# DEPARTMENT OF HEALTH CARE SERVICES
# STAKEHOLDER ADVISORY COMMITTEE
# Friday February 21, 2014
# 9:30AM – 3:00PM

## MEETING SUMMARY

### Attendance

*Members Attending:*
Frank Mecca, County Welfare Directors Association; Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance; Anthony Wright, Health Access California; Elizabeth Landsberg, Western Center on Law and Poverty; Richard Thomason, Blue Shield of California Foundation; Michelle Cabrera, Service Employees International Union; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center; Erica Murray, CA Association of Public Hospitals and Health Systems; Suzie Shupe, CA Coverage & Health Initiatives; Brenda Premo, Harris Family Center for Disability and Health Policy; Lishaun Francis, CMA; Gary Passmore, CA Congress of Seniors; Sandra Naylor Goodwin, CA Institute for Mental Health; Steve Melody, Anthem Blue Cross/ WellPoint; Chris Perrone, California HealthCare Foundation; Herrmann Spetzler, Open Door Health Centers; Marty Lynch, Lifelong Medical Care and California Primary Care Association; Kristen Golden Testa, The Children's Partnership/100% Campaign; Judith Reigel, County Health Executives Association of California; Kim Lewis, National Health Law Program; Stuart Siegel, Children's Specialty Care Coalition; Marvin Southard, LA County Department of Mental Health; Kelly Brooks Lindsey, CA State Association of Counties; Amber Kemp, California Hospital Association; Cary Sanders, CPEHN; Lee Kemper, County Medical Services Program; Marilyn Holle, Disability Rights CA.

*Members Attending by Phone:*
Anne Donnelly, Project Inform; Bob Freeman, CenCal Health; Rusty Selix, CA Council of Community Mental Health Agencies; Bill Barcelona, CA Assoc of Physician Groups

*Members Not Attending:*
Mitch Katz, MD, LA County Department of Health Services; Ingrid Lamirault, Alameda Alliance for Health; Jim Gomez, CA Association of Health Facilities; Michael Humphrey, Sonoma County IHSS Public Authority; Teresa Favuzzi, CA Foundation for Independent Living Centers;

*Others Attending:* DHCS staff: Toby Douglas, Jane Ogle, Laurie Weaver, Brenda Grealish, Rollin Ives, Anastasia Dodson, Allan Roush, Karen Baylor

*Public in Attendance:* 29

**Welcome, Purpose of Today's Meeting and Introduction of Members**
*Toby Douglas, Director, DHCS*

The meeting was called to order at 9:30am.

*Douglas* welcomed Cary Sanders as a new representative from CPEHN, replacing Ellen Wu.

*Douglas:* As we look to the future, we are planning to review the structure and membership of the SAC in light of the need to prepare for the next 1115 waiver and continue to design new initiatives.

*Douglas* reviewed the day's agenda focused on three important areas of the ACA. First, Behavioral Health Transition, next, the Coordinated Care Initiative and Managed Care for Dual Eligibles, and, finally, a focus on Outreach and Enrollment as we continue to promote and streamline enrollment in Medi-Cal.

*Elizabeth Landsberg, Western Center on Law and Poverty*: A moment of congratulations for the enrollment numbers.
*Douglas*: It is a joint celebration for everyone. We have huge enrollment of 1.6 million, and growing.

*Gary Passmore, CA Congress of Seniors*: Jane Ogle is retiring this month, and I want everyone to join in to thank her for a remarkable job.

**Behavioral Health Expansion and Transition to Managed Care**
***Karen Baylor, Laurie Weaver, and Jane Ogle, DHCS***
**Transition to Managed Care and Substance Use and SUDS Wavier**

*Douglas*: The changes related to integrated Behavioral Health (BH) is a significant expansion of benefits beyond the basic requirements. Coverage is important, but we need to ensure there is access; create a strong continuum across medical and behavioral health care. How we strengthen the system and take it to the next level is now our focus.

Karen Baylor and Laurie Weaver presented slides available at
http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx
Topics included benefit expansion, specialty mental health services, and timeline review of the expansion implementation. She opened up the dialog to gather experiences from the stakeholder members.

## Managed Care Plan Experience

*Steve Melody, Anthem Blue Cross/ WellPoint:* Thank you for the readiness summary. From the perspective of the health plans, there was early anxiety about the expansion and transition to managed care. We support the change, but there are many priorities on the same timeline. We have landed on an arrangement that works well. Networks are in place to begin January 1st, but will not have a fully contracted network until March 2014. The plans are working hard and have providers in all markets, but we do not view the network as completed. There are challenges with contracting with psychiatrists in some areas. We are not seeing delays or issues with continuity of care. It has been a good working relationship with state staff. All in all, going well, more to be done, pleased with collaboration, and the anxiety is lessening.
*Douglas*: Are there things you need from counties or the state?
Melody: From counties, there is continued work to be done on MOU's, templates and referral process to adopt across counties. The continued oversight and monitoring of the network to be sure it remains intact and that we add providers to fill gaps identified.

*Michael Harris for Bob Freeman CenCal Health*: Thank you to DHCS. The transition is a new venture but, DHCS has been good to work with. I agree that the network challenge is with psychiatrists. The MOU template is a help. We have learned a lot from our work with San Luis Obispo and Santa Barbara Counties. We are learning about evaluation tools. We want to continue to work on 5150/involuntary hold to clarify the responsibilities between the plan and the county. The rates for psychiatrists are likely to continue to be an issue.

## Mental Health Experience in Counties

*Marvin Southard, LA County Department of Mental Health*: I want to begin by saying what a great bridge the 1115 waiver was for us. It allowed us to strengthen partnerships with FQHC's and establish relationships with managed care plans. We have cooperation from providers and plans to allow us to put a system in place. There has not been a surge of referrals, and we are able to handle the needs we have. Overall for counties, the goal is more than a warm hand-off – we want a system that looks indivisible from the view of the consumer. The way we have operationalized this in LA and many counties, we have used a 3-tier criteria. Tier 1: seriously and persistently mentally ill; Tier 2: not disabled by their mental health needs, but people needing more than primary care can do; Tier 3: population's mental health needs served by primary care. Tier 1-2 remain specialty mental health and the responsibility of mental health plans. Tier 3 is the expansion opportunity for benefits available. Not really a move for Tier 1-2 away from specialty mental health. That is the way we are looking at it. We have a set of principles that can be stated as: we want patients to get the care they need wherever they reach out for care; whether primary care or other. This addresses parity and will move forward for those who have not received parity in the past. We have defined a boundary between specialty mental health and non-specialty mental health in a patient-friendly way that benefits the consumer.
*Douglas*: should the tool be county-specific or a universal tool?

