or any statute. Some counties have not chosen a method though one county wants to use the State's MEDS option to transfer its data to MEDS. Healthy Way LA is in the process of migrating its population to LEADER. CalWIN has LIHP programming that will be live in October for non-CMSP counties.

*Anthony Wright, Health Access:* supports starting the notification process early and would like to see redeterminations and pre-enrollment in 2013. He supports informing them that their coverage will continue, including what is going to change and what is not. In 2-plan model, selection of the right plan may be done later (after default).

*Dylan Roby, UCLA:* Claims data might need to be transferred for plan selection purposes. He asked if the panel was comfortable with a statement similar to “In January, 2013, you will lose the benefits if you don’t agree to transition to Medi-Cal.”

*Lee Kemper, CMSP* stated that sounds heavy handed and the State should decide how much information is necessary for an eligibility determination. He favors grandfathering the population into Medi-Cal to avoid unnecessary disruption in care.

*Mitch Katz, LA County* stated LIHP is clearly a Medicaid program and a “flip the switch” approach is needed. He proposed “flipping” aid codes and leaving everything else the same. *Elizabeth Landsberg, Western Center* stated “coverage is changing” is “warm and fuzzy” but noted that the CalHEERS MAGI rules engine won’t be ready until July 2013 at the earliest.

*Ellen Wu, CPEHN* stated a positive message should be “Thank you for participating in LIHP. Congratulations, you’re now in Medicaid.”

*Alice Mak, DHCS* brought up using enrollee information to match the medical home and plan with a local provider may require consent.

*Ken Jacobs, UCB and Elizabeth Landsberg, Western Center Law and Poverty* stated enrollees would need to join or pick a health plan during the transition.

*Brian Hansen, DHCS:* suggested patients might be put in a plan by default.

*Ken Jacobs, UCB:* reminded him claims data would be needed to figure out which provider to default to. There was some discussion among the group as to the overlap of the LIHP and Medi-Cal provider networks. It was noted that there is some overlap, but not completely.

*Mitch Katz, LA County:* would like to give people a choice of providers instead of just having them select just plan. Most people don’t know which plan their provider is in.

*Lee Kemper, CMSP:* would like to have one place for enrollees to go to get information. Selecting an office or clinic as a medical home is fair since most people see more than one provider in their medical home now. And pay special attention to continuity of care.

*Mitch Katz, LA County:* suggested based on claims history, the default should be telling enrollees “your medical home is X, your plan is Y, but if you don’t want that, you can pick something else.” The health plan is the problem since there is no plan now. An algorithm is needed.

A discussion followed where the need for early and frequent notification, education and live people to speak to was reiterated by several panel members.

*Anthony Wright, Health Access:* explained it was important to inform enrollees early about what the transition is.

*Lee Kemper, CMSP:* is not sure informing enrollees early is a good idea as it may cause confusion. He suggested the transition be brought up at renewal and notifications at various times and in different venues (direct mail, eligibility workers, county health departments, physician's office, etc.) Engagement of CBO's was also suggested by *Elizabeth Landsberg*.

*Ellen Wu, CPEHN and Lee Kemper, CMSP:* stated enrollees should have the option of speaking to live representatives.

*Melissa Stafford Jones, CAPH:* expressed the need to use caution and not confuse the enrollees and make them think LIHP has already ended.

*Jalynne Callorri, DHCS:* stated there will be outreach by the Exchange and it can be tied to current efforts by the outreach contractor.

*Ken Jacobs, UCB:* stated the Ryan White population has their specific issues and asked if there are other populations that need special attention.

*Elizabeth Landsberg, Western Center Law and Poverty:* noted the homeless and those requiring mental health care.

*Anthony Wright, Health Access:* stated the LIHP population is made up of diverse constituents.

*Mitch Katz, LA County:* asked about healthy 18 yr olds. They are not being actively enrolled now but with capitation, it would be a good idea to reach out to them.

