

**SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
STAKEHOLDER ADVISORY COMMITTEE (SAC)
Meeting #8 – Thursday, February 10, 2011
9:30am – 12:30pm**

The meeting convened at 9:30 AM.

Attendance

Members attending: David Alexander, Lucile Packard Foundation for Children’s Health; Bill Barcellona, California Association of Physician Groups (CAPG) (by phone); Richard Chambers, California Association of Health Insuring Organizations (CalOptima); Mike Clark, Kern Regional Centers; Catherine Douglas, Private Essential Access Community Hospitals (PEACH); Juno Duenas, Family Voices; Teresa Favuzzi, California Foundation for Independent Living Centers; Jeff Flick, Anthem Blue Cross; Brad Gilbert, Inland Empire Health Plan (IEHP); Sandra Naylor Goodwin, California Institute of Mental Health (CiMH); Daniel Gould, CA LGBT Health and Human Services Network; Peter Harbage, SEIU; Marilyn Holle, Disability Rights California; Michael Humphrey, Sonoma County IHSS Public Authority; Melissa Stafford Jones, California Association of Public Hospitals and Health Systems (CAPH); Ingrid Lamirault, Alameda Alliance for Health; Elizabeth Landsberg, Western Center on Law & Poverty (WCLP); Sherreta Lane, California Children’s Hospital Association (CCHA); Marty Lynch, California Primary Care Association (LifeLong Medical Care); Jackie McGrath, California Council of the Alzheimer’s Association; Santiago Munoz, University of California; Chris Perrone, California HealthCare Foundation (CHCF); Tom Petersen, Association of California Health Care Districts; Cheryl Phillips, On Lok Lifeways; Bob Prath, AARP California Executive Council; Brenda Premo, Harris Family Center for Disability and the Health Professions (CDHP); Sharon Rapport, Corporation for Supportive Housing (CSH) (by phone); Judith Reigel, County Health Executives Association of California (CHEAC); Lisa Rubino, Molina Healthcare of California; John Schunhoff, Los Angeles County, Department of Health Services; Timothy Schwab, SCAN Health Plan; Rusty Selix, California Council of Community Mental Health Agencies (CCCMHA); Barbara Siegel, Neighborhood Legal Services of Los Angeles County (NLS); Stuart Siegel, Children’s Hospital Los Angeles (CHLA); Hermann Spetzler, Open Door Community Health Centers; Richard Thomason, Blue Shield of California Foundation; Anthony Wright, Health Access California.

Others attending: Toby Douglas, DHCS; Tanya Homman, DHCS; Jalyne Callori, DHCS; Luis Rico, DHCS; Paul Miller, DHCS; Bobbie Wunsch, Pacific Health Consulting Group.

Public in attendance: 43 members of the public attended in person, and 146 attended via the listen-only call-in line.

Welcome, Introductions and Purpose of Today's Meeting

Bobbie Wunsch, Pacific Health Consulting Group, introduced new members of the Stakeholder Advisory Committee: Sherreta Lane, California Children's Hospital Association and Tom Peterson, Association of California District Hospitals. She provided an overview of the agenda, and announced the upcoming meetings on June 1 and November 3 in Sacramento.

Stakeholder Advisory Committee Process and Future Meetings

Toby Douglas, Director, DHCS, said that he was honored to be in his new role as DHCS Director, and was committed to moving the waiver forward even in these challenging times. The Stakeholder Advisory Committee process is tremendously important to waiver implementation. As the waiver process moves from design and development to implementation, the stakeholder role will also be evolving. The SAC will serve as a "feedback loop," through which information will be disseminated out to the public and in to the Department. Additional 2011 meetings will be held in June, just before the implementation of SPD managed care enrollment, and again in November. While meetings will continue through the life of the waiver, their structure and focus will be evolving.

Toby Douglas introduced *Jennifer Kent, Associate Director, DHCS*, who will oversee the waiver work. She will assign someone on her team to be a point person for waiver questions and issues.

Waiver implementation will depend in part on the budget situation. The budget has implications for work on the waiver, but DHCS hopes and believes that even in this difficult environment California can have a successful waiver that will be a cornerstone of health care reform implementation.

Jeff Flick, Anthem Blue Cross, commented that in his view DHCS had done a very good job in the development of actuarially sound rates for SPDs, something that Jeff had raised as a serious concern at the last meeting. DHCS staff listened to plans, were open to ideas, and made meaningful adjustments. While concerns remain, there has been good progress in this area.

Anthony Wright, Health Access, asked for more detail on how specific budget proposals, such as visit and prescription caps, could mesh with the waiver. What are the implications for negotiations with the federal government?

Toby Douglas, DHCS, said that communications with CMS are ongoing on a number of levels, and that Governor Brown and Secretary Dooley met recently with Secretary Sebelius. CMS understands that California is committed to being a leader in health care

reform, but that the state can't be successful in these efforts without shoring up our budget. Both the implementation of health care reform and the budget are federal/state partnerships. California has received a great deal of support from the Administration recently, and is not expecting more money, but is seeking additional flexibility in areas including cost-sharing, DRA requirements, and payment reductions. CMS understands that they have to be responsive to states' needs.