*Marvin Southard, LA County Department of Mental Health*: The principles underlying the tool should be the same but the actual tool may not be universally useful. Some counties have special needs to attend to and we can accommodate those needs as long as the principles are statewide. Initially the tools are likely to be different in counties, but likely to evolve to a common tool in the long term.

**Mental Health Provider Experience**

*Marty Lynch, Lifelong Medical Care and California Primary Care Association*: Health centers are pleased with the mental health benefit expansion and are committed to integrating care. We have worked with the state and Sandra Goodwin to decrease the 25 year mortality disparity for those with mental illness. Health centers already have mental health services and this is different than other providers. Some only serve mild to moderately mentally ill, but others have services for seriously mentally ill. Health centers are struggling now with re-siloes – the fact that health plans will deal with mild/moderate and counties with seriously mentally ill - the health centers are stuck in the middle to figure out how to get the bills paid across the whole continuum. We need more definition to know where people fall on the continuum and assurances that health centers can serve and be reimbursed for all patients. The state has helped with this by saying health centers can continue to bill in the traditional way until this is finalized. Health Plan interactions generally work well for health centers. The move to subcontract with special Behavioral Health Plans requires new education about health centers. The subcontractors are generally receptive. There are some issues where LIHP patients were being required to be re-assessed even though they were in care with us already. All in all, we can work through all the issues but need more work on definitions, billing, and support for the warm handoff. This would work best if we could bill for a same-day visit for mental health services and primary care.

*Herrmann Spetzler, Open Door Health Centers:* We are fully committed to make integrated behavioral health work in the primary care setting. There are numerable hurdles – some due to rural. For example, some services are only available in the economic centers, and this is difficult for coordination and for patient access. Providers are being required to work differently than the way they were trained, and this is a challenge in hiring. I hope the MFT issue is resolved soon. Also, facilities are not set up with integrated behavioral health in mind. Exam rooms are not set up for behavioral health care. Where we have new facilities designed to accommodate behavioral health in primary care, it is radically better. So, we need to make these changes in all facilities based on physical plant best practices for integrated behavioral health. We don't have the economies of scale the urban centers have – for example, we have no private providers willing to contract for services through managed care for this population. There can be a point where patients need to move to the county for care and this means services that are 45 minutes away – the concept of a warm handoff is right but the reality in rural areas do not allow it. There are issues related to providers' differing view of the severity. We need to remember that ¾ of state is rural and 50% is frontier. Mental illness crosses all incomes and geographies so we need to make this work in rural areas. Finally, the bifurcation of Substance Abuse from Mental Health only works

inside the bureaucracy. Patients often have both substance abuse and mental health issues. If we need to divide for funding reasons, let's make this seamless for patients.

*Douglas*: As we look at health centers and the interaction with substance use and mental health systems, it raises lots of questions about how we create a strong system with FQHC's included. We are working with county mental health and health centers to incorporate them into the waiver both substance abuse and mental health, so we can solve the bifurcation. We have ability to break down the siloes, and we need to work through this.
*Weaver*: On the issue of Marriage and Family Therapist and interns, we have been discussing this with CMS and identifying how other states incorporate them into the networks. We anticipate submitting a SPA that would be retroactive to January 2014, so we think this will be resolved quickly.
*Douglas*: On the same day issue, we are looking at bundled payment alternatives to address the reimbursement issues in a way that provides the right incentives for the patient.

*Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center:* I love the vision that Marv Southard outlined – but it is still in the future to realize this vision. From my experience as a provider, we operate 5 primary care clinics with mental health and substance abuse services, but they are not FQHC. The bridge to reform was a fabulous opportunity to get things working well. Because I am not FQHC, we have worked with county to fully integrate mental health into primary care and this is working well (on specialty care side). On the mild to moderate, there has been negotiation with plans but we are quite far from a seamless system. We contract with most plans for substance abuse/mental health services. We can bill for seriously mentally ill and be paid, but we can't use the same staff with mild to moderate because the plans won't reimburse and rates are an issue as well with some plans. The plan case managers often say they prefer not to work with organizations – they want to refer to individual providers. All of these issues create barriers to a seamless system. Staffing and reimbursement make me want to serve the seriously mentally ill and not the mild-moderate. These issues will grow if we don't resolve them. The SBIRT is overly restrictive, and I hope we work to expand it so it is effective. Finally, if we cannot get care coordination reimbursement at the service level, we will never achieve our goals; there is no incentive for a warm hand-off. It exists in the specialty care system but not in the mild/moderate. It is fine to have coordination at the administrative level but we need this at the service level.

*Douglas*: There are lots of issues there to follow up on.

*Erica Murray, CA Association of Public Hospitals and Health Systems:* Public health systems work across all three tiers. We operate hospitals, clinics and county systems. I echo that the Bridge to Reform waiver helped us prepare – DSRIP delivery system pay for performance reform. Seven of the systems built specific systems to prepare for integrated medical and behavioral health. We are culling lessons learned from those projects to offer to other providers and FQHC's. We would love to partner on a project

around facility issues to understand how to do this. Another lesson from San Mateo indicated that getting a screen for mental health increased compliance with medications by 80% for diabetics. One reflection from members is that we need to see this as a whole person opportunity – it is even larger than physical/mental health but also housing and other issues so that people can stay healthy.

*Bill Barcelona, CA Assoc of Physician Groups*: Similar to other providers, we have many medical directors and others very excited about re-integrating mental health and physical health. We span the continuum of integration from tightly integrated to loosely organized IPA's over 160 medical groups. All of these groups operate in Medicare Advantage and serve about 1/3 of Duals statewide. Most providers have built infrastructure that can be ramped up to deal with more severe behavioral health conditions and the ability to coordinate across providers and contract for delegated risk. There are transparency strengths, including web information about who the providers are, where they are and what their capabilities are. On accountability side, they have infrastructure at the federal and state levels to accomplish reporting. On the down side, it has been 20 years since the carve-out, and on the commercial side, there is little integration. We can build a better model in Medi-Cal by developing delegation for specialty mental health and measuring services. We are looking to integrate Tele-psychiatry into our networks. This will allow us to ramp up providers but the facilities are not built to handle the severely mentally ill population. A lesson learned from the duals demonstration: the faster providers know they will be in a network, the faster they can ramp up to be ready. Some groups are not clear if they are in or out and this causes delays.

