

**SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
HEALTH CARE COVERAGE INITIATIVE (HCCI) TECHNICAL WORKGROUP
Meeting #1 – Tuesday, February 23, 2010
12:00pm – 4:30pm
Sacramento Convention Center, Room 103**

The meeting convened at 10 AM.

Attendance

Technical Workgroup members attending: Jennifer Abraham, Kern Medical Center; Maya Altman, Health Plan of San Mateo; Tangerine Brigham, City and County of San Francisco Department of Public Health; Kelly Brooks, California State Association of Counties; Sandy Damiano, Department of Health and Human Services, Sacramento County; Irene Dyer, Los Angeles County Department of Health Services; Bob Gates, Orange County Medical Services Initiative; Nancy Kaatz, Santa Clara Valley Health and Hospital System; Lee Kemper, CMSP Governing Board; Elizabeth Landsberg, Western Center on Law and Poverty; Louise McCarthy, Community Clinic Association of LA County (by phone); Anne McLeod, California Hospital Association; Erica Murray, California Association of Public Hospitals and Health Systems; Judith Reigel, County Health Executives Association of California; William Walker, Contra Costa Health Services; Ellen Wu, California Pan-Ethnic Health Network.

Others attending: David Maxwell-Jolly, Director, Department of Health Care Services (DHCS); Gregory Franklin, Director of Medi-Cal Operations and Project Director, 1115 Demonstration Waiver Project, DHCS; Jalyne Callori, DHCS; Caroline Davis, Health Management Associates; Bob Sands, DHCS; Nadereh Pourat, UCLA; Gerald Kominski, UCLA; Bobbie Wunsch, Pacific Health Consulting Group and Catherine Teare, Pacific Health Consulting Group.

Public in Attendance: 10 individuals attended in person, and 20 people called in on the listen-only telephone line.

Welcome and Introductions

Bobbie Wunsch, Pacific Health Consulting Group welcomed the group and provided an overview of the agenda. Key questions to be considered include:

- What have we learned about HCCI to date? What has worked well? What challenges have the CI counties experienced?
- What could be standardized across the HCCI programs? What might this look like?

Overview of Purpose and Desired Outcomes of HCCI Technical Workgroup

David Maxwell-Jolly, Director, Department of Health Care Services (DHCS) and Chair, Stakeholder Advisory Committee thanked the workgroup members for their participation,

noting that seven of ten Coverage Initiative (CI) counties are represented on the Workgroup. He also thanked the California HealthCare Foundation (CHCF) and The California Endowment (TCE), without whose support it would not be possible to engage so many individuals in the stakeholder process.

DHCS believes that the CIs are an important piece of the existing waiver, representing an important step forward and a great jumping off point for further development, and wants to build on the foundation that the CIs have established. Specifically, DHCS is interested in several issues in the context of the waiver renewal:

- 1) Explore the possibility of expanding to additional counties;
- 2) Explore the possibility of expanding within the existing counties; and
- 3) Figure out what we've learned: what is effective, what CI features have allowed the safety net to provide better care, should we standardize those features that are successful, and, if so, how.

The waiver application process was initially framed in the context of building a foundation for national health reform. Although the prospects for federal legislation are uncertain, from DHCS's perspective the CIs are worthwhile. One challenge for the Workgroup is that we will not know, during this process, how much additional money, if any, will be available in the next waiver.

David Maxwell-Jolly discussed the Workgroup charter, and emphasized that the role of the Workgroup is to provide DHCS with information to help the Department figure out what the essential elements of successful CIs are, and the direction the waiver should take with regard to CIs.

Elizabeth Landsberg, Western Center on Law & Poverty, asked about language in the charter referring to transitions between CIs and Medi-Cal, and offered that the linkages should be viewed from the point of view of clients, not only administrators. She also said that she believes statewide centralized enrollment and eligibility is beyond the scope of the Workgroup. David Maxwell-Jolly agreed, saying that the Workgroup would not look at statewide integration, but rather integration of eligibility at a county level. *Bobbie Wunsch* said that the charter would be amended with regard to the fourth deliverable.

