

**SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER  
STAKEHOLDER ADVISORY COMMITTEE (SAC)  
Meeting #2 – Wednesday, March 10, 2010  
9:30am – 12:30pm  
Sacramento Convention Center, Room 204**

The meeting convened at 9:30 AM.

Attendance

*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; Sandra Naylor Goodwin, California Institute of Mental Health; Daniel Gould, California LGBT Health and Human Services Network; Peter Harbage, SEIU; Marilyn Holle, Disability Rights California; Michael Humphrey, Sonoma County IHSS Public Authority; Ingrid Lamirault, Alameda Alliance for Health; Elizabeth Landsberg, Western Center on Law & Poverty; Marty Lynch, LifeLong Medical Care (by phone); Jackie McGrath, California Council of the Alzheimer's Association; Anne McLeod, California Hospital Association; Santiago Munoz, University of California, Office of the President; 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; Timothy Schwab, Senior Care Action Network (SCAN) Health Plan; Rusty Selix, California Council of community Mental Health Agencies; Al Senella, California Association of Alcohol and Drug Program Executives; Barbara Seigel, Neighborhood Legal Services of Los Angeles County; Marv Southard, Los Angeles County Department of Mental Health; Herman Spetzler, Open Door Community Health Centers; Sarah Takahama, California Association of Physician Groups; Richard Thorp, California Medical Association; Anthony Wright, Health Access.

*Others attending:* David Maxwell-Jolly, DHCS; Greg Franklin, DHCS; Chris Perrone, CHCF; David Alexander, Lucile Packard Foundation for Children's Health (by phone); Bobbie Wunsch, Pacific Health Consulting Group.

Welcome and Introduction

*Bobbie Wunsch, PHCG*, welcomed the Committee members, including those on the phone, and the public attending in person and by phone. She announced the upcoming meetings of the Stakeholder Advisory Committee:

- May 13, 2010, 9:30am – 12:30pm
- July 8, 2010, 9:30am – 12:30pm

### Waiver Development Strategy

*David Maxwell-Jolly, Director, DHCS* presented the Department's strategy for the Section 1115 waiver. The concept paper released in December was broad but not detailed, and the Department now has a better sense of their plans in many areas. David Maxwell-Jolly's presentation is available at

[http://www.dhcs.ca.gov/provgovpart/Documents/Waiver\\_Development\\_Strat1.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/Waiver_Development_Strat1.pdf)

### **Strategy Outline**

The Department's strategy includes the following principles:

- *Building upon existing systems of care where available:* We are not starting from a clean slate, and need to figure out the most effective and efficient ways of improving on the job that the current institutions, of all kinds, are doing.
- *Advancing additional program changes targeting delivery system reform*
- *Integrating and structuring safety-net provider financing to promote inclusion in delivery systems that will emerge:* The safety net will be critical whether or not national Health Care Reform is achieved. Safety net institutions need to survive the change and will be key partners in any new structure.
- *Seeking credit for past cost cutting efficiencies:* California will be seeking additional funds from the federal government. Given how parsimonious the state's program is, this will mean getting credits for past savings.
- *Laying the foundation for broader system reforms under pending federal legislation:* The situation is complicated by not knowing whether we should be preparing for an environment with HCR or without it. We need to remain open to the possibility, but cannot wait for the resolution.

### **Strategy Components**

- Technical Workgroups: The Workgroups have had excellent participation, the process has been a wonderful opportunity to talk about new ideas and reconsider

how California is providing care in the Medi-Cal program. All four workgroups have met at least once. The four are: Seniors and Persons with Disabilities (SPD), California Children's Services (CCS), Health Care Coverage Initiatives (HCCI), and Behavioral Health Integration (BHI).

- Seniors and Persons with Disabilities (SPD): That Workgroup has discussed the standards that we would want in place in order to facilitate the transition of SPD groups into mandatory organized care. The overall idea is that with enhanced standards, we can rely on the current managed care system to handle the care of most SPD individuals. In some localities, the state would allow an alternative structure at county option – this plan provides an opportunity for us to entertain an additional approach within the existing context of our managed care structure. A summary document discussing the overall approach is available at <http://www.dhcs.ca.gov/provgovpart/Documents/SPD%20Concept%20Summary%203-3.pdf>

*Jack Burrows, Association of California Health Care Districts*, asked whether enrollment for SPD would be mandatory in all counties. David Maxwell-Jolly replied that the state's focus in the near term is enrollment in existing managed care counties. Counties without existing managed care arrangements need further discussion, but mandatory enrollment is not planned for the near term. The waiver will include a context for addressing rural and non-managed care counties.