*Douglas*: We are hearing a theme about how do we get a tool to help distinguish mild/moderate to seriously mentally ill. Also from FQHC's, we are hearing questions about how to deal with them fitting in both systems.

*Lishaun Francis, CMA:* I want to highlight issues about relationship between providers and the plan. One thing that will help is for providers to know what benefits are covered – especially with subcontracted plans. Medication payment responsibility is not clear; who should pay for what. A psychiatrist may want to order a brain scan, but there is push back on who pays for that, what is covered or not.

**Mental Health Advocates Experience**

*Rusty Selix, CA Council of Community Mental Health Agencies*: This is very exciting. Mental health providers I represent are the backbone of county system. Their referrals are from hospitals, child welfare and the justice system. This will change as we go forward. One item that has not been mentioned is rates. Our agencies have cost-based rates. If all goes well, they break even. If not, they have to make it up. Rates offered by plans are half, or below, of what counties currently provide. Therefore, no agencies in our system have a contract to participate with a health plan. Unless there is a dramatic change in rates, we won't have the integrated system we seek. We are not in rural counties but we are interested in bridging this gap through Telehealth or other

mechanism. One other issue is that for some counties, there is now a centralized assessment – this is a step backward. We need to move to a universal screening model so everyone is assessed wherever they show up. Our agencies see extensive levels of substance abuse but these services are not reimbursed through their contracts. I am hoping we can work closely with plans and with all of you to make this a success.

*Douglas*: On the rates and contracting, is the issue around psychiatry?
*Rusty Selix, CA Council of Community Mental Health Agencies*: Psychiatry is where the need is but the rates have been so low that the conversations have not progressed very far – my sense is that it is not exclusively psychiatry.
*Douglas*: We set rates to be at 80% of what Medicare pays. We can follow up with plans to understand this.
*Steve Melody, Anthem Blue Cross/ WellPoint:* To add to this, most of the challenge is with psychiatry. Generally the rates have been well received.

*Sandra Naylor Goodwin, CA Institute for Mental Health*: I agree that benefits and service expansions are great. On the implementation side, the sooner we get on the many issues, the better it will be. The issues are different in rural, suburban and urban. We have a system that should cover all needs. The system includes providers who don't know each other. We need to educate the systems about each other to increase the partnerships. In some cases, this exists, but in other cases providers are unknown to each other. The template for an MOU is very helpful. It is important to remember that people with serious mental illness die 25 years earlier mostly due to physical disorders. We hope the new coordination leads to better medication information, and we see that this will be a huge benefit to their health. These patients are very sick by the time they get help, and we have to do a better job creating a seamless system between physical and mental health care. We are thrilled to have these problems – we can work through them.

*Douglas*: Thank you all. We have lots of 'to do's' so we can offer direction. I want to move on to Substance Use presentation and then open it up to other members.

***Laurie Weaver* reviewed Substance Use slides and described the inpatient detoxification benefit and handed out materials available at: http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx**

*Douglas*: We need to monitor implementation and continue to improve. We hear from SAMHSA that California is a leader. No other state has implemented SBIRT and SAMHSA wants to learn from us as a model.

*Herrmann Spetzler, Open Door Health Centers:* Reimbursement is in connection to alcohol use only?
*Douglas*: Under prevention requirements, this is where the efficacy is – to focus on that population. We need to continue to assess, is this sufficient?

*Herrmann Spetzler, Open Door Health Centers:* Do we stop talking when we see needle marks?
*Douglas:* I would hope not – and I know you and other providers would not stop - but the efficacy is with alcohol and the reimbursement is for alcohol. We can continue to assess that going forward.
*Herrmann Spetzler, Open Door Health Centers:* It's a poly problem. There is no reward system for outcomes. The reward is to push the patient off to another system for reimbursement because that is the best way to make money. The reward ought to be, what is the best outcome for the patient, and are we better off collectively for that service.
*Douglas:* As we work on the pilot for payment reform, that is what we hope to achieve.
*Weaver:* At the moment there is not a recommendation with respect to drug use, but I expect that is coming.

***Karen Baylor* discussed re-certification process currently underway and announced a webinar presentation, February 26th on the certification process and application.**

*Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center:* It is too bad we didn't have SUD in the original waiver, and we didn't have the same opportunity with substance use as we had with mental health to ramp up and work through these issues. I am glad we are having the training. I hope this also results in changes on both sides – the issues in re-certification are on both sides. Some things cited as deficiencies are incorrect, errors by those reviewing the application mixed with things that are deficiencies. We are on record about this overarching issue: if an application is returned with deficiencies, the agency denies it completely and this means the de-certification of a currently operating program – shutting down an operating program. I hope this hasn't actually happened, and I hope this practice is reviewed and reversed.
I am glad the state has taken on residential issue, and I hope you also take on the detox issue. It is equally important. For example, LA contracts with 2 hospitals for detox. It is accredited for detox for Medicare and Duals, but can't do detox for Medi-Cal because of language in the provider manual for Medi-Cal. We need to address this. CADPE has a neutral position on the waiver; other associations have taken oppose position due to concerns about access. If the waiver can solve the IMD issue and other service issues, we need to support it. It has tremendous opportunity, but there are things that need to be addressed. Another part of the Drug Medi-Cal benefits, that are not waiver issues but are regulatory or legislative issues related to outpatient restrictions on group size, are individual counseling and methadone benefit constraints that need to be addressed here in California. Finally, the medication management system is too difficult to access. The TAR system is unnecessary for some good medications.

*Douglas*: The inpatient detox needs follow-up to know what is a CMS issue or state issue. We agree about the IMD issue - it does need to be resolved.