Elizabeth Landsberg also said that the process should remain open to the possibility of federal health care reform, and David Maxwell-Jolly agreed.

Bob Gates, Orange County Medical Services Initiative, asked about the waiver condition prohibiting counties from enrolling people effective March 1, 2010. *Jalynne Callori, DHCS*, responded that DHCS recently received approval for that restriction to be waived, so that CIs can continue to enroll people until August 31, 2010. The Safety Net Financing Division will make an announcement about this change shortly.

Workgroup Structure and Process

Bobbie Wunsch, Pacific Health Consulting Group, recognized The California Endowment and the California HealthCare Foundation for funding the Workgroup, and thanked Cecilia Echeverria and Robert Phillips of TCE, and Len Finocchio and Chris Perrone of CHCF for their participation and support.

The Workgroup will meet three more times:

- March 17, Noon – 4:30pm (UC Office of President, 1130 K Street)
- March 29, 10:00am – 2:30pm (Sacramento Convention Center, Room 103)
- April 29, 10:00am – 2:30pm (California Primary Care Association)

Jalynne Callori, DHCS and *Caroline Davis, Health Management Associates*, will serve as co-leads of the HCCI TWG, with Caroline's work supported by TCE.

Members were reminded that meeting materials will not be printed, but will be sent out in advance. A summary of each meeting will be posted on the website within a week of the meeting date.

HCCI: A Qualitative and Quantitative Interim Assessment

Nadereh Pourat, UCLA, gave a presentation based on data reported by CI counties to the state. Her presentation compared CI enrollment, provider networks, inpatient days and outpatient visits, medical home visits, ED visits, costs per enrollee, and other data points. Data presented were for year 1 (ending 8/31/08) and year 2 (ending 8/31/09). Dr. Pourat's presentation is available at <http://www.dhcs.ca.gov/provgovpart/Documents/Feb%2023%20Waiver%20TWG%20briefing%20on%20HCCI-2-17-10.pdf>.

Ellen Wu, CPEHN, asked for detail on LA's enrollment, which falls short of its target. *Irene Dyer, Los Angeles County*, said that LA had set its enrollment target high, and had also struggled with enrollment, particularly related to the DRA requirements.

Anne McLeod, CHA, asked whether there was a minimum standard for medical homes in CIs, and specifically, whether there was any requirement in terms of the number of patients/medical home. *Dr. Pourat* said that "medical home" as described in the contract and state statute is very broad, that there is a need for more information about the structure of medical homes overall, and that the definition should be standardized in order to facilitate comparisons across counties. *Jennifer Abraham, Kern County*, also noted that the definition of medical home is very broad.

Several Workgroup members suggested that the definition of medical home be part of the Workgroup discussion; *Bobbie Wunsch* referred to two upcoming events on medical homes: a medical home webinar sponsored by the California HealthCare Foundation on February 26, 2010 at 9:00am – 10:30am with Dr. Thomas Bodenheimer of UCSF and safety net providers, and a discussion of medical home models to be held on March 4, from 2:00 – 4:00pm at the State Capitol Room 112.

The Workgroup discussed the differences between counties in terms of medical home structure. Nady Pourat pointed out that some counties (Contra Costa, Santa Clara) use their existing managed care plans for their CI programs, while Alameda uses panel management as a strategy to bring patients in before they have an acute need.

In reference to data about emergency department (ED) visits, Nady Pourat said that most counties show a decline in Year 2, which may be a sign that patients have been linked to a regular source of care. However, with the exception of Orange County, no county includes all hospitals in the county in its CI network, so data on visits to non-CI EDs would not be included. *Bob Gates* said that Orange County's enrollment strategy relies on EDs as the point of entry, so its ED numbers are high for that reason.

Lee Kemper, CMSP, asked whether the data allowed researchers to track ambulatory care sensitive conditions. Nady Pourat said that since many issues are not controlled for and because of the variation in models, it was hard to say from the data reported whether ED visits were appropriate or not.

