

**DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
FRIDAY, FEBRUARY 22, 2013
10:00AM – 3:30PM
MEETING SUMMARY**

Attendance

Members Attending: Bill Barcelona, CA Assoc. of Physician Groups; Katie Murphy, Neighborhood Legal Services- Los Angeles and Health Consumer Alliance; Anthony Wright, Health Access California; Kim Lewis, National Health Law Program; Lee Kemper, County Medical Services Program (CMSP); Marty Lynch, Lifelong Medical Care; Lynch, LifeLong Medical Care and California Primary Care Association; Elizabeth Landsberg, Western Center on Law & Poverty; Anne Donnelly, Project Inform; Kelly Brooks, CA State Association of Counties;; Marilyn Holle, Disability Rights CA; Rusty Selix, CA Council of Community Mental Health Agencies; Melissa Stafford Jones, CA Association of Public Hospitals and Health Systems; Ellen Wu, CA Pan-Ethnic Health Network; Casey Young, AARP CA; Stuart Siegel, Children's Specialty Care Coalition; Herrmann Spetzler, Open Door Health Centers; Teresa Favuzzi, CA Foundation for Independent Living Centers; Kristen Golden Testa, The Children's Partnership/100% Campaign; Steve Melody, Anthem Blue Cross/ WellPoint; Cathy Senderling, County Welfare Directors Association; Anne McLeod, California Hospital Association; Brenda Premo, Harris Family Center for Disability and Health Policy; Judith Reigel, County Health Executives Association of California; Kelly Brooks, California State Association of Counties; Ingrid Lamirault, Alameda Alliance for Health; Chris Perrone, California HealthCare Foundation

Members Attending by phone: Richard Thorp, MD, CA Medical Association; Bob Freeman, CenCal Health; Mitch Katz, MD, LA County Department of Health Services; Richard Thomason, Blue Shield of California Foundation.

Members Not Attending: Michael Humphrey, Sonoma County IHSS Public Authority; Marvin Southard, LA County Department of Mental Health; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center; Jim Gomez, CA Association of Health Facilities; Sandra Goodwin, CA Institute for Mental Health; Suzie Shupe, CA Coverage & Health Initiatives; Sara Nichols, Service Employees International Union.

Others Attending: Toby Douglas, DHCS; Brian Hansen, DHCS; Len Finocchio, DHCS; Rene Mollow, DHCS; Jane Ogle, DHCS; Dr. Peter Lee, Covered California

Public in Attendance: 14 members of the public were in attendance

Public Attending by Phone: 84 members of the public attended by phone

The meeting was called to order at 10:00 am

Welcome, Purpose of Stakeholder Advisory Committee, Introduction of Members and Review Today's Agenda

Toby Douglas, Director, DHCS

Douglas thanked the Blue Shield of California Foundation and the California HealthCare Foundation for all of their support including their input to the agendas and the meetings. *Douglas* welcomed everyone and reviewed the day's agenda.

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

Survey Results and Changes to SAC based on feedback Health Care Reform Stakeholder Group Role Updates

Toby Douglas, Director, DHCS

Douglas thanked the group for providing input about the meetings via survey. He reviewed the key input from members. The agenda for today's meeting and the materials sent ahead of the meeting reflect this input. In addition, in response to comments, we are considering adding one additional meeting. Survey comments included:

- Include fewer updates and more time for discussion on agendas
- Provide clear feedback and report back on issues raised
- Include information about other stakeholder meetings going on
- Send materials farther in advance for meetings
- Increase the number of SAC meetings.

Douglas: DHCS decided to have separate stakeholder meetings on the two proposed Medi-Cal expansion options. This meeting agenda will continue to focus on all of the other topics related to health care reform implementation and the waiver implementation.

Marty Lynch, Lifelong Medical Care: Who is on the Medi-Cal expansion stakeholder group?

Douglas: We invited a broader array of stakeholders than this group since the options involve realignment and impact social services and child care. Some members from this group were invited to join that meeting. It is open to public as well.

Anthony Wright, Health Access: I appreciate the responsiveness to our feedback. It was useful to receive written materials ahead of time. Can we have time to comment on the documents during the agenda?

Douglas: That is on the agenda for 2:45 today.

Katie Murphy, Neighborhood Legal Services- Los Angeles: I understand there will be a separate meeting. It was canceled for next week. Can we have an update?

Douglas: There were many conflicts due to legislative hearings and we are looking for another date. We are having conversations with county partners, stakeholders and legislative staff. We can't separate expansion and financing. We are receiving comments from many on these topics.

Douglas: Update to Healthy Families transition to Med-Cal: About 180,000 children are transitioning in phase 1. All the metrics show a smooth transition so far. Almost 100% are staying with same primary care provider. We are working to smooth out some eligibility issues and transferring cases from Maximus to the county. But as far as services are concerned, looking at grievances and appeals - all data seems to indicate a successful transition. The plan is to move forward with phase 1B on March 1st; April 1 is phase 2 which is subcontracted health plans and Health Net.

Douglas: Update to the Medi-Cal Managed Care expansion to rural counties. We have had stakeholder meetings in Shasta, Imperial, San Benito and Sacramento. We are reviewing six applications for the Northern Counties (26 in one group; San Benito; and, Imperial are each separate). We expect to release an announcement in the next week or two for Northern Counties. We are working with Central Coast Alliance to extend the County Organized Health System (COHS) Plan into San Benito and moving forward with San Diego Geographic Managed Care extending into Imperial County.

Elizabeth Landsberg, Western Center on Law and Poverty: Can you offer some details about the applications for the Northern Counties? Were there cluster requests?

