

**DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
MONDAY, NOVEMBER 19, 2012
10:00AM – 3:30PM
SACRAMENTO CONVENTION CENTER**

Attendance

Members Attending: Katie Murphy, Neighborhood Legal Services- Los Angeles; Anthony Wright, Health Access California; Jim Gomez, CA Association of Health Facilities; Kim Lewis, National Health Law Program; Lee Kemper, County Medical Services Program (CMSP); Marty Lynch, LifeLong Medical Care; Elizabeth Landsberg, Western Center on Law & Poverty; Anne Donnelly, Project Inform; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center; Kelly Brooks, CA State Association of Counties; Marilyn Holle, Disability Rights California; Sandra Goodwin, CA Institute for Mental Health; Bob Freeman, CenCal Health; Rusty Selix, CA Council of Community Mental Health Agencies; Suzie Shupe, CA Coverage & Health Initiatives; Melissa Stafford Jones, CA Association of Public Hospitals; Ellen Wu, CA Pan-Ethnic Health Network; Casey Young, AARP CA; Sara Nichols, Service Employees International Union

Members Attending (on phone): Michael Humphrey, Sonoma County IHSS Public Authority; Stuart Siegel, Children's Hospital Los Angeles; Herrmann Spetzler, Open Door Health Centers; Brenda Premo, Center for Disability Issues and the Health Professions

Members Absent: Bill Barcelona, CA Assoc. of Physician Groups; 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; Marvin Southard, LA County Department of Mental Health; Richard Thorp, CA Medical Association

Others Attending: Toby Douglas, DHCS; Brian Hansen, DHCS; Margaret Tatar, DHCS; Rene Mollow, DHCS; Jane Ogle, DHCS; Dr. Neal Kohatsu, DHCS; Juli Baker, Covered California; Meredith Mayeri, Mercer; Charles Lassiter and Melinda Dutton, Manatt Health Solutions; David Hughes, HSRI

Public in Attendance: 22 members of the public were in attendance

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

Welcome, Purpose of SAC, Introduction of Members and Review Today's Agenda; Looking Ahead to the Special Legislative Session's Key Issues

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

Douglas noted that the Stakeholder Advisory Committee (SAC) has been meeting for two years and has adopted an expanded focus that includes items within the 1115 Bridge to Reform waiver, as well as, the Affordable Care Act (ACA). He reviewed the agenda for today, which includes updates on eligibility changes under the ACA, implementation status of the CalHEERS system and updates on various components of the 1115 waiver. The afternoon agenda includes a review of Essential Medicaid Benchmark Benefits Options.

Douglas shared that the Administration is very pleased by the passage of Proposition 30 and acknowledged the significant role that many members of the SAC had in its passage. Additionally, he shared that the presidential election provides clarity around ACA implementation moving forward. He highlighted that California has a number of important decisions to make around ACA implementation that the Administration is still assessing. Today's meeting will include discussion of the implications of different components.

Douglas also stated that several other important projects are underway. The Healthy Families transition is on track for implementation on January 1st, 2013 and Medi-Cal Managed Care expansion to rural counties is expected to begin in June 2013. Lastly, Douglas noted that the Administration is evaluating the potential impact of the "fiscal cliff" on entitlements, including Medicaid.

Douglas reminded the SAC that there are three meetings scheduled for 2013:

- Monday, February 11
- Friday, May 17
- Monday, October 21

Douglas solicited questions and comments from the SAC before beginning the agenda.

Katie Murphy, Neighborhood Legal Services- Los Angeles, expressed concern that the tone from DHCS and Administration leadership appeared as though California was now looking at Medicaid expansion as optional, which represents a departure from previous conversations. She asked Toby Douglas to share more with the SAC about their intent around Medicaid expansion.

Toby Douglas, DHCS, replied that Secretary Dooley has spoken to this and that California will need to assess all of the ACA components along with federal guidance. Until this assessment has been done and the special session completed, the Administration cannot say definitively how we will proceed.

Anthony Wright, Health Access California, asked about the timetable for making these decisions, given that enrollment activities for Medicaid expansion is expected to begin within six months.

Toby Douglas, DHCS, shared that the SAC will discuss the benefits package and options and receive updates on the Health Care Coverage Initiative (HCCI) today. Additionally, the Governor has talked about a special session of the legislature in January 2013.

Jim Gomez, CA Association of Health Facilities, expressed concern that the State is moving too quickly on the CCI and the Dual Eligible expansions. He noted particular concern that advanced negotiations with providers and plans appeared to be underway before receiving approval from CMS. He asked that *Jane Ogle, DHCS*, address this issue in her presentation.