David Maxwell-Jolly noted that while the populations enrolled in the various CIs are very different, the overall trends in the percentage of ED visits that lead to inpatient admissions are relatively similar across most of the counties.

Gerald Kominski, UCLA, emphasized that the data show just how different the counties are – there is no single CI program, but rather 10 unique programs that enroll different populations at different entry points and that offer different services. He noted that, while the data provide valuable background, it is difficult to compare across counties, and the performance and outcome measures may not be comparable at all.

Nady Pourat, UCLA, presented a final data point, based on UCLA's analysis of data supplied by San Francisco County (outside of the CI-required reports). Looking at individuals with diabetes who had been enrolled in San Francisco's CI for at least six months, the percentage who had had an HCA1 diabetes screen increased from 63% to 77% between 2006 and 2009, and their mean score on that test, which looks at average blood sugar over a three-month period, decreased from 8.1 to 7.8, a small but significant decrease. (A "good" result on that test is under 7.)

UCLA presented the following *Interim Lessons Learned*:

- Strong evidence of:
 - Expansions in covered services
 - System redesign
 - Innovations in specialty care and network creation
- Limited/preliminary evidence of:
 - Improvements in patient health outcomes
 - Efficiencies in health care delivery:
 - Increased adherence to clinical care guidelines
 - Decreased utilization of inpatient care and ER

- Decreased average cost of care per enrollee

UCLA's *Recommendations* included:

- Contractually-require submission of timely program and patient data to document waiver impact
- Provide clear and specific guidelines for program design, but allow flexibility in implementation
- Continue the program among participating counties
 - Likely to show strong evidence of success
 - Sustainability of most programs in the absence of federal funds is unlikely
- Consider expanding the program statewide, based on successes of the current pilot program:
 - Reimbursement procedures are tested and implemented
 - Enrollment challenges and barriers are largely overcome
 - Innovations in care delivery and system redesign are replicable in other counties

Several Workgroup members questioned these recommendations. *Tangerine Brigham, San Francisco*, said that while a statewide expansion was of interest, she questioned UCLA's conclusion that the reimbursement and enrollment systems were working. She said that some counties continued to face enrollment challenges, in part based on the DRA eligibility criteria identified by CMS for this program. The fact that people had worked so hard to make these programs successful should not disguise a fundamental problem with who is eligible for this program.

Erica Murray, CAPH, asked whether the UCLA recommendations addressed long-term sustainability given that the county:federal match brings in only 50 cents for every dollar that the counties contribute. Nady Pourat said that there was very little expenditure data available. Gerry Kominsky added that while the analysis might be able to identify savings from the CI programs, there are a number of expenses related to development of the safety net that are difficult to quantify, and without that investment and maintenance, the programs cannot be sustained.

Lee Kemper, CMSP, asked whether anyone is looking at how long CI enrollees remain enrolled in the program.

Workgroup members asked for information that compares the various CI programs in terms of their eligibility, enrollment strategies, terms of enrollment, benefits, and other issues. *Ceci Echeverria, TCE*, suggested that, as more final data becomes available, it would be helpful to compare among more similar programs (e.g., those that target people with chronic conditions versus those that enroll a broader population, or by whether counties have a public hospital).

Ellen Wu, CPEHN, asked whether it was possible to stratify the data by race, ethnicity, and/or language preference. Nady Pourat said the next analysis would look at those issues.

Judith Reigel, CHEAC, asked whether the counties had expressed the need for additional resources in order to collect the data that UCLA needs. *Gerry Kominski* said that UCLA's contract with state and CMS required them to look at seven areas. They defined an ideal set of data, and worked with counties to see what they already were collecting. In most cases, counties were already collecting information that met the wish list in some areas, but not others. *Maya Altman* said that the Health Plan of San Mateo was collecting HEDIS data for their CI, via the Health Plan. *Tangerine Brigham* said that their CI is a subset of the overall Healthy People San Francisco plan, which collects administrative and HEDIS data.