*Catherine Douglas, PEACH* asked whether plans were equally ready in all counties, and what the Department's vision was for Los Angeles. David Maxwell-Jolly responded that Los Angeles presents a special situation, but that the state has a certain imperative to move quickly to operationalize this idea of organized care, and the Department has set a mark for getting enrollment done in first year of waiver. The Department is open to ways to stage this transition in Los Angeles. The SPD TWG will discuss enrollment at their March 11 meeting - in particular county situations, the pacing will need work and the waiver itself won't have those details.

*Anthony Wright, Health Access California* asked whether the county-option alternative was envisioned only for non-managed care counties. David Maxwell-Jolly said no, that in any existing managed care county, the county can propose an alternative model. For non-managed care counties, we need to figure out a model, but this alternative is proposed for counties in which local conditions give rise to an interest in such an alternative.

*Bob Prath, AARP*, noted that the paper emphasizes the cost of SPD beneficiaries to the system, and asked whether there would be more discussion of home and community-based services (HCBS), which is what stops people from cycling through the system. David

Maxwell-Jolly agreed and noted his support for HCBS, and said that the Department feels that the HCBS conversation is most appropriate in the context of the plans for dual eligibles, where the greatest potential for integration exists.

*Barbara Siegel, Neighborhood Legal Services of Los Angeles County*, had the following questions:

1. Is it contemplated that behavioral health remains a carve-out, or would it be carved in as part of this transition?
2. Who will be at risk for long-term care (LTC)?
3. What kind of payment reforms are envisioned over the life of the waiver? How can managed care assume this expensive population without immediate payment reforms?

David Maxwell-Jolly said that the initial payment reform is just enrolling these individuals in managed care – then we will address what’s included in the rate and how the rate is set. For Medi-Cal only populations, LTC could be included in the rate. For duals, rate reform may allow for that integration. As they’re developed, each rate package will need work to ensure that it’s stable and doesn’t entail undue risk, but has the right incentives to encourage appropriate service mix. We need to push forward organizational structures and then make the rate processes as comprehensive as possible to allow local organizations to meet the needs of enrollees.

David Maxwell-Jolly also said that broad-based changes to the mental health carve-out are not under consideration, though financing may be rearranged in one or more of the planned BHI pilots.

*Cheryl Phillips, On Lok Lifeways* said that a good fully-integrated model exists in PACE, and warned against hurting existing structures that are working. David Maxwell-Jolly said that the plan is not to dismantle existing models, but to build new ones that take the successes into account.

*Jack Burrows, Association of California Health Care Districts* noted that health care districts are not only rural, but exist in almost every county in the state. One hospital in Los Angeles serves over 500,000 indigent patients annually, but is not a safety net hospital. He asked that the process consider financing for these institutions. David Maxwell-Jolly said that the hospital financing discussion depends on how much money the state can negotiate through the process, and how we can structure non-federal expenditures.

*Jackie McGrath, Alzheimer’s Association* asked for clarification of the meaning of “long-term care” in this context, and suggested that the HCBS discussion should not be confined to the dually eligible population, but should be part of the SPD discussion overall. David Maxwell-

Jolly said that for the Medi-Cal only program, the level of financial integration has to do with how the rate is constructed and the level of responsibility that the local organization has. He would like to move to a rate that's as all-encompassing as possible.

*Mike Humphrey, Sonoma County Public Authority*, echoed Jackie McGrath's concern that the HCBS discussion would be limited to the dual-eligibles. David Maxwell-Jolly said that, in the context of the waiver, it's the most important piece to get right with respect to including dual-eligibles, because the gap that exists between Medi-Cal and Medicare financing structures creates barriers. He acknowledged that gaps in access to HCBS exist for the Medi-Cal-only population, too, but said that step one was to organize care with a single point of responsibility. The Department has a number of programs that have worked to prevent institutional care, and they have moved very slowly. The Department believes that progress can best be made by delegating those responsibilities as locally as possible.