Affordable Care Act (ACA) and Medi-Cal Eligibility Changes

Renee Mollow, DHCS, presented on changes in Medi-Cal eligibility rules under the Affordable Care Act. Her presentation can be found at: <http://www.dhcs.ca.gov/Documents/SACMAGI101.pdf>

Mollow noted that an estimated additional 1.6 – 2 million people will be coming into Medi-Cal as a result of the eligibility changes in the ACA. Predominantly, these will be individuals of color, between 18-44 ages and one-quarter will not speak English well. Additionally, there remain a notable number of individuals who are currently eligible but not enrolled.

Major Medicaid eligibility changes under ACA include the following:

- Allows for a “bright line” of income eligibility at 133% FPL along with a 5% income disregard;
- Establishes the use of Modified Adjusted Gross Income (MAGI) to determine income, household composition and family size. MAGI is based on federal tax rules for determining adjusted gross income and can be drawn from tax returns. Additionally, under the new income guidelines property and assets will not be considered;
- Requires the use of a single streamlined application for all health subsidy programs, including Medi-Cal, CHIP (Healthy Families) and the Exchange;
- Simplifies eligibility verifications to allow for self-attestation along with “reasonably compatible” review (conducted through use of a federal electronic verification hub)

Toby Douglas, noted at the conclusion of the presentation that while the MAGI does streamline the process, it is still extremely complicated in terms of non-tax filers versus tax filers, which makes having accessible and easy to use rules engine to ensure that families apply only once rather than multiple times.

Kim Lewis, National Health Law Program, asked if those individuals at 133-138% FPL would be directed to the Exchange or to county departments of social services.

Douglas responded that the purpose is for individuals to have many entry points. He noted that the purpose of the online portal was to enable individuals to apply and have their application verified online without needing to go to any other entry point. He also highlighted other entry points, including the phone service center, Certified Application Assistors and county departments of social services.

Lee Kemper, CMSP, asked if the federal government has given an update on the electronic verification system and what their timeline is for implementation. *Douglas* said that they have not.

Marty Lynch, Lifelong Medical Care, asked *Douglas* to talk about the role of community health centers in enrolling individuals. He noted that health centers are caring for a significant portion of those that will become eligible for Medi-Cal under the ACA.

Douglas stated that health centers are an essential component of “in-reach” and that it will be important to examine if health centers can play a larger role in enrollment. He noted that there is always the challenge of funding for Certified Application Assistors and that he did not have any definitive answers about additional resources that will be available.

Kim Lewis, National Health Law Program, requested that *Douglas* describe the Administration’s process and timeline for making important decisions about Medi-Cal eligibility rules and benefit options, among other important decisions, as well as what stakeholder processes will be used to vet decisions.

Douglas stated that stakeholders will be engaged through the SAC and other means prior to the legislative special session in January 2013.

Brian Hansen, DHCS, added that a chart outlining what states can consider for ACA eligibility rules is available at the AB 1296 web site:
<http://www.dhcs.ca.gov/Pages/StateOptionsandLegislationNeeds.aspx>

Katie Murphy, Neighborhood Legal Services- Los Angeles, asked *Morrow* how the income eligibility “bright line” will be set and encouraged *DHCS* to think through how family structure/size will be determined. She noted that family courts often favor 50/50 splits that alternate dependent classification for separated families every other year. This raises the potential that individuals will be placed out of Medi-Cal on alternating years.

Mollow, DHCS, commented that DHCS is working with RAND to establish an income eligibility methodology. Although this is not yet finalized, in the aggregate, the major coverage groups will be protected. She agreed that the question about tax laws and the setting of family structure was an important question and that more discussion is needed.

Elizabeth Landsberg, *Western Center on Law & Poverty*, added that this highlights the need for an important conversation with family court judges.

Anne Donnelly, *Project Inform*, inquired about the level of streamlining and self verification that will be applied to non-MAGI populations.

Mollow noted that the streamlined application will be applied to all populations but the State may need to include some supplemental forms for the non-MAGI populations.

Donnelly, *Project Inform*, asked if there are any intended changes to other programs (up to 250% working disabled).

Mollow stated that there would not be.

Suzie Shupe, *CA Coverage & Health Initiatives*, commented how complex enrollment will be for families even with simplification and the importance of continuing to assist families with enrollment. The demographics of the new enrolling population speaks to the importance of a trusted assistor population. She noted that there has been much conversation about the importance of navigators but little discussion of compensation. She asked what the forum will be to discuss this issue and provide stakeholder feedback.

Toby Douglas, *DHCS*, stated that the largest issue for the navigator program is financing the Medi-Cal portion of these services since finding the non-federal share is not something we have available. He shared the need to continue these discussions, while also noting the fiscal realities the state is facing.

CalHEERS Update

Douglas introduced Juli Baker, Chief Technology Officer, Covered California (California Health Benefit Exchange) to provide a CalHEERS update. He shared that an MOU has been signed between Covered California and DHCS and that decisions on the system are being made jointly.

