



**SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER  
STAKEHOLDER ADVISORY COMMITTEE (SAC)  
Meeting #1 – Thursday, January 7, 2010  
9:30am – 12:30pm  
Sacramento Convention Center, Room 204**

The meeting convened at 9:35 AM.

Attendance

*Stakeholder Advisory Committee members* attending: Kelly Brooks, California State Association of Counties; Jack Burrows, Association of California Health Care Districts; Richard Chambers, CalOptima; Mike Clark, Kern Regional Center; Diana Dooley, California Children's Hospital Association; Catherine Douglas, Private Essential Access Community Hospitals; Juno Duenas, Family Voices; Teresa Favuzzi, California Foundation for Independent Living Centers; Jeff Flick, Anthem Blue Cross; Bradley Gilbert, Inland Empire Health Plan; Daniel Gould, Equality California; Peter Harbage, Harbage Consulting representing SEIU; Marilyn Holle, Disability Rights California; Michael Humphrey, Sonoma County IHSS PA; Gregory Janos, Children's Specialty Care Coalition; Ingrid Lamirault, Alameda Alliance for Health; Elizabeth Landsberg, Western Center on Law and Poverty; Marty Lynch, Lifelong Medical Care; Jackie McGrath, California Council of the Alzheimer's Association; Anne McLeod, California Hospital Association; Santiago Munoz, University of California, Office of the President; Sandra Naylor Goodwin, California Institute for Mental Health; Cheryl Phillips, On Lok Lifeways; Bob Prath, AARP California Executive Council; Brenda Premo, Western University of Health Sciences; Sharon Rapport, Corporation for Supportive Housing; Judith Reigel, County Health Executives Association of California; Lisa Rubino, Molina Healthcare of California; John Schunhoff, Los Angeles County Department of Health Services; Rusty Selix, California Council of Community Mental Health Agencies; Al Senella, California Association of Alcohol and Drug Program Executives; Barbara Siegel, Neighborhood Legal Services of Los Angeles County; Marv Southard, Los Angeles County Department of Mental Health; Melissa Stafford-Jones, California Association of Public Hospitals and Health Systems; Sarah Takahama, California Association of Physician Groups; Richard Thorp, California Medical Association; Anthony Wright, Health Access

*Others attending:* Kimberly Belshe, Secretary, California Department of Health and Human Services; David Maxwell-Jolly, Director, Department of Health Care Services and Chair, Stakeholder Advisory Committee; Gregory Franklin, Director of Medi-Cal Operations and Project Director, 1115 Demonstration Waiver Project, DHCS; David Alexander, Lucile Packard Foundation for Children's Health (on phone); Ray Colmenar, The California Endowment (on phone); Chris Perrone, California HealthCare Foundation (on phone); Richard Thomason, Blue Shield of California Foundation; Bobbie Wunsch, Pacific Health Consulting Group, and Catherine Teare, Pacific Health Consulting Group.

*Public in Attendance:* 115 people in person and 230 people on the telephone

## Welcome and Introductions

*David Maxwell-Jolly, Director, Department of Health Care Services (DHCS) and Chair, Stakeholder Advisory Committee* opened the meeting. He recognized the philanthropic organizations that are providing support for the waiver process including the California HealthCare Foundation, the Blue Shield of California Foundation, The California Endowment, the Lucile Packard Foundation for Children's Health, and the Scan Foundation.

*Bobbie Wunsch, Pacific Health Consulting Group*, introduced the structure of the meeting, and welcomed participants on the phone. All SAC meetings are to be conducted according to the rules of the Bagley-Keene Open Meeting Act.

## Legislative Intent of ABX4 6 (authorizing legislation) and Purpose of Stakeholder Advisory Committee

*David Maxwell-Jolly, Director, DHCS and Chair, Stakeholder Advisory Committee* discussed the authorizing legislation for the SAC. ABx4 6 sets out a vision for renewal of California's Section 1115 waiver that is much broader than the current waiver. The goal of the waiver is to control costs as part of a fiscal solution for the state, and to take advantage of flexibility offered by the waiver to reinvest some federal savings into programmatic innovations. ABx4 6 establishes the Stakeholder Advisory Committee to bring a diversity of voices together to work on building the concepts and implementing a comprehensive 1115 waiver for California.

Specifically, ABx4 6 has six objectives:

- Strengthen the health care safety net
- Provide care for the uninsured and reduce the number of uninsured
- Maximize opportunities for additional federal financial participation (FFP) and delivery of care
- Promote more effective use of state and federal funds
- Improve quality of care and outcomes
- Promote home and community-based services.

David Maxwell-Jolly emphasized that the SAC has a very large agenda, and will have to be very focused in its work to achieve these goals within a tight time frame.