Mike Humphrey said that it is critically important to get the HCBS issue right with Medi-Cal only populations in managed care counties, or we won't get it right with dual eligibles, and noted that there is still a lot of work to be done with the Medi-Cal only population in this regard. It is not clear how managed care counties are connecting with HCBS, and Mike would be interested in hearing about any counties where a strong connection exists between the plan and IHSS. He agrees with the letter circulated at this meeting by AARP **link?** -- the issue of HCBS linkage requires real discussion, and so far the SAC and Working Groups is not happening.

*Marilyn Holle, Disability Rights California* asked the following questions:

1. Is IHSS included in the Department's definition of LTC?
2. Protection of members' rights and enforcement of standards is a particular concern in the case of a fast enrollment schedule, as the one the Department is proposing.

David Maxwell-Jolly confirmed that IHSS is part of LTC, and clarified that it is the Department's goal to include IHSS in the rate, although that is difficult and has not been done yet. He said that the SPD Workgroup would be discussing enrollment and protection of members' rights on March 11.

- Dually-eligible beneficiaries (Medi-Cal/Medicare): David Maxwell-Jolly said that the Center for Health Care Strategies released a document on March 9, entitled *Options for Integrating Care for Dual Eligible Beneficiaries* that included options for integrating financing and care for the dual-eligible population. (Available at [http://www.dhcs.ca.gov/provgovpart/Documents/CA\\_Options\\_030810\\_CHCS%20br\\_and.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/CA_Options_030810_CHCS%20br_and.pdf).) The Technical Assistance Tool was prepared by the Center for Health Care Strategies with support from the SCAN Foundation. The paper lays out the types of

opportunities that the State has with respect to the dual population, and mentions PACE, expansion of Special Needs Plans (SNPs), and more aggressive options including California taking on risk for the full set of Medicare benefits. During the next few weeks, the SCAN Foundation will be hosting a webinar to discuss the paper in more detail, and the Department will initiate discussion with CMS regarding the various options. The Department plans to begin this discussion with the most aggressive approach – California taking on full financing of Medicare services in the context of Medi-Cal – and gauge CMS' interest in taking on such a large change. Following that, most likely in May, the Department will have realistic and specific discussions with stakeholders.

*Rusty Selix, CCCMHA*, offered that he hoped that some mental health people were involved in these discussions, since there are particular issues for mental health billing, service definition, and parity issues for which the regulations have yet to be written.

1. Mental health providers struggle with definitional difficulties between the programs, since they are required to bill Medicare first, but almost everything is denied because Medicare's definitions don't fit what county mental health programs provide.
2. People with serious mental illness (SMI) is the largest group of dual eligibles who qualify via disability, but their initial applications for SSI are denied 100% of a time, and it often takes a year to qualify. Thus the timing of someone with SMI becoming dually eligible (first getting Medi-Cal via SSI, and then Medicare), is a big problem.

David Maxwell-Jolly said that he was familiar with both the claiming and eligibility issues.

*Marilyn Holle, Disability Rights California*, noted that the problem of eligibility for SMI is not unique to California. One concern is assessment of homeless individuals who come in without records. Appropriate assessments need to be pushed forward so that people who are eventually found eligible by an Administrative Law Judge (ALJ) can be found eligible earlier.

*Tim Schwab, SCAN Health Plan*, commented that the proposal for California to take on risk for dual eligibles sounds like one source of financing combining federal and state dollars for duals. He asked whether there would also be one set of regulations for that population. Was the Department considering mandatory enrollment for the Medicare portion, as well, and would they include "near-duals," people who are on Medicare already, and heading toward Medi-Cal due to spend-down? David Maxwell-Jolly said that he would be interested in looking at the issue of "near-duals," but said that this most aggressive approach is already a very significant policy change, and that the Department would not be asking for mandatory

enrollment for this population, though they would like to have a substantial portion of the population enrolled in an organized system.