*Marvin Southard, LA County Department of Mental Health*: I would second everything Al said about the restructuring of the detox benefit as well as the other issues. Also, as you think of reconstituting the Drug Medi-Cal provider network, it would be useful to reach out to traditional Mental Health and FQHC providers to see if they would be interested in becoming Drug Medi-Cal providers. If we market this as an issue of improving integration, I think many would be interested in participating.
*Douglas:* That is a great point. We want to recruit more good providers across the system, and there is a need to contract across the modalities to create one system. We want to work on this and do this in a way that creates a more organized delivery system. We have the elements, and we need to continue to structure it with integrity.

*Brenda Premo Harris Family Center for Disability and Health Policy*: I will begin with an example. The four partners are represented, but the 5th partner is left out – the person. The most essential partner is left out. Here is a real-life story. I am in charge of accommodation for Western University and we have an employee who went through an episode of medication contraindication, substance use, and depression as she received a cancer diagnosis. We cannot separate substance use, mental illness and physical health. We are talking about contracts and reimbursement, but we need to talk about the reality from the person's point of view. I am not feeling very comfortable that what we are talking about is really what it takes to coordinate care. It is more than a warm hand-off. It is someone to count on.
*Baylor:* Thank you for your comments. We are aware of the "nothing about us without us" campaign. There are two issues you raised that are important: one is stigma and the other is consumer engagement. We are setting up a forum to receive input from advocates, families, and consumers and will roll it out mid-March. We are committed to having stakeholders involved and at the table.

*Elizabeth Landsberg, Western Center on Law and Poverty*: I am glad to hear about the stakeholder process to involve consumers because we haven't heard much today about how consumers will learn about changes and understand where to get services. We need to get very practical for people to know where to get care. I think one notice went out in November?
*Weaver*: Yes, one notice has gone out, and as new eligibles come into the program, we communicate individually and post documents on the web site.
*Douglas:* Also, each of the plans added to their evidence of coverage and all beneficiaries received that information about benefits.

*Elizabeth Landsberg, Western Center on Law and Poverty*: We have been hearing about the managed care side, there are some people who are still in fee-for-service. What network is available and who is overseeing that aspect? Are people on their own to find providers?
*Douglas*: Related to consumer engagement, we want to develop a consumer handbook or other document to help consumers with navigation. Yes, in fee for service, we will monitor utilization. In general, in fee for service, consumers find their own providers – that is how the system works. They can call the beneficiary hot line.

*Kim Lewis, National Health Law Program*: We want to see that people are at the table to help design the system. The funding streams continue to push people from place to place. I am hoping we can resolve this to create a truly seamless system and put it in place – not just talk about it as a goal.

*Marvin Southard, LA County Department of Mental Health*: The method we want to use is to create a Health Neighborhood concept. Beyond health care, providers will reach out to deal with social determinants of health for the community as well. We have applied for federal grants to implement this but we will move forward regardless.

*Katie Murphy, Neighborhood Legal Services- Los Angeles and Health Consumer Alliance*: Specifically, what materials, other than evidence of coverage and the November letter are going out? Providers and plans are in the conversation, but are they going to other groups who help consumers? These organizations may be the first point of contact for those not yet connected to the mental health system. Currently, there is confusion about how to use benefits. We need consumer friendly materials and an outreach campaign about this.
On the mental health side, I think it is important that we have clear state guidance about the issues we heard comments about. We want to have local innovation but only within clear guidance. I am not hearing that the detail is widely communicated yet. The more we can hear from state about the expectations, the easier it will be to work things out. Finally, I want to hear what are we doing for monitoring? The more we learn about delays, barriers and other issues, the better.
*Douglas*: This is going to be an ongoing process of developing materials. As we learn about the needs, we are developing materials and will share drafts. On monitoring, plans are providing reports on utilization of SBIRT, mental health and on the substance use side, we will hear through Short Doyle.
*Weaver:* One of the materials we are revising is called the Pub 68 and this is given to consumers. As result of last meeting, we have put together a trifold for beneficiaries on how to navigate primary care and how that will lead them to the other services they may need. On guidance, we did work with managed care on some all-plan letters as we rolled out. We are trying to go through the provider manual to clarify each area. It is on line and we welcome comment.

*Marvin Southard, LA County Department of Mental Health*: On the first letter, it confused people and they thought they were not going to be able to continue to receive specialty mental health services.

*Gary Passmore, CA Congress of Seniors*: I am glad to refocus the conversation on consumers. I have a basic question: will every health screen for dual populations include a behavioral health specialist to quickly identify and refer? How is that explained and how do they get referred into an assessment. I think you will identify lots of people who have clinical mental health problems.
*Ogle*: The intent is that every person will receive an assessment. The plans are required to do assessments. The goal is to do these in person, but many will be on the phone to identify needs. It is incumbent on plans to identify the needs because it changes the risk

stratification. It is difficult to find everyone and get this done, but this is one of the goals of the Duals Demonstration.
*Gary Passmore, CA Congress of Seniors*: Who helps explain and encourage consumers to get the services they need?
*Ogle*: We want providers to use motivational interviewing and will be reaching out to train on this.

*Michelle Cabrera, Service Employees International Union:* I want to follow up on Katie's question about how integrated and detailed is monitoring by DHCS? Are you tracking patient outcomes to identify what is working or not on behavioral health side to find disparities in screening or utilization? Where more attention is needed? Where is cost savings happening?
*Douglas*: Globally, we track outcomes and utilization through a dashboard. We will be able to gain information from that level. In order to get to what you are asking, it would require a more detailed monitoring approach that we are not currently pursuing. Those are good points, but it is a work in progress. There are also conversations with CPCA to find new ways to pay them to provide care that rewards outcomes and allows for groups, telemedicine and other ways to improve care.

*Sandra Naylor Goodwin, CA Institute for Mental Health*: I want to share data. About 1/3 seniors have a mental health issue; 40% of Medi-Cal have a mental health issue. We need better screening tools, beyond the SBIRT, to see what all the issues are and how to move forward. That is the vision and we have work to get there.

*Cary Sanders, CPEHN*: I want to say we appreciate the SPA to deal with substance use and mental health co-morbidity. We are interested in hearing more about metrics and data on race, ethnicity and language. We want to hear more about the timeline for this. I also hope to review the toolkit. Will it be translated?
*Weaver*: Yes, it will be translated.