## Today's Environment: Upcoming State Budget Release and CMS 1115 Waiver Process and Timeline

*Kim Belshe, Secretary, Health and Human Services Agency* provided comments on the larger context of the Section 1115 demonstration waiver process and the status of the California state budget. With the Governor's proposed 2010-11 budget due to be released on January 8, Secretary Belshe told the SAC that the upcoming budget process would seek to

find a solution to a \$20 billion gap, and that structural deficits would continue to compel the Governor, the legislature and voters to make very difficult decisions.

Secretary Belshe said that health spending would not be protected from budget cuts and that Medi-Cal in particular, because it is the second largest state expenditure and because spending continues to grow quickly, also would not be immune. The Governor's proposed budget is a starting point for discussion of his approach as well as alternate approaches.

Although the budget negotiations will require considerable investment of time, we nonetheless must focus on the waiver, which offers a number of opportunities. Specifically:

- The waiver provides an opportunity to transform service delivery through care coordination, with which California already has a long history.
- The waiver provides an opportunity to expand coverage, building on the work of the ten HCCI coverage initiative counties, design models that are showing success in getting people into care with the right providers at the right time.
- The waiver provides a critically important bridge to national health care reform which, if passed as expected, will call for expansion of coverage to millions of otherwise uninsured and will require different approaches to delivering services.

Secretary Belshe recognized and thanked David Maxwell-Jolly and Toby Douglas, Medi-Cal Director, for their work to date on the waiver. A draft concept paper was submitted to CMS in September 2009, and a final concept paper in December 2009. (Available at <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Final%20Concept%20Paper%2012-16-09.pdf>.) Conversations with CMS will be on-going, with a goal of a complete waiver negotiated and approved by September 2010.

Secretary Belshe charged the SAC with moving from a conceptual proposal to a more concrete proposal, with specific milestones and deliverables in order to make the strongest possible case to the federal government. Support from stakeholders is a key part of a strong waiver proposal. Secretary Belshe encouraged SAC members to take a broad perspective in addition to sharing their particular expertise and experience.

Secretary Belshe then took several questions from members of the Stakeholder Advisory Committee:

*Marty Lynch, Lifelong Medical Care*, asked about the linkage between the waiver proposal and federal health care reform, and the fate of county- and state-only programs in this scenario. Secretary Belshe responded that she viewed the waiver as a bridge to national health care reform. Even in the best case, where federal health care reform proposals are amended to address California concerns, implementation is some years away. As proposed, there is still a long way to full implementation and many people would remain uninsured, based on the enforceability of the individual mandate, lack of a "culture of coverage," and the federal legislation's failure to address the undocumented population. New coverage should enable some people in disease-specific programs or high-risk pools to transition into broader pools, but it would be premature to say what would happen to the state's safety-net programs given what we know now.

*Anthony Wright, Health Access*, commented that Governor Schwarzenegger's recent comments about the limitations of federal health care reform seemed counter-productive when the state government and advocates should be presenting a united front in order to get the best possible outcome for California.

*Jeff Flick, Anthem Blue Cross*, commented on the great opportunity presented by the Section 1115 waiver to improve the Medi-Cal program.

#### Organization, Structure, Staffing, Roles, Funding and Role of Foundations, Schedule of Meetings and Timeline for Stakeholder Advisory Committee

*Bobbie Wunsch, Pacific Health Consulting Group* discussed the structure, schedule, and funding of the SAC. She urged members to attend meetings in person to the extent possible, and emphasized the participatory nature of the meetings. The next meeting, on March 10, will include a full discussion of the details of the waiver proposal, and materials will be sent out in advance.

#### History of California's Hospital Waivers: An Overview of Hospital Financing and its Relation to the Section 1115 Waiver/Demonstration Project

*David Maxwell-Jolly, Director, DHCS and Chair, Stakeholder Advisory Committee* introduced Section 1115 waivers, provided detail on the existing waiver which deals primarily with hospital financing, and described the needs that the state has identified for the upcoming waiver: a focus on Seniors and Persons with Disabilities, the California Children's Services program, the Health Care Coverage Initiatives, and Behavioral Health Integration. Other areas of focus include dual-eligibles and value-based purchasing. David Maxwell-Jolly's presentation is available at <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Discussion%20Presentation.pdf>.

SAC members asked the following questions:

*Bob Prath, AARP California Executive Council*, asked whether the federal government's budget neutrality requirement that is central to the 1115 waiver process applies to the entire Medi-Cal population or only those groups affected directly by the terms of the waiver. David Maxwell-Jolly responded that it depends on the terms of the waiver itself.

Bob Prath also asked about the status of the Long Term Care Integration (LTCI). David Maxwell-Jolly responded that while he was not in a position to comment on the status of that effort specifically, DHCS has recently had discussions with some of the key players in that integration effort and that it was a very important candidate for advancement in the context of this waiver.

*Marv Southard, Los Angeles County Department of Mental Health*, commented on the information presented on behavioral health in the DHCS PowerPoint presentation and asked whether DHCS had similar data on drug and alcohol treatment expenditures. He said that in Los Angeles, the integration of physical, mental *and* substance abuse health services had been the source of savings.