DHCS is not prepared to discuss specific budget proposals, given that they are still under discussion with the legislature. Toby said that some proposals would have more impact on wavier implementation than others. Managed care reductions would be on an actuarially equivalent basis, so plans would have flexibility on how to implement these cuts. As the situation becomes more concrete, DHCS will be talking to federal partners about the specifics of implementation.

Update on Implementation Efforts - SPDs, LIHP, CCS and Dual Eligibles

Tanya Homman, DHCS, provided an update on implementation efforts related to SPD enrollment, including plan readiness and network adequacy assessments. A more detailed discussion of these activities is included below in the summary of the SPD breakout session.

- Contract language – Draft contract language is under CMS preliminary review, with a response expected very soon. Contract language will go to health plans in early March, with contracts due back to DHCS in early April. Contracts will then be submitted to CMS for review.
- Outreach and education – On February 28, Health Care Options (HCO) will be mailing informing notices to the first group of new members.
- A new website specifically for SPD information is at <http://dhcs.ca.gov/SPDINFO>. It is geared to members but all stakeholders will find it useful.
- Community presentations will be held in March and April. DHCS is looking for assistance from community-based organizations and others who want to host information sessions, and Tanya asked potential hosts or stakeholders with ideas of organizations that might be good hosts for these sessions to contact Cheryl Bates: Cheryl.bates@dhcs.ca.gov.
- SPD cultural awareness training – Two 2-day sessions were held in January, and Brenda Premo, CDHP, is now modifying the training and developing a “train-the-trainers” toolkit by April. Internal training for DHCS staff begins February 16, and will reach operations staff, ombudsman office, and finally other staff who will have contact with beneficiaries.
- Site review tool – In-person training on using this tool is ongoing; plans are encouraged to begin using it now and are required to use it by June.

- Member data – Test data will be sent this month, with a conference call for technical questions to be scheduled in March. Plans will receive data on new voluntary SPDs in April.
- Risk assessment tools – A letter was sent in January, based on guidance received from stakeholders; it includes baseline standards and how tools should be submitted.
- Interagency audits – Plans for these audits should be completed in February.
- Monitoring – Refined performance measures were discussed in detail in the breakout session. New measures will be introduced in March, and in August DHCS will publish required performance measures for 2012.
- Rates – Final rates were sent to plans on February 2.
- Letter of interest – DHCS hopes to release an LOI in February or March to assess the interest of other plans in serving this population. In a two-plan area, if one doesn't want to enroll SPDs or doesn't have an adequate network, DHCS wants to bring in another plan to serve members.

Jalynne Callori, DHCS, provided an update on implementation of the county Low-Income Health Program (LIHP). Her presentation is available at <http://www.dhcs.ca.gov/Documents/Low%20Income%20Health%20Program%20Update.pdf>

As of the meeting time, fifty-seven counties (all except Stanislaus, with CMSP representing 34 counties) had submitted Letters of Interest, as had the City of Pasadena and the California Rural Indian Health Board, representing 12 Indian Health Programs in 11 Counties (10 of those CMSP) counties.

Jalynne reviewed the application process:

- Informational Meetings were held in Orange County and Sacramento in January
- FAQs were posted on the LIHP webpage on February 9, 2011
- Applications are due to DHCS on February 14, 2011. Many won't be complete, and that is acceptable – the point of the application is to begin the authorization process.
- DHCS will collaborate with applicants to secure authorization to implement LIHP
- There will be another application round in early June
- The LIHP website is at <http://www.dhcs.ca.gov/provgovpart/Pages/lihp.aspx>

Key issues that have been identified in the early stages of the process include:

- Maintenance of Effort (MOE)
- Due process
- Cost estimates – Counties are finding it challenging to develop cost estimates and thus to determine where to set the upper income limit for MCE.

- Mental health and substance abuse benefits and delivery systems – Regulations are expected mid-year but counties need guidance now on how to develop these networks
- Out of network emergency services for MCE
- On-line LIHP application and interface with standardized eligibility determination for Medi-Cal (2014)
- Alternative primary and specialty access standards for counties with rural areas or other where standard adequacy requirements are too stringent
- Managed care and Medi-Cal eligibility rules applicable to LIHP

Jalynne said that DHCS would be working closely with the LIHP advisory workgroup on these issues.

Luis Rico, DHCS, reported on the status of the CCS pilots. His presentation is available at <http://www.dhcs.ca.gov/Documents/CCS%20Update.pdf>.

Four potential models for CCS pilot projects emerged from the CCS Technical Working Group and the SAC: existing Medi-Cal Managed Care Plans (MCO), Specialty Health Care Plan (SHCP), Enhanced Primary Care Case Management (EPCCM), and provider-based Accountable Care Organization (ACO).

DHCS has released two draft RFPs, in July 2010 and January 2011. DHCS plans to release a final RFP in March 2011 with responses due in May. Decisions would be announced in July 2011 with operations to begin in January 2012.

