

**SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER  
STAKEHOLDER ADVISORY COMMITTEE (SAC)  
Meeting #9 – Wednesday, June 1, 2011  
9:30am – 12:30pm**

The meeting convened at 9:35 AM.

Attendance

*Members attending:* Kelly Brooks, California State Association of Counties (CSAC); Mike Clark, Kern Regional Centers (by phone); Cindy Ehnes, California Children's Hospital Association (CCHA); Jeff Flick, Anthem Blue Cross; Brad Gilbert, Inland Empire Health Plan (IEHP) (by phone); Sandra Naylor Goodwin, California Institute of Mental Health (CiMH); 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); Eileen Kunz, On Lok Senior Health Services; Ingrid Lamirault, Alameda Alliance for Health; Elizabeth Landsberg, Western Center on Law & Poverty (WCLP); Marty Lynch, California Primary Care Association (LifeLong Medical Care) (by phone); Chris Perrone, California HealthCare Foundation (CHCF); Tom Petersen, Association of California Health Care Districts; 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); 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) (by phone); Barbara Siegel, Neighborhood Legal Services of Los Angeles County (NLS); Stuart Siegel, Children's Hospital Los Angeles (CHLA); Marv Southard, Los Angeles County Department of Mental Health; Hermann Spetzler, Open Door Community Health Centers; Richard Thomason, Blue Shield of California Foundation; Anthony Wright, Health Access California.

*Others attending:* Toby Douglas, DHCS; Brian Hansen, DHCS; Tanya Homman, DHCS; Bob Baxter, DHCS; Neal Kohatsu, DHCS; Luis Rico, DHCS; Steve Day, TAC-HSRI.

*Public in attendance:* 40 members of the public attended in person, and \_\_\_\_ attended via the listen-only call-in line.

Welcome, Introductions and Purpose of Today's Meeting

*Toby Douglas, Director, DHCS, welcomed the group and introduced the agenda.*

He thanked Bobbie Wunsch, Pacific Health Consulting Group, for facilitating the SAC meetings since 2010, noting that DHCS would be taking over direct facilitation now that the process is in the implementation phase.

Toby Douglas said that DHCS has been reorganized to put a focus on financing, delivery systems, and eligibility and benefits. He introduced Jane Ogle, formerly of the Santa Clara Health Plan, as Deputy Director, Health Care Delivery Systems, and Mari Cantwell, formerly of California Association of Public Hospitals, as Deputy Director, Health Care Financing. He also introduced DHCS' new Medical Director, Neal Kohatsu, MD, who will work on efforts to enhance clinical quality and outcomes.

Douglas described the impact on DHCS of proposals in the May Revise:

- *Integration of DMH into DHCS* – This proposal would bring the state's behavioral health functions, including Short-Doyle and drug Medi-Cal, under DHCS. Douglas described it as a good proposal from the perspectives both of financing (having a single entity within the Health and Human Services Agency that understands Medicaid rules and financing) and delivery. DHCS is strongly supportive of this proposal, which enhances the importance of behavioral health within the overall health care context.
- *Healthy Families into Medi-Cal* – The proposal in the May Revise would transition all children currently in HFP into Medi-Cal, expanding Medi-Cal income eligibility for children to 250% FPL. This proposal anticipates the changes that will come in 2014 by streamlining and combining programs, and is similar to what the state has done with SPD transition. Douglas said that DHCS was committed to maintaining access to services, and said that the two programs currently share plans and provider networks, including dental. The proposal is the right thing to do from both the state's and the consumers' perspectives.
- *Plan Change Restriction* – The May Revise also contains a proposal for 12 months continuous coverage in the same plan. DHCS proposed it from a budgetary standpoint, but also believes it would improve continuity of care, coordination with providers, and measurement, as some accountability is lost when people move between plans. Both the Assembly and Senate have rejected this proposal.

Douglas also reported on other developments related to the waiver and ACA implementation:

- *Medicare/Medi-Cal Dual Eligibles* – Douglas reported that California was one of 15 states to receive a federal grant (\$1 million for California) from the Office of Duals at CMS. RFIs from plans and consumers about how to structure pilots were due to

DHCS on June 1, 2011, and these will be used to help DHCS write the RFP for pilot integration programs.