*Marty Lynch, LifeLong Medical Care*, suggested that it would be better to convene stakeholders to discuss the dual options sooner rather than later. David Maxwell-Jolly said that while he agreed in principle, there is a logic to discussing these options after the SPD discussions are concluded, since those lay the groundwork. Marty Lynch also asked about the Department's thinking on financing. David Maxwell-Jolly noted that the concept paper emphasizes that managed care expansion could put safety net at risk, given that the safety net is not fully integrated into managed care networks. However, the Department believes that at some point the state will cover indigent/uninsured populations, and the safety net, which has been providing the majority of care to these individuals, will have to be fully integrated to serve a covered population.

*Elizabeth Landsberg, WCLP* asked whether the aggressive proposal was literally that California would get all the Medicare money, that the person would no longer have a Medicare card or be able to use the Medicare provider network. David Maxwell-Jolly said that that would be the fundamental idea. While the proposal still has to be fully developed, it has the potential to expand Medi-Cal provider networks to include those who currently provide only Medicare. The Department's belief is that if we want to integrate care, with the right balance between acute and long-term care, then the greater the integration the better.

*Peter Harbage, SEIU*, asked whether the Department had made a decision on the policy, or had only decided to bring the idea forward to CMS. David Maxwell-Jolly reaffirmed that the paper includes a range of possible options, and that, as it's not usual to have a discussion about Medicare in the context of a Medicaid 1115 waiver, they believe that they should have a conceptual discussion with CMS first, before doing detailed planning.

*Catherine Douglas, PEACH*, noted that were the state to move into Medicare, the existing concerns about the viability of the public hospital system apply also to private hospitals, since they are bigger providers on the Medicare side. If private hospitals' Medicare financing were to shift, they would lose funding sources like Medicare DSH, and could be further marginalized. David Maxwell-Jolly said that the Department is aware of the profound changes that this option would entail, and of how much many of our DSH hospitals rely on Medicare.

*Jeff Flick, Anthem Blue Cross*, offered that this is a bold, interesting idea, but that there are no trickier finances than Medicare. He said that a conversation like this would show CMS that California is serious.

*Bob Prath* said that AARP would have a huge problem with mandatory enrollment of dual eligibles, and was glad that this was not on the table. In addition, HCBS and expanded services would be very important in attracting this population to managed care on a voluntary basis.

*Al Senella, CAADPE*, asked why behavioral health integration merited only a pilot. Regarding dual-eligibles, he noted that a substance use disorder by itself does not qualify anyone for Medi-Cal or Medicare. However, some of this population does have addictions. They are relegated to drug Medi-Cal, a carve-out administered by DADP, and restricted to five services only – hardly parity. If the program isn't fixed, to allow them to work with duals and also Medi-Cal only populations, they can't do their part to deal with costs. He expressed a hope that this issue will remain on the agenda as something that offers the possibility of having a real impact on reducing costs and improving outcomes. David Maxwell-Jolly said that the reason for pilot projects in BHI is that there is a lot to learn, one being the overlap between mental health and substance use issues, and the extent of cost mitigation possible in this area. The pilots provide an opportunity to construct settings, get data, and build the record for cost-effective interventions. Al Senella said that there is already a great deal of data demonstrating cost savings related to substance use treatment.

David Maxwell-Jolly said again that he expected to begin detailed stakeholder discussions regarding these options in late April/early May.

- California Children's Services (CCS) and Behavioral Health Integration (BHI). David Maxwell-Jolly reported that the focus in both workgroups is to come up with good ideas for pilot projects, and to try them out. Both groups are making progress.
- Hospital Financing. David Maxwell-Jolly said that two key elements in the concept paper are changes in the FFS system payment methodology to diagnosis related groups (DRGs). Discussions about these issues are ongoing with the hospitals. In addition, the Department has requested reconsideration of the upper payment limit. The rest of the issue centers on how much the state can justify in the safety net care pool.