*Melissa Stafford-Jones, California Association of Public Hospitals and Health Systems*, offered comments on the current waiver, noting that

- Although the current waiver is largely focused on hospital financing, for public hospitals that also includes outpatient care (primary, preventive, and outpatient specialty).
- Although the dollar numbers in the current waiver are large, due to the shift from intergovernmental transfers (IGTs) to certified public expenditures (CPEs) the public hospitals receive only 50 cents on each dollar, and this amount is capped.
- The waiver requires a non-federal share, and under the current waiver county public hospital funds are used to match these fed dollars. Finding the non-federal match is very challenging.

*Al Senella, California Association of Alcohol and Drug Program Executives*, commented on the limitations of Medi-Cal coverage for addiction services and suggested that data on the costs of addiction treatment for the indigent population would be helpful.

*Lisa Rubino, Molina Healthcare of California*, asked whether there were lessons from the HCCI that the SAC should be aware of. David Maxwell-Jolly cited early evaluations of the various initiatives, and said that a number have very promising results. An interim evaluation report conducted by UCLA researchers is available at <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Interim%20Evaluation%20of%20the%20Health%20Care%20Coverage%20Initiative%20in%20California%208-10-09-%20in%20response%20to%20state.pdf>.

*Barbara Siegel, Neighborhood Legal Services of Los Angeles County*, commented that, in Los Angeles, the HCCI had demonstrated the importance of enrollment simplification. Another lesson has been that housing is a critical component of success for homeless populations. She suggested that the waiver be used to look at ways to fund services that lead to cost savings down the line – for example, lactation services to encourage ongoing breast-feeding, or continued financing of anti-rejection medications for post-transplant individuals. In these contexts, the five-year duration of the 1115 waiver is very short to show results.

*Sharon Rapport, Corporation for Supportive Housing*, also spoke to the importance of housing and other social supports when thinking of care coordination. The Frequent Users Initiative found that people without stable housing had increased hospital admissions and numbers of stays every year, whereas those with stable housing reduced ER use and hospital stays.

*Cheryl Phillips, On Lok Lifeways*, offered a concern that integration not be defined only as a single payer source, given that a single payer using multiple vendors can lead to equally fragmented care. Integrated should be defined from a person-centered model.

*Jeff Flick, Anthem Blue Cross*, said that when he served as CMS Regional Administrator based in San Francisco, he asked staff to identify the state in the region that was “the best,” and that this assessment was tremendously difficult for CMS staff. California was identified as having low costs for their TANF population, and this was assumed to be because of the adoption of managed care for much of this population, but CMS does not have clear metrics for determining quality of care, either.

*Anne McLeod, California Hospital Association*, said that hospitals are underfunded by \$ 4.3 billion each year, and that that should not be defined as doing well. We should look at access expansion, but not through continual undercutting of provider reimbursement.

*Teresa Favuzzi, California Foundation for Independent Living Centers*, asked whether the SAC would discuss IHSS and public authorities. David Maxwell-Jolly responded that IHSS has been an important element of home and community-based services (HCBS) in California, and that in the midst of budget woes, the program is being fundamentally changed, with a goal of targeting those with the greatest need. The waiver offers an opportunity to pool resources and establish responsible organizations to make sure that these resources are administered to meet beneficiaries' needs appropriately. Ms. Favuzzi stated that the waiver process should be aware of the needs of the disability community as it relates to disability access issues, and the concerns of the community about the system's ability to meet these needs.

*Brenda Premo, Western University of Health Sciences*, described the origins of the IHSS program, and said that it began as a system under which people can exercise their independence to tell other people what to do for them in terms of home care, getting to school, and being active in the community. Over time, the system became medicalized (and moved into Medi-Cal), but it should not fundamentally be a medical service.

*Marty Lynch, Lifelong Medical Care*, commented that the Long Term Care Integration (LTCI) effort offered a model for talking about the integration of home, community, and medical services, but that there remain chasms between aging/ disability providers and medical providers, and between behavioral health and primary care providers, and all these people must be involved in planning. The challenge is that the money comes mostly from Medi-Cal, but the costs don't come only from the medical side, and thus a disease management medical vendor approach is inadequate.

*Catherine Douglas, Private Essential Access Community Hospitals*, commented on the need for the waiver to continue to include hospital financing at its core, given the tremendous need to support DSH hospitals. She suggested that the waiver use the accountable care organization (ACO) concept in order to achieve system integration, and that the state should look again at using IGTs for core providers including clinics and public and private hospitals.

*Richard Thorp, California Medical Association*, commented that we should not measure success only as cost containment, since we currently achieve that goal by not providing care. He provided examples of the difficulty of finding specialty providers in rural communities, resulting in an over-reliance on the university hospitals and health systems, and attendant long waits for patients in need of care. He also raised concerns about the accuracy of Medi-Cal eligibility systems for beneficiaries, cumbersome processes for providers, and low reimbursement rates.