- *Health Home Option* -- DHCS has contracted with Health Management Associates and Mercer for assessments of the viability of picking up the health home option under the ACA. The option includes 90% federal financial participation; the challenge is to implement it without creating a new general fund impact. The program would be focused on SPD and family populations, but the legislation also requires that the option be provided to dual eligibles. That piece would be a new expense for state, but might be offset by the change from 50/50 to 90/10 federal/state share. The funding might potentially be available for behavioral health services, In Home Supportive Services (IHSS) and other home- and community-based services (HCBS), as well as for the county Low Income Health Programs (LIHP).
- California received a six-month extension of the hospital fee, which helps ensure viability of the hospital system and brings in additional general fund resources.
- DHCS has been working on technical changes to the waiver's Terms and Conditions, including adding additional state-only programs and rolling some funding over to other components of the waiver.

*Elizabeth Landsberg, WCLP*, asked whether those technical amendments were complete and available. Toby Douglas replied that they are in progress, and will be posted when finalized.

*Elizabeth Landsberg, WCLP*, asked whether the health homes proposal would include fee-for-service Medi-Cal as well as managed care. Toby Douglas said that the contracted assessment is looking at all different options. Federal law allows states to limit it geographically, and by certain conditions, but not by population.

#### Update on Implementation Efforts on SPDs

*Tanya Homman, MMCD*, presented an update on mandatory enrollment of Seniors and Persons with Disabilities (SPD) in Medi-Cal managed care, effective June 1, 2011. Her presentation is available at

<http://www.dhcs.ca.gov/Documents/SPD%20Transition%20Update.pdf>.

- **Community Presentations** were conducted in all 16 counties.
- **Internal/External Trainings** have been extensive, and have included the DHCS Office of the Ombudsman, DMHC, and the DSS Fair Hearings Office, among others.
- **Network Access Reviews** called for numbers higher than are necessary for the initial rollout, in order to assure that plans will be able to provide the care. MMCD will continue to watch this process carefully, including through DMHC quarterly monitoring.

- **Contracts** – DHCS worked closely with the plans and CMS to amend contract language. Boilerplate contracts were to be posted by June 3, 2011.
- **Deliverables**, including health assessment policies and access measures, among others, have been revised by plans and approved by DHCS.
- **Risk Stratification / Health Assessments** – Plans are required to conduct risk assessment for all newly enrolled SPDs, and conduct a health assessment within either 45 or 105 days after enrollment. DHCS issued a policy letter on this topic in January 2011. Plans received test files of data in order to test their risk stratification.
- **DMHC/DHCS Interagency Agreement** regarding quarterly reviews and other issues is due to be finalized soon.
- **Data Sharing** – DHCS conducted live data sharing in May 2011 in order to test the systems. DHCS was able to transmit data more quickly than anticipated (6 days v. 8 days), but fixing TAR data required two additional days. Tanya said she expects this time to improve. All plans pulled down the data within the allotted time period (2 weeks).
- **Stakeholder Data Workgroup** (established under SB 208) met four times in April and May 2011 to review existing encounter data and provide input on data quality. Their work will lead to a new data system to be implemented in 2012, with an all-plan letter anticipated in October 2011. Data collection according to this system will be a new contract requirement; plan failure to submit data according to the standard will result in penalties.
- **Webinars** – Tanya thanked the California HealthCare Foundation for funding five statewide sessions to present a webinar on the Senior and Persons with Disability (SPD) transition into Managed Care. The webinar was made accessible to a broad audience with captioning and sign language interpretation and is available online at: [http://c669403.r3.cf2.rackcdn.com/MEDI-CAL\\_Webinar\\_10min%20DL.wmv](http://c669403.r3.cf2.rackcdn.com/MEDI-CAL_Webinar_10min%20DL.wmv)
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- **Letters of Interest** – SB 208 permits DHCS to contract with additional interested health plans for SPD and other Medical beneficiaries. A Letter of Interest released April 21 solicited plans that are interested in contracting in certain managed care counties, and approximately 12-14 plans responded by the deadline of May 23. All were Knox-Keene licensed plans. In the event that DHCS decides that it does need to bring in additional plans, the Department would release an invitation for the particular county and proceed from there.
- **Adjustments**
  - Informing notices had to be edited to clarify for members the last date on which they can seek enrollment. The amended notices did not reach all May birthday members in time, so the Intent to Default letter and HCO scripts were modified accordingly.
  - A new member notification about who to call for assistance also was developed; it went out as a separate mailer for the May group but will be part of the confirmation of health plan enrollment letter for members going forward.