Douglas: Yes, some applications requested all counties; some requested clusters of counties. We are assessing the viability of different alternatives, based in part on the number of enrollees. We are including Seniors and Persons with Disabilities and families in the expansion. The COHS will include Dual Eligibles as well. There will be a readiness assessment for plans next – in March and we are aiming for a June start.

Richard Thorp, CA Medical Association: Who will assess network adequacy/plan readiness? Word of caution on this as this is a key concern and DMHC has not always been robust in their network adequacy monitoring. DHCS should enhance this monitoring since this is a whole new geography to managed care.

Jane Ogle, DHCS: DMHC and DHCS will do the assessment

Douglas: Each plan has to ensure they have network. It would be good to have your input about how/what you advise.

Marilyn Holle, Disability Rights California: How will you assess cross-border issues? In Inyo, Imperial and Northern California, the care patterns are in Nevada and Oregon. I have a concern that Partnership Health Plan has a CCS carve-in and this could represent a creep expansion of carve-in.

Douglas: Cross-border issues will be handled as it is currently in other counties. On the carve in for CCS, I think only certain counties are approved for carve-in.

We were pleased to receive an award under Center for MediCare and Medicaid Innovation grant to begin the stakeholder process design for payment reform. We are

not ready for implementation. This will be run through HHS beginning in April. Want to look at ways to reform payment systems to build on Triple Aim. How do we use this to integrate Mental Health/Behavioral Health into physical health? How can we learn from Ryan White? There will be six different work groups building on the previous work in Let's Get Healthy California. Pat Powers will manage this process.

Eligibility and Enrollment in 2014

Len Finocchio and Rene Mollow, DHCS

Rene Mollow, DHCS: I am providing an update on ABx11. At end of January, we released information for mandatory provisions on Modified Adjusted Gross Income implementation (MAGI). We are taking a measured approach and where possible, we are maintaining status quo given the need for federal guidance and other unknowns. This language includes our understanding of guidance from March 2012 but does not include more recent language in January 2013 from CMS. The language does not touch on optional adult Medi-Cal expansion or benefits. This will be in separate statute. We did include implementation of MAGI for MediCal populations and applying those provisions to pregnant women, children and parent caregiver relatives. Also, language reflects changes to 1931B program and income methodologies for applicants. The language reflects going to MAGI with the intent of establishing a bright line of income eligibility at 138%. There is language about Authorized Representatives. We sunset the provisions on re-determinations and create a new section on re-determination. Federal guidance changed residency and how it is established and verified so our language includes this, including language related to paper verifications vs. self attestations. There was new information out as of yesterday that will be incorporated as we go forward. Where applicable, self- attestation will be incorporated but where we can't verify electronically, we will need different documentation. There is also new guidance on this area. We seek to maintain pregnancy-only benefits (status quo). In 2013, state-only program enrollees will need to apply to the Exchange and if not eligible, can remain eligible for state-only. Language gives the Director of DHCS authorization to revert to previous language based on changes at federal level on mandatory provisions and federal matching. We will do implementation via all-county welfare director letters and report out to the legislature semi-annually. We have had had calls and we have a call coming up to explain changes. We welcome questions ahead of time to prepare for the call. We want your ongoing collaboration and input – even where we are at odds.

Kim Lewis, National Health Law Program: Based on review of most recent guidance and regulations, what is the timeline for when will you update?

Mollow : We don't have a date for changes now but will get out this information.

Anne Donnelly, Project Inform: The AIDS drug assistance program does not belong in the state-only category because it is a wrap around program. We would like to see this program removed.

Mollow : thank you

Marilyn Holle, Disability Rights California: I have a concern about genetically handicapped person's program: What is planned to protect GHPP to retain case management through Centers of Excellence. Important to have the single location of providers and other services available for these difficult cases e.g. sickle cell
Mollow: thank you

Stuart Siegel, Children's Specialty Care Coalition; to follow-up on the issue raised by Marilyn. We did have a meeting with plans and there is interest in working together. It would be important to have directive from state about this program. The issue concerns both coordination and situations that can occur in an emergency that result in death. There is an opportunity for a win-win however, there is a need recommendation to plans to "ensure proper involvement" of GHPP centers.
Mollow: thank you for that input.

Katie Murphy, Neighborhood Legal Services- Los Angeles: My concern is about people going in state-only programs: what about affordability and notice to clients? It seems like a wrap around or a secondary coverage approach would work better because clients won't necessarily know what is covered. We should have a system that allows them to carry state-only programs as a secondary coverage.
Mollow: As we look at this, our goal is to get people into comprehensive coverage. We are aware that these programs were created because there was not coverage or benefits elsewhere, but we need to balance access to services on a narrow basis vs. desire to get them into comprehensive coverage. Comments are helpful as we craft this.

Elizabeth Landsberg, Western Center on Law and Poverty: Many concerns about the approach the administration is taking and we are glad to have conversation. Time is of the essence. Strongly support including expansion in legislation.
Douglas: MAGI decisions do need to be made quickly and it is in the administration's proposed language for the special session. Expansion needs to be connected to financing and needs to move as quickly as possible too, but is not included in the administration's proposed special session language.

Anthony Wright, Health Access: On the philosophy of maintaining status quo, it is disappointing as opposed to maximizing benefits to California or maximizing federal funding. This philosophy was announced before Obama administration said, "Medicaid cuts not on the table". Has there been consideration since this announcement, given that the risk of cutting the match is lower than previously.
Douglas: We are focusing on streamlining and simplification. We agree that we have disagreement on how far to go. We are consulting with CMS on this to receive clarification. We do want to move quickly, yet the Governor is very committed to long term stability.