## **CMS Activities**

David Maxwell-Jolly outlined the Section 1115 waiver process. He reported that at this juncture, discussions with CMS are intensifying, informed by the options document (available at [http://www.dhcs.ca.gov/provgovpart/Documents/CA\\_Medi-Cal\\_Waiver\\_Options.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/CA_Medi-Cal_Waiver_Options.pdf)), the SPD document (<http://www.dhcs.ca.gov/provgovpart/Documents/SPD%20Concept%20Summary%203->

3.pdf), and the dual eligibles document

([http://www.dhcs.ca.gov/provgovpart/Documents/CA\\_Options\\_030810\\_CHCS%20brand.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/CA_Options_030810_CHCS%20brand.pdf)

). As the HCCI group formulates their ideas, those will be put on the table with CMS as well.

The waiver process includes:

- Additional proposal details – CMS will formally request information, and there will be conference calls, meetings, and written responses.
- Statement of Terms and Conditions – drafted by CMS, and then negotiated and finalized between the State and CMS
- Budget neutrality – how we calculate the amount of money available in context of waiver. The Department is working with data staff and consultants to demonstrate where Medi-Cal has demonstrated savings, where the base should be set, what programs are encompassed, etc. DHCS expects to begin discussions with CMS within 3-4 weeks.

*Anthony Wright, Health Access* asked who drafts the Statement of Terms and Conditions (STC), and where the forum is for stakeholders to discuss potential savings and budget neutrality. Given that there is no CMS administrator currently, at what level is the Department connecting with CMS? David Maxwell-Jolly replied that CMS typically drafts the STC, with the state responding, and that discussions are occurring at all levels, such that the absence of an administrator is not an impediment. He stated that it is important that California be unified in supporting the 1115 request, and send an unambiguous message to CMS that stakeholders and the Department are working on the issue together. There is no plan for stakeholder engagement around the budget neutrality calculations or discussions, but David Maxwell-Jolly would be happy to hear suggestions for cost savings.

*Rusty Selix, CCCMHA*, said that there are a number of ideas that do not appear to be on the table, first among them the lack of funding for outpatient mental health and substance abuse treatment, which could save a great deal in hospital costs. He said that these things could be done statewide without a pilot, and do not require integration between behavioral and medical services to succeed. David Maxwell-Jolly replied that these ideas should be brought to his attention, and that, assuming they link to the overall concept, they'll be incorporated to the extent possible.

*Catherine Douglas, PEACH*, asked about the schedule for moving the waiver proposal through the legislative process. David Maxwell-Jolly said that the structure of the current waiver must be continued without a break, and that the Department has a strategy to manage this. By the next SAC meeting in May, the Department expects to present key elements of the waiver, and around the same time to have prepared implementing legislation.

*David Alexander, LPFCH*, commented that DRG does not have a way to recognize co-morbidities for kids with special needs – for example, different types of pneumonia that may vary based on the child’s other medical conditions. He urged the Department to consider a system that uses enhanced groupers. *Anne McLeod* said that CHA is working with DHCS on the APR DRG, which does work for complicated kids.

*David Maxwell-Jolly* said that if SAC members have ideas about statewide expansion of certain program elements, they should be sent directly to him.

### Technical Workgroups: Work to Date and Next Steps

*Greg Franklin, DHCS*, introduced the Technical Workgroups (TWG) and their work to date. All groups have met at least once, and the SPD and BHI groups have met twice. All meetings have been well-attended, with an average of 40 members of the public listening in by phone. Future agendas are being adjusted based on the work to date, so agenda outlines posted on the website may not be entirely accurate.

*Bobbie Wunsch* said that a representative from each Workgroup had been asked to summarize the work done by the group to date, and to propose a question for consideration by the SAC. (All presentations are available on the SAC website at <http://www.dhcs.ca.gov/Pages/SACMeetings.aspx>.)

### **HCCI TWG: Elizabeth Landsberg, WCLP**

The HCCI TWG presentation is available at [http://www.dhcs.ca.gov/provgovpart/Documents/SAC\\_March\\_10\\_HCCI\\_TWG\\_Presentation.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/SAC_March_10_HCCI_TWG_Presentation.pdf) In addition to summarizing work done to date and work still planned, the HCCI group presented the following question:

### Key Question for Discussion and Feedback

Should HCCI renewal focus on:

- Strengthening efforts in the current 10 counties?
- Expansion to new counties?
- Both?