- Mandatory enrollment for ICF, CCS, foster care, and other aid codes was eliminated.
- Continuity: There is a legal conflict between two-plan model regulations, which prohibit disenrollment after 90 days, and the SPD transition regulations that allow beneficiaries with continuity issues to remain with their FFS provider for 12 months. DHCS is now working with advocates on what happens to those beneficiaries who continue to have continuity problems past 12 months. More is forthcoming on this issue.  
(Additional clarification: The 90 day period relates to requirements in CCR, Title 22, Section 53887 that outlines the requirement on Medi-Cal Exemption Requests (MERs). Under this process, a beneficiary is requesting to not be in a managed care health plan, but instead go back to or remain in Fee-For-Service.)

Homman reviewed the results for the first month of mandatory SPD enrollment:

|                                 |        |                                  |
|---------------------------------|--------|----------------------------------|
| • 90-day Upcoming Change Notice | 30,230 |                                  |
| • 60-day Enrollment Packet      | 29,532 |                                  |
| • 30-day Reminder Letter        | 19,908 |                                  |
| • Plan Choosers                 | 7,976  | (31% of those receiving packets) |
| • Defaults                      | 17,792 | (69%)                            |
| ○ Linked                        | 1,411  | (8%)                             |
| ○ Defaulted                     | 16,381 | (92%)                            |
| ○                               |        |                                  |
| • Total May Enrollees           | 25,768 | (-14.76% from 90-day notices)    |

Homman said that the 30:70 ratio between choosers and those defaulted into a plan is similar to rates DHCS has seen in other new areas and populations, and that the ratio typically flips to a majority choice over the course of the first year. According to HCO, the June birth month cohort is responding much more quickly than the first group.

Homman said that among the 69% who were defaulted into a plan, DHCS was able to link only 8% to an existing provider, and said that DHCS had hoped to see a significantly higher rate. Staff are analyzing the data, which only became available the day before the meeting, and while there are no definitive findings yet, a few potential factors were cited:

- While overlap between FFS providers and plans did increase in 2011 compared to the 2010 test period, that increase was in the broad network required of health plans, and may not reflect the overlap for PCPs and clinics, which is what linkage requires.
- Early indications are that 20-22% of the population defaulted did not have any usage information in MEDS.

- Physician identifiers in the FFS system may be “off.” An individual doctor may work with a hospital, IPA or clinic (or more than one of those), and may bill by different mechanisms which makes matching more difficult.

*Hermann Spetzler, Open Door*, asked how many total enrollees remained with their FFS providers. Tanya Homman replied that it is too early to answer that question, and that even if beneficiaries were not linked, plans are able to use the file data they received to enroll the FFS providers in their networks and thus more beneficiaries may end up in care with their existing providers.

The gap between the number of enrollment packets and the number who eventually enrolled (-14.76%) may be due to enrollment fluctuations: a member may have lost eligibility, or moved into the dual population. DHCS will be looking closely at the data, and working to increase provider linkage rates in particular.

*Anthony Wright, Health Access*, asked for clarification on the DHCS’ thinking on why 92% of defaulted beneficiaries could not be linked to an existing provider. Tanya Homman repeated that 22% of those who were not linked had no utilization, and that staff are working to answer the question for the remainder.

*Elizabeth Landsberg, WCLP*, asked whether the linking algorithm looked for specialists as well as primary care providers: Tanya Homman said that it did, but that even so the linkage rate was only 8%.

*Anthony Wright, Health Access*, asked why DHCS believes that the June cohort will be less likely to default. Tanya Homman said that she believes that information about mandatory enrollment is disseminated fairly rapidly, so the situation can change from month to month, as it has in places like Kings and Madera counties most recently.

*Barbara Siegel, NLS*, asked whether county-level data would be made available. Counties have the ability to help people choose. Tanya Homman said this data will be in the HCO enrollment report, and that staff are currently developing a template. *Brad Seligman, IEHP*, said that in the first month, Inland Empire Health Plan’s data show that 60% chose a plan but only 50% chose a PCP that IEHP can match.