#### Technical Workgroups: Purpose, Scope and Feedback on Key Issues to be Covered

*Gregory Franklin, Director of Medi-Cal Operations and Project Director, 1115 Demonstration Waiver Project, DHCS*, introduced the technical workgroups that DHCS is establishing around the four key goals of the waiver. The technical workgroups are in development stage, with some participants identified. DHCS is accepting names of interested participants, though

the goal is to keep the groups fairly small. The technical workgroups will be supported by several of the foundations and DHCS will announce the membership and schedule of meetings very soon. Gregory Franklin's PowerPoint presentation is available at <http://www.dhcs.ca.gov/provgovpart/Documents/SAC%20TWG%20OVERVIEW.pdf>.

The four technical workgroups are:

- 1) Children with Special Health Care Needs and the CCS Program (to be staffed by DHCS staff Luis Rico and Don Fields)
- 2) Seniors and Persons with Disabilities (to be staffed by DHCS staff Tanya Homman and Bob Martinez)
- 3) Behavioral Health Integration (to be staffed by DHCS staff Barry Handon and Pilar Williams)
- 4) Health Care Coverage Initiatives (to be staffed by DHCS staff Bob Sands and Jalyne Callori)

A workgroup on dual-eligibles (beneficiaries of both the Medi-Cal and Medicare systems) may be established in the future.

In response to questions, *Bobbie Wunsch* clarified that the workgroup invitation process is being led by DHCS. The workgroups will work with the Department, and will be advisory to the SAC. Each will have approximately 10-15 members.

*Anne McLeod, California Hospital Association*, suggested that workgroups on financing and value-based purchasing would be important. David Maxwell-Jolly responded that workgroups on these topics are not currently established because of the focus, first, on developing a comprehensive proposal to justify additional federal resources.

*Bobbie Wunsch* introduced the process by which SAC members and the public could comment on the questions already identified for each of the workgroups, and noted that additional ideas could be submitted through the website at <http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx>. The comments submitted in writing by SAC members and members of the public in attendance at the meeting follow.

### Summary of Technical Workgroup Suggestions

#### **California Children's Services (CCS)**

##### Proposed Questions

What CCS conditions are appropriately handled in the context of a beneficiary's existing managed care plan rather than through CCS?

What approaches in the delivery of care for children with CCS eligible medical conditions can be designed to effectively manage and coordinate all of the children's health care needs?

How can these approaches be implemented and tested?

## Comments and Questions

### Data Questions

- What is the basis of rising Medi-Cal/CCS costs? Is it:
  - There are greater numbers of CSHCN
  - Greater NICU costs
  - Children with extensive medical needs are living longer
- What do families in California think about:
  - Medi-Cal FFS
  - Medi-Cal managed care
  - Private managed care
- What are CCS conditions?
- Total number of children served and total costs are insufficient. Need the following data:
  - Number of children served in each of the eligible conditions
  - Spending by payer, by condition
  - Of the \$160 M administrative cost, how much is state v. counties
- How does the cost of providing care in CA to CCS population compare to the cost of treating same conditions for same population in other states?
- To analyze effectiveness of current CCS program, need additional data, e.g.,
  - Outcomes data from other states
  - Outcomes data for children with CCS conditions who are in the private market
- How does a COHS with CCS carved in compare with counties with CCS carve-outs on
  - Family satisfaction
  - Provider satisfaction
  - \$\$ comparisons
  - Utilization of services

### Clarifications

- Why does the first question focus on managed care as opposed to any other plan the family may have?
- Question 1 should be reworded: Are there CCS conditions that should be handled in traditional managed care?
- Question 3: add "... and evaluated" at the end of sentence.

### "Whole Child"

- Rather than ask question with reference to the current way we do business, i.e., "should we carve in some CCS-eligible diagnoses to managed care and carve out other diagnoses to CCS," why not ask instead: What would health care systems design look like if we authorized and treated the whole child rather than individual diagnoses? Much of the fragmentation of care and inefficiencies of the system

stem from the practice of treating the series of diagnoses rather than the whole child. Examples:

- Intercounty variations in care
  - Prolonged wait times for access to specialty care
  - Patients falling through the cracks or forced to receive primary care from specialty [providers].
- How do you “treat the whole child” and deal with the three different funding sources? Possible solutions:
    - Create a CCS health plan
    - Hospital liaison teams that directly case manage (to decrease hospital length of stay) -- this could be done through a waiver demo pilot project

#### Transition to Adult Care Systems

- Another common thread with *all* of the other work groups is assuring integration and continuity of care as our patients transition, i.e. CSHCNs moving to adult and aged [systems].
- There is a real need for improved coordination and guidance for young adults/older children as they transition from children’s medical services to “adult medical services.” This seems to be an expansion concern for question 2.
- How can we better coordinate care when children with CCS conditions age out of CCS but continue to need specialty care as adults? (Now, they often simultaneously lose CCS and Medi-Cal, or at minimum they lose care coordination, providers, and case management.)
- How do we ensure a coordinated transition from pediatric care to adult care for young adults with disabilities?