The California Health Care Foundation (CHCF, Chris Perrone) and the Lucile Packard Foundation for Children's Health (LPFCH, David Alexander) are assisting with evaluation efforts related to the CCS pilots. Paul Weiss is conducting an in-depth analysis of CCS data (including cost, utilization, health condition and health status data); he presented preliminary results in December 2010 and his final report will support evaluation and be useful in other contexts as well. LPFCH also has engaged Mathematica, Inc. to develop and evaluation methodology for the pilots, supported by an advisory committee of hospital and provider representatives, led by DHCS CMO Robert Diamond, MD.

David Alexander, LPFCH, said that Mathematica would develop draft evaluation methodology for Dr. Diamond and the committee to respond to. The evaluation will provide information about whether various models help children or not, but instead of a classic case-control study they will be proposing an evaluation in real-time. There is an opportunity for HRSA funds to support that evaluation, which would be the first effort at real-time quality measurement for a vulnerable population under Medicaid. Outside funding is critical, since the evaluation costs will exceed DHCS and LPFCH's resources.

Luis Rico noted that CCS clients who are also identified as Medi-Cal SPD beneficiaries will not be mandatorily enrolled in Medi-Cal managed care at least until the geographical locations for the CCS pilots have been identified.

Paul Miller, DHCS, reported on the status of integration pilots for dual (Medi-Cal/Medicare) eligibles. SB 208 directed DHCS to identify four models to test integration of duals. Although this was an original component of California's waiver application, it was removed at CMS request due to the formation of the CMS Innovations Office, which is developing its policies and approaches on this issue.

In December 2010, the CMS Innovations Office asked for proposals for innovative service delivery and payment models for duals, funded at up to \$1 million, with implementation in 2012. Coordination with behavioral health is a required feature of the models. With the support of the SCAN Foundation, DHCS in January 2011 asked for \$1 million to support project management, actuarial services, data analysis, and seed grants to pilots for outreach and education. Notification is expected in March. If the grant is awarded, DHCS would expect to hold stakeholder meetings beginning in April, issue an RFP in October, announce pilots in March 2012, and begin operations in the last quarter of 2012.

The state's application and other materials are available on the duals web page at <http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupDE.aspx>.

David Alexander, LPFCH, said that one of the holes in the draft CCS RFP is evaluation. He said that it would be imprudent to release a final RFP until the state is ready to tell applicants what's expected of the pilots in terms of evaluation data.

Tim Schwab, SCAN Health Plan, asked whether DHCS had thought about implementing real-time evaluation, along the lines of the CCS model, in the other pilots such as duals. *Toby Douglas, DHCS*, said that DHCS was working with foundation partners, including CHCF, BSCF, and the California Medicaid Research Institute, to design evaluation plans for LIHP, SPD and the whole delivery system reform investment pool (DSRIP). He said it was too early to say what the evaluation plan for duals would be, but that real-time evaluation would be part of the discussion. *Chris Perrone, CHCF*, said that he supported real-time evaluation in CCS for reasons of practicality and cost, but noted that unlike CCS, the SPD and LIHP programs are not demonstrations – they are being implemented fully. Those programs need a monitoring plan that incorporates these measures, and should include real-time data.

Sandra Naylor Goodwin, CIMH, said that she was not surprised by CMS' emphasis on behavioral health in the duals pilots, given that approximately half of this population, especially the disabled population, has serious psychiatric conditions. She said that she hoped DHCS would bring in people experienced in care delivery for people with SMI.

Richard Chambers, CalOptima, said that both San Mateo and Orange Counties have looked at inclusion of duals. He asked for an update on behavioral health integration. *Toby Douglas* replied that the behavioral health integration pilots did not move forward as a stand-alone proposal in the waiver, but actually will take place as part of duals integration pilots and as part of LIHP. DHCS is working on behavioral health capacity assessment with SAMHSA and the state departments of mental health and substance abuse.

Brenda Premo, CDHP, asked whether contract requirements around accessibility and service standards would be the same in duals pilots as they are for Medi-Cal only SPD managed care enrollment. She said that extending the SPD contract requirements to the dually-eligible population would be important.

Small Groups Discussions on SPD Enrollment and LIHP Expansion

SPD Discussion led by SAC Member Richard Chambers

- Rates/Contract

Tanya Homman, DHCS presented the following information:

- The health plan capitation rates for SPD have been adjusted with less aggressive assumptions about ER and hospitalization reductions.
- Overall, the new rates represent a 4.7% increase over the initial draft rates.
- Final rates went out Feb 2; back-up documentation sent to plans.
- These rates are only good for June – October 2011.
- Rates have not been approved by CMS yet. Rates/contract etc. will all go to CMS as a single final package.

Brad Gilbert, IEHP: The plans feel that the risk is significantly the same – can't argue with data – but utilization may be quite different and members may be different. We would like an early look to make sure that the rates are working for plans. Can we look quickly and not wait a full cycle?

Jeff Flick, Anthem Blue Cross: We are satisfied with the interaction – DHCS really listened, and the right partnership is in place going forward. We are still concerned about pent up demand: members may not have had access to care.

Flexibility and partnership are important – even in TANF populations the first year costs are different from costs going forward.

Richard Chambers, CalOptima: The experience going from FFS to managed care has been good so far for COHS – rate-setting has been adequate. Tanya Homman noted that DHCS did start with real-time data and COHS experience. Data lag is a problem.