Elizabeth Landsberg suggested that it would be useful to have a document that shows how the CIs are related to the counties' prior medically indigent adult program, perhaps building on the CHCF paper on Section 17000 programs, available at <http://www.chcf.org/topics/view.cfm?itemID=134110>

California Health Care Coverage Initiatives: County Perspectives, Policy Options and Implications for the Future

Caroline Davis, Health Management Associates, presented an overview of a qualitative assessment that HMA conducted in late spring of 2009. HMA staff spoke to representatives from the CI counties, selected non-CI counties, and to other stakeholders in a project funded by CHCF. HMA identified the early challenges and successes for the existing CI counties, and asked all stakeholders to reflect on the possibility of expanding the CI in a new waiver.

The presentation is available at <http://www.dhcs.ca.gov/provgovpart/Documents/2010-2-23%20HCCI%20workgroup%20HMA%20eval.pdf>.

The full report is at [http://www.dhcs.ca.gov/provgovpart/Documents/HMA%20CHCF%20HCCI%20Interim%20Assessment%20Sept%202009%20\(2\).pdf](http://www.dhcs.ca.gov/provgovpart/Documents/HMA%20CHCF%20HCCI%20Interim%20Assessment%20Sept%202009%20(2).pdf).

Highlights of the presentation included:

Early Successes and Challenges

- Start-up was slow, with federal reimbursement for medical services not available until December 2008 (although reimbursement was retroactive to the start of the CI in September 2007), and administrative reimbursement is still not available.
- The citizenship and identity requirements slowed enrollment – all counties reported that the identity verification requirement was very difficult for this population.
- Enrolling medically indigent adults in an organized system of care is a significant achievement, for the counties, state, and as a national model.
- Counties have used CI to improve the efficiency of their safety-net delivery systems and to expand network capacity

- Counties intend to apply CI-related reforms to broader population of patients served by local safety-net.

Key CI Elements

- Eligibility and enrollment: developing a formal enrollment process is crucial to transforming fragmented system of episodic care into an organized system of health coverage. *Recommendations* -- Consider standardizing enrollment processes across counties streamline eligibility determination, allow for a single process regardless of payer, address the challenges of the DRA requirement
- Organized systems of care: focus on integrated care with disease management/medical home, health IT as a foundation of system redesign, CIs have been a catalyst to consolidate and spread earlier efforts to improve health system operations, such as staff training, health IT, and clinic redesign. *Recommendations* -- preserve county flexibility within framework of coverage expansion and delivery system reform, implement payment reforms to delink payment from site of care/tie to CI goals, provide support for IT, consider regional strategies and portability of coverage
- Network enhancement: focus on enhancing existing provider networks, specialty care challenging across all counties. *Recommendations* -- need network governance as they expand and build public-private networks, need to identify models that offer lower cost primary care and preventive services.

Sustainability

- Counties concerned about long-term sustainability
- Care management strategies likely to prove cost-effective over time
- Some system reforms (health IT) likely to be retained in absence of continued federal funding
- *Recommendations*: Need sustainable, predictable funding strategy; recognize county challenges re: populations who do not qualify for HCCI; and create efficiencies across payers and administrative entities.

David Maxwell-Jolly asked about counties' capacity to sustain CI programs, given the state of county budgets. *Jennifer Abraham* said that to date, counties had essentially funded the program entirely, due to late payments, and that she was not sure how much longer Kern County could sustain the program in this way. *Tangerine Brigham* said that San Francisco County is committed to continuing to provide services to those individuals already enrolled, and that if there were sufficient federal funds to allow for expansion, San Francisco would identify local funds for a match. Similarly, *Bob Gates* said Orange County is in a position to accept additional federal funds. However, the fact that, with 6 months left in a 3-year initiative, no county has received administrative funding creates difficulties. *William Walker* said that while the Contra Costa Board of Supervisors recognizes its section 17000 obligations with the CI, "things could get worse." *Maya Altman* said that San Mateo has

dollars that haven't yet been matched, and the county is particularly interested in including behavioral health services in their CI.