*Rusty Selix, CCCMHA*, said that he understood that county mental health dollars aren’t eligible for a match as currently constructed, and asked whether this could be fixed so that people with SMI, with their high costs and frequent use, could be targeted for enrollment. *Marv Southard* said that Los Angeles data indicated that focusing coverage on some high-

risk groups can provide both savings and better outcomes. He said that the eligibility for match depends on the services provided.

*Marilyn Holle, Disability Rights California*, asked what percentage of the HCCI populations has disability determinations via SSI, and thus end up on Medi-Cal. Elizabeth Landsberg said that the TWG had had this discussion, and know that many are SSI-pending. The HCCI have been an entrée to Medi-Cal for many people.

*Marv Southard, LAC DMH*, said that in Los Angeles, the vast majority should be on SSI, but a significant portion have never completed the evaluation process. Eligibility determination should be a centerpiece of the work.

*Chris Perrone, CHCF*, asked if, to the extent that resources are identified through budget neutrality, the Workgroup had taken on the question of whether to plow the money back into 1) the existing HCCIs, or 2) existing HCCIs and expansion CIs. Bobbie Wunsch noted that this topic is on the agenda for the March 17 HCCI meeting.

*Kelly Brooks, CSAC* said that it is difficult to have a conversation about putting savings back into Medi-Cal, when it's the counties that are putting up the match.

*Brad Gilbert, IEHP*, said that some level of standardization in the CIs is important from the point of view of eligibility and benefits (since people move), and as regards performance measurement (while there are interesting things happening in the HCCIs, we can't define these well unless we can compare across programs). Whatever happens with health care reform, we should be positioned. Elizabeth Landsberg said that from a consumer perspective she agreed, but noted that the counties are putting up the CPE, and they may feel differently.

*Jack Burrows, ACHCD*, said that there are many SPD, dual-eligibles, and chronically ill people who are going to the 10 HCCI counties for tertiary care. If they had primary and acute care in an organized system in the counties where they live, California could save a lot of money.

*Sharon Rapport, CSH*, noted that a number of programs target high-cost, frequent users and link them to services, with proven cost savings. Those programs are being overlooked in CI counties, but some, such as Alameda, get some CI funds to support those initiatives. Another thing often overlooked in CIs is the care management to link people to non-medical services, important because this population also faces social barriers to appropriate care.

*Catherine Douglas, PEACH*, said that she hoped that HCCI standardization would include both outpatient and inpatient services in the standard benefit. Expansion of the provider network will be critical in an HCCI expansion – currently those include mostly county

networks, but the PEACH hospital down the road may be seeing some of these patients without receiving any HCCI funding.

*Anne McLeod, CHA*, said that every county in the state puts resources into enrollment in coverage programs, and that HCCI has strengthened that. One thing that the Workgroup has discussed is that a lack of standardization could create magnet counties. CHA supports strengthening and expanding the CI network, but believes that the focus should be on strengthening the entire hospital safety net, through rate stabilization.

### **CCS TWG: David Alexander, LPFCH**

The CCS TWG presentation is available at [http://www.dhcs.ca.gov/provgovpart/Documents/SAC\\_Mar\\_10\\_CCS\\_TWG\\_Presentation.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/SAC_Mar_10_CCS_TWG_Presentation.pdf). In terms of work still to be done, the CCS TWG will be looking at four potential models for pilots:

- Enhanced primary care case management –within the existing FFS CCS, or within any of the other three models
- Provider based accountable care organization
- Specialty health care plan, organized around a clinically defined population
- Carve CCS back in to Medi-Cal managed care

The first two of these models will be discussed at the next CCS meeting on March 16, and at the third meeting the Workgroup will discuss the third and fourth.

### Key Question for Discussion and Feedback

Given the four possible models, are there any barriers or major issues that you believe would prevent any of these models from being implemented as a pilot, and then if successful replicated in other parts of the state or statewide?

*Brad Gilbert, IEHP*, noted that CCS includes a wide range of conditions, and that some do not require the extra attention that is being discussed. Has the Workgroup discussed that? David Alexander said that, although there is no plan to redefine the CCS list, the list of conditions will be discussed in each model. For example, there is not much of a role for a primary care provider for neonates, so the EPCCM model may not make sense for these children.