Marilyn Holle, Disability Rights California: From the consumer point of view, it is important to know what is in and out of the rates (case management, administrative responsibility for transportation, e.g.). We need to see the contract to know what the obligations are. Lots of responsibilities are in the ethers – no funding for transportation – SPD's sometimes have to go out of county for services, and may not be able to use paratransit.

Tanya Homman: The boilerplate contract language for both two-plan and GMC counties is on the website. The rate development took into account increased administrative load (0.5% admin load) – plans do need to coordinate the process of arranging for transport.

Brenda Premo, CDHP: There has been some experience of putting these requirements into contract. Sign language interpreters are not required by contract. If the health plan delegates this responsibility to providers, it will not occur. Lawsuits are won over this. It is best to have in contract requirements as a plan responsibility.

Brad Gilbert, IEHP: Care management is clearly the plan's responsibility. Medical transport is very limited. Other than medical transport, it is not clear in contract, and does not always work as well as it should.

Marilyn Holle, DRC: Out of county services may mean out of pocket expenses, and this can be critically important to clients. Advocates are looking for clear lines of responsibility.

Question: What were the specific assumptions for reduced inpatient/emergency department? Was the original assumption 60% reduction and it is now at 40% reduction?

Tanya Homman, DHCS, said she would get back to the group about the assumptions in rate changes.)

Jackie McGrath, Alzheimer's Association: What specific supplemental contract criteria will deal with the complexity of this group? We have not seen standards beyond the boilerplate. When will we see additional criteria for care management, for example?

Tanya Homman: DHCS has 78 contract changes in the works, and has gone back and forth with health plans and CMS. Tanya will look at which elements can be shared. Tanya stated that contracts have broad language and that the details are handled via All

Plan Letters. Stake holders should look at All Plan Letter for details and criteria: Health Risk Assessment, Facility Site Review, etc.

Jeff Flick, Anthem Blue Cross: Blue Cross has taken care of this population already, already conduct risk assessments and use Impact Pro. The tools are getting better and better. The health plan was already ahead of the requirements, and now that the requirements are getting more stringent, they will be doing more of this work. The work is very data intensive, and it is in the health plans' interest to get good at it quickly. Having FFS data for the first time is very important.

- Plan Readiness

Tanya Homman, DHCS:

- Good standing review, including review by ombudsman complaints, financial audits and medical reviews, is complete
- Provider network: All plans have submitted data, under big review, clarifying with a few plans – will have final next week.
- Contract deliverables: One is related to what is in place for transportation. Tanya will gather a list of what is new. Well ahead of game right now. Stakeholder process with health plans has been incredible.

Brad Gilbert, IEHP: The network assessment process was very scientific and data-driven. Tanya Homman credited Rita Marowitz and her staff.

Question: What has been done to ensure access to *pediatric* specialty care providers? We are concerned about plan readiness for the pediatric population and would like to review data with DHCS.

Richard Chambers, CalOptima: Even with 15 years of experience, CalOptima is still working on pediatric specialty access; subspecialty access is a particular problem. Plans would also like to solve this but it will not be easy.

Marilyn Holle, DRC: Primary care is another issue. Not all MDs have the same affinity for playing this role. Providers may be on the list but not have room to add new patients to their caseload.

- Data Delivery to Health Plans

Comment: The process outlined for receiving historical claims data is unacceptably slow: up to 8 days to receive claims. The plans will then need up to a month to get contracts in place

with non-participating physicians. This is not reasonable for kids who are in the middle of treatment. People need to have access to FFS providers while they are waiting.

Tanya Homman: The data process begins with MEDS renewal, which is shortly before the beginning of each month. At that point, we know the member is eligible and which plan was chosen. Then we begin pulling data from the warehouse, and also pull TARs and scrub to make sure we are not releasing incorrect PHI. We have to account for weekend and holiday schedule. Thus we need 8 *working* days, maximum, from MEDS renewal to make sure they are in compliance with HIPAA. Once the beneficiary is a plan member, DHCS can share information (1st day of month of eligibility). We expect refinements as we go forward. Currently, plans do not receive *any* claims data information on their members.

Jeff Flick, Anthem Blue Cross: The new process is a big improvement from the current system.

Brad Gilbert, IEHP: It does not make sense to change providers in the middle of treatment – the main way the health plans find out is the member calls the plan.

The group discussed the importance of educating members that they should call the plan. Members will act if properly educated. The mantra should be “call member services” – there is a cost to teach members how to get access, but it pays off. Providers also have a role in this education. Need to educate providers about what to do – provider service and then figure out contract later.

Question: Will a family like mine have the same access to our pediatric neurologist when our child moves into a plan?

It is in the plan’s interest to keep the child with same provider – it is also state law.

Tanya Homman: Plans will look at historical data and try to match up to existing provider network.

Question: Will DHCS take into account delegated groups’ financial solvency?

Tanya Homman: DMHC reviews delegation agreements.

Teresa Favuzzi, CA Foundation of ILC’s: What happens after FSR? Who is responsible to make sure problems are addressed? Will DMHC hold plans accountable? Why isn’t DMHC at the table? What is the process for health plans to survey programmatic access? How is state going to measure whether plans are providing programmatic access (i.e., plan materials provided in Braille, other accommodations for this population)?