*Anne Donnelly, Project Inform*: I support the comments on involving consumers and consumer organizations. For people with HIV, high numbers have co-morbidity with mental health and substance use. Much of what I heard today takes into account involving more Ryan White providers through the health plans, but how would an HIV patient with co-occurring mental health and substance abuse find that specialized care? How would a new HIV client be referred to a Ryan White provider? Who can help me find this out?
In terms of integrated screening, methadone clinics screen for syphilis, and are finding very high incidence. The services are being provided with short term grants but reimbursement needs to be addressed as we are looking at integration. Finally, we need a way to troubleshoot along the way. It is difficult right now to get answers and response to solving issues. I waited for Office of Patient Advocate to return my call and found out they are not the right place to solve a very acute problem.
*Douglas*: Sarah Brooks is your point of contact. We can follow up on methadone clinic issues.

Public comment on this topic: None

***Jane Ogle, DHCS***
**CCI/CalMedi-Connect**

*Ogle r*eviewed status of plan readiness, enrollment timeline, ombuds program and outreach. Toolkits are on DHCS web site as train the trainer materials. DMHC are managing the ombuds program. It will be contracted to the Health Consumer Alliance through San Diego Legal Services. Slides available at http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

*Marilyn Holle, Disability Rights CA*: If I leave CalMedi-Connect blank and choose a Medi-Cal plan, is that equivalent to "opt out"?
*Ogle*: Yes, that is opt-out. The form indicates you can choose one, not both.

*Marty Lynch, Lifelong Medical Care and California Primary Care Association*: What is the current thinking about people who opt out on the Medicare side where there are no savings to realize and are receiving LTSS. Will plans have resources to offer additional care coordination for non-CBAS to improve their care?
*Ogle*: CalMedi-Connect is where we have focused our effort on care coordination. We anticipate that plans will reach out to Medicare providers to coordinate services using the information they gain from LTSS. For example, how might they coordinate wheelchair benefits between Medicare and Medi-Cal.

*Brenda Premo Harris Family Center for Disability and Health Policy*: What is happening with alterative formats?
*Ogle*: All materials are in alternative formats; large type, braille, CD, braille in Spanish. For advocates, they can request from DHCS.
*Brenda Premo Harris Family Center for Disability and Health Policy*: Braille is less an issue with new technologies. What happens when I call a broker?
*Ogle*: Anyone who calls can request alternative format and HCO will send it out to beneficiary. HCO will do a follow up phone call after sending material to see if people need help. Also, we will continue to do town hall meetings to inform consumers.

*Brenda Premo Harris Family Center for Disability and Health Policy*: The brochures and letters going out use confusing terminology – like Continuity of Care. We are working with DMHC to move notices to 4$^{th}$ grade reading level, but we need to use lay language and not initials and program names. I think it will be an issue on the phones also. We need to be sure we have people speaking plainly.

*Elizabeth Landsberg, Western Center on Law and Poverty*: Does the 60 day notice have a choice form?
*Ogle*: The choice form goes out a few days later in a packet with materials.

*Elizabeth Landsberg, Western Center on Law and Poverty*: On the MediCal Managed Care Ombudsman, we have concerns about the staffing. It can be hard to get through. How much staff is in this office?
*Douglas*: There are about 10 staff there, and we try to balance all the priorities. In the short term, we are looking at taking some staff over to DMHC. We want to build it out more with more staff and phone lines. We will give an update over the next weeks about the response time.

*Katie Murphy, Neighborhood Legal Services- Los Angeles and Health Consumer Alliance*: Thank you for your work. I want to flag a few issues going forward I am hearing from LA. We want to have the July roll-out date to be provisional until readiness is determined. It feels too much too fast for LA county. If you find the readiness is not there, we support waiting. The timing to be sure that member services at the plans are ready with the right messaging is another concern. The timing with the Medi-Cal expansion is causing challenges, and the Medicare needs will be on top of that.
*Douglas*: One thing to remember is that 2 out 3 plans in LA were already doing this and should be going through readiness broadly. Yes, the changes are big, but they are not starting from scratch.

*Lishaun Francis, CMA*: What has changed; what is different about the forms and booklets specific to stakeholder input?
*Ogle*: The choice booklet health assessment form was removed; the choice form was reorganized and instructions were moved to a separate document; demographic information was removed; clarity about what happens for each choice option was improved; changed the information about continuity of care; clarity on grievance and appeal.

*Anthony Wright, Health Access California*: How do consumers know about Ombudsman and continuity of care availability? How prominent is it?
*Ogle*: The Ombudsman phone number is on all notices, in the guidebook, on choice form and in all plan information. The continuity of care information is in the guidebook in a simple form and in the “evidence of coverage” member handbook from the plan. The grievance process is also in the guidebook and member handbook.

*Kim Lewis, National Health Law Program*: What are the additional materials for this population you are developing?
*Ogle*: We are developing a continuity of care website specific for this population that will have all materials.

*Anthony Wright, Health Access California*: For Continuity of Care (COC), do you need to be in the middle of care?
*Ogle:* No, you need to show you have seen a primary provider twice in the last year or specialist once in past year and you want continuity of care with this provider.

*Anne Donnelly, Project Inform*: The COC with medication treatment is a problem. Where will that be spelled out as to the rights to continue medications?

*Ogle:* The plans are Medicare Part D plans and that requires them to do Part D COC for medications. It requires ongoing supplies.
*Anne Donnelly, Project Inform*: It is difficult to find this information as to where it is spelled out clearly
*Ogle*: It is in the member handbook.

*Anne Donnelly, Project Inform*: Providers don't understand how to access this either so perhaps there should be another way to make them aware?
*Ogle*: When a provider is not part of the plan, it is difficult to know who to communicate with. Nonparticipating providers will likely learn this through patient.
*Anne Donnelly, Project Inform*: In this case, we are hearing the problem from providers who are part of plans.
*Douglas*: We will follow up to see about using the provider bulletin

*Gary Passmore, CA Congress of Seniors*: There are 2-3 people here who have been very involved in this transition and COC initiative. This has been very different than the SPD transition. We have webinars, advocacy meetings, receive documents in draft form. I want to compliment the state for the efforts.
*Ogle*; Thanks to Scan Foundation at the state level and the county level for their support.