*Judith Reigel, CHEAC*, said that once challenge is to figure out what's best for the kids, but the different populations within CCS complicate things. Some children only have CCS and not Medi-Cal, while others are served through the MTP program. She warned against further fragmenting the population.

*Barbara Seigel, NLS*, noted that the document circulated in advance showed that the large majority of costs were incurred in hospitals, particularly children's hospitals. She asked what the Workgroup was planning for hospital-based systems. David Alexander said that the accountable care organization model would be hospital-based.

*Diana Dooley, CCHA*, noted that the CCS world is finite – all the people involved know each other and already work together. Children's hospitals provide a lot of the care, and most children go through special care centers located mostly at these hospitals, largely because of the shortage of sub-specialty care in pediatrics. CCHA has worked with the State on a pilot that would move toward a hub and spoke system and regional centralized care, and that effort is continuing.

*Chris Perrone, CHCF*, offered an observation regarding the pilots in CCS and BHI, generally. He noted that the management task entailed by these pilots would be significant, in a state that's stretched thin as far as overseeing even the statewide programs. He asked whether the goal of the pilots was to test what works and then replicate it, and cautioned that California's history in this regard is of creating multiple models, with little effort to find out what works best and apply it statewide.

*Herman Spetzler, Open Door Community Health Centers*, asked about telemedicine in the CCS context, noting that three-fourths of the state is rural and that families with children in CCS may have to miss 3 days of work to travel to a short specialist visit. David Alexander said that this is on the table, and requires attention regardless of the type of pilot. *Diana Dooley* said that CCHA is working on telemedicine as well. The CCS system is a very efficient delivery system, though expensive because of these children's high needs.

*Santiago Munoz, UCOP*, observed that the points regarding the intensity and complexity of care for CCS children is true in academic medicine across the board. Telemedicine has been very successful, and electronic health records (EHR) linked to FQHCs holds great promise for care to these populations.

*Mike Humphrey, Sonoma County Public Authority*, said that specialized care access in rural counties is very difficult, and that the transition from the pediatric to adult medicine world is not usually handled well. David Alexander agreed, saying that California does not handle transitional care well, but that there are no strong state models elsewhere.

### **BHI TWG: Sandra Naylor Goodwin**

The BHI TWG has met twice. At its first meeting, the group focused on foundational work, including adopting the NCCBH Four Quadrant Model as the conceptual framework for pilots. Work still to be done includes defining the specific components of potential BHI models. The BHI TWG presentation is available at

[http://www.dhcs.ca.gov/provgovpart/Documents/SAC\\_Mar\\_10\\_BHI\\_TWG\\_Presentation.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/SAC_Mar_10_BHI_TWG_Presentation.pdf).

### Key Question for Discussion and Feedback

How should the work of the BHI TWG be integrated into the work of the other TWGs given the data that supports the presence of complex BH needs within those populations?

*Elizabeth Landsberg, WCLP*, said that she was glad to hear that the data is available to hone in on high-cost, high-need individuals, because we need to get the right level of care to the right people.

*John Schunhoff, LAC DHS*, said that he hoped the TWG, in designing pilots, would think not only of the existing drug Medi-Cal program, but of using resources for substance abuse more flexibly and effectively.

*Marty Lynch, LifeLong*, said that the group should think in terms of shared incentives, so that the mental health and medical sides share in the savings and the outcomes. This is a perfect place for a pilot between mental health and community health centers.

*Rusty Selix, CCCMHA*, said that one phenomenon that this discussion presents is the underfunding of all systems: primary care, mental health, and substance abuse. The Four Quadrant proponents would say that you need additional money in all three systems, plus funds to pay for management, but that it still pays for itself in inpatient savings. The elephant in the room is that mental health and substance abuse are carved out from the rest of Medi-Cal, and it's difficult to get people medically necessary services under the current financing structure. Revenue neutrality can't mean no additional money for substance abuse and mental health.

*Herman Spetzler, Open Door*, said that from his vantage point, this is the most complex of all the issues. The Four Quadrant model is good, but people move between these categories – we are building quadrant-specific models that don't address the management of patients as they move back and forth between quadrants 3 and 4.

*Marv Southard, LAC DMH*, said that integration of care will look different in each quadrant. Quadrants 3 and 4 require an outreach mechanism, and that we can't wait for patients to come in. Outcomes measurements also deserve attention and should include not only more efficiency, but healthier lives.