*Chris Perrone, CHCF*, said that while it’s helpful to know that DHCS is concerned about the 8% linkage, it would also be helpful to know what DHCS’s numerical goal is, and what rate would trigger a change in course (whether by expanding outreach, working locally, or through some other means). Tanya Homman said that while DHCS does not have a formal trigger, if improvement is not forthcoming over a 3-6 month period, DHCS will look at how FFS providers are submitting billing, for example. The process is continually evolving, and DHCS’ goal is to make it as smooth as possible for all members. *Peter Harbage, SEIU*,

suggested looking at other states to determine a benchmark, and Tanya Homman agreed that DHCS would do that.

*Melissa Stafford Jones, CAPH*, asked how the enrollment numbers relate to the Department's projections regarding budget neutrality and savings. Toby Douglas, DHCS, said that the Department does not have an exact answer; that monthly numbers fluctuate and savings are projected annually. Exempting the ICF population from mandatory enrollment reduced the savings, but there is no reason to think that the overall projections are off. He also said that the interface with plan will be very important, since if the plans actually have the providers enrolled but the state systems aren't linking people to them, it may be a data issue more than an actual network issue.

*Jeff Flick, Anthem Blue Cross*, said that while there may be problems with the data, the critical issue is that everyone gets to an appropriate medical home. While the goal is to maintain people with existing providers, a provider change may not be a problem, and may in fact be a good thing if a member ends up with a medical home that they like and where they receive comprehensive care.

*Anthony Wright, Health Access*, said that in addition to concerns about continuity of care, linkage is also a marker of how well the system is working and of the level of consumer engagement. While it may not be a bad thing to change providers, consumers should be actively engaged in this process.

*Marty Lynch, LifeLong*, asked whether existing data allowed Health Care Options (HCO) to link beneficiaries to county clinics and FQHCs, or only to individual doctors. Tanya Homman clarified that linkage is to both providers and clinics.

*Bob Prath, AARP*, said that some dual eligibles and CCS-linked children received informing letters erroneously, and asked whether that problem was being corrected going forward and if those individuals would be or had been defaulted. Tanya Homman said that investigations by DHCS had found that the problem was due to people being miscoded by county eligibility systems or mistaking annual voluntary letters for mandatory letters, and said she was very confident that the system is in line. *Barbara Siegel, NLS*, disputed this, saying that her office has seen dual eligibles who are in aged and disabled aid codes and who are getting letters. Tanya asked to see these letters.

*Barbara Siegel, NLS*, also said that some beneficiaries who use a specialist as their PCP but do not see their names listed in the enrollment materials are failing to choose those providers, although they are entitled to do so.

Tanya Homman also described statistics regarding outbound calls to beneficiaries to encourage them to choose a plan and the receipt of health information forms.

- Outbound Calls:
  - Contact Success 35,408 (31%)
    - Choice Made 273 (.24%)
    -
  - Contact Failed 80,143 (69%)
  
- Health Information Form (HIF)
  - Mailed 121,016
  - Completed 23,644 (19.54%)

Homman noted the very low success rate of outbound calls as far as leading to a plan choice in that call. Of all the outbound calls (up to five per beneficiary), only 31% were successfully completed: 23% were hang-ups, 5% wanted more information, and 1.5% were wrong numbers. Only .24% of calls resulted in a plan choice by phone.

*Jeff Flick, Anthem Blue Cross*, said that reaching this population by phone is a huge challenge for health plans, as well. People are willing to give information by phone when they are seeking health care services, but not in “cold calls.” *Brenda Premo, Harris Center*, took issue with the focus on a particular population, and said that reaching people by phone in an era where they have become cautious about identity theft and other privacy issues is universally difficult. In focus groups, SPD individuals say that they do not trust people on the phone and don’t want to provide personal information in that setting. *Barbara Siegel, NLS*, seconded that comment and said that in trainings people had complained both about “pressure calls” from HCO, and also had been surprised that they would be asked to make such a choice on the phone. Tanya Homman clarified that no one is *required* to choose in the phone call, but otherwise agreed with those comments.

*Cindy Ehnes, CCHA*, suggested that plans could help benchmark reasonable expectations for this work. *Marilyn Holle, Disability Rights California*, suggested trying to collect and use beneficiaries’ email contacts, but Tanya Homman said that MEDS does not have that capacity.