Tanya Homman: It is the plan's responsibility to make sure the member has access. Let's have a separate discussion on your particular concerns and will try to have DMHC at the table.

Jeff Flick, Anthem Blue Cross: Plans have these conversations with providers – one by one – to convince them to make changes to achieve accountability.

Lisa Rubino, Molina Healthcare: Accessibility of providers is very important to plans.

Brenda Premo, CDHP: Molina has direct control of some providers and that makes a difference.

- Topics for Future Meetings

Topics not addressed in detail due to lack of time included:

- Community outreach – DHCS is asking for assistance in identifying locations for additional presentations.
- PMs and plan monitoring – DHCS will post updated monitoring indicators and will plan a follow up meeting focused on this topic.

LIHP Discussion led by SAC Member Judith Reigel

- Questions About the Morning LIHP Presentation

Jalynne Callori, DHCS, reviewed the information that had been provided to the full SAC in the morning session. She reiterated that the point of the application process outlined so far is to collect basic information, and that the state will then ask counties for more information about their provider networks to assure that they will meet adequacy and access standards. DHCS will develop primary and specialty access standards for rural and other areas where the standard requirements are too stringent. The information that these counties provide in their applications will help the state formulate these standards, and DHCS staff will be working with the county workgroup on this process.

Anthony Wright, Health Access, asked for confirmation that the adequacy and access standards would not be the same as Knox-Keene standards. Jalynne Callori confirmed that it would not be Knox-Keene, but rather the standards spelled out in the STC.

Marty Lynch, Lifelong Medical Care, asked whether counties can go beyond the minimum standards in terms of behavioral health integration. Would the state support a county that

puts together a frequent user program as part of the LIHP that might include more intensive case management? *Sandra Naylor Goodwin, CiMH*, said that some counties are approaching this by defining a medical necessity standard under which people who met a certain acuity standard would get additional services. Jalyne Callori said that while any benefit available under the LIHP must be available to all enrollees, a plan like the one that Sandra describes might work and could certainly be sent to CMS for review.

Elizabeth Landsberg, WCLP, asked about the stakeholder process for the due process standards that have already been sent to CMS. Jalyne Callori said that DHCS did have input from CHEAC, CMSP, and CSAC, but not from consumer advocates. She said that the next version will be shared more widely, and that since CMS had very few comments the version on the LIHP website can be considered current. Per the STC, the due process standards must be finalized by May 1. Elizabeth Landsberg said that a consumer advocate workgroup would be interested in commenting.

Peter Harbage, SEIU, said that he had heard that most of the applications went only to 133%, and do not include the HCCI part of the program. He asked how DHCS plans to encourage counties to go higher. Jalyne Callori said that it wasn't yet clear what income limits counties would set, but if it turns out that counties don't have much interest in HCCI, the state will be following up with them individually. *Melissa Stafford Jones, CAPH*, noted that since the STC requires that the MCE population be covered first, at the local level questions have been raised about whether, with the combination of resource limitations and program requirements, counties can manage to go beyond 133%. It may be in that case that the same number of people get into a coverage program, but that they are all from a lower-income population. For some counties, it is too much to cover both populations at the same time, given the program requirements.

Peter Harbage, SEIU, also asked what happens to funds that counties leave on the table by not including higher-income groups. Toby Douglas, DHCS, said that they automatically roll over, but DHCS needs approval to use them somewhere else.

Anthony Wright, Health Access, asked at what point a county has to get specific about coverage levels, and whether there will be opportunities for counties that are conservative about eligibility levels raise those levels at a later date. Jalyne Callori said that counties can amend their upper income limits during the application process or once a contract is signed, but way of a contract amendment. Melissa Stafford Jones noted that once a contract is in place a county has to give 90 days' notice of changes, but federal approval is not required.

- LIHP Process

Jalynne Callori presented the planned approval process, which is posted on the LIHP webpage:

Approval Process

- Once applications are received (deadline February 14), DHCS has 60 days to approve them.
- DHCS will begin asking for additional information from counties on a flow basis as soon as they receive the applications.
- By March 1 DHCS anticipates providing its LIHP workgroup with draft LIHP cost-claiming protocols. That document will go to CMS by March 31, and federal approval is expected to take 30 – 45 days. The CPE component of the protocol will be similar to the protocol for the previous HCCI program. The capitation rates component may take more time for CMS to review.
- By April 4, DHCS will provide guidance on the MOE calculations and expenditure exemptions to the counties. DHCS has asked CMS for an STC amendment regarding MOE, and base years in particular. The request is that existing HCCI counties, use state FY 2006-07 as the base year, and new counties use state FY 2009-10. DHCS will be meeting with CMS on February 24 to discuss these corrections, but Jalynne does not anticipate a problem.
- By April 8, DHCS will notify applicants about approval or denial of applications. They do not anticipate any denials, but April 18 will be the deadline for counties to request reconsideration.

Authorization Process

- Once applications are approved, the authorization process – whereby the state must show CMS that the LIHPs meet network adequacy and access requirements – will begin.
- By April 8, DHCS should have draft primary and specialty care standards, and will provide additional instructions and requests for information on a flow basis.