Brenda Premo, Harris Family Center for Disability and Health Policy: I have an observation across the issues. My overarching policy approach is for the person with a disability and this creates a concern, based on the discussion of integrating separate programs, that special programs may be lost. Polio is an example: there are people with

post-polio syndrome. They can't find a doctor and they get no care or poor care. These are orphan programs. We need to have an overarching approach for orphan disabilities. I understand why we are focusing on trying to put programs together but we should not artificially destroy the Centers put together for special circumstances. This requires overarching policy on disability care and access.

Douglas: This is a good discussion for the transitions issue. I want to focus now on eligibility and hold the transitions for the afternoon.

Len Finocchio, DHCS: Overview of CalHEERS

The take-away from slides is that contractors are on time.

Slides available:

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

Ellen Wu, CA Pan-Ethnic Health Network: Is screening for “ineligible for full scope Medi-Cal but eligible for ER coverage” being built into CalHEERS screening?

Mollow: The applicant will need to verify citizenship and go through MAGI eligibility screening. If it looks like they are eligible for Medi-Cal, CalHEERS will screen and passed to county. Also, presumptive eligibility will still occur at hospital level so providers can screen for ER-eligibility. It is not clear if hospital providers can enroll for Emergency Scope Medi-Cal.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Are you on schedule for October 1st?

Finocchio: Yes, we are on time. We have contingencies if timeline changes. There is a large team (25 people) working on aspects of this. DHCS, Covered California and also working with county systems.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Is there a plan for how to transition, especially for kids from single point of entry, into the new systems.

Douglas: This gets to some questions we have and we are seeking guidance.

Kim Lewis, National Health Law Program: Is there a document with timeline targets?

Douglas: It will be out next week

Marilyn Holle, Disability Rights California: In the past with Healthy Families screening, there have been problems with identifying kids eligible without share of cost because there could be a group of kids shifted to the Exchange with disability who would be eligible for Medi-Cal. My concern is that they not get into the wrong system.

Douglas: There is a question to identify disability.

Elizabeth Landsberg, Western Center on Law and Poverty: Are you building for hospital presumptive eligibility process?

Douglas: We are sorting this out. We just got regulations yesterday.

Katie Murphy, Neighborhood Legal Services- Los Angeles: Are you building in a transfer to counties for those not eligible that actually links the information and assists the

county to help reach out to the residual uninsured populations? My concern is that the message is really clear to create a pathway to the counties. Is there a user training plan?

Finocchio: Yes, there will be training but a link to counties may not happen by 2014.

Elizabeth Landsberg, Western Center on Law and Poverty: It is the law (AB1296) that this be included.

Len Finocchio, DHCS: Update on AB1296:

We had five meetings last year and we are planning a meeting in March to review data elements, usability, eligibility, readability issues and the paper application. Stay tuned for a save-the-date. Today, it would be helpful to hear what topics or questions you might want to include in the agenda for the meeting.

Kristen Golden Testa, The Children's Partnership/100% Campaign: You mentioned integration of the streamlined, simplified application - are you using the federal model?

Finocchio: No, we are building our own using the federal model as a guide.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Are you building horizontal integration to other programs in CalHEERS - when will it come out?

Finocchio: Horizontal integration is part of the design process and I think the link to other programs happens during 2014.

Brenda Premo, Harris Family Center for Disability and Health Policy: Are you building to ADA requirements? We want to offer to test it.

Finocchio: Yes, your help would be great

Len Finocchio, DHCS: Update on Federal Performance Measures

We are looking for your feedback on the list of indicators proposed in the materials attached to the meeting announcement. Especially, we would like your input on: Are these the right indicators to improve the system; how frequently should we report out; which indicators are important to provide information about continuity of coverage and the intersection between Medi-Cal and the Exchange; how important are indicators about re-determination? We welcome your input. It is section 14102.5, page 48 that spells out what we will report.

Elizabeth Landsberg, Western Center on Law and Poverty: Thank you for including this. It is important to collect the reasons for terminations and declined eligibility because this information is important to fix things as we go forward.

Anne Donnelly, Project Inform: I want to add an indicator on "Timely engagement with provider".

Katie Murphy, Neighborhood Legal Services- Los Angeles: Can we add a cluster about application user experience. How many applications are aborted before completed; How long does it take to get through the application; how many are doing it alone; are there multiple applications for applicants in the system? This will teach us a lot.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Accelerated enrollment is a different process and should be asked separately.

Marilyn Holle, Disability Rights California: We should have questions about redetermination if they are found ineligible due to excess resources or at the end of continuous coverage and are accessing the exchange. We should be able to follow them as they change coverage from Medi-Cal or Exchange and information about provider continuity. .

Chris Perrone, California HealthCare Foundation: Can we transfer some of our lessons to the federal level beyond numbers? What are the expectations and goals for each measure? To the extent we have baseline data or data from Massachusetts; it could give California early comparisons.

Herrmann Spetzler, Humboldt Open Door: We should have "Point of Service" (POS) eligibility tracking to monitor prequalification at POS transferring to full eligibility determination.

Anthony Wright, Health Access: Is there any tracking of how people get to the portal? Is there tracking of how well pre-populating data works?

Finocchio: Yes, Covered CA is going to track how they get to the portal.

Mollow: Are you concerned with those who remain eligible or where we need more information?

Wright: My question is broadly about tracking pre-populated data.

Teresa Favuzzi, CA Foundation for Independent Living Centers: Is there a cross-walk of demographics and indicator data? Do you have a list of demographics?