*Peter Harbage, SEIU*, said that given the very low response rate the outbound calls may not be worth the effort as part of plan choice, though they may have some use as an educational tool. *Tim Schwab, SCAN Health Foundation*, noted that this experience will be useful in planning for enrollment of dual eligibles.

- **Next Steps**

Tanya Homman reviewed the monitoring plan. She noted that DHCS had seen an increase in Medical Exemption Requests (MERs) and fair hearings calls. The Office of the

Ombudsman reported 1002 calls between March 1 and May 20; of those, 28.5% were about remaining in FFS, 22% were eligibility-related, and 13.77% were people asking for additional information or to enroll in managed care.

DHCS will continue to work with stakeholders to implement Expanded Utilization Data.

Tanya Homman said that DHCS is committed to “Adjust to Improve:” looking at the data and making things better. She cautioned that changes take time, and said that the SPD enrollment process has prompted a wholesale review of informing and enrollment materials for all populations. She said she would be asking stakeholders for help on this.

*Jeff Flick, Anthem Blue Cross*, noted the exceptional effort by Tanya and her staff. Toby Douglas commented that Tanya has done an amazing job of working through these issues under a great deal of pressure.

Website for SPD enrollment: [www.dhcs.ca.gov/spdinfo](http://www.dhcs.ca.gov/spdinfo).

#### Update on Implementation Efforts on LIHP

*Bob Baxter, Chief, LIHP Implementation Unit* presented a timeline of activities and a chart of LIHP application data, both available with the rest of his presentation at <http://www.dhcs.ca.gov/Documents/LIHP%20Update.pdf>.

In all, DHCS is processing 27 applications including 24 counties, the California Rural Indian Health Board, the City of Pasadena, and the California Medical Services Program (CMSP), representing 34 rural counties.

#### **Program Issues**

- Ongoing discussions with LIHP Workgroup regarding deliverables and federal guidance on STC provisions including:
  - LIHP hearings and appeals process
  - Managed care requirements applicable to LIHP
  - Cost claiming and reimbursement protocol (CPE only)
    - Under development and will go to CMS for approval
  - LIHP contract process
    - DHCS is working with CMS on documentation to show compliance with MCE requirements by July 1, 2011, with a goal meeting the requirements via contract
  - Interface between LIHP and Ryan White Act federal funding
    - DHCS will meet with Ryan White program representatives, HRSA and the LIHP workgroup to talk about the implications of including Ryan White patients in LIHP. That meeting has not yet been scheduled.

- Development of the LIHP component of the waiver evaluation and secure funding
- UCLA is the evaluator for the LIHP
- Collaborating with LIHP workgroup to identify significant and valuable evaluation needs for LIHPs and the State
- SSN Validation/Citizenship requirement system approach
  - DHCS is polling the original 10 counties; their approach will guide what the state does with the new counties

### **HCCI Allocation and Program Authorization Interface–**

- Collected HCCI allocations for submittal for CMS
  - Waiting for CMS approval
- Major Steps in the authorization process and prioritization
- State Prison Inmates Project interface
  - Project on target, began eligibility determination in May 2011, discussions ongoing with LIHP workgroup, counties and new counties.

### **LIHP Collaboration**

- Collaboration with LIHP Workgroup for development of procedures and protocols
  - Bi-monthly working conference calls
  - Workgroup represents 10 existing CI counties, 2 new LIHP county representatives, and other stakeholder partners
- LIHP Forum – New opportunity for latest info on program and to provide input (first meeting 6/6/11)

*Anthony Wright, Health Access*, asked whether the LIHP Workgroup has any consumer representation. Bob Baxter said that while they are not seated on the workgroup, members of the workgroup do talk to consumer advocates. *Elizabeth Landsberg, WCLP*, clarified that there are no consumer advocates at the table, and that it is a problematic process from the advocates' perspective.

*Toby Douglas, DHCS*, said that the new biweekly meeting is designed to respond to these concerns, and will be venue in which consumers can engage with the LIHP workgroup. *Anthony Wright, Health Access*, said that his organization, CPEHN, WCLP and others had all written with concerns about the existing process. He clarified that the new meeting would be distinct from the LIHP Workgroup, and asked what the distinction is. Toby Douglas replied that the LIHP Workgroup is more internal, due to specific concerns that affect county and state governments, and agreed that there is a need for a broader engagement.