*Melissa Stafford Jones, CAPH:* brought up the people on the LIHP waiting list and other population of users. She asked is there something to streamline getting those groups enrolled.

*Elizabeth Landsberg, Western Center Law and Poverty:* asked if MIA's above the LIHP poverty level were in the plan.

*Dylan Roby, UCLA:* noted it was not in the scope of the CMS plan but they may end up in the policy briefs.

*Melissa Stafford Jones, CAPH:* stated we should be mindful of not putting something in that is not under the federal purview but to build something basic that can be added to later.

*Ken Jacobs, UCB:* noted they will continue to reach out to advocates and stakeholders as the plan is developed.

*Dylan Roby, UCLA:* reminded everyone that Elizabeth Lytle is the main contact for the UCLA/UCB team.

## **SPD/Dual Eligible Breakout Session**

**Question 1: One challenge encountered with the SPD transition was that FFS providers were reluctant to participate in Managed Care. How can DHCS gain better FFS provider participation in Managed Care so that the same issue is not encountered with the Duals transition? What would be a productive method to inform and educate FFS providers about the transition to Managed Care?**

Jane Ogle prefaced conversation: We anticipate that health plans participating in the demonstration counties will be paid Medi-Cal/ Medicare comparable rates for Medicare services. They will not receive Medi-Cal rates for Medicare services.

Comments from SAC members:

- These doctors for dual eligibles are Medicare doctors, not Medi-Cal doctors. They are not familiar with Medi-Cal rates. You need to make doctors feel that they are not dominated by the managed care plans.
- In Los Angeles, doctors weren't informed of the SPD transition process. DHCS need to more proactive educating providers about the transition. Otherwise, when providers are finally aware that the transition is happening, it's just an extra burden with little to no additional money. All the focus in outreach was on the beneficiaries.
- There was an attitude that the SPD rollout was big enough that the providers would just join. No effort was made to show how this transition would be in the interest of the providers. The assumption was that the change was so big providers would just go with it.
- It is harder to bring specialists into a managed care network. Specialists already have long waiting lists.
- Possible suggestion: Split contract with those who contracted with Medicare Advantage (MA) plans and those who didn't.
- There are challenges in getting Individual Practice Associations (IPA) and medical groups to engage in this conversation. Suggestion: differentiate communication strategy between IPAs and medical groups.
- Last year there was discussion of a crosswalk. (Crosswalk is referring to list that shows the list of providers and specialists that two plans share). This is a good idea.
- Do we know how many dual eligibles are in a Medicare Advantage plans in the demonstration counties? *Jane Ogle*, DHCS: No, we are working with CMS to get the numbers.

*Jane Ogle, DHCS* asks members: what are some strategies that DHCS should think about for to gain more participation by providers who do not currently contract with the plans but are needed in the network to care for the dual eligible population?

Comments from SAC members:

- This is a grassroots approach, but one method that had proven effective in San Luis Obispo is to have a plan's provider services team make appointments with the providers. Get on the local provider association agenda and discuss upcoming changes. Primary doctors will help them reach out to specialists.
- There is a need to understand the environment in each county and figure out how doctors get their information (i.e. CMA, local provider associations, etc). Flexibility is needed on how to communicate/educate providers.
- A strategy that worked well in the Inland Empire – letters were sent to providers with information on where they can go to get questions answered that they may have.
- Dual eligibles are very different than SPDs. To limit overload of information being disseminated, DHCS and plans should work together to communicate one united message to the community.
- There is a challenge with behavioral health. DHCS needs to work with providers to explain and market the behavioral health resources available.
- DHCS should get feedback on how Medi-Cal only plans expanded networks for their Dual Eligible Special Needs Plans (DSNPs).
- Getting dental and vision benefits helped in the success of DSNPs—persons that the providers are serving will receive more comprehensive set of services.
- Need to give greater attention to getting more information on the certain populations, like HIV patients. Who are the primary care and specialists that care for special populations in the community? There is an information gap and we need to demystify who the HIV providers are.