Juli Baker presented an update on the CalHEERS system. The presentation can be found at: <http://www.dhcs.ca.gov/Documents/CalHEERSupdate11-19-12.pdf>

Baker shared the following highlights:

- The program is currently in the design phase. The system requirements have been validated with the vendor. They are posted on the Exchange web site and available for comment until November 30th, 2012 (www.hbex.ca.gov). The business system design definition document will be released for comment in December and the single streamlined application will be released for comment in January. Lastly, client usability testing will be conducted with various stakeholders/communities between December and March.
- CalHEERS will be released in three phases with portal access in July and open enrollment beginning in October 2013. Assistors and eligibility workers will have training available prior to July.
- The CalHEERS web portal will provide an option for residents to apply online for insurance coverage and some residents could apply and be enrolled exclusively online without any other assistance or provision of additional documentation. They anticipate the first year only 10% of applicants will enroll without any other assistance, although this rate could potentially increase to 65%. Initially, most applicants will also need to rely on customer service over the phone or other means to complete their application.
- Covered California and DHCS are also aware of and working on the intersections of the Exchange and Medi-Cal. Some residents using customer service over the phone will be eligible for Medi-Cal. Other residents will have income on the threshold and may change between Medi-Cal and the Exchange program. To prepare for this, Covered California is establishing agreements with the counties to support referrals back to the counties (and vice versa).

Toby Douglas, DHCS, asked Baker to talk about the interfaces with the county automated welfare systems. Baker noted that there will be interfaces for each of the SAWS systems with the idea that SAWS will be the system of record for Medi-Cal, whereas CalHEERS will be the system of record of the Exchange programs. She further noted that there is a lot of churn that is expected from patient eligibility shifting from Medi-Cal to the Exchange and vice versa. To address this, the system will transfer data back and forth at key points where the counties need to see some of the key data that CalHEERS has and vice versa. Douglas noted that this is an extremely ambitious project both for CalHEERS but also for all of the other systems that need to change in a short period of time.

Jim Gomez, CA Association of Health Facilities, commented that the scope of the project appears to be a four year project compressed into 8 months. He asked if CalHEERS is modifying an existing program or developing the system from the ground up. He shared concern that this ambitious project could be completed in the required timeframe unless something was already built.

Juli Baker, Covered California, noted that they are not leveraging an existing CMS system because it does not exist. However, they are not starting from scratch and selected a vendor that brings a framework that can be built upon. The architectural layers of the system already exist, which are then being customized. She emphasized that it is very important to not allow scope creep. Anything that is not absolutely necessary for the October release is not included.

Casey Young, AARP CA, stated that one of the challenges appears to be that they do not yet have all of the business requirements and asked Baker to comment on how big these gaps are.

Baker responded that the biggest issue right now is the single streamlined applications noting that there is a huge risk if they are not able to identify the requirements. The team has developed a set of data elements for the streamlined application and has attempted to over-estimate the number of requirements. She stated that it is easier to take away requirements than to add them.

Suzie Shupe, CA Coverage & Health Initiatives, Asked if residents will be able to use the portal to look at their options and browse prior to the 2nd phase release in October. She also asked if Certified Application Assistors will be limited to the public portal or will have a different kind of access to the portal.

Baker affirmed that residents will be able to see the system and get a sense of their eligibility prior to the October release. She also confirmed that assisters and customer service representatives will have a certain type of security sign-on that will allow them to access appropriate information securely.

Katie Murphy, Neighborhood Legal Services- Los Angeles inquired where in the system the affordability calculator comes up, both in the phone call and online, in terms of understanding how the tax credits come into play. Knowing there will be a lot of churn, she asked how they are communicating with insurers to make sure that churn does not result in disenrollment.

Baker stated that the reason for focusing on churn is to mitigate dis-enrollment. She stated that they are working with the counties to make sure that if residents become higher income and no longer eligible there is clear communication between Covered California and counties.

Toby Douglas, DHCS, added that this becomes an issue for qualified plans and provider networks in ensuring that patients remain in their networks. He encouraged the group to think differently about disenrollment and noted that this is a very big issue and concern.

Baker, Covered California, added comments on tax credits and affordability. She shared that in the plan selection component applicants would see the cost

information, including premium and cost sharing, and that customer service representatives will be able to talk applicants through the tax credit information.

Katie Murphy, Neighborhood Legal Services- Los Angeles, encouraged Covered California to make affirmative efforts to address these issues and to prepare scripts and training for staff to engage patients.

Elizabeth Landsberg, Western Center on Law & Poverty, commented that there are legal requirements to make sure we do not disenroll people but transition them to other programs. She asked Douglas how California would accommodate mixed coverage families and make sure that the incoming experience of “no wrong door” does not result in dealing with multiple entities.