Finocchio: Yes.

Marilyn Holle, Disability Rights California: Can an assistor be on the phone and see the same screen that the consumer is looking at?

Finocchio: Yes.

Kim Lewis, National Health Law Program: I want to understand the relationship between data and how it will tie to performance measures?

Finocchio: It ties to Chris' question. What are we aiming at?

Douglas: We can't say yet what the indicators are. We want to set the baseline indicators and then we can have a discussion of what the performance should be. We are not coming out of the gate with the benchmark in place.

Anne Donnelly, Project Inform: We need to strengthen the retention in care. For provider engagement indicators – not just first visit.

Katie Murphy, Neighborhood Legal Services- Los Angeles: Is this about Medi-Cal only? What about the intersection with the Exchange? What about provider overlap? We need a parallel set of questions to get at managed care as well as fee for service.

Finocchio: We want to align indicators with what the Exchange is doing to measure performance.

Douglas: Some of these are related to fee for service. The questions are different than managed care questions. How are we measuring capacity in Medi-Cal; the Bridge Plan.

Herrmann Spetzler, Open Door Health Centers: Community Health Center's use locums. The timetables here don't work for this. In addition, health centers bring in specialists for only 10 days a time. How would we enroll?

Douglas: I don't know the answer for Community Health Centers. We can follow up with Hermann and CPCA on this specific Issue.

Kim Lewis, National Health Law Program: How far down can you drill in on procedural reasons and codes?

Finocchio: Let us know what you propose.

Katie Murphy, Neighborhood Legal Services- Los Angeles: Is there any idea of having a pivot table so stakeholders/public can answer our own questions without the need for a special report?

Douglas: Let deal with the indicators and then we can move to reports.

Marty Lynch, Lifelong Medical Care: These are important to eligibility and enrollment. What about big picture of how many of those eligible for Medi-Cal are getting enrolled? I am looking for tight tracking of enrollment of the new population. This data would tell us why it is not happening.

Finocchio: CHIS will give us the big picture.

Chris Perrone, California HealthCare Foundation: We are working with the University of Minnesota (SHADAC) to develop a framework for monitoring coverage access and affordability aspects of ACA. Many of you were interviewed for this. Now that we have the framework, we are working on specific measures and who is collecting it – Covered CA, DMHC, etc. This report will be updated as frequently we can get the data.

Ann McLeod, CA Hospital Association: Is there an ability to track the point of entry for a person so we can see who is successful in enrollment – clinic, hospital, etc?

Cathy Senderling, County Welfare Directors Association: There are many reason codes for both enrollment and denials e.g. over income, etc. We can look at existing codes and see if they should be changed.

Chris Perrone, California HealthCare Foundation: On "medically needy" coverage, there is a comment, 'position no' - what does this mean?

Mollow: In traditional Medi-Cal, there is a medically needy category that has a spend down requirement. This is about the new eligibility expansion category that only has to

meet MAGI (childless adults). There is no spend down requirement under MAGI for new eligibility.

Finocchio: In summary, please look at indicators included in the packet and send comments to Rene Mollow and Len Finocchio. Comments are due March 1, so we can turn them in March 8. Thank you.

Peter Lee, Executive Director: Update on Covered California – Health Benefit Exchange

Slides are posted

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

This is a quick review of progress since the last time I was here about six months ago. We were awarded a Federal Level Two implementation grant to operate thru 2014. In my estimation, January 2014 will be a red letter date for history, similar to the way we look at the beginning of MediCare from our vantage point now.

At the center of our focus are 2.6 million Californians who are eligible for subsidies, 1.7 million others who don't qualify for subsidy but need coverage, those on Medi-Cal; and, others who want to keep employer coverage. The scale of Covered CA is very large – there are 16 other states that, added together, are the size of California. Inside the state, there are eight different areas with different approaches.

Success= affordable plans, smooth enrollment, effective outreach.

Health plan selection is a big deal and 33 different bids were received. It will be confidential as to who applied. California will not include “any willing plan” - we will be an active purchaser.

Every plan will be selected in a platinum, gold, silver or bronze level. What is part of the covered package is the Essential Health Benefit. California will have a high bar for consistent information to the consumer about each plan in each level.

We define: Premium + Out of pocket = Affordable care.

We are focused on statewide outreach mobilization efforts. There will be grants to Community Based Organizations to do outreach in the community plus paid media direct response television (e.g. call the number now) and targeted to the media our populations use. Over \$200 million for outreach.

Teresa Favuzzi, CA Foundation for Independent Living Centers: I want to encourage you to ensure the public relations firm designs a campaign that is accessible for the disability community. The disability access to the consumer website needs to be upgraded and improved. We are working with your staff and media contractor to identify improvements.

Lee: I appreciate your input. We need to do better but I am proud that we are out of the gate with fact sheets in eleven languages.

Brenda Premo, Harris Family Center for Disability and Health Policy: I want to remind everyone that the disabled are not all poor and we need all aspects to be usable for them, because they will be looking for affordable coverage in the Exchange. For example, ads need to be captioned.

Lee: For enrollment, 80% will probably need human help, some in a service center and most through community certified assistors. Those assistors must be able to do Medi-Cal as well as the Exchange. Small Business Health Options Program: this is not changing dramatically although there are small tax credits. Small employers (under 50 employees) can come to Covered CA through a separate exchange to pick plans that are competitive.

Ann McLeod, California Hospital Association: I think there is an additional item for success. We need to add access to care through sustainable networks of providers.