*Suzie Shupe, CA Coverage & Health Initiatives*: At the last stakeholder meeting, you agreed to work on improvements to the website to make it clear to consumers. We have worked with state staff on this and the process is ongoing. There is more to do, but it has been very positive and I want to thank DHCS for their partnership.
*Douglas*: We appreciate the stakeholder input to help us.

**Medi-Cal Expansion and Enrollment Update**
***Anastasia Dodson, Rene Mollow and Allan Roush DHCS***
**Enrollment Initiatives Update: Data Reports, New Target Populations, and Transitions**
Slides available at
http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

*Anthony Wright, Health Access California*: It would be interesting to know what routes people are taking to apply.

*Richard Thomason, Blue Shield of California Foundation*: When will you know who actually enrolled? What will be the ongoing lag in reporting data? Can you put the data on the website more prominently placed?
*Dodson*: This is difficult because of many lag factors, such as retroactive coverage, and duplicate applications. We are working to unravel this. We release the data as a projection and then doing matches with MEDS system to clarify the actual. We can put the numbers on the DHCS website more prominently. We are communicating with CMS because this is an issue across states.

*Marty Lynch, Lifelong Medical Care and California Primary Care Association*: Can you update us on the ability of CalHEERS and SAWS to interface?
Dodson: The cases do flow back and forth as of Jan 21st. We will comment more later.

*Kristen Golden Testa, The Children's Partnership/100% Campaign***:** On the kids enrollment numbers reported, are these accelerated enrollment?
*Dodson*: Yes, we are checking weekly to confirm.

*Lishaun Francis, CMA*: Are applicants told immediately if they are eligible for Medi-Cal?
*Dodson*: They are told if they are likely eligible and that they should mail in additional information to confirm.

*Cary Sanders, CPEHN*: On the "Other" category, the paper application asks people to check a box. We are hoping this option will become available. Just a note, it looks like the Asian and African American data is higher than expected.
*Dodson*: We need to tease out what this data means.

*Cary Sanders, CPEHN*: In CalSIM, it asks for how well they speak English on a scale.

*Gary Passmore, CA Congress of Seniors*: Do you know if this information exists for CovCA?
*Dodson*: CovCA is issuing press releases with tables on specific data.

*Katie Murphy, Neighborhood Legal Services- Los Angeles and Health Consumer Alliance*: We are pleased to see the numbers. There is confusion that this is not a one-time only opportunity for enrollment in Medi-Cal through CalFresh. In a recent meeting, county DPSS were not aware.
*Mollow*: The mailings from the department will only happen once, but the opportunity is not one time. Our county partners are doing updates at local level to modify CalFresh application, so consumers can choose to be express enrolled in Medi-Cal. This express enrollment is available through 2015. We are revising guidance to the counties to clarify that "one time" refers to mailings from the state.

*Katie Murphy, Neighborhood Legal Services- Los Angeles and Health Consumer Alliance*: The other confusion is that there was guidance from DSS that was not completely consistent with information from DHCS. It is going in a very positive direction, but I think a bit more clarification is needed.
*Mollow*: We have ongoing meetings with social services to clarify how this works, so this is helpful to know.

*Kristen Golden Testa, The Children's Partnership/100% Campaign***:** Just to clarify, people can express enroll during a renewal in CalFresh?
*Mollow*: Yes.

*Kristen Golden Testa, The Children's Partnership/100% Campaign***:** What about people who lose their PIN, how do they enroll?

*Mollow*: The County can go into MEDS to do the express enrollment because we have built the function into MEDS to add people.

*Anthony Wright, Health Access California*: This is awesome. Is there a second mailing? Is the PIN for each person?
*Mollow*: A second mailing has been discussed and we are considering it. There has been a mailing to adults and today a mailing to parents for their children. There is a PIN for each person. The PIN is needed to enroll online, but if they call without the PIN, we can assist them.

*Gary Passmore, CA Congress of Seniors:* Is there a reverse process to let new Medi-Cal enrollees know they may be eligible for Cal-Fresh? Also, there are utility and other income assistance programs available that are not operated by the state and this is another income assistance that is available.
*Mollow*: There is information in the single streamlined application asking if applicant wants CalFresh information, but it is not express enrollment into CalFresh.

*Katie Murphy, Neighborhood Legal Services- Los Angeles and Health Consumer Alliance*: I just reviewed all-county letter from DSS and it has errors. In addition, our county says, like SSI, there is no case in the county system. It means they don't have an eligibility worker.
*Mollow:* Yes, their case is in MEDS, not the county system and, for now, their worker would be the Cal-Fresh worker. This is a temporary problem until the case is built out in the SAWS system. We did this to expedite the implementation, but it will be fixed.

*Kristen Golden Testa, The Children's Partnership/100% Campaign*: When will the next phase of express lane roll out for parents who have children in Medi-Cal?
*Mollow*: We are working on this but do not have a timeline.

*Elizabeth Landsberg, Western Center on Law and Poverty*: What about GA recipients – can they be express enrolled? We would love to see this:
*Mollow*: CMS did not grant express authority for this population. We need to do some additional work to identify income eligibility groups and satisfy CMS questions.

*Katie Murphy, Neighborhood Legal Services- Los Angeles and Health Consumer Alliance*: Are the hospitals approved for Hospital Presumptive Eligibility listed on the website. It looks like 67 hospitals were denied?
*Mollow:* We can make the names available on the website. Hospitals were not denied, we just need more information from some.

*Anthony Wright, Health Access California*: What are the reasons that patients would be denied?
*Mollow:* It could be that individuals have existing coverage or couldn't provide enough information for us to do the file clearance. We have to do this for PE.

*Lee Kemper, CMSP*: On hospital PE, how does it interface on the back end?

*Mollow:* It works like CHDP Gateway with an online transaction through MEDS. The eligibility sits in MEDS, but the application still needs to be completed. The hospital is required to assist with the application or partner with Certified Enrollment Counselors or hand the person an application to complete.

*Judith Reigel, County Health Executives Association of California*: Are there limits to once per year for PE?
*Mollow:* Hospital PE can happen once per year or during pregnancy.

*Lee Kemper, CMSP*: It would be helpful for local county workers to know which hospitals are doing PE because, like express enrollment, the information is not listed in the county system.
*Mollow:* Yes, the application is not in the SAWS system, and the information is self-reported and has not been validated until the application is completed.