Toby Douglas, DHCS, reiterated that there have been no changes to any of the requirements for the determination of Medi-Cal eligibility to be made by county eligibility workers. In MC cases a county worker needs to make that determination. For those applicants calling or coming online through the portal, there will be a simple sort to direct them appropriately. He agreed that what has not been decided is how to deal with mixed households – it is an open question. He stated that DHCS is working with Covered California, the counties and within the Administration.

Ellen Wu, CA Pan-Ethnic Health Network, asked that given the understanding that there will be so many limited English proficiency (LEPs) residents eligible for the Exchange, what languages will be included in the system? Baker shared that the web site will be in English and Spanish and that the customer service center will include thirteen languages either on site or through a language line.

Wu next asked what is the definition of “real-time” under real-time determination. Baker responded that this is still being finalized and acknowledged that “near real time” needs to happen.

Marilyn Holle, Disability Rights CA, asked how the expanded child MAGI eligibles relate to CCS eligibility. *Douglas, DHCS*, shared that it will be just as it is today. They will become eligible for Medi-Cal up to 250% and, if in need of CCS, will go through the county process.

Delivery System Reform Incentive Pool (DSRIP) Update

Neal Kohatsu, DHCS provided a brief update on DSRIP. The full presentation can be found at: <http://www.dhcs.ca.gov/Documents/DSRIPProgramUpdate.pdf>

Anthony Wright, Health Access California, asked when the first results are expected on whether the goals are being met. Kohatsu shared that there are qualitative metrics in development as well as the establishment of baseline data. Quantitative data will be coming in over the next year.

Rusty Selix, CA Council of Community Mental Health Agencies, stated that there was no mention of behavioral health even though the impact of behavioral health on the programs goals is well understood. *Kohatsu* agreed that it was a very good question and affirmed the need for integrative care. He highlighted that there is a lot of work across the system on the Patient Centered Medical Home (PCMH) and that behavioral health is a part of this work.

Anne Donnelly, Project Inform, asked if the HIV transition is intended to be five years. Douglas stated that it extends through 2014 and that one issue is how the LIHPS are structured.

California Children's Services (CCS) Pilot Update

Jane Ogle, DHCS, presented a brief update on the California Children's Services (CCS) Pilot. A copy of the presentation can be found at: <http://www.dhcs.ca.gov/Documents/CCSUpdate.pdf>

Ogle acknowledged that the pilots have been challenging to get underway.

Stuart Siegel, Children's Hospital Los Angeles, commented that it is clear that the timetable for implementing the CCS pilot has gone on a lot longer than anticipated and that the evaluation process and timeline is well out of sync with the original plans. The evaluation was originally intended to inform decisions after the sunset.

Toby Douglas, DHCS, responded that until they know what the pilots are going to look like it is very difficult to create a baseline evaluation. He acknowledged that the delay creates some challenges in determining how to proceed after the CCS carve-outs sunset. He said that once it is known what the pilots are going to look like, there will need to be some decisions made about how to proceed with the evaluation and decision-making.

Kim Lewis, National Health Law Program, asked what kind of notices patients are receiving and how it integrates with managed care expansion and all other notices going out.

Jane Ogle, DHCS, stated that patients do not experience a change in health plans or providers in San Mateo County. It is just a change in who is accepting risk for it. Lewis responded that this might not be true for other counties. Ogle agreed and said these issues would be addressed once the other county pilots were better defined.

Stuart Siegel, Children's Hospital Los Angeles, commented that originally there was going to be no movement of CCS kids in counties where the pilots were

underway but that evidently it was happening. We've asked about it before and it continues to happen. He asked if any conversations or actions have taken place.

Ogle, noted that DHCS was made aware of an error in enrollment information for a group of CCS patients in LA County that incorrectly received mandatory enrollment letters. The patients were subsequently informed that there was no mandatory enrollment and it was still voluntary. They have been tracking this closely to make sure that patients receive the correct communication.

Katie Murphy, Neighborhood Legal Services- Los Angeles, added that their organization receives a trickle of folks that were outside of this group but for whom this still happened. She commented that they were periodic and always get fixed but that it is important to look at what is happening.

Coordinated Care Initiative Update

Jane Ogle, DHCS, provided a brief update for the Coordinated Care Initiative. No powerpoint presentation was made available. Highlights included the following:

- DHCS is in conversation with CMS and hope to have the MOU done before the end of 2012. They are also moving forward with establishing waiver amendments during the winter and spring 2013.
- It is estimated that there are approximately 526,000 enrollees within the 8 counties eligible to participate in the demonstration project for Dual Eligibles, including about 221,000 in Los Angeles.
- DHCS anticipates that the Dual-Eligible program phasing will begin in June 2013 with phasing varying by county depending on county structure and circumstances.
- DHCS has been working with the managed care plans to generate de-identified data on the Dual-Eligible population so that they may gain a better understanding of what the population moving into care will look like in terms of service needs. One important emphasis is data on patients who are most at risk of institutionalization, which is a big focus of the program.
- DHCS is also actively working with the managed care plans to determine what outreach will look like for both providers and beneficiaries.