**SPD TWG: Brenda Premo**

Brenda Premo's presentation is available at [http://www.dhcs.ca.gov/provgovpart/Documents/SAC\\_March\\_10\\_SPD\\_TWG\\_Presentation.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/SAC_March_10_SPD_TWG_Presentation.pdf). Brenda reviewed the Workgroup's progress to date in two meetings (with the third scheduled for March 11), and questioned the assertion in the slide that "Managed care plans have experience and infrastructure to serve the SPD population."

#### Key Question for Discussion and Feedback

How will we measure success for SPD populations enrolled in managed care or organized systems of care?

*Jackie McGrath, Alzheimer's Association*, said she wanted to add to the list of work still to be done the question of how to promote HCBS. She also raised the issue of access for people with cognitive impairment. For people with dementia, that access requires a comprehensive care coordination system. Tim Schwab echoed the importance of HCBS. Standards, data and care have to be considered differently for seniors as compared to younger individuals with disabilities.

*Cheryl Phillips, On Lok*, said that approximately 72,000 seniors who are in Medi-Cal-only because they're not eligible for Medicare, yet they need the Medicare-type services, which typically are not available through Medi-Cal managed care. Many measures appropriate to younger people with disabilities don't apply to older individuals, and this group is typically not well managed under traditional managed care structures.

*Marty Lynch, Lifelong*, said that what health plans currently do is usually medical care coordination, even though we call them patient-centered medical homes (PCMH) and pay lip service to broader coordination. For certain things that move people into higher cost/higher need categories (homelessness, SMI, dementia, etc.), we need to acknowledge a care coordination that goes beyond purely medical care coordination.

*Brenda Premo* said that the shortage of primary care providers requires attention. The waiver should include plans for recruitment and training, including of geriatric primary care providers. Dick Thorp, CMA, agreed that this is important, and that without an adequate provider network, these efforts won't be successful.

*Lisa Rubino, Molina*, said that managed care organizations have a good *foundation* for serving SPD, with sophisticated technology, care management strategies, and focus on their level of readiness and the CHCF guidelines. She said she was surprised at Brenda Premo's assertion that the existing managed care organizations lacked the infrastructure to care for these beneficiaries.

*Teresa Favuzzi, CFILC*, said she supported Brenda's assessment of plan readiness, and suggested looking at the Office of the Patient Advocate survey on SPD readiness, noting that 2/3 of managed care organizations declined to participate in it. She echoed calls to bring HCBS and Olmstead into what the TWG and SAC are trying to achieve.

*Juno Duenas, Family Voices*, said that the discussion of costs needed to take not of the expenses that families incur in keeping their children at home.

### Next Steps

*Bobbie Wunsch* thanked the SAC for engaging in the conversation, and thanked presenters from the Workgroups.

*Greg Franklin* briefly described the data presented in several documents presented to the SAC (available at <http://www.dhcs.ca.gov/Pages/SACMeetings.aspx>, see in particular [http://www.dhcs.ca.gov/provgovpart/Documents/March\\_10-SAC\\_Data\\_Presentation\\_3-8.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/March_10-SAC_Data_Presentation_3-8.pdf)), noting the wide variety of data sources tapped for this summary. He pointed to additional data available on the TWG sites.

### Public Comment

*Gary Passmore, Congress of CA Seniors*, asked that DHCS reconsider the projected timeline for discussing the proposals around dual eligibles. He said that he did not believe the Department should wait 45 days to meld that discussion into others, particularly the SPD Workgroup. He supported getting initial information from CMS, but said that a stakeholder process should run concurrently with those discussions.

*Beverly Granda, American Nurses Association*, supported the comments regarding public support. Care management and case management are important factors for a wide variety of populations, from those with complex needs all the way to people who don't speak or read English. She asked that the workgroups continue to push for that access.

*Bobbie Wunsch* thanked the Committee members and the public, and reminded the group of the next meeting on **May 13 from 9:30am-12:30pm**. David Maxwell-Jolly expressed the Department's appreciation for the Committee's input in this complex task.

The meeting was adjourned at 12:40 pm.