#### Other Questions

- What potential criteria will be used to carve out CCS services?
- How will the Department measure effectiveness of such a carve-out?
- How would changes in responsibilities for CCS Medi-Cal children impact administration of CCS HF and CCS-only population?
- How do you maintain the role of university-affiliated children’s hospitals in defining quality standards?
- What is proposed for expanding the list of specialty clinics, i.e., neurodegenerative clinics, additional genetic clinics, etc.
- Does there have to be a single solution for improving services for CSHCN, or can there be county-by-county solutions?
- More money has to be brought to the table by utilizing IGTs and CPEs more effectively.
- ACO pilot is essential before any program redesign.
- NICU care needs to be evaluated separately from chronic CCS conditions.
- Are parents’ care-giving capacities supported through this waiver process?

- Home care and DME limitations affect discharge and readmit rates.
- How can we capitalize on the case management focus and history of the CCS program and work from it and learn from it before handing it over to other, non-trained, non-CCS persons.
- CCS has created administrative policies that limit the ability of qualified primary care physicians in the community to participate. This creates costly, sometimes uncoordinated care. Waiver should relax unnecessary limits on PC participation.
- CCS system improvement ideas:
  - Improve payment system as DHCS negotiates with new fiscal intermediary.
  - Allow a CCS provider to be paneled without first having to obtain a Medi-Cal provider number.
  - Revise conditions and have separate case management for episodic v. chronic conditions.
- Family involvement in medical care may need to involve treatment of parents for related mental health problems from stress.
- What type of provider groups will be needed to serve the needs of children in new system of care?

## **Seniors and Persons with Disabilities (SPD)**

### Proposed Questions

What are the organizations that will be necessary to ensure the Department's ability to serve seniors and persons with disabilities?

What are the approaches to determine the capacity of existing managed care plans and fee-for-service counties ability to serve the target populations?

What are the special needs of seniors and persons with disabilities that may affect transition into systems of care?

What is the transition process to best meet needs identified?

What is the monitoring plan for organized systems of care?

### Comments

#### Data Questions

- Data on cost of addiction and mental health [problems] to seniors.
- It will be important for the waiver proposal to include quantifiable expected positive outcomes. Is there data available related to the quality of care for SPDs in FFS, e.g., preventive care, specialty care access, inpatient readmissions?
- What is current risk-adjusted cost of managing this population in FFS v. managed care? Does the state have HEDIS or other quality data on SPD population in FFS and managed care?
- DHCS noted that most expensive 10% cost \$50,600 on average. What are the characteristics of that group? Do they fall into particular categories? Can we understand the population and its needs/challenges more specifically?
- Please provide current quality data for the over 500,000 SPD members currently in

COHS/Two Plan/GMC Health Plans both collected by state and done by Health Plans on their own.

- Can current Medi-Cal HMOs tell us how many of their adult enrollees have disabilities? How do they gather this information?
- What indicators are currently available to compare quality of care provided *and* health outcomes for the current delivery systems: COHS, LIs ,GMC, FFS.
- Need data on where target population currently gets its care. Also where 10% of most costly users get care – including primary, specialty and hospital.
- What [system of accountability and consumer protections] exists now? How does it work?
- Data needed to assess medical, acute, chronic and outpatient services used by seniors and adults with disabilities.
- What services do SPDs use with greatest frequency? Which are the costliest? Which have seen greatest cost increases in past decade? What savings have been produced from current managed care for SPDs?
- Data from CalOptima on providing services to SPDs (access and cost-effectiveness)

#### Clarifications

- What are all the services that hospitals are providing under this waiver?
- Is this for adults and children with special health care needs?
- Does SPD include people who are disabled and receive SSI and Medi-Cal due to severe mental illness? Or are this group's physical health needs to be addressed in BHI. (This group is 25% of SSI recipients and 35% of SSI due to disability.)

#### Question 1: Organizations

- Clarifications for question 1: what's meant by "organizations"?
- Question 1: Organizations should include HCBS providers, ADHC (?); Independent Living Centers; Public Authorities; Case management, etc.
- Question 1: DDS, Association of Regional Center Agencies are two such organizations.
- Shouldn't we look beyond "necessary" to find organizations that are best given cost and outcomes?
- How will MCOs collaborate with community-based organizations that also provide services?
- Question 1: Please expand as to who will be the lead organization in financing the waiver.
- Question 1: Necessary organization include Section 202 Supportive Housing seniors
- Beyond assessing the capacity of existing organization, what are different, new structures and organizations that should be explored?
- How will MCOs collaborate with CBOs that also provide services?