Contracting Process

- Contracting process will begin April 18.
- HCCI allocations will be submitted to CMS for approval by May 17. Counties have been asked for their estimated allocation, and those will go to CMS after the state analyzes how they fit within the SNCP restricted limit. The state and CMS also must sign off on rates.

- By May 20, DHCS will have notified all HCCI applicants about their approved allocations.
- By May 20, all program requirements should be met to allow for implementation on June 1, 2011.

Richard Thomason, BSCF, asked whether the process for engagement with counties, once applications come in, will be on an individual basis or whether there will be additional meetings and webinars. Jalyne Callori said that staff will be assessing the applications to determine how much technical assistance is needed before making that decision. The LIHP advisory workgroup, currently comprised of four of the existing HCCI counties plus representatives of CHEAC, CSAC, and CAPH, will also assist in this process.

- Eligibility and Enrollment Processes; Outreach Plans

Hermann Spetzler, Open Door, asked whether there would be flexibility to allow for point-of-service enrollment, to allow the individual to enroll wherever they present for care. Jalyne Callori replied that screening information could be collected at the point of service/provider site, but that actual eligibility determination must be done by a county employee. Toby Douglas noted that the waiver does not include presumptive eligibility in this program.

Hermann Spetzler commented that the issue of point-of-service enrollment is important if health care reform is going to work, particularly for this population that has difficulty with life issues. If they are going to be enrolled, it must be done when they interact with their provider, whether in a mental health or medical setting. The enrollment process may seem irrelevant to them once their immediate needs are met, and this bureaucratic burden must be lifted from this vulnerable population. In addition, adding a layer of complication will further discourage participation by private providers who already avoid Medi-Cal because of low reimbursement rates. Toby Douglas said that out stationing of county workers to enroll people on site, and the use of community-based application assistants who can take applications and send them on to the county, remain options. People don't necessarily have to appear twice. In 2014 there will be an opportunity to expand presumptive eligibility to hospitals. *Hermann Spetzler* replied that with the available technology, there should be a way to make on-site enrollment happen. Out stationing county workers is cost-effective for hospitals because their bills are so high, and works in some FQHCs because of the volume, but will not work in small provider offices, and may keep the private sector from participating. It also may work indirectly to keep the most expensive individuals, who are least likely to manage an application process, out of the system.

Peter Harbage, SEIU, asked whether counties are supposed to have the same enrollment process for Medi-Cal and LIHP, or whether the LIHP process could be simpler and faster. Jalyne Callori said that counties are reporting that linking LIHP to some Medi-Cal

processes, such as DRA processes, may help streamline the LIHP process. LIHP eligibility is supposed to be similar to the Medi-Cal requirements in terms of income deductions and disregards. The application asks counties to identify what they are currently using, and in most cases they are aligning it with the existing Medi-Cal system. The state will be working over the next three years to link the county processes to an automated LIHP application that can then be linked to MEDS.

Marty Lynch, LifeLong, reported that his clinics (Alameda County) use One-e-App for their indigent care system, and that even with the county approval process, it works more quickly than the standard Medi-Cal process. Having to use the standard Medi-Cal process would be a tremendous barrier. Peter Harbage agreed, and said that while he sees there could be benefit to linking to the existing infrastructure, DHCS should permit flexibility to the extent possible. *Melissa Stafford Jones, CAPH*, said that while the first-round CIs did have some success with more streamlined processes, the DRA requirement put a weight on that process. There is a tension between the most expedient enrollment of the greatest number of individuals, and alignment with 2014 Medi-Cal enrollment. Peter Harbage said that it would be preferable to get more people enrolled in 2011, and then go back and figure out how to link them to Medi-Cal.

Elizabeth Landsberg, WCLP, clarified that there will not be an assets test in LIHPs, so it is the income and citizenship documentation that needs to be solved. Counties want to have access to the state system for citizenship documentation. Jalyne Callori replied that the state is working to design a parallel system to allow LIHP information to be transferred to MEDS. The 2014 transition will be a big process, and the state intends to support the counties in moving to that.

Tom Peterson, Association of California Health Care Districts, said that people are most likely to enroll only when they need health care services, not in advance. Is there a state plan for outreach and engagement or will that be counties' responsibility? Jalyne Callori said that this is left to the counties. *Anthony Wright, Health Access*, suggested that if all counties are participating in LIHP, it might be possible to have a statewide outreach and media plan, with a unified common message. The state should look for commonality wherever possible and market LIHP as a joint program, recognizing that there will be county-to-county variation. Counties might be able to chip in to support a statewide effort. Jalyne Callori agreed to look at this issue; Judith Reigel noted that statewide outreach efforts have not always been as effective as local ones and that in reality this will not be a statewide program.

Hermann Spetzler, Open Door, reiterated that the people who will be eligible for LIHP are already in the clinics and hospitals – in Mendocino, an estimated 3,000 individuals are potentially eligible, and 80% are already clinic patients while 20% use the emergency

department -- so inreach will be critical. Creative staffing and the use of technology for enrollment are essential. *John Schunhoff, Los Angeles County*, said that clinic and emergency department inreach had been the primary enrollment strategy in their HCCI. Jalyne Callori said that the HCCI experience to date was that behavior change in terms of health care utilization remains a challenge. USC is studying this issue and will be providing some information soon.