Jennifer Abraham asked whether researchers had data on the overall utilization and cost of this population across all providers and payers. In Kern County, they had collaborated with some non-profit hospitals to try and get this data, but without success.

Lee Kemper, CMSP, asked for clarification on the administrative reimbursement issue, and *Jalynne Callori* described the problem: a requirement under the STC amendments effective 10/5/2007 was the development of administrative protocols to identify administrative costs and how they would be reimbursed. CMS required time-study protocols and limited administrative cost-claiming categories that could be reimbursed at 100%. Negotiations have been lengthy, but the state now has, with help from the counties, developed a proposed protocol for startup and prior period costs.

Small Group Discussions

The HCCI TWG broke into small groups to discuss three different issues, and then reviewed their discussions with the full Workgroup. Each small group was asked to discuss the following question:

- What components of the program would you recommend be standardized across all current and future counties?

Enrollment and Eligibility: Irene Dyer, Erica Murray, Lee Kemper, Bob Gates, Ellen Wu

Group members from Orange County, Los Angeles, and CMSP shared information about their own programs and others they were familiar with.

- CIs currently vary in terms of eligibility – all may enroll individuals up to 200% FPL, but not all set the limit that high; they also vary in terms of targeting subsets of populations – some do target, some don't. Bob Gates clarified that assets cannot be considered in HCCI.
- Overall, the group felt that the variability in eligibility was working. In places where subpopulations have been targeted with a medical home model, they're seeing benefits.
- There is also wide variation in terms of where and how people come into the CI system. In LA, enrollment is primarily through clinics, whereas in Orange County the EDs are the most common point of entry. Eligibility and enrollment staff varies as well – enrollment is done by county staff, CI staff, social service staff, etc.
- Given the importance of the linkage between CIs and Medi-Cal, it is important to think about how to enroll in a way that data can be shared with Medi-Cal and vice versa.

Tangerine Brigham said that in San Francisco, all the Medi-Cal rules are embedded into the CI enrollment system (One-e-App). Thus, when someone goes through the HCCI process,

the HCCI application is automatically screened for Medi-Cal, and, if appropriate, is sent to county social services and accepted as an MC 210 (the Medi-Cal application). All counties should identify individuals who are eligible for and not enrolled in Medi-Cal.

Jennifer Abraham agreed that this kind of coordination is important. In Kern County, patients who apply to Medi-Cal and are denied then have to bring all the paperwork to the CI to apply there. When patients convert to Medi-Cal, the CI does not find out automatically, but instead has to check once a month to see who is covered. *Anne McLeod* said that hospitals are very supportive of linkage, and said that in cases where the linkage between programs does not work, the providers are left holding the bag.

Lee Kemper described the CMSP enrollment system, which generally follows Medi-Cal processes and works through county social services departments. Applicants are ruled out for Medi-Cal before they are evaluated for CMSP. When patients are enrolled in CMSP, they get a CIN that follows them as they move between CMSP and Medi-Cal.

Bob Gates said that Orange County DSS does the eligibility determination for both CI and Medi-Cal, and pushes people to Medi-Cal if they appear to be eligible. In Contra Costa County, according to *Bill Walker*, there is up-front financial counseling from the beginning. County staff take a CI application, but move it to DSS as soon as it's Medi-Cal.

Elizabeth Landsberg said that the fact that California starts from a place where counties have different eligibility for section 17000 programs, and then have CI programs on top of those with different eligibility requirements again, is problematic from the perspective of clients. She wondered how well the variability between programs really works.

Ellen Wu said that, in an ideal world, the CIs would be seamless and consistent – and all would include individuals to 200% FPL. She said, though, that it made sense that Los Angeles, for example, has limited its population.

Erica Murray said that the small group had discussed limiting the CI population, particularly in light of proposals to raise the income limit for Medi-Cal under health care reform. While this made sense in terms of equity and transition, it was not popular with CI counties that want to keep their programs, and raised concerns among some about adverse selection.