### Question 3: Special Needs

- Question 3: Obviously, limited cognitive and communications abilities are two such special needs.
- How will the mental health issues [of SPD populations] be addressed?
- How will DHCS address the confidentiality and HIPAA requirements in identifying the population with disabilities for inclusion in special needs plans, chronic care management programs, etc?
- Are there particular sub-populations of person with disabilities that will be focused upon?
- How will the behavioral health needs of this population be integrated/coordinated when those needs are not the focus of care?

### Question 4: Transition

- Expand on the transition process for the population leaving hospital, institution or SNF; who are high users and who are at risk for institutionalization.
- Will enrollment be phased in? Recommend enrolling by date of annual renewal to allow a phase-in. Safety net and traditional providers welcome new members, but need a phased-in approach?
- With the Two Plan Model it was helpful to roll out the information to the community over time and with plan participation. What will be the process for SPDs? Plans can assist with community presentations.
- What will be the technical assistance offered to the safety net to prepare for increased enrollment?
- Will there be any type of default enrollment for SPDs that do not choose?

### Question 5: Monitoring

- What processes or systems will be taken to ensure that managed care providers for SPDs have accessible medical equipment, written materials that are accessible, and adequate staff training? How will compliance be evaluated? What reward incentives will be employed, or, conversely, what penalties will be imposed for non-compliance?
- How do we ensure that health plan providers are capable of providing services to PWD in an ADA accessible compliant manner, and are held accountable?
- How to fix the lack of state-level enforcement of standards, i.e., how to separate the helping part from the policing part.

### Care Coordination and Medical Home

- What are the best practices for non-MCO case management and care coordination of SPDs to try to replicate?
- How is care coordination going to be defined to insure that it is patient-centered?
- How will systems identify those who need care coordination?
- What would a patient-centered medical home model look like both for the SPD and

coverage expansion populations? What would it take to establish this model(s) in different places in California? We need to drill down on the nuts and bolts in this.

- How can a senior or person with a disability be sure to continue to receive treatment from a trusted provider in whatever new system is designed?
- How should health care homes be structured to ensure access to specialty care and linkage to community-based social/human services?
- How will safety net facilities be included in the enhanced care coordination for SPDs?
- Need specific question to identify the range of options to provide medical home/coordinated care to SPD, and the opportunities and challenges of those approaches. Is there a mix of approaches/options that could work?

#### Home and Community-Based Services (HCBS)

- What are the strategies for promoting HCBS when these services are being de-funded?
- What are the ways we can achieve/further the objectives of Olmstead through this waiver? HCBS are cheaper and more desirable than institutional care. How can we make sure that an organized system of care for this population includes less costly, more desirable social supports that make medical supports/care less costly?
- How will HCBS support Olmstead implementation?
- How will HCBS take into account the anchor of IHSS and public authorities?

#### Other Questions

- To the extent we're looking at MCOs, how can we address adverse impact within plans, i.e., high-cost folks gravitating to a few provider groups?
- Expand PACE – look at On Lok as a financially sustainable model. If the state wants to provide comprehensive services to SPDs, this is an effective model. It also functions as a health plan. They manage to sue money from many sources and maintain flexibility.
- Pay incentive payments to primary care homes in addition to capitated rates.
- Anti-trust restrictions need to be addressed (as other states – CO, NJ, UT – have done) to all our discussion around cost, coordination, etc. The Attorney General could convene such a discussion. Without this, the program may be up and running before we discover it is inadequately funded.
- What is the appropriate methodology for reimbursement for care for the SPD population? How should the rate be structured to ensure adequacy and create the correct incentives?
- What are the programs and services that aid this population that should be integrated to help meet the goals of the waiver? I.e., how can IHSS, Linkages, MSSP, be integrated into this picture to make “managed care” or “medical homes” effective and successful? What other models should be considered to achieve the same purposes?
- “Approaches” = minimum core standards? Baseline possible?
- “Monitoring” = assessment/evaluation. Who creates benchmarks?
- Where are long term care services in this?

- Seniors and PwDs need access to *all* types of providers and services. What types of provider groups (MDs, podiatrists, therapists etc.) are needed to serve the needs of SPDs?
- The safety net core pool is too narrow in scope. It should be spread statewide to enable better access to preventive, primary and acute care so all Medi-Cal, under-insured and uninsured have better access to care that will ultimately reduce costs.
- Design a non-HMO based health home model for organizing, financing and delivering services (as an alternate to health plan approach).
- How will “quality” be measured for this population? Will DHCS integrate the SPD conversation with value-based purchasing strategy?
- How should financing be changed to provide incentives for the outcomes ABx4 6 envisions?
- How is Ryan White Funding relevant/being considered in waiver financing?
- What consumer protections do SPDs need in an organized system? How can they be enforced?
- What are the organizations/models of care that should be pilot-tested to transform health care delivery for the SPD population beyond existing managed care plans?
- As a Medi-Cal plan, we find individuals on TANF aid codes who have disabilities that should qualify them for PD aid codes. We have even found that some of these individuals have Medicare coverage. We need to identify ways to simplify Medi-Cal enrollment *and* ways to improve enrollment so that plans can be reimbursed correctly and so that individuals qualify for federal benefits faster.
- The future of Medicare SNPs is unclear. However, currently there are several Medi-Cal plans in CA that are also SNPs. There are several states working with CMS on integration. If SNPs, or something SNP-like, survive, how does the state recognize SNPs as a strategy for addressing care to dual eligibles?
- How can waiver programs like PACE be expanded from their current “boutique” status?
- What are the lessons learned from the LTCI program?
- Training and support of the direct-care workforce.