- Other Questions

Anthony Wright, Health Access, asked how LIHPs would be affected by the current budget proposals for hard caps and copays. Jalyne Callori said that DHCS will have to see what the legislature decides and then have a conversation with CMS. Melissa Stafford Jones said that the STC contains language on that issue, saying that to the extent that the State Plan changes, those changes can trickle down. Currently, the State Plan imposes medical copay protections, but if those are waived they may be waived for LIHP. She noted that CAPH is opposed to the hard caps in particular, as they contradict the whole premise of the waiver.

Anthony Wright, Health Access, asked how the public will be kept informed about the county application process. Jalyne Callori said that DHCS intends to provide as much information as possible on the website, and that people can register for the LIHP listserv as instructed on the first page of the LIHP webpage. Public meetings may also be scheduled.

Elizabeth Landsberg, WCLP, asked what questions counties had raised about out-of-network emergency care requirements. Jalyne Callori said that counties are asking whether these requirements, which apply only to MCE, would apply out of state, or out of country, as well.

Richard Thomason, BSCF, asked what technical corrections to the STC DHCS was seeking, beyond those mentioned earlier regarding MOE requirements. Jalyne Callori said that DHCS was only seeking clarifications, and that these would be posted by the end of February.

Elizabeth Landsberg, WCLP, asked for clarification of the definition of managed care according to the STC. Jalyne Callori confirmed that the definition is essentially any closed network, and that she anticipated that all applications would include closed networks. As a result, the timeliness and network adequacy standards in the STCs would apply, and these programs would have the option of implementing capitated rate structures.

DSRIP: Hospital Incentive Payments – Examples from Local Public Hospitals

Melissa Stafford Jones, President and CEO of CAPH, and Susan Ehrlich, MD, MPP, CEO of San Mateo Medical Center and Chair, CA Safety Net Institute, discussed the Delivery System Reform Incentive Pool (DSRIP), a key part of the Section 1115 Waiver. Their presentation is available at <http://www.dhcs.ca.gov/Documents/Waiver%20Stakeholder%20Advisory%20Group.pdf>.

Melissa Stafford Jones, CAPH, said that waiver renewal offered an opportunity for public hospitals to take the role that they provide today, along with some of the successful pilots they had been engaged in around quality improvement, and make them systemic, to better position the safety net and their patients to realize the goals of health care reform.

The DSRIP has a very strong future orientation. While there are elements of the waiver that continue public hospitals' essential core funding of 50 cents on the dollar for care to Medi-Cal beneficiaries and the uninsured, the new funding is tied to changing how hospitals do what they do. Essentially, the DSRIP embeds delivery system reform in hospital financing for the first time. DSRIP is closely linked to coverage expansion: the safety net's ability to provide additional hundreds of thousands of individuals with medical homes is dependent on these reforms.

Delivery System Reform Incentive Pool

- **Purpose:** The public hospital system requires investments to get to the promise of health care reform – similar to the federal investment in clinics under ACA. The waiver also tries to invest in financial alignment between the dollars that hospitals get and outcomes/quality of care. All the financing under DSRIP is risk- and performance-based. Hospitals lay out a series of goals and milestones that have to be achieved before money is paid out. DSRIP is part of a matching program, with public hospital systems providing a match via IGTs.
- **Opportunity:** The delivery system reform work will cross all elements of the public hospital systems' work, simultaneously, and will be very challenging. Some of it will be in areas where particular reforms are proven to work, and others will be more in the nature of testing innovations. There is a strong focus on learning and sharing learnings under DSRIP. CAPH members and the affiliated Safety Net Institute are very committed to that process.
- **Status:** The waiver was submitted without detailed plans for the DSRIP, and those are being completed now. Once the guidance is complete and approved,

each of the hospital systems will be required to submit 5-year-plans to the state and to CMS for review.

The DSRIP is organized under a Triple Aim Framework, with four categories of goals. Each public hospital system will have to achieve certain milestones in each category.

- Category 1: Infrastructure Development.
- Category 2: Innovation and Process Redesign
- Category 3: Population Health
- Category 4: Urgent Improvements in Care

Susan Ehrlich, San Mateo Medical Center provided an example of how her institution is proposing to meet the DSRIP requirements. She noted that the plans for SMMC are not final, and that while there are some broad similarities across hospital systems, each plan will be unique. SMMC had already developed broad goals, which underlie their DSRIP plan.

SMMC is a fully integrated system, with a hospital that providing acute medical and psychiatric care and a complete ambulatory system (11 clinics). SMMC served 70,000 patients last year, half in the ambulatory system (where 1/3 of visits are to children). SMMC partners with the one other FQHC in San Mateo county, and works closely with the Health Plan of San Mateo, a County-Organized Health System that functions not only as the payer for Medi-Cal and Medi/Medi, but also runs the county's indigent care program and previous coverage program. She noted that the DSRIP and LIHP are integrally related, and that it will be challenging to implement the DSRIP projects at the same time as LIHP.