Lee: Ongoing success does include high quality care – right care at the right time in the right setting. We brought together health plans and essential community providers to talk. We are working on dashboards for this. Right out of the gate we will be looking at health plan performance.

Katie Murphy, Neighborhood Legal Services- Los Angeles: Will you have a path for us to engage in the future beyond 2013? Beyond launch, we should include retention issues, such as why people don't retain insurance. Another issue is how nimble are we to fix problems. We also need vertical integration between assistors, outreach and the Health Consumer Alliance.

Lee: Thanks to all for coming to meetings and commenting to us. We are posting draft model contracts now. How we assure performance standards to assure right care at right time. The plans are responsible for engaging providers and reaching out to consumers to make sure they understand their coverage. Retention is also important.

Douglas: Can you please comment on the Bridge Plan?

Lee: We care about affordability and continuity. There is going to be churn between Medi-Cal and Covered CA – especially at, and around, 138% FPL. Close to one million individuals will have incomes that bounce above Medi-Cal limits. We are creating a Bridge Plan that will allow a Medi-Cal plan to also be a certified plan in Covered CA as a Bridge Plan. The subsidy is geared to the 2nd lowest silver plan. There are issues with CMS that we are working out.

Rusty Selix, CA Council of Community Mental Health Agencies: County Mental Health providers are only included in county plans, however, they provide care that is often not well covered in private plans – habilitative and rehabilitative care for seriously mentally ill. We are not hearing from private plans. We are hearing from Medi-Cal plans but my question is about the Bridge Plans. There is more dialog that needs to happen.

Douglas: In Special Needs Plans/Duals as an example, the Medi-Cal plans are reaching out to county mental health.

Lee: The issue of the Medi-Cal plans reaching out may carry over. There will be bumps on this. Medi-Cal has richer benefits in some cases.

Stuart Siegel, Children's Specialty Care Coalition: Coordinated care for serious, uncommon conditions is normally cared for in specialty centers. Are you ensuring plans in Covered CA are looking at this? Plans may say we have a doctor to do this care but it is not the existing continuum of care.

Lee: Yes, plans have to provide medically necessary care. We rely on the existing regulatory structure and we are monitoring additional standards on our dashboard. We are not setting up a parallel review process,

Herrmann Spetzler, Open Door Health Centers: Is there discussion of dental?

Lee: The Essential Health Benefits include pediatric dental benefits. Every plan must offer dental for kids. We also decided to offer vision, dental as a supplemental benefit – not covered by subsidy but it will be offered as a benefit.

Marty Lynch, Lifelong Medical Care: How are we planning for those who don't or can't take the products? What are the plans for these to get care? This will fluctuate over time.

Douglas: The discussion of preserving the safety net system to care for those who remain uninsured is part of the discussion – there is not a number used. We acknowledge the need for a system to care for them.

Lee: We will know more in January 2014 and Apr 2014 – at the end of the first open enrollment. People can't enroll after 4/14 until next open enrollment unless there is a life circumstance like loss of job.

Anne Donnelly, Project Inform: Those with HIV are moving into Covered CA. We are concerned with strong continuity of care standards. There should be explicit standards that are distributed to consumers and that plans need to meet. For example, they must honor the first prescription from out of plan provider.

Lee: We are not creating new regulatory system. If there is a failure under existing law, we need a new law.

Kim Lewis, National Health Law Program: Will you set rules and standards around access to existing providers and network adequacy aside from affordability?

Lee: One of the core elements from the federal agencies is to have separate network adequacy. To be approved as a Bridge Plan, one of the rules from CMS is to demonstrate capacity but not in the general market.

Elizabeth Landsberg, Western Center on Law and Poverty: We are concerned about affordability and we appreciate your work on this. The federal government is pushing back on the Bridge Plan. Can you let us know what the issues are?

Lee: It is about the continuity issues for those who are getting care and in coverage. All plans must issue coverage – it may be crossed up with guaranteed issue requirements.

Melissa Stafford-Jones, California Public Hospitals and Health Systems: Can you comment on whether folks are meeting the inclusion of essential community provider?

Lee: We don't know yet.

Anthony: Is there advocacy to be done on Bridge 1 or Bridge 2?

Lee: Even Bridge 1 is not slam dunk – there are issues of continuity and how to do this so it does not disadvantage people.

Casey Young, AARP: The assistors are not paid to enroll in Medi-Cal but they are going to ensure there is a pathway into Medi-Cal. We will also be enrolling Dual Eligibles. What is the hand-off for Dual Eligible Demonstration?

Douglas: That is on our list to talk about in the afternoon.

**Perspectives Provided by SAC Members: Lessons Learned from Transitions: SPD, CBAS, Healthy Families: What Can be Learned for 2014 Transitions
Kristen Golden Testa, Ingrid Lamirault, Katie Murphy, Marty Lynch**

Kristen Golden Testa, The Children's Partnership/100% Campaign

This is the very early aspect. On the transition of children from Healthy Families into Medi-Cal, the design is to transition the easiest first, so it is not clear what we are learning for future, more difficult aspects. I will raise a few issues on eligibility and enrollment:

1. For new applications coming in through the single point of entry: why were there not more accelerated enrollments?
2. Why were dis-enrollments higher than expected in a normal month?
3. Why were there fewer transitions than expected/fewer kids?
4. On network adequacy: there should not be an issue with switching networks. A few (2,000) that did have to switch – why? Does this indicate a problem with the network or a choice on the part of the consumer?