Gerry Kominski said that UCLA is able to analyze the CI enrollees in terms of poverty levels. Data provided by counties is not consistent: some counties give aggregated FPL groups, while others provide more detailed information.

David Maxwell-Jolly asked what state policy should be in terms of expansion, and what the equity concerns are when paying up to 200% in one county but only 133% in another.

Judith Reigel said that while standardization is appealing, it's hard to know how to get there when the program involves counties putting up their own resources.

Bob Gates said that Los Angeles couldn't afford Orange County's program (primary and preventive care for everyone to 200% FPL); if Orange County adopted Los Angeles'

program (to 133% with a focus on certain disease entities), they would lose most of their beneficiaries.

There was extensive discussion of the federal DRA requirement. *Tangerine Brigham* said that in San Francisco, where the CI enrolls a highly transient population, many people have one but not the other of the DRA requirements, with the result that there are over 5000 individuals whose HCCI applications are pending because they lack a birth certificate or identification. Because every state is different, it is not possible for SF to develop a single form to send to other states to request birth certificates. The DRA is preventing SF from meeting their goals, and it would be helpful to rethink ways to maintain the rigor of the requirement without meeting the specific DRA requirement. *Louise McCarthy* noted that a number of CPCA providers did not participate in the HCCI because of the DRA.

Irene Dyer noted that previous waivers included arrangement whereby a certain percentage of people were deemed ineligible for the program, without the need for individual determinations. *Jalynne Callori* said that CMS had not allowed such an arrangement for the HCCIs, but that the issue could be revisited with CMS in the new waiver.

Benefits and Medical Home: Anne McLeod, Bill Walker, Maya Altman, Judith Reigel, Jennifer Abraham, Cecilia Echeverria

- There is a great deal of variability in medical home models and definitions among the CIs.
- It may be easy to figure out what it means in an HCCI network or county hospital, but if the HCCI is a subgroup of a health plan, then the health plan model must be considered as well.
- How a CI defines a medical home depends (and should depend) on the subpopulations that the CI is serving.
- Kern County focuses first on linking patients to a primary care provider, but is striving toward a full medical home model. They don't want to be tied to specific medical home requirements that they can't meet.
- Increasing numbers of uninsured pressure CIs to focus on expansion of basic access rather than medical homes and care management.

Elizabeth Landsberg said that since many low-income individuals have multiple chronic conditions, disease management programs focused on single conditions will not be successful. It will be hard for the CI to capture the savings from people who are involved with multiple systems.

Erica Murray wondered how medical homes and care management could be built into the financing. Anne McLeod said, in general, that the Workgroup needed to start talking more about financing the waiver renewal.

Maya Altman said that P4P in the San Mateo Health Plan was working well with the private providers, but not as well with public employees. Bill Walker said that the incentives might be different for public employees, but that if you invest in systems that make it easy for

public doctors to do the right thing, they will. *Tangerine Brigham* said that SF has P4P in its chronic care program. Each medical home receives funding to start to use disease registries, and when they meet certain standards they get incentive dollars. *Bob Gates* of Orange County said that their P4P pool pays for numbers of visits, preventive services, etc.

Anne McLeod noted that the small group discussed standardizing benefits. The benefits are largely similar county to county, but some cover dental and some don't. Were HCCI to expand to additional counties without standardization of benefits there could be magnet counties. *Bob Gates* said that Orange County added Denti-Cal level services, quickly discovered they were unaffordable, and then shut them off. *Jennifer Abraham* said that Kern County spent \$300,000 on dental in their ED in one year, and does not cover dental services in the HCCI.

Louise McCarthy raised the question of including behavioral health in a CI, noting that there are prevention dollars for behavioral health, it might be an area where a standard benefit would make sense and where it would be possible to draw down a match.

Maya Altman suggested that it should be possible to define a minimum benefit standard that all CIs should adhere to; *Nady Pourat* said that there is considerable consistency already in terms of basic benefits.