Jeff Flick, Anthem Blue Cross, commented that Anthem is trying to do the same sort of work on a much larger scale (Anthem manages 34 million lives), and said that the company is interested in being helpful to these efforts as they are able. He said that this work is challenging regardless of the size of the system: trying to understand data and do evidence-based care every day is a huge undertaking.

Marty Lynch, Lifelong Medical Care, said that he hopes that the DSRIP plans will present opportunities for institutions across the low-income delivery system to collaborate.

Chris Perrone, CHCF, noted that the DSRIP development was not part of the public Stakeholder process, and asked what the plan would be going forward to keep people apprised of different hospital systems' plans. *Toby Douglas, DHCS*, responded, first, that DHCS is very excited about DSRIP and the opportunity for the department to focus more on quality and Triple Aim. DHCS will be bringing in more staff to provide providing consultation and oversight public hospitals. DHCS is responsible for reviewing hospitals' plans to ensure that they meet all the categories and that objectives are meaningful. (CMS will also review

DSRIP plans.) Plans will be publicly available, but there is no plan for stakeholder involvement in deciding the milestones.

Anthony Wright, Health Access, asked about public process at the county level? Susan Ehrlich said that the hospital board was the primary location for public involvement, though San Mateo also has a number of stakeholder meetings. Melissa Stafford Jones noted that once the protocol is done it becomes part of the waiver Statement of Terms and Conditions, and that there will probably be an annual aggregate report. CMS is very focused on shared learning and moving the field forward, and will require extensive dissemination of the DSRIP results.

Richard Thomason, BSCF, asked how DSRIP financing works. Melissa Stafford Jones said that each plan will have the dollars associated with the total plan, allocated across the hospitals. Each hospital will allocate dollars across the categories and the projects or bundle of projects, by year. At the end of each time period, hospitals will report, and once the state and CMS have signed off on them meeting the milestones, they will be paid.

Santiago Munoz, University of California, said that the DSRIP is an exceptionally exciting effort, and that it is great to be paid to move in a direction in which you'd want to move anyway.

Public Comment

Connie Arnold introduced herself as an individual with disability and an advocate. She raised the following questions:

- How is Medi-Cal Managed Care going to impact seniors and persons with disabilities who are part of the 250% working disabled program?
- How will access to out-of-network hospitals be handled? What if a person has particular needs and wants to go to Stanford Hospital, for example?
- How many appeals will a person need to fight for specialty access?
- How is IHSS impacted by the waiver? The social model of IHSS should not be lost in favor of a medical model.
- What happens to physician and prescription access for people with disabilities if the proposed limits of 10 visits/year and 6 prescriptions/month go through?
- Is the HIPP program telling people they have to pay up front and be reimbursed? I have a friend transitioning from federal to state COBRA. Kaiser Oakland called in December and then the person received a letter denying them access because they'd reached the 18 month limit, even though they have 11 month extended COBRA through ARRA. This is a person on a low income/fixed income who is

transitioning to Medicare to in 5 months. A lot of people with disabilities don't have the skills to negotiate with member services and make this happen for themselves.

- Access is important, including accessible patient rooms and bathrooms. Barrier removal is supposed to have happened already, but unless the providers hire a competent person to review access, there are still barriers.
- How will patients have access if a hospital chain decides to exclude certain services, particularly reproductive health services, or if a person is assigned to a hospital that restricts services on a religious basis?

Connie Arnold said that she hopes to see answers to these questions in writing, and noted that many questions about the SPD transition have not yet been answered, and that many people are not happy about the change. Toby Douglas asked for a copy of the questions, and noted that dually eligible individuals will not experience any changes in coverage at this time. Connie Arnold said that she understood that as a dual-eligible she was not immediately affected, but that she is representing the viewpoints of others, including Medi-Cal beneficiaries who know that providers don't want to treat them because the reimbursement rates are so low. There are many issues that people don't think about when people with disabilities want to enter the workforce, and rules that constrain their lives.

Tom Bone, ED, APS Health Care, said that he wanted to bring notice to an innovative program that his agency currently runs. APS Health Care has two contracts, one with Aged, Blind and Disabled (ABD) beneficiaries in 16 counties who need care coordination, and a second contract for people with serious mental illness (SMI). APS uses coaches who are nurses and social workers, field-based and supported by a team in Sacramento. These coaches focus first on members' psychosocial needs and then, when those are satisfied, do specific disease case management. Seven of the contracted counties will be transitioning to managed care for SPD under the waiver. APS has a strong knowledge of the individuals who will be affected and would like to assist DHCS as it goes forward.

Next Steps, Next Meetings, and Adjourn

Bobbie Wunsch thanked Judith Reigel and Richard Chambers for facilitating the small group discussions, and thanked Melissa Stafford Jones and Susan Ehrlich, MD for their DSRIP presentation. She acknowledged the work of Toby Douglas and the DHCS staff.

The next meetings of the SAC will be on Wednesday, June 1, 2011, and Thursday, November 3, 2011 from 9:30 AM to 12:30 PM at the Sacramento Convention Center.

The meeting adjourned at 12:34 PM.