*Jeff Flick, Anthem Blue Cross*, commented on the proliferation of new initiatives and projects, and suggested that DHCS give some thought to how to maintain stakeholder engagement in all these efforts, perhaps through sub-committees of the SAC. Toby Douglas

agreed that all the ongoing efforts need stakeholder engagement. He said that for the LIHP effort the approach seems right, that it is important both to have a forum for state and local governments to meet privately, and also something broader.

*Bob Prath, AARP*, raised concerns about potential confusion among consumers about LIHP and SPD programming, particularly in the area of mental health, and suggested that outreach to providers would help in minimizing this confusion.

*Marv Southard, LACDMH*, said that there is also information-sharing and stakeholder involvement at the local level, with both providers and consumer representatives.

### **Next Steps**

- Complete building the internal claiming process for authorizing invoices and payments to LIHPs
- Capitation rate development and approval process
- Full contract execution on a flow basis per local LIHPs demonstration of readiness
- Plan and convene LIHP statewide meetings in October 2011 and October 2012

*Barbara Siegel, NLS*, asked about the July 1 implementation date, and what would happen if contracts are not complete at that time. Bob Baxter said that DHCS is currently in discussions with CMS to allow the claiming process to go forward even if contracts are not complete, by proving compliance in all other areas as of July 1. At this point, DHCS believes that counties will be able to claim as of that date.

*Richard Thomason, BSCF*, asked for more detail on the claiming authorization process. Bob Baxter responded that the authorization process begins with the first RFP. An authorization team made up of experts from each county and DHCS staff meets individually with counties to make sure they meet the requirements. This will happen over the next six weeks, and DHCS is simultaneously working with CMS to get MCE approval. In response to a question from Barbara Siegel, NLS, Bob Baxter also said that they are moving forward with establishing hearing and appeals processes, and have asked counties to supply that first. The state appeals process is in place and will be ready on time.

Toby Douglas commented that there is a lot to do in the LIHP area but that CMS and DHCS are both committed to being ready on time.

### **DSRIP: Hospital Incentive Payments – Update**

*Neal Kohatsu, MD, Medical Director*, presented an update on the DSRIP, available at <http://www.dhcs.ca.gov/Documents/DSRIP%20Progress%20Report%205-20->

[11%201220.pdf](#). He acknowledged the assistance of Amber Kemp in preparing the presentation.

### **Year 1 Progress:**

- All 17 public hospital systems completed Year 1 milestones
- Payments of \$600M were paid out pursuant to the agreement, most in the category of infrastructure development

### **Examples of Category 2 (Innovation and Redesign) projects**

- Expand medical homes
- Expand chronic care management
- Primary care redesign
- Integrate physical and behavioral health
- Apply process improvement methods to improve quality and efficiency

### **Conclusions**

- The public hospital systems are on track with respect to each DSRIP plan
- Payment systems have been established and payments released, on time
- Years 1-2 are building infrastructure and systems
- Years 3-5 will be focused on outcomes

*Brenda Premo, Harris Center*, asked what the Department's plans were to ensure physical access to hospital equipment for SPD populations. The accreditation process does not include equipment access, and while public hospitals say that serving persons with disabilities is high on their list of priorities, she said she had yet to see anything related to this issue, which is critical for both patient and staff safety. Neal Kohatsu said that he could not answer on behalf of plans or hospitals, but from the DHCS perspective is interested in evaluating hospitals in this regard. He proposed putting it on the planning list for working with hospital and plan partners in accordance with ACA. Brian Hansen, DHCS, said that he would raise this issue with MMCD, as well.

*Anthony Wright, Health Access*, asked how DSRIP outcomes would be reported. Melissa Stafford-Jones said that each hospital's plan details the outcomes they will report each year, and that these are required to be reported every six months. The waiver STC calls for an annual aggregate report, as well. Neal Kohatsu said that DHCS will work with CAPH and the Safety Net Institute on the reporting of outcomes.

### **Update on Implementation Efforts for CCS Pilots**

*Luis Rico, DHCS, Systems of Care*, provided an update on the CCS pilots. His presentation is available at

<http://www.dhcs.ca.gov/Documents/Stakeholder%20Workgroup%20Update%20June%202011v2.pdf>.