Toby Douglas, DHCS, noted that DHCS has learned of the importance of outreach and readiness in programs such as these and that it is essential that managed care plans reach out to their networks and have an awareness and understanding of the service needs.

Jim Gomez, CA Association of Health Facilities, agreed that it is important to get early engagement but cautioned that negotiations were already underway with providers.

Marty Lynch, Lifelong Medical Care, asked about the June 2013 timeline and if DHCS was still planning a phased timeline.

Douglas stated that they have not finalized the decisions and are talking with CMS about the plan.

Low Income Health Plan (LIHP) Update

Brian Hansen, DHCS, provided a brief update on the Low Income Health Plan (LIHP). A copy of the presentation can be found at:
<http://www.dhcs.ca.gov/Documents/LIHPTransitionUpdate.pdf>

DHCS is continuing to receive technical policy guidance from CMS. DHCS will continue working with Manatt who is managing technical assistance for CMS regarding 1115 Waiver transitioning expansion populations.

Elizabeth Landsberg, Western Center on Law & Poverty, asked if the current LIHP transition plan intends to transition enrollees as a default to the same medical home rather than allow choice.

Hansen responded that the final plan allows beneficiaries a choice of their provider plan. While there is a structure and a default process, patients are also provided an up-front opportunity to select their provider. If they make no selection then they will be defaulted to their same medical home.

Katie Murphy, Neighborhood Legal Services- Los Angeles, commented that if the medical home is in more than one plan, it would be very important to communicate with patients that their medical home is in multiple plans (e.g. Health Net and LA Care).

Melissa Stafford Jones, California Association of Public Hospitals, said that the emphasis of maintaining a medical home is very important. We want to make sure to provide choices for patients, but we also want to keep in mind the importance of keeping people within a medical home.

Anne Donnelly, Project Inform, asked if an assessment has been completed on whether medical homes in the LIHPs are the same as in Medi-Cal managed care, particularly for HIV patients.

Toby Douglas, DHCS, stated that it has not been done but that the majority of LIHPs are public hospitals and community providers.

Anthony Wright, Health Access California, stated that it was his understanding that there are now 51 counties participating and asked if there has been any progress on the remaining seven, as well as DHCS' thoughts on transitions for counties not participating in the LIHPs.

Douglas noted that they are projecting 54 counties that will ultimately be involved in the LIHPs. In terms of remaining counties, Covered California will serve as both the health benefit exchange and the face of the state marketing effort, and will target both bringing people into the health benefit exchange and eligible but non-enrolled eligible individuals into coverage.

Jim Gomez, CA Association of Health Facilities, asked if the Dual-Eligible patients will be allowed the same choice of provider or will be auto-assigned.

Jane Ogle, DHCS, confirmed that Dual-Eligible patients will have provider choice and will receive standard 30/60/90 day notices.

Seniors and Persons with Disabilities Update

Margaret Tatar, DHCS, provided a brief update on the Seniors and Persons with Disabilities (SPD). A copy of the presentation can be found at: <http://www.dhcs.ca.gov/Documents/SPDsUpdate.pdf>

Tatar noted that a workgroup including legislative staff, advocates and others has been assembled to work through a number of challenging issues related to Medical Exemption Request (MER) processing. She shared that the workgroup continues to look at specific issues that come to the group's attention or irregularities in the processing. The workgroup is engaging in fairly deep scrutiny about the processing and hope to share what they have learned in the near future. She stated that the backlog is hovering around 300 per month, which is significantly lower than the past, and the turnaround time is 1 week.

Katie Murphy, Neighborhood Legal Services- Los Angeles, stated that there has been a small but challenging number of patients who have had their MER renewal denied without any explanation of why. She asked why this was happening. *Tatar* requested that *Murphy* provide specifics after the meeting so these issues can be understood and addressed.

Marilyn Holle, Disability Rights CA, requested a description of how DHCS is monitoring the risk assessments. *Tatar* responded that they receive and review reports from the managed care plans and conduct annual medical audits that include elements of the assessment and stratification.

Holle expressed concern about the monitoring of initial assessments and stated that she does not feel that annual monitoring is adequate. She asked if spot checks are conducted. *Tatar*, stated that there are no spot checks per se but that there is an active feedback loop on issues that they learn of from the managed care plans.

Holle said that she would feel much more comfortable if there was an active way to spot check the plans and reiterated that what was described does not seem to be adequate oversight.

Kim Lewis, National Health Law Program, expressed appreciation for the DHCS MER workgroup and said it is an important area where there can be ongoing dialogue. She further advocated that it was critical that as a next step the scope of the workgroup be expanded to include continuity of care more broadly. She expressed a hope that all of the tools (e.g. dashboards) could be used to look at advancing the continuity of care requirements.