## **Behavioral Health Integration (BHI)**

### Proposed Questions

What does a review of the current integration pilots tell us regarding best practices for integration models?

What are the models of integration to be pilot tested in various systems of care in specific areas within the state?

What are the recommended strategies and methods of implementation for models to be tested including?

### Comments

#### Data Questions

- What are some successful models of integrated care employing FFS? (Hint:

Wisconsin)

- What programs are successful in the early identification diagnosis and treatment of mental illnesses? (White House Commission Report noted average 8 year delay from onset to diagnosis and treatment.)
- Where do the BH population AND the top 10% most get care now?
  - Primary care
  - Behavioral health
  - Specialty care
  - Hospital care
- Do we know if there is a behavioral health cost difference with FFS v. coordinated care models?
- More specific information about the best care integrative mechanisms (from the patient's, not the financing perspective).

#### Dual Diagnoses/Integration with Other Services

- Real cost of addiction and mental health to ERs and hospitals.
- Need a workgroup on addiction and mental health. These services have a huge impact on reducing cost and improving outcomes.
- How to integrate people with substance abuse and mental health and physical health needs.
- Inclusion of people with a mental health diagnosis and a diagnosis of cognitive disability (DD) is a very important consideration in this area.
- How can integration be addressed bi-directionally – i.e., ensuring that person with psychiatric disabilities access physical health care and vice versa?
- How do we include substance use as well as mental health in this work?
- Very important to include impact of substance abuse and treatment in analyzing data, true costs, etc and in reviewing integration models.
- Since the enhanced medical home is emerging as the leading model of integrated person-centered care, how will this affect carve out programs of Medi-Cal? Specifically, AOD substance abuse treatment services are paid under Drug Medi-Cal FFS. If substance abuse treatment services need to be integrated with primary care, mental health, etc., would Drug Medi-Cal remain as a carve-out program? The medical home appears to require a managed care system to better provide integrated services.
- One thing that became very apparent in the frequent user initiative project was the high incidence of dually diagnosed patients and their very high cost. To be comprehensive and achieve savings the waiver must address this population in a significant way.

#### Social Supports

- How should the waiver address the needs of people who have social barriers to appropriate care (i.e., homeless people, frequent users, people with multiple behavioral/physical health needs)?
- How can housing, food security, etc. (i.e. holistic approaches to this population) be incorporated?

## Dual Eligibles

- For dual eligibles, how to integrate Medicare and Medicaid funding in light of Medicare's 1950s approach to mental health services and coordination of MH and [physical health] of dual eligibles?

## Other Questions

- Why is it generally assumed managed care exceeds FFS coordinated care?
- What is the role of school-based programs recognizing that most kids who get mental health care get it at school on campus and that schools are in the best position to ID mental illnesses early in their onset?
- Move beyond traditional payer-contracted medical provider. Goal is true integration of payment/provider/HCBS.
- How are issues of access and enrollment being considered in integrated care systems?
- I was struck by the statistic that beneficiaries with serious mental illness have 23% more readmissions. Plans can ID some members with mental illness by looking at pharmacy data (the meds we pay for). There are real data sharing issues, with lots of real concerns to balance (privacy considerations).
- What are the life or health outcomes that will be measured? Will they be different by quadrant?
- What are the specific outcomes to be tested?
- Generally Medi-Cal does not cover mental health needs for individuals without persistent and serious disorders. Will integration address that gap?
- Investigate the structure for reimbursement and authorization of services between mental health and substance abuse services within FFS Medi-Cal, DMH, and Drug Medi-Cal.
- The question of who provides the state match and CPE for specialty mental health under the current program is critical to exploring options for integration.
- How can current county mental health managers and providers serve as medical health care home?
- Would like to see use of the term "medical home" broadened to "health care home" to better represent the range of services used for people with behavioral health needs.
- Can the waiver address the same-day billing issue that poses significant challenges to integration of primary care and BH care?
- Can county mental health departments effectively serve as health care homes to achieve integration of mental health care and primary care?
- Integration of family input in the treatment and management of severe mental illness is crucial. How will they be involved in keeping appointments, treatment compliance, housing, etc.?
- How to differentiate individuals who need specialty BH care that is more intensive or specialized than typical in a primary care setting.