American Academy of Pediatrics (AAP) did a survey of 500 pediatricians in California about the transition and asked, Will they continue as a Medi-Cal provider if were a previous Healthy Families provider? How has the transition gone so far? A good number, (17%) will not be taking new Medi-Cal or may not continue Healthy Families patients as Medi-Cal. There is difficulty with dental referrals, but it is unclear if this is recent under the transition. Also, 50% said they did not have information from the state. We don't know if perhaps they did get information from health plan.

Lessons:

- Follow up on the areas listed above to identify if problems exist or if data represents a problem with enrollment or network issues.
- Follow up on AAP survey to determine if the problems are significant.

Rusty Selix, CA Council of Community Mental Health Agencies: Our providers in County Mental Health are being rejected for payment as they try to transition to Medi-Cal.

Douglas: Rusty, we need examples of this to follow up.

Bill Barcelona, CA Assoc. of Physician Groups: There is potential disruption of as many as 53,000 enrollees in San Diego, Los Angeles and Stanislaus, due to contracts not being negotiated. Physicians are asked to take a 40% cut in rates. These are providers who were dually contracted already in Healthy Families and Medi-Cal, but now contracts have to be re-negotiated due to rates. Because of the renegotiation of contracts and lower rates, there may be a disruption.

Ogle: The populations you mention are in a later phase – in April. They have not actually transitioned yet (1-C).

Steve Melody, Anthem Blue Cross: We are watching this closely because we are having to ask for substantial reductions. Communication was a challenge early on given that some decisions weren't made until the very end. Getting the word out quickly enough was difficult. A lesson learned might be looking at a county by county transition.

Katie Murphy, Neighborhood Legal Services- Los Angeles: SPD Transition.

I will list a few of the issues that we are encountering.

- I will not focus on MER: A few reflections – The MER's are coming too late. People establish a relationship with the plan. When MER is approved, some providers won't take them back. The MER numbers are small.
- Continuity of Care (COC): This is troubling because to be successful requires magic words. Consumers are coming in who have gone thru grievance but still not getting COC. Sometimes COC is only granted for a certain doctor but doesn't cover the ancillary issue (medicine is ok/syringe not ok). We solve these individually for those we see, but most folks are not receiving our services.
- Population does not understand Managed Care. They are getting into difficulty because they don't know what the managed care referral process means. The plans, the Exchange the state all need to do more education.
- Plan does not have solution for some rare needs: One plan we work with actively asks for disenrollment; we need to expand this as a way of business.
- Pharmacies are verbally denying because they don't know how to bill.
- Billing issues related to old defaults: There are patients who go to their old doctor and then receive a bill (some of the providers are out of network; some are balance billing because the IPA is not accepting payment). There are lots of these.
- Relationship dependent: These issues are being resolved one by one but how do we institutionalize the solutions?
- Inconsistency across plans: Case management and Continuity of Care needs to be done routinely; the affirmative tracking of Emergency Room frequency

and changes in the primary care provider helps; we need to have alternatives when patients need something outside of IPA.

- Case numbers requesting help are not slowing down but changing to these new types.

Lessons: Figure out how to make sure that complex need patients are recognized affirmatively and problems are prevented.

Marty Lynch, Lifelong Medical Care: CBAS and SPD from Provider Perspective

- Community Based Adult Services (CBAS): This is relevant to Duals Transition. It is an example of how not to make policy change. The policy decision was that the benefit was not worth it and court action reinstated the benefit. For providers and patients, the back and forth is very difficult. This accentuates the need for communication and coordination for the most disabled, sick population. At the end of the day, it may be a better benefit than previous due to deliberations that resulted.
- Gaps between the old benefit of Adult Day Health Care: Ideally, we need a seamless transition into plan. Even in counties where plans were trying, there were difficulties.
- FQHC issue: There were changes in the way the benefit was paid. Some providers dropped or changed programs due to this.
- Patients: There were different levels of decision making with patients left hanging as decisions moved up the ladder and were appealed. Appeals should be fast and straight forward.
- Duals: Coordination of medical care will be a benefit.
- SPD: Continuity of Care with primary care provider. The data from state was not very good about the providers to help assigned patients to primary care or for patients' to choose. Best practice was developed when providers gave a roster of patients to the plan and the plan tried to assure continuity.

Ingrid Lamirault, Alameda Alliance for Health:

- What went well: Plans being part of process and building relationships
- What didn't go well: We got too focused on process and not enough on bigger picture/outcome. For Dual Eligibles: we will continue to worry about days/timeline but we will worry more about good assessments, care and connections to ensure quality
- Willingness to work together to learn about new topics went well. We know Medi-Cal but not all needs of new populations. There are lots of programs and we are still learning the benefits are of each program.

Observations

Marilyn Holle, Disability Rights California: There are problems in the transition of fee for service to managed care that are not always about providers but the ability to authorize services. Another issue is not knowing EPSDT standards. Another issue is providers knowing MediCare standards but not Medi-Cal standards. They do not know continuity

of care rules or severe psychiatric disability accommodations. There are problems of recognizing the right to disenroll. We need training for EPSDT/DME.

Anne Donnelly, Project Inform: Out of county contracting for providing care for HIV is a big issue. There is inconsistent willingness of the plans to consider this. Because of the nexus of primary care and specialty providers and difference in reimbursement, we have a situation where care is being fragmented because comprehensive care is being limited to primary care.

Elizabeth Landsberg, Western Center on Law and Poverty: It is important to think through how things work on the ground. It is humbling to know how policy implications work out on in the real world. What are the mechanics of some policy measures? Do providers understand?

Chris Perrone, California HealthCare Foundation: There is importance of relationships and contractual requirements. We need to draw a distinction between ACA outreach, federal Dual Eligibles, Medicare Part D; and contrast this with the investment the state put into those issues that were not federally led. The lesson is that we need to invest in policy change outreach and education – at provider and consumer level. I see this at federal level and not for state policy change.