Performance Metrics: *Tangerine Brigham*, *Kelly Brooks*, *Nancy Kaatz*, *Sandy Damiano*, *Len Finocchio*, *Caroline Davis*.

The group reported the following discussion:

- CIs need metrics for research and evaluation purposes but they may differ depending on the audience (e.g., UCLA, Board of Supervisors, DHCS, etc.). One approach would be to identify the common metrics across various audiences to develop a standard set of measures.
- Metrics may have to be different for different models: all-inclusive versus chronic model, continuing HCCIs versus new CI counties, public hospital counties versus non- public hospital counties, limited versus comprehensive benefits package.
- Much data may already exist and be collected for Knox-Keene purposes, contract compliance, etc
 - HEDIS measures could serve as proxy for some of the medical home questions
- Some of the questions considered important to investigate were:
 - What's the cost?
 - How many individuals coming in are new v. existing (and how is that defined)?
 - How many people go through the application process are determined eligible for Medi-Cal?
 - ED visits (emergent and avoidable), but with caveat that, with the exception of Orange County, the HCCI network does not include every hospital in the counties, and thus data is incomplete.

- What percentage of enrollees have had primary care visits?

Maya Altman suggested that CAHPS data could be used to measure consumer satisfaction; *Tangerine Bringham* said that CAHPS would be easier where the CI is partnered with a health plan, but could be useful anywhere. *Gerry Kominski* said that the challenge with CAHPS is the high cost of administration.

Jennifer Abraham said that, in general, the administrative and resource costs of data collection needed careful consideration.

Kelly Brooks notes that it is hard to define metrics before the rest of the program is defined (e.g., eligibility levels, benefits package, etc.)

Lee Kemper wondered if there was any self-reported health information in the current HCCI programs. *Tangerine Bringham* said that San Francisco asks 10 questions of beneficiaries after their eligibility is determined, and again at renewal. The questions focus primarily on access. Lee said that CMSP is doing extensive surveying on self-reported health status as part of a behavioral health and substance abuse project. *Bill Walker* said that patients do a quality of life assessment at the time of application, which is then used to target care management for those who are enrolled.

Next Meeting and Feedback on Today's Meeting

Caroline Davis discussed the planned topics for the next meeting (March 17, Noon - 4:30pm, UC Office of the President, 1130 K Street, Sacramento):

- *Expansion*: Criteria for expanding the CIs (e.g., by increasing the number of individuals enrolled in the current projects, by expanding into additional counties);
- *Reimbursement*: How much California should seek in federal reimbursement;
- *Financing*: How counties should be paid.

UCLA will also provide information at the next meeting on the uninsured and likely CI-eligibles by county using CHIS data to analyze income level and immigration status.

Bill Walker suggested that the group design for different financial scenarios, including if CI funding remains flat under the next waiver. *Judith Reigel* commented that it is challenging to have these conversations before knowing how much additional federal money we're going to have.

Bill Walker also said that, depending on the financing, the group might want to think about using the money creatively not in a hospital or health center, but for upstream activities like nutrition and prevention. *Elizabeth Landsberg* cited a paper produced by advocates that included prevention activities, among others, as an item that should be in the waiver. That paper is available at

<http://www.wclp.org/Resources/WCLPContent/tabid/1088/smId/3613/ArticleId/429/Default.aspx>.

Several participants asked when there would be additional information from CMS. Jalyne Callori said that DHCS is in regular communication with CMS, and has the opportunity to share the outcomes of the workgroups. The majority of concepts will be consolidated into a final paper that will be submitted to CMS in early May. It will be more specific than the concept paper, but not as specific as waiver terms and conditions.

Tangerine Brigham asked whether DHCS was considering asking for an extension of the current waiver, given the tight timeline. Jalyne Callori said that that was Plan B, but agreed with Bill Walker, who noted that the disincentive to seeking an extension is that it would yield, at best, only an additional 10% in federal funding for the HCCIs.

The meeting was adjourned at 4:25.