- The final RFP was released on April 19, 2011, with a proposer's conference held on May 10, 2011.
- Proposals are due to DHCS on July 15.
- Potential bidders had a number of questions about the data. A data book with 58 different data elements is available. Because of the small numbers, there are confidentiality concerns about potentially identifying information, and so the book can be available with a Letter of Intent and signed confidentiality agreement. A proposer's conference on the data book is scheduled for June 8, 2011.

Rico discussed the evaluation of the CCS pilots, and said that, at minimum, evaluations would include assessment of:

- The types of services and expenditures for services.
- Improvement in the coordination of care for children.
- Improvement in the quality of care.
- Improvement in the value of care provided.
- The rate of growth of expenditures.
- Parent/Provider satisfaction.

Rico thanked the stakeholders who had been part of the CCS group, and thanked CHCF for supporting the work of Paul Weiss in analyzing the CCS data.

*Jeff Flick, Anthem Blue Cross*, asked whether DHCS had an understanding of the savings expectations in the CCS pilots. Luis Rico responded that there is no specific savings goal, and that the focus is primarily on improving the quality of care while remaining budget neutral.

*Barbara Siegel, NLS*, suggested that DHCS be sure to look at primary care outcomes as well as specialty care outcomes in doing the evaluation of the pilots.

In response to a question, Rico said that the implementation date remains January 1, 2012.

*Barbara Siegel, NLS*, noted that it was possible to get around the HIPAA issues with the CCS data through a signed confidentiality agreement, and wondered why the same mechanism couldn't be used to allow SPD claims data to be provided to plans in a more timely manner. Toby Douglas said that DHCS would look at this.

*Marilyn Holle, DRC*, asked how the Department would judge cost neutrality in a program which may achieve cost savings in the out years, but not immediately. Toby Douglas responded that this important issue will be raised with the final evaluation team.

*Stuart Siegel, CHLA*, said that at a symposium on CCS pilots and the ACO model in particular, one repeated theme was that development of such a model takes a lot of time. He asked whether the evaluation of pilots would take this timetable into account. Luis Rico said that DHCS is aware of this issue and will look at the development of the ACO or any other model as it's submitted.

*Barbara Siegel, NLS*, asked whether CCS-enrolled children who do not become part of pilots will then be part of the mandatory SPD enrollment, or if they would remain carved out. Toby Douglas said that DHCS is not now enrolling CCS/SPD beneficiaries, but that the current plan is that those not in CCS pilot counties will be phased in to managed care plans once the CCS pilots are identified. There is legislation pending on extending the CCS carve-out, and DHCS has no position on that at this time.

#### 1115 Waiver Behavioral Health Assessment and Plan

Toby Douglas, DHCS, said that one requirement of the waiver was to investigate the continuum of services across medical and behavioral health. DHCS has contracted with Technical Assistance Collaborative (TAC) and Human Services Research Institute (HSRI), both in Boston, for this work, with funding from SAMHSA and TCE.

*Brian Hansen, DHCS*, said that DHCS has been working with the contractor, a broad external workgroup of behavioral health organizations both inside and outside of government, and CMS and SAMHSA, on the broad structure of the assessment. TAC/HSRI has also reviewed the work of the Behavioral Health Integration workgroup. The assessment's primary goal is to describe current behavioral health utilization and need, and to determine what additional services and resources will be needed to accommodate the ACA expansion.

A separate website has been established for this project, linked through the waiver renewal website or available directly at

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

. The workplan will be made available at that site, with comments due by June 15, 2011.

The contractor is seeking the names of individuals and organizations for key stakeholder interviews; these can be sent to [1115BehavioralHealthAssessment@dhcs.ca.gov](mailto:1115BehavioralHealthAssessment@dhcs.ca.gov). DHCS will provide updates at future SAC meetings, including a midterm update on the progress of the assessment.

*Steve Day, Technical Assistance Collaborative (TAC)* presented on the proposed structure of the workplan. His presentation is available at <http://www.dhcs.ca.gov/Documents/CA%20Logic%20Model%20-%20draft%20v6.pdf>. Day said that the timeline for the work is June 2011 through January 2012; DHCS has a report due to CMS in March 2012 for which this project can be a source.