Brenda Premo, Harris Family Center for Disability and Health Policy: In the transition of SPD, provider communication was not handled well and many are angry. In a presentation to an IPA, I found they had no idea they would have responsibility for disability needs and understood why the assessment was important for disability needs. We need to inform not just the doctor, but the office manager and front office staff. This population has special needs that were not taken seriously. For the Dual Eligibles, we need to do a better job to ensure this goes well.

Rusty Selix, CA Council of Community Mental Health Agencies: We have hoped that the transition to managed care will result in better physical health care. We are meeting with consumers that tell us this is not happening. We must move to bi-directional integration so that physical health is available in mental health setting. We need to make it explicit that care must be delivered at the mental health setting.

Kim Lewis, National Health Law Program: The 1115 waiver is a joint federal-state effort. The federal ability to step up is not sufficient. While there are good requirement on paper, we need to look to ourselves. On health homes, it is critical for those with multiple needs/multiple systems. Some things got watered down. Who is singly accountable – we must establish final accountability for what needs to happen. Health home needs to designed so that there is follow through.

Katie Murphy, Neighborhood Legal Services- Los Angeles: How are we framing the transition? We said we are moving people but we need to say we are moving care plans and we must plan for each kind of level.

Douglas: There is a key point on outreach and messaging/communication to providers and consumers. The focus on partnership is important. There were many problems identified and best practices are emerging. It would be good to have these to share with others and to incorporate in future transitions.

Coordinated Care Initiative: Moving Forward

Jane Ogle, DHCS and Peter Harbage, Consultant to DHCS

Steve Melody, Anthem Blue Cross and Ingrid Lamirault, Alameda Alliance for Health

Ogle: I don't want to report that we are close to signing MOU with CMS. Most of the issues are worked out but there is not much to say as update. Thank you to everyone who has contributed thru CBAS and SPD transition. I have heard the concerns on provider communication and we need to figure out how to do this better. CMS has sent the readiness criteria (similar to MediCare advantage + Medi-Cal benefits) to the plans. We have just put out LTSS information: these are home and community based services are services the Plan can provide to keep the consumer in the home that are NOT included in regular Medi-Cal. These are services – not benefits. They are not in the rates and they are not grievable. They are paid for out of savings, not as benefits. People can opt in or out: choice will go forward as to providers choosing plans. People can go onto waiting lists or waivers. We hope this is not needed but the access to waivers is available.

Consumer outreach: Department of Aging is working with HICAP to do outreach to consumers. September 1 is go-live: We expect to do plan readiness in March/April; contract in May/June; notify consumers in June for implementation in September.

Peter Harbage: Some work being done in preparation for signing the MOU with the federal agency, so that we are ready to go. The outreach plan has three overarching themes: 1) this is a heavily retail operation; 2) we need to learn from CBAS/SPD; 3) every county is different. There are representatives in every county helping to support information for consumers and providers through existing groups. We will use these pathways to provide accurate information for informed choice.

Steve Melody: Dual Eligibles is a complex endeavor. The plans are very pleased with DHCS and staff engagement here in California as compared to other states. The website is commendable. Lessons: the requirements for CCI are important for underlying, traditional managed care consumers.

Ingrid Lamirault: I echo that we have changed. Regardless of Dual Eligible Demonstration, things have changed. We are trying to be in the room with stakeholders to learn. Data sharing opportunities to develop HIPPA-compliant, privacy agreements with community organizations to share care plans, data on utilization to improve care. As a health plan, we have to think differently. Move beyond medically necessary to functionally necessary.

Douglas: As it relates to IHSS, what are lessons learned?

Ingrid Lamirault, Alameda Alliance for Health: IHSS is huge. The level of knowledge from IHSS workers is huge – when does it make sense to include them in care team. When do we make consumer vs. employer policies and procedure?

Steve Melody: We are developing partnerships before we can solve problems.

Katie Murphy, Neighborhood Legal Services- Los Angeles: LA has active conversation of when to launch: what is assessment of actual launch timeline. If decisions not made, how do we provide education?

Ogle: In June, there will be a broad notice about new care will go out. This will not be a notice about health plans yet, but there will be more through summer. Consumers will have many questions.

Douglas: What is happening related to Mental Health and Behavior Health side?

Ingrid Lamirault, Alameda Alliance for Health: We are working through the data sharing and HIPPA issues. We need to move past templates to contracting – to a more formal relationship.

Ogle: We posted drafted MOU's and templates on the website.

Rusty Selix, CA Council of Community Mental Health Agencies: There is great work on the ground. I hear negative things about Alameda – they brought in Beacon. I want to emphasize that coordination is not enough. We need integration and the documents don't call for this – they only call for coordination. With severe mental illness, coordination will not be enough. The reverse is equally important to have primary care at behavioral health.

Douglas: As a state, we realigned mental health to counties. The state can't mandate integration when counties have responsibility.

Rusty Selix, CA Council of Community Mental Health Agencies: This is a requirement on the plans, not the county. It is in the interest of plans to do this but they don't have relationships. Untreated physical health problems will cost more when mental health problems go untreated. Kaiser has committed to do co-location. How do we create the incentives to make this happen? Finally, we do have the health home option to make this happen.

Marty Lynch, Lifelong Medical Care: I am equally an advocate for co-located care. We do have examples of this happening in Alameda. So far these are isolated and we need to build the infrastructure in two different systems that are not used to working together.