Tatar, DHCS thanked Lewis for the comment and noted that DHCS sees a similar path forward and very much values this feedback.

Marilyn Holle, Disability Rights CA, stated a concern that for individuals enrolled in managed care and Genetically Handicapped Persons Program (GHPP), there does not seem to be a requirement that they maintain their linkage to specialty care centers.

Tatar agreed that they have heard that comment and are working on a survey that will inform an All Plans Letter for the managed care plans that delineate how the plans work with providers to ensure linkage. She thanked Holle for the input and shared that they look forward to getting her input on the issue.

Stuart Siegel, Children's Hospital Los Angeles, shared that he and others made a presentation to a conference of all the health plans of California in Huntington Beach about this issue and that there was very good discussion. He said he would be happy to share the specifics of the conversation.

Anne Donnelly, Project Inform, stated that she is very much looking forward to efforts on continuity of care. She further shared that there are some cases where patients are denied MER, then go to court and receive a positive judgment, but are then overturned by DHCS. This can result in the full loss of care and she asked that DHCS provide a more information on the thinking behind these decisions.

Al Senella, CA Association of Alcohol and Drug Program Executives/Tarzana Treatment Center, asked if the reported patient satisfaction is self-reported by the plans. He further asked if substance abuse was a benefit under the waiver.

Tatar, DHCS, explained that the survey responses are from an external survey provided by UC Berkeley. In terms of substance abuse, she commented that they have initiated some preliminary surveys to see how managed care plans are working with county mental health plans. She emphasized that these efforts are preliminary but extremely important.

Al Senella, CA Association of Alcohol and Drug Program Executives/Tarzana Treatment Center, added that one of the issues is that there is a problem when billing for substance use medications, which are carved out.

Essential Medicaid Benchmark Benefits Options Presentation

Toby Douglas, DHCS, introduced representatives of Mercer, the Human Research Services Institute and Manatt to provide a presentation on the Essential Medicaid Benchmark Benefit Options. He stated that the presentation today is focused on the Medicaid benchmarks only, not the Exchange benchmarks.

Presenters included:

- Meredith Mayeri, Mercer and Charles Lassiter and Melinda Dutton, Manatt Health Solutions, which is completing the actuarial analysis of current Medi-Cal benefits that will allow the State to model benchmark options;
- Charles Lassiter and Melinda Dutton, Manatt Health Solutions, which is evaluating the federal legal and strategic considerations and synthesizing the analysis into a final report, and;
- David Hughes of Human Research Services Institute (HSRI), which is assessing the behavioral health/substance use services and estimates of services used by the income expansion population.

Highlights of the presentation are included below. A full copy of the presentation can be found at:

<http://www.dhcs.ca.gov/Pages/November19,2012SACMeeting.aspx>

Manatt Health Solutions – Federal Legal and Strategic Considerations

- The Affordable Care Act (ACA) stipulates that states must provide a “benchmark” state-selected benefit plan defining “essential health benefits” EHB for the Medicaid newly eligible adult population and the Exchange.
- Today’s analysis is focused on the analysis and approach for evaluating benchmark benefit options for the California Medi-Cal expansion only and does not address the Exchange.
- The timeline for the analysis includes: initial data collection, research and analysis between October and November 2012; refinement of the research/analysis including cost estimates, crosswalk of plan options, stakeholder convening and draft report through December 2012, and; completion of a final report for the Special Legislative Session in January 2013. The State must provide public notice and reasonable opportunity to comment before submitting benchmarks for approval.
- Benchmark plans must include all ten EHB categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory

services, and preventive and wellness services and chronic disease management.

- Open questions requiring additional federal guidance include the following:
 - How will the requirement that Benchmark include EHB be implemented?
 - How will the requirement that Benchmark apply mental health parity rules be implemented?
 - May states include in their benchmark services not listed in Section 1905(a) as either a mandatory or optional benefit?
 - Do the Benchmark exemptions in Section 1937(a)(2)(B) apply to the new adult eligibility group?
 - Will states receive enhanced FMAP for providing services to individuals in the new adult eligibility group who fall within a Benchmark exempt category?

Mercer – Actuarial Analysis Approach to Model Benchmark Options

- The analysis compares benefits across four potential benchmark plan options, including the Blue Cross Blue Shield Standard PPO, Anthem Choice PPO state employee plan, Kaiser tradition HMO and Medi-Cal standard benefit. The Anthem Choice PPO was selected because it appeared as the “skinniest” option that allows for an analysis of the spectrum of options. Medi-Cal standard plan is assumed to provide the richest level of benefits.
- The three steps to the analysis are to: 1) compare plan benefits across potential benchmark options and identify meaningful differences in cost and coverage; 2) estimate the total cost of each “bookend” benefit and the costs of key service differences, and 3) Trend cost estimates to 2020 and project estimates of future costs including estimates of state and county shares.
- It was noted as important to examine differences in the state and county share of the benefit package cost because although newly eligible adults would be funded 100% by federal funding initially, and after 2017 the State are expected to have pay a share of this cost from 4% to 10% after 2020.
- Initial areas where we may see meaningful coverage differences include Long Term Care, FQHC services, bariatric surgery, abortion, chiropractic, non-severe mental illness, substance use disorder services, applied behavioral analysis therapy for autism, acupuncture and infertility services. These are initial observations.