*Sandra Naylor Goodwin, CIMH*, said that she is familiar with the work of the contractor organizations and is happy with the choice. CIMH has done some of the work that TAC describes and would be happy to share it. She asked about how the project will handle parity requirements. Steve Day said that Medicaid expansion and parity go hand in hand, and that the project will use the federal definition of essential services as part of the template.

*Marv Southard, LACDMH*, said that one thing that will complicate the analysis and timeline is the proposal for public safety realignment, which will move new people with significant behavioral health needs from state to county responsibility. The analysis must take that into account. A second complicating factor is the gap between those needing and those wanting services, which is a significant issue among our stakeholders. Steve Day agreed, citing studies that fewer than 50% of people with schizophrenia nationally ever present for services.

*Sharon Rapport, CSH*, also praised the selection of TAC, and asked whether the project would look at social determinants of health -- such as housing -- on costs and outcomes, and at linkage to services outside the traditional health care system. Steve Day said that TAC has worked with CSH on other system costs and linkages, and while that research won't be recreated here it will be discussed in terms of the negative impacts of underutilizations. At a qualitative level, the project will include incentives and mechanisms for linkage to non-health services, recognizing that people with behavioral health needs typically get most of their services from other systems.

Steve Day said that the analysis will include best practices in other states, as well as in the private sector.

*Hermann Spetzler, Open Door*, mentioned issues specific to rural California, among them staffing for behavioral health care. One limitation is that master's level therapists, such as MFTs, can't participate in Medi-Cal. As a result of staff shortages, many of those that health centers could most effectively treat are left behind as providers have to use their very limited resources for individuals who present in the "4<sup>th</sup> quadrant" of high behavioral and medical need. Steve Day said that TAC is experienced in rural and frontier access issues.

*Marilyn Holle, DRC*, said that she hoped the analysis would look at the intersection between behavioral health and the Department of Rehabilitation. California uses Medicaid to fund

supported employment for regional center clients, but not for individuals in the behavioral health system. She cited programs at Boston College as a model.

*Brenda Premo, Harris Center*, said that the research should look at people with dual diagnoses (schizophrenia and deafness, Alzheimer's and mental illness) and figure out where to provide the service in order to reduce the very high cost of care for this relatively small group of people.

*Richard Thomason, BSCF*, said that he hoped the study could look at policies and strategies to address local barriers to integration between behavioral health and primary care at the county level, and disincentives for behavioral health integration as a result of FQHC payment through a PPS rate.

#### 1115 Waiver Evaluation – Update

*Brian Hansen, DHCS*, discussed evaluation of the waiver components. His presentation is available at <http://www.dhcs.ca.gov/Documents/Evaluation%20Components%20Update.pdf> and he can be contacted directly with questions at [Brian.Hansen@dhcs.ca.gov](mailto:Brian.Hansen@dhcs.ca.gov).

*Stuart Siegel, CHLA*, asked how long it will take to build the CCS pilots to a point where they can be evaluated sufficiently to choose one model over another for statewide implementation. Luis Rico, DHCS, said that the evaluation advisory committee and the evaluators themselves will have the job of determining that. Neal Kohatsu noted that Steve Shortell at UCB and others are looking at factors that predict ACO success, and that DHCS is following the research in that area.

*Marilyn Holle, DRC*, said that the federal goals of Title V/CCS are broader than just serving the children in the program, and include defining community standards for care of the CCS conditions. She asked that the evaluation look at the CCS role in defining community standards, which have been important in raising the level of care for children throughout the state.

*Anthony Wright, Health Access*, asked for follow up on issues including satisfaction outcomes, concerns about CAHPS, and how to include data that isn't collected through national systems (such as timely access to care).

#### Public Comment

There was no public comment.

#### Next Steps, Next Meetings, and Adjourn

Toby Douglas said that over the next few months DHCS will be reaching out to advocates on issues including SPD, LIHP, CCS, and DSRIP.

He acknowledged Jennifer Kent, now with Health Management Associates, for her work on many aspects of the waiver implementation, including the TAC assessment, and thanked Brian Hansen and Amber Kemp for their work on this meeting and in other areas of waiver work.

Douglas thanked the California HealthCare Foundation, the Blue Shield of California Foundation, The California Endowment, the SCAN Foundation, and the Lucile Packard Foundation for Children's Health for their support, and participants for their involvement.

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

The meeting adjourned at 12:31 PM.

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