On behavioral health:

- Medicare provides a mental health benefits that is different than the Medi-Cal mental health benefit.
- Medicare managed care organizations have a provider network for mental health/behavioral health. Counties are not in this provider network but should be.
- The behavioral health carve out in the dual eligibles demonstration proposal will not affect Medicare benefits. It will impact Medi-Cal mental health benefits more than Medicare.
- CMS will give a description of how behavioral health integration will work.
- There are significant opportunities for cost savings associated with integrating mental health as well as alcohol and drug programs. Unresolved mental/behavioral health issues cause medical problems that could have been prevented if the patient had access to quality mental health care.
- There is a lack of understanding about the benefits of mental health and LTSS services. Materials would be helpful to educate providers on all of these services.

- A clear scope of beneficiary services is needed.

On network adequacy care management/continuity of care:

- There are concerns with plans having enough time to build adequate networks.
- Just because a plan had a small DSNP doesn't mean they understand dual eligibles.
- Dual eligibles are complex patients with multiple, chronic needs. Need to make sure providers are able to handle these types of patients.
- Development of case management will be a slow progress. This cannot happen on the telephone since many dual eligibles and seniors and people with disabilities cannot be reached by telephone.
- We need to continue with the good aspects of case management already in place, such as outreach by phone, and build off of it.
- This is an opportunity to build in care management through nurse navigators and coordinators.
- Plans should connect with local centers with navigators and build off their systems.
- Don't use "case"- use "care." "Care management"-patients are people
- CAPG members already have the capabilities to do this; they are just not involved on the Medi-Cal side.
- Need to recognize what is happening in the field and not just rely on health plans to lead case management efforts.
- Patients being transitioned may not currently in a managed care organization. We need to educate them of the benefits of managed care.
- Need to build of the "four quadrant" model for care coordination.
- Timing is a critical issue. When the dual eligibles demonstration implementation happens, a gradual transition should happen (for both plans and beneficiaries). Care needs to be transitioned before implementation.
  - *Jane Ogle*, DHCS: HIPAA is an issue. Plans cannot get information on a beneficiary before they are enrolled.
  - Could integration happen after enrollment?—gradual transition of care to ensure continuity of care.
- Need increased dialogue between transitioning (old) physician and new physician before care is completely transitioned from one to the other to ensure continuity of care.
- Since providers will know ahead of time when their patients will transition (transition based on beneficiary's birth month), could there be a transition plan that includes everything the original physician prescribes to continue for the patient after a certain period with a new physician (including medications).
- Those in low-income subsidy plan must be transitioned in January for no interruption of care.
- *DHCS*: Plans are required to engage in a local stakeholder process including beneficiaries and providers. DHCS is working with the plans on this.
- Recommendation to include disease-specific experts/advocates in the stakeholder groups.

**Question 2: What communication vehicles should the department use going forward to inform SPDs of their choices regarding enrollment into Medi-Cal managed care? How can DHCS improve communications and outreach efforts to beneficiaries to notify them of large scale rollout of transitional activities? What were lessons learned from the SPD transition outreach efforts?**

*Jane Ogle, DHCS* framed these questions with three requirements:

- Three notices will be sent to beneficiaries; one that is a joint notice with CMS.
- Beneficiary outreach work group is developing a process/timeline for these notifications.
- DHCS will work to determining the best parties to be doing the notification.

Comments from SAC members:

- Dual eligibles need housing and transportation: both need to properly receive information.
- For IHSS beneficiaries, make sure that service providers of all types, who have regular contact with beneficiaries, have information to share. The State should give IHSS agencies, CBAs centers, etc. the information to distribute to care/service providers in order to reach beneficiaries.
- Educate beneficiaries on non-medical services that keeps them healthy—preventive and supportive services.
- Plans need to develop trust in the community- reach out to local AAA and other groups.
- Look at clinics and navigators that can help streamline care.
- DHCS may need to expend additional resources for successful transition.
- Need to educate providers so they can share this information with their patients.