HSRI – Behavioral Health Analysis

- The behavioral health analysis will be used for implementation as part of special terms and conditions of the section 1115 waiver. The basis for the analysis is the needs assessment completed on needs and service utilization of current Medicaid recipients. This will be used as a basis for the development of a mental health and substance use service plan for Medi-Cal expansion population.

- The estimated users of mental health and substance use from the needs assessment is based on the predicted behavioral health composition and status of the Medi-Cal expansion population.
- Cost projections take into account assumptions about the services included in the benefit, enrollment take-up rate of eligible new adults, proportion that will present for services, distribution and intensity of service use and medical inflation.
- The utilization methodology relies on claims/encounter data in the existing Medi-Cal population to project utilization for the expansion population. The experience of other state expansions is also factored into the analysis.

Marty Lynch, Lifelong Medical Care, stated that he understands why we might want to understand costs of individual benefits or services beyond commercial coverage. He asked how the analysis factors in “FQHC services”. He also asked if the analysis is looking at the impact of individual benefits on the overall cost of care or if it is just looking at the incremental cost of services.

Charles Lassister, Manatt, responded that they understand FQHC services as unique services themselves and also at location and delivery. Secondly, he commented that at this point the analysis is just looking at the cost of incremental care but that the expectation is to explore questions about the overall cost of care at a later date.

Anthony Wright, Health Access California, inquired if it is correct that a benchmark benefit can be changed so what we put in place in 2014, we’re not tied to it in 2020? He added that one way you can look at it is as additional cost, whereas another way you can look at it is maximizing federal revenue and benefits for a limited period of time.

Meredith Mayeri, Mercer, responded that it is correct that the benchmark benefit can change. *Toby Douglas, DHCS*, stated that in regard to the second question, at the high level you are getting the raw cost of services.

Wright commented that a public policy goal of the State for many years has been to maximize federal revenue into the system. If you ask the question a slightly different way you may get a different answer to the question.

Douglas stated that we are at the options period. Those are the exact policy questions but this analysis will give us the information to evaluate the options in front of us. After we have the menu of choices, these are the policy questions we will address.

Wright, responded that as an example dental is one of those things that would be an opportunity for the next three years, even if just to deal with the pent up demand.

Rusty Selix, CA Council of Community Mental Health Agencies, stated that he is sure it is clear that the behavioral components are all carved out to the counties, so this would not be a part of the analysis. *Douglas* agreed that to the extent of what the behavioral health package is, it would be run through the county systems.

Selix, CA Council of Community Mental Health Agencies, noted that there is a unique carve-out for anti-psychotic medications in Medi-Cal, even in managed care, and it is a particularly significant category. He asked if this is part of the analysis. *Douglas* responded that he sees this as a little different; the question is who is going to administer it.

Selix posed a question to David Hughes. He said that it is our understanding that a percentage of this population are people with extremely high need, but are also extremely hard to enroll. He wondered if the consultant team would consider sharing their assumptions with some agreed upon experts to see if the assumptions match with the perspectives of the experts. He shared that with the initial needs assessment nothing was shared until the final 700 page analysis was released. He commented that there is a need to have some lead time now to get input and feedback. He suggested getting some expert feedback on the assumptions and that he and others can provide names.

Elizabeth Landsberg, Western Center on Law & Poverty, asked how the analysis is taking into account that people who need Long Term Care are also applying for SSI or other non-MAGI services.

Meredith Mayeri, Mercer, commented that they certainly have had discussion about administrative costs and how that might impact costs to have two Essential Health Benefits.

Melinda Dutton Manatt, added that as we think about the population that would be utilizing Long-Term Care, to the extent they are utilizing them as the new group, we get enhanced match and to extent not, we do not get match. One of the reasons we are looking at this is to remove the incentive for patients to leave the high match category and move into a lower match category. From a financial modeling perspective, there are some potential advantages to members staying in the program.

Toby Douglas, DHCS, said that a big unanswered question is that the State needs the new FMAP methodology to understand who is new and who is old. What are going to be the implications of determining who is in or out? How is the federal government going to take a number of factors into account?

Kim Lewis, National Health Law Program, asked the presenters to elaborate more on the methodology for projecting who will be covered by the benchmark

group, noting that there are probably a lot of variables such as churn that will impact the modeling.

Meredith Mayer, Mercer, responded that they are still early in that conversation.