*Amber Kemp, California Hospital Association*: We would be happy to work with the hospitals who have not completed the PE approval if we can get the names. Also, I want to commend the department for being farther along than most states.
*Mollow*: Thank you, our application is used as a model on some webinars.

*Erica Murray, CA Association of Public Hospitals and Health Systems:* Do you know the number of LIHP transition enrollees who stayed with their primary care provider?
*Roush*: The linkage process was accomplished through their PCP to a managed care plan.
*Douglas*: The majority remained with their PCP. This is still in flux as some people are choosing to change PCP.

*Marty Lynch, Lifelong Medical Care and California Primary Care Association*: Is there a presumption that people who are held up due to paperwork will be able to get PE coverage?
*Dodson*: We are working with counties to be sure that we embrace a culture of coverage. If people have a medical need, they should get coverage. Staying within the law, Counties have maximum flexibility.

*Gary Passmore, CA Congress of Seniors*: We just added 1.5 million Medi-Cal recipients, are you concerned about pressure on the provider network?
*Douglas*: This is a key question. Do we have capacity to continue to serve everyone? It is a big concern. Yes, there is a question of whether we have the capacity to continue to take on additional members. It is a matter of looking at a region and monitoring plans on a range of issues such as network adequacy. We are watching this. The PCP bump in rates is helping. But we also need to look at alternative ways to provide care: groups, e-consults and other approaches to expand our capacity. Payment is certainly part of this also. If access is not adequate, we will react.

*Steve Melody, Anthem Blue Cross/Wellpoint:* Given the dynamics, we need to add telehealth/telemedicine to the list of opportunities.

*Lishaun Francis, CMA*: How long is it taking beneficiaries applying on CalHEERS to get ongoing coverage?
*Dodson:* On Jan 21st, we launched the linkage between SAWS and CalHEERS, which is a more stable link. I don't have an average number to give you but we are working with Counties to be sure we expedite coverage.

*Katie Murphy, Neighborhood Legal Services- Los Angeles and Health Consumer Alliance*: On that point, this is a massive issue in LA. I am not sure that the solution can be a County work around. We have a record number of appeals right now and we prefer not to work that way. In some subsets of cases, calculations and other errors are happening and recipients are getting erroneous letters. Flexibility is good but not really a solution in a county like LA. This is one that is getting to crisis levels in LA.
*Dodson*: You are right. We have system issues to work out. We are prioritizing the problems that impact the biggest number of people. We are giving guidance that allows maximum flexibility.
*Katie Murphy, Neighborhood Legal Services- Los Angeles and Health Consumer Alliance*: I am not sure broad flexibility is useful for this. Putting this in the County hands is a short-term solution.
*Douglas:* Can we see some examples of this?

*Elizabeth Landsberg, Western Center on Law and Poverty*: We appreciate having the weekly meetings and overwhelming number of issues. We raised this with staff recently. We will continue to work with you on this.

*Cary Sanders, CPEHN*: Can you update us about the County outreach and enrollment grants?
*Mollow:* We have given out $23M to 36 counties and CMSP. We held a grantee call yesterday on next steps to meet the requirement that they provide funding to CBO's. Counties may need to do procurement or modify existing contracts, and we are working through those issues with them. We will post information about the partner agencies on the outreach and enrollment website. We will continue to monitor this through calls. We are also partnering with Enroll America to offer best practices.

*Cary Sanders, CPEHN*: Are the County grant deliverables public? What target populations they will address?
*Mollow*: Yes, Counties are going back to revise their scopes and budgets. As information comes in, we will make it available.

*Cary Sanders, CPEHN*: What counties did not contract?
*Mollow:* There are a few counties not covered, but CMSP will see if they can cover those counties.

*Cary Sanders, CPEHN*: AB82 requires seven different categories for race and ethnicity. How will you report out information on the target populations?
*Mollow:* I will follow up on that and report back at the next meeting.

**Local Implementation Roundtable Discussion**

- **Latino Enrollment** – facilitated by Katie Murphy
- **Hospital PE** – facilitated by Elizabeth Landsberg
- **Children's Coverage** – facilitated by Suzie Shupe
- **Special Populations** (Re-entry, Homeless, Mentally Ill) - facilitated by Marty Lynch

**Roundtable Questions:**

1. **What have you seen as the best strategies to increase enrollment in Medi-Cal for this population?**
2. **Where are new partnerships being formed, and where is there further opportunity for partnership and learning? How can this new learning be communicated statewide?**
3. **What are some of the barriers to reaching these individuals and helping them to enroll?**
4. **How can DHCS, SAC members and other community partners work together effectively to make improvements and overcome these barriers?**

Roundtable discussion notes for outreach to Latino population:

1. What have you seen as the best strategies to increase enrolment in Medi-Cal for this population?
    a. In-person meet & greets
    b. Use of promo tours
    c. Engagements at churches
    d. Use of community groups and organizations
    e. PSAs
2. Where are new partnerships being formed and where is there further opportunity for partnership and learning? How can this new learning be communicated statewide?
    a. Partnerships between state agencies that are already widely known and trusted (for example CC & DHCS team up with SSA, DMV, etc.)
    b. Communicate thorough community events such as farmers markets, health fairs, schools
    c. CC/DHCS partner with communities, hospitals, etc. to have dedicated CEC staff to assist with questions.
3. What are some barriers to reaching these individuals and helping them enroll?
    a. LA county only using existing contracts to assist with outreach, therefore new entities are unable to receive any funding unless they are subcontracted.
    b. DHCS to encourage counties to partner with additional entities
    c. Incentives for FQHCs

4. How can DHCS, SAC members and other community partners work together effectively to make improvements and overcome these barriers?
    a. Engage “right” people
    b. start corporate sports leagues
    c. catch people through life change events
    d. help people understand scope of coverage
    e. request that CECs follow-up after enrollment to ensure retention

Roundtable discussion notes for Hospital PE

- Public hospitals have had no issues bubbled up. Generally the program is working well.

- At the time of HPE determination, beneficiaries should be provided information on Medi-Cal benefits and other Medi-Cal providers who may be able to help them avoid re-hospitalization.