Marilyn Holle, Disability Rights California: Does it still exist that people apply to MSSP to establish Medi-Cal eligibility?

Ogle: Yes, we have not touched this spousal impoverishment.

Marilyn Holle, Disability Rights California: Do slots still exist in long term care?

Ogle: I will check.

Marilyn Holle, Disability Rights California: Are the plans at risk for those in long term care?

Ogle: The plans will be responsible for mandatory enrollment on the MediCal side.

Herrmann Spetzler, Open Door Health Centers: Is there a tailored approach to outreach in rural areas?

Ogle: There are no rural areas involved in the outreach. Even in counties with Dual Eligible Demonstrations – they are carved out.

Anne Donnelly, Project Inform: How is outreach and education working with Office of AIDS. People with HIV and their providers often do not get information. HICAP does a great job but does not know Ryan White.

Ogle: HIV can remain in fee for service. The Office of AIDS will review potential enrollees.

Harbage: There are specific conversations with Public Health and Office of AIDS.

Brenda Premo, Harris Family Center for Disability and Health Policy: LA Care and Health Net are working on a common approach and education framework. Their goal is to have education roll out in multiple steps from broad to more specific.

Harbage: Less than half of the population has English as a primary language. It is very important to operate in multiple languages.

Marty Lynch, Lifelong Medical Care: Will rates and contracts be in place prior to June notice to consumers?

Ogle: Yes.

1115 Waiver Updates and Follow-Up Issues

Toby Douglas, Director, DHCS

Douglas: I will provide updates and amendments then open up to comments on items sent out with agenda. First, we have an amendment on the non-designated public hospitals. We are moving non-designated public hospitals to CPE payment method and include them in Delivery system incentive pool and safety net care pool. We will have an amendment for Dual Eligibles Demonstration and SPD into the 1115 waiver. Also, we will include the rural managed care expansion amendment into the waiver. Finally, for American Indian and Alaska Native populations in the LIHP and optional benefits, those benefits are 100% federal financial participation. We have submitted a waiver amendment for cost claiming in LIHP thru California Rural Health Board.

An update on the medical exemption process and the programming errors in MER notices. We sent out letters to 9,000 beneficiaries regarding the right to appeal. We are working with Maximus to fix the problems. The MER's were a larger issue than we expected.

Stuart Siegel, Children's Specialty Care Coalition: On the CCS pilot update, the original legislation included an evaluation of pilots before deciding best way to go forward. The CCS exemption sunsets in 2016. We have less than three years to do the pilots and evaluate and decide best way forward. Should there be discussion of CCS exemption not sunset until decisions are made?

Douglas: Not all five CCS pilots will be up and running, we should check on implications for evaluation and for legislation.

Anthony Wright, Health Access: Responding to the LIHP report, we are pleased to see additional counties. We want to continue to urge more timely numbers than three month enrollment numbers. We are alarmed that work has stopped to transition LIHP to Medicaid. I understand the Administration wants to go through a stakeholder discussion. Even if I was not of the opinion that county option is not viable, we still need to get plans and procedures in place. To delay this is troubling. Has the work stopped and can we please restart it as we continue the discussions about options?

Hansen: It isn't actually accurate that all the work has stopped. Data and eligibility work behind the scenes is moving full speed. There are ongoing discussions with CMS about eligibility transfer process, MAGI and requirements for notice that are continuing. Also, operational planning is continuing. What is stalled is the stakeholder engagement process. We realize those issues are critical and we will reach out to identify what we should discuss in the context of the two-option discussion.

Douglas: For issues independent of the two options, like eligibility, we can continue.

Anthony Wright, Health Access: Regardless of whether they are independent of the two options, it is important to have contingency plans for both options – in particular the state option but we should have discussions about all of the issues.

Melissa Stafford Jones, CA Association of Public Hospitals: I want to discuss the DSRIP report. There is an annual aggregate report, the DY7 report, due to CMS. Folks have asked me about it. Also, a clarification that chart includes the gross amounts (twice the federal benefit amount).

Kim Lewis, National Health Law Program: Is there going to be a separate process for reaching out?

Hansen: The LIHP transition work group met on communications and outreach and was intended to reconvene. We will reach out to the key stakeholders for discussion as a preliminary step to identify what makes sense and when.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Now that the Healthy Families transition is part of the waiver, I want to request that we have the materials submitted to CMS be part of these meeting materials? There was an evaluation design required for January?

Douglas: We can do that. We will send around the draft evaluation design

Elizabeth Landsberg, Western Center on Law and Poverty: I echo the concern on stopping the LIHP transition. I concur that the state option is the only option and we need to be sure the transition is prepared. We hope you are considering a request in the budget for additional ombudsperson as you look to the additional transitions of

populations. They are helpful but it is difficult to get through to them. Especially as we move more populations, it will only get more difficult to get through to them.

Douglas: We want to ask the group to think about what makes sense on ombudsperson. Should it be DHCS to fill this capacity or others?

Elizabeth Landsberg, Western Center on Law and Poverty: We are concerned about the current fragmentation of ombudsmen and, for some issues and problems, there is no one else to go through but DHCS.

Brenda Premo, Harris Family Center for Disability and Health Policy: The contractor needs to do their job better. The department is responsible to make sure the contractor does a good job and avoids some of the mistakes. For those with disabilities, the lack of the right response or a quick turn-around can have devastating consequences.

Douglas: On the Dual Eligibles Demonstration, we are talking to Scan Foundation about how to be sure there are resources.

Public Comment

There was no public comment.

Future Meetings in 2013: Thursday, May 30, 2013 and Monday, October 21, 2013