Brian Hansen, DHCS, added that DHCS is looking at the UC Berkeley model, but are not sure if it gets to the right level of sophistication.

Marilyn Holle, Disability Rights CA, asked the presenters to talk about meaningful differences in DME.

Charles Lassister, Manatt, commented that at this point, we can talk about the coverage of the plans. The analysis has sought to capture as many of the inclusions in DME commonly presented in commercial plans. The template solicits information on limitations.

Holle shared that UC Berkeley has completed an analysis on the impact of removing caps from DME. She added that the analysis also has to look at the Medicare vs. Medicaid standards – whereas, one has the standard of getting you integrated into daily life, which should be the standard. Charles Lassister, Manatt, reiterated that this is the reason for using Medi-Cal as the most robust package.

Katie Murphy, Neighborhood Legal Services- Los Angeles, said that the experience of LIHP in LA has been that enrollees are not utilizing services in the ways that someone does who is used to having health insurance. The idea of integrating into a medical home is very unusual. She stated that she is not sure how this is integrated into the analysis. Secondly, she asked where is the next moment where stakeholders can provide input and feedback on the analysis.

Brian Hansen, DHCS, stated that it would be helpful to get some input on the assumptions they are using.

Murphy asked if there will be any policy decisions made in January.

Toby Douglas, DHCS, commented that he understands that the timeline is very tight. He added that this is a dynamic process and we want to hear all of these inputs.

Brian Hansen, DHCS shared that DHCS has an email listserv and they will also develop an email to stakeholders to go out with that email address.

Kim Lewis, National Health Law Program, suggested that in terms of process, to the extent DHCS can release the assumptions and allow stakeholders to comment that would be extremely helpful.

Katie Murphy, Neighborhood Legal Services- Los Angeles, emphasized that there will be some platforms, some decisions to make and it is that second level of decisions that she and other stakeholders want to be a part of.

Anne Donnelly, Project Inform, stated that she is concerned about formulary particularly for patients with chronic conditions. She asked if the analysis is going to capture all the limitations on formularies and what standard they expect to compare that to as they complete the analysis (e.g. open formularies, Medicare standards). What are the assumptions?

Charles Lassister, Manatt, responded that at this point, they have not addressed this issue knowing that they will have to in the future. *Anne Donnelly, Project Inform*, commented that on her side, they feel that the federal guidance on the Essential Health Benefits is far too weak and hope that the State will be more forward thinking.

Al Senella, CA Association of Alcohol and Drug Program Executives/Tarzana Treatment Center, stated that he does hope the consultant team will look at the subject of residential care for substance use. He asked where they will look to for cost data on substance use. He added that this was raised during the early part of the waiver and there was significant recognition that this data was very limited. He asked where will the team go for information on the “full picture” and how the analysis will include the cost offset of providing this benefit.

David Hughes, HSRI, noted that the only information they have now is the historical Medi-Cal utilization and cost to project out. He added that he wished they could get the cost offset.

Senella asked why they cannot do the offset. *Hughes* responded that it is not part of the scope at this point. *Toby Douglas, DHCS*, inserted that this is what *Katie Murphy* raised as the next level of policy analysis.

Senella reiterated that the analysis needs to consider the Medi-Cal cost data but that there are also a whole array of county and local services that are provided. He added that they should also talk to the Department of Corrections.

Jim Gomez, CA Association of Health Facilities, shared that it is important that we be able to get the cost implications for each of the policy options and understand the extent to which it can be broken out on both a state and federal level. He added that there are many ways to bring in federal funds. In regards to IMD, you could make that a part of FFP and immediately relieve the counties of 50% of that without putting out an additional dollar. One question he encouraged the group to look at is how can we assist counties in better capturing federal funds without making additional state commitments?

Toby Douglas, DHCS, responded that part of this process is figuring out if they are county obligations and what are the implications, adding that the counties have a role in how these will be applied.

Lee Kemper, CMSP, commented that the group has not really talked about the requirements in terms of LIHP in comparison with these EHB options. He would like to see this since we are taking 500,000 people and moving them from one benefit package to another – if not just for cost, but for the patient’s transition.

Toby Douglas, DHCS, thanked the group for the good input and noted there were a number of to-dos as well as the need to let stakeholders know how they can be involved. He stressed that this analysis is about options at this point.

Brian Hansen, DHCS, added that if anyone has seen good comparative analyses that lend themselves to the Essential Health Benefits analysis to please send them along.

Public Comment

Diane Van Maren, Senator Darryl Steinberg’s Office, made public comment. She stated that it is clear that we need more federal guidance and added that it would be helpful to have another meeting before the February meeting. She added that there is a lot of expertise here and that it would be great to have the consultants share a draft of their analysis so the group can have a more robust discussion that engages a lot of the experts here. She noted that Senator Steinberg is interested in returning to the question of adding back adult dental as well.

The meeting was adjourned at 3:42 p.m.