- Defined hospital performance requirements are important; however, measurement by actual completed Medi-Cal applications can be a challenge since applying for Medi-Cal is a choice.

- CalHEERS system will eventually have HPE capabilities which will enable a more effective follow up process for a complete Medi-Cal application.

- SB 82 provides for triage workers to connect emergency room services to outpatient services. Existing grants have sponsored these workers in 22 counties. There may be opportunities for these workers to also do HPE and follow up with beneficiaries for a complete Medi-Cal application.

- Hospitals can use outside vendors to assist with HPE and Medi-Cal applications.

- Group suggests posting online the list of hospitals that are able to do PE determinations.

- The group is interested in the denial reasons for hospitals and PE applications.

- Clarification is needed on freestanding psychiatry hospitals and whether they can participate in HPE.

Roundtable Discussion Notes: Children’s Coverage

What have you seen as the best strategies to increase enrollment in Medi-Cal for this population?

- Express Lane
    - People are excited to use the Express Lane for kids because it is easy, and it is not time limited for kids
    - The food bank is having a webinar to get the word out about the Express Lane

Where are new partnerships being formed, and where is there further opportunity for partnership and learning? How can this new learning be communicated statewide?

- WIC is an area for opportunity
    - Woman with children and Pregnant moms utilize WIC's services
        - they can be utilized to reach the children and pregnant women
    - Many churches are working on outreach
        - There has been success all over the state with this outreach (e.g., Kern County and San Joaquin County)
- Mobile units are an area for opportunity
    - There are mobile units that can go around to schools to provide medical services, and this could be an area to help get those kids enrolled in Medi-Cal

What are some of the barriers to reaching these individuals and helping them to enroll?

- Schools are a barrier for kids to gain access
    - Schools have not received any funding since 2010, so they are dropping out
    - Communication issues with the schools
        - DHCS just recently started engaging the schools
- There are concerns and fears around signing up for Medi-Cal because of the cross-referencing that occurs in order to be approved for Medi-Cal
    - Example: Fear of the IRS or Immigration looking at their information

How can DHCS, SAC members and other community partners work together effectively to make improvements and overcome these barriers?

- Work to bring medical mobile units out to the school districts
- Utilize WIC to help children and pregnant women coverage

Roundtable Discussion Notes: Special Populations

Participants at the *Special Populations Roundtable* discussed the importance of outreach. Often times, transportation issues prevent eligible individuals from enrolling, thus the need to go into their communities.

More so, outreach among toward these special populations requires coordination among the disparate entities that we normally don't think of collaborating, i.e. prisons, schools, mental health facilities.

- Said one participant, "If we can tinker with that, we could get these people into Medi-Cal."
- Massachusetts was mentioned as an ideal state in that regard.
- The importance of community locales where different populations congregate was stressed, i.e. churches, barbershops, basketball courts.

It was mentioned social services don't have a deep understanding of the Affordable Care Act. Strengthening such comprehension was highlighted as a good first step. An individual applauded efforts to streamline the process between programs like CalFresh and CalWorks with Medi-Cal.

- Said one participant, "Instead of recreating the wheel, let's utilize our existing systems."
- Asked another participant, "Will there eventually be a similar process at county jails considering the implications of realignment?"
- Remarked another participant, "We have a captive audience, let's try to figure out a way to get them to fill-out the application while there."
- A difficulty cited was that probation officers aren't necessarily geared toward enrolling individuals in healthcare once folks are released.

Regarding homelessness, strategies for outreach cannot be 'one and done'. That is not a reality. A continuously follow-up is necessary to make sure they fill out the application and access their healthcare.
*Safe Housing First* was stressed by one participant as paramount, otherwise subsequent work becomes difficult to impossible. Also, consider expanding presumptive eligibility to these groups as well.

Large Group: Report Back from Each Roundtable Table

Latino Enrollment: We need to share information out to grant recipients about specific challenges and confusion on using funds between grants and Covered CA. Counties are primarily funding those with existing contracts and this leaves out some emerging organizations who are strong. Other strategies discussed that are emerging include building on trusted organizations like sports leagues and partner with libraries and others. We will look for ways to put best practices on the web site.

Hospital PE: Everyone is pleased about how this is going. We want to make sure that folks know applicants are eligible for full-scope services. We discussed the requirement for follow up and the ability to partner with CEC's. There are some technical problems we discussed.

*Richard Thomason, Blue Shield of California Foundation*: Where can hospitals do PE? Can hospitals do PE in clinic locations and with partner organizations?
*Mollow:* They can do PE anywhere that is part of the hospital license.

Children's Coverage: Express eligibility is very exciting for adults as well as children. A suggestion was made to do express enrollment in WIC and gain additional numbers. In addition, school enrollment is an opportunity, mobile health units. We want to do accelerated enrollment in all venues to maximize enrollment.

Special Populations: We discussed the use of unusual partners like criminal justice system, social service organizations, food banks, housing/homeless organizations that touch eligible populations can help with enrollment. Electronic systems are not as

helpful with this population and they require more face to face assistance. Could we simplify the process or even have PE for homeless/supportive housing clients.

*Kristen Golden Testa, The Children's Partnership/100% Campaign*: For a future meeting, we need to be sure we don't lose sight of renewal and retention efforts. There are upcoming times where we could lose folks.
*Cary Sanders, CPEHN*: We should add utilization to this as well as a focus for discussion. We need to educate folks about how to use insurance since they are insured for the first time and how to stay enrolled. There are best practices in Counties we might discuss.
*Katie Murphy, Neighborhood Legal Services- Los Angeles and Health Consumer Alliance*: LA County is requiring utilization and retention as part of County outreach and enrollment grants. We believe this is industry standard and should be promoted to others.

**Public Comment**
*Kim Flores, California Senate Office of Research*: In terms of Latino enrollment, is Covered CA using your data to see if parents are enrolled?
*Douglas:* Yes, DHCS sent out a notice about availability of CoveredCA to alert parents about the opportunities.

*Kim Flores, California Senate Office of Research:* There have been difficulties with MAA and there are school districts dropping out because of all the problems Schools have not gotten any reimbursement since 2010. They do enrollment at schools and it is important funding.
*Douglas:* We are working with federal partners to get off the interim claiming and create a long term approach.

Thanks to the foundations for ongoing support and funding.

**Adjourn**