## Workgroup Participation

- Hospital ERs are overwhelmed with BH patients seeking primary care or experiencing and acute episode. CHA requests representation on this working group.
- Would like to see CMHDA as a participant on this work group.

## Health Care Coverage Initiative (HCCI)

### Proposed Questions

How is consistency created across HCCI program counties so that the HCCIs will be compatible with changes that will result under national health care reform and will be able to meet the same goals and requirements established for organized systems of care for seniors and persons with disabilities in Medi-Cal?

What are the possible HCCI expansion opportunities to new counties and to new populations in existing counties?

### Comments

#### Data Questions and Clarifications

- Question 1: What standards should be developed across HCCI counties for HCCI implementation?
- What happens to counties' § 17000 obligations under this model?
- Are the HCCIs doing anything more than they were before the current waiver?
- If patients are enrolled in HCCIs, how do providers who are out of network get reimbursed?
- How do we better integrate HCCI projects that are currently operating in Medi-Cal managed care counties and are *not* connected to the health plans?
- How do we identify *current* models that are successful (cost and quality)? In our desire to innovate we may risk dissolution of small programs that work.
- What are the pros and cons of using the Medi-Cal eligibility and enrollment systems for the CIs as compared to 58 different county eligibility and enrollment systems? What systems do the current 10 CIs use and what challenges to enrollment have they experienced?

#### Federal Health Care Reform

- Since this is essentially a key part of Medicaid expansion population under national health care reform, need to think carefully how to prepare for that expansion.
- What consistency [can be/should be] created across HCCI program counties if national HCR does *not* pass?

## Status

- Question of “undocumented status” is a big concern to us. Any chance of inclusion here?
- What about individuals not eligible for Medi-Cal or HCCI?
- Can the coverage initiatives be used to address the coverage of undocumented immigrants who will in all likelihood be left out of national HCR?

## Participation in Workgroup

- CHA needs to be represented on this group on behalf of *all* of California's hospitals.

## Other Questions

- How are the existing HCCIs going to be handled in the new waiver? Are they going to be required to meet the consistency standards being discussed in the new waiver?
- How can existing HCCIs work together to provide cross-county opportunities for access to care? How can they align their own eligibility requirements, etc.?
- What incentives could HCCI offer to address the needs of highly vulnerable people (i.e., homeless people)?
- What is the downside of allowing all counties able and willing to establish a CI to do so?

## **Additional Comments**

### Technology

- Role of technology in all of the technical workgroup [areas] to help provide cost-effective care (Michael Martinez).
- Tech group on VBP?

### Dual Eligibles

- Dual eligibles
- We are interested in finding a way to maintain the dual eligible program for seniors.
- How about having more integration of the dual eligibles?

### Financing

- How to meet required \$\$ match?
- Coordination with federal health care reform
- Hospital financing?

## Health Disparities and Cultural Competence

- How will this group ensure that culturally competent care will be included, since CA is so diverse (especially with Asians)?
- In what workgroup are issues of health disparities – racial, ethnic, cultural, language – being addressed?

## Additional Topics/Workgroups

- Re: Goal #2: Opportunities to Reduce Uninsured and Get Ready/Align with Health Reform -- [This should be] much bigger than just coverage initiatives -- [Health Access] paper submitted to Department outlines range of ideas.
- Where are integration of acute and LTC services ideas addressed? SPD workgroup? Duals workgroup (if established)?

## Public Comment

*Jon Hultman, Executive Director, California Podiatric Medical Association*, commented that many provider types were not represented in the SAC, and that the CPMA wanted to be active in the waiver process.

*Mary Ader, Principal Consultant, Assembly Appropriations Committee*, asked whether technical workgroups would be open to public.

Response: David Maxwell-Jolly responded that the workgroups needed more flexibility than the public process allowed, but that the product of the workgroups would be discussed in the SAC.

*Doug Hillblom, California Pharmacists Association*, expressed his organization's interest in participating in the waiver process.

*Greg de Giere, ARC of California*, asked whether membership in the workgroups would be public even if the meetings are not. David Maxwell-Jolly responded that the list of members would be published.

*Beth Capell, Health Access*, asked about the basis for DHCS' decision not to conduct the technical workgroups according to the open meeting act.

Response: David Maxwell-Jolly responded that ABx4 6 establishes the SAC to help advise the waiver implementation plan, but that the technical workgroups are being called by DHCS in support of the Department's planning process, with the results presented to the SAC. The workgroups are consultants to DHCS.

### Next Steps and Next Meetings

The next meeting of the Stakeholders Advisory Committee will be Wednesday, March 10, from 9:30 AM to 12:30 PM in the Sacramento Convention Center. *Bobbie Wunsch* requested that any suggestions for meeting organization be sent to her at [bwunsch@pachealth.org](mailto:bwunsch@pachealth.org).

The meeting was adjourned at 12:30 PM.