

**SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER  
STAKEHOLDER ADVISORY COMMITTEE (SAC)  
Meeting #5 – Thursday, July 22, 2010  
9:30am – 12:30pm**

The meeting convened at 9:35 AM.

Attendance

*Members attending:* David Alexander, Lucile Packard Foundation for Children's Health; Bill Barcellona, California Association of Physician Groups (CAPG); Jack Burrows, Association of California Health Care Districts; Diana Dooley, California Children's Hospital Association (CCHA); Catherine Douglas, Private Essential Access Community Hospitals (PEACH); Juno Duenas, Family Voices; Teresa Favuzzi, California Foundation for Independent Living Centers; Jeff Flick, Anthem Blue Cross; Bradley Gilbert, Inland Empire Health Plan (IEHP) (by phone); Sandra Naylor Goodwin, California Institute of Mental Health (CiMH) (by phone); Peter Harbage, SEIU; Marilyn Holle, Disability Rights California; Michael Humphrey, Sonoma County IHSS Public Authority; Melissa Stafford Jones, California Association of Public Hospitals and Health Systems (CAPH); Liz Kniss, California State Association of Counties (CSAC) (by phone); Ingrid Lamirault, Alameda Alliance for Health; Elizabeth Landsberg, Western Center on Law & Poverty (WCLP); Marty Lynch, LifeLong Medical Care; Jackie McGrath, California Council of the Alzheimer's Association; Anne McLeod, California Hospital Association (CHA); Santiago Munoz, University of California, Office of the President (UCOP); Chris Perrone, California HealthCare Foundation; Cheryl Phillips, OnLok/PACE; Bob Prath, AARP California Executive Council; Brenda Premo, Harris Family Center for Disability and the Health Professions (CDHP); Sharon Rapport, Corporation for Supportive Housing (CSH); Judith Reigel, County Health Executives Association of California (CHEAC); Lisa Rubino, Molina HealthCare; John Schunhoff, Los Angeles County Department of Health Services (LAC DHS) (by phone); Rusty Selix, California Council of Community Mental Health Agencies (CCCMHA); Al Senella, California Association of Alcohol and Drug Program Executives; Barbara Seigel, Neighborhood Legal Services of Los Angeles County (NLS); Stuart Seigel, Children's Hospital Los Angeles (CHLA); Marv Southard, CMHDA, LAC DMH; Richard Thomason, Blue Shield of California Foundation; Anthony Wright, Health Access California.

*Others attending:* David Maxwell-Jolly, DHCS; Toby Douglas, DHCS; Greg Franklin, DHCS; Tanya Homman, DHCS; Don Fields, DHCS; Bobbie Wunsch, Pacific Health Consulting Group.

*Public in attendance:* 46 members of the public attended in person, and 37 attended via the listen-only call-in line.

## Welcome and Introductions and Purpose of Today's Meeting: Review Logistics for Today's Meeting and Webinar

*Bobbie Wunsch, Pacific Health Consulting Group*, welcomed the Committee members and the public and provided an overview of the agenda. She announced that at this meeting, legislative staff would also be allowed to ask questions and participate in the discussion.

## Status of CMS Discussions, Timeline, and Waiver Legislation

*David Maxwell-Jolly, DHCS*, thanked the group for their work to date. He said that he was aware that many members of the SAC were working actively on the waiver legislation, and thanked them for their interest and efforts, which have been very productive.

David Maxwell-Jolly said that materials sent to the SAC in advance of the meeting include a draft Request for Information (RFI) for the SPD county alternative model, and a document prepared for CMS that includes additional detail on how DHCS envisions the waiver working as a bridge to federal Health Care Reform (HCR). The proposal released in June focused on the waiver as a foundation for change leading to 2014, and the demand that health insurance expansion will place on California's health care and enrollment systems. That vision document provides additional detail.

**Status of Negotiations with CMS:** In June, DHCS provided CMS with a detailed waiver proposal. Since then there has been a steady and intensive back-and-forth, including many phone calls and a variety of new materials detailing California's current programs and projections for the proposed new programs. David Maxwell-Jolly said that California's proposals have been well received by CMS, and that federal officials have been attentive and vigorous in their responses. CMS and the state are both in problem-solving mode, and the working relationship is very productive. He is confident that an agreement will be reached.

The proposal leads with eligibility and coverage expansions, through an expansion of the county-based Coverage Initiative (CI). DHCS considers this an early implementation of the upcoming federal coverage expansion for childless adults. CMS is very supportive of this approach. One area of ongoing discussion is the trade-off between putting more requirements on the CIs and covering larger numbers of people. With that tradeoff in mind, CMS and DHCS are looking at realistic benchmarks with regard to new as well as existing county programs. CMS is interested in a set of benefits that closely mirrors the expected benchmark benefits. CMS also wants the CIs to meet the Medicaid cost-sharing limitations by 2014, and California will need a plan to get there.

State officials and CMS have also engaged in extensive discussions about delivery system reforms. CMS is interested in California's proposals regarding more organized systems of

care, advancing medical home and care coordination approaches, and effective investments in safety net systems. There have also been extensive discussions regarding global payments and risk-based payments for the coverage initiative.

DHCS has provided CMS with estimates of the SPD population currently enrolled in managed care, and the likely size of the new mandatory enrollment population. CMS is interested in ensuring that the transition is graceful, that provider networks are adequate, and that people with high needs are identified early and served well. CMS is also concerned about coordination of services such as long-term care (LTC), and will expect the state to be explicit about plans for such coordination.

CMS is extremely interested in the integration of physical and behavioral health. They are aware and concerned that the indigent childless adults who will be covered in Medicaid in 2014 will have a significant demand for behavioral health services. CMS wants to know how California will be building capacity in that area and how integration of physical and behavioral health will be promoted. DHCS will be talking to counties and to behavioral health stakeholders about how to advance work in that area via the CIs.

Overall, CMS is very interested in and supportive of the idea of California using the waiver as a bridge to health care reform, but wants the state to be explicit about how that will happen, with clear milestones and detailed approaches that will allow the federal government to ensure that federal investments are being used effectively.

**Status of Waiver Legislation:** DHCS has had intensive discussions with stakeholders and the legislature over the past few months regarding the waiver legislation. Currently, the bill language includes significant detail regarding mandatory enrollment of SPD populations, a section addressing CI expansions, and discussion of pilot programs for duals and children with special health care needs (CSHCN). Stakeholders have submitted extensive suggestions, criticism, complaints and praise, there has been productive dialogue around the issues, and as a result there are good solutions in a number of areas. Language regarding enrollment, continuity of care, identification of high-need enrollees, care coordination, and medical homes is now significantly more detailed than in the initial draft.

David Maxwell-Jolly said he appreciated that people may yet have reservations about what is not included, and that he expects one or more rounds of changes. The goal has been to strike a balance among various approaches to enrollment in organized systems, and that balance is being struck. Both advocates and plans are deeply engaged with respect to the legislation.

David Maxwell-Jolly introduced *David Panush, Senate President Pro-Tempore's Office, California Legislature* and *Sumi Sousa, Assembly Speaker's Office, California Legislature*, to provide their perspectives on the progress of the legislation.

*Sumi Sousa, Assembly Speaker's Office*, said that while she expects more amendments, with respect to the policy provisions, specifically those related to SPDs, CCS and duals, she believes that they are reaching the end of that process. The focus must now be on financing provisions, given the tight timeline for completion, and that requires more definitive information from CMS.

*David Panush, Senate President Pro-Tempore's Office*, said that amendments are being made through an iterative process, and that while they expect a near-final bill next week, there may yet be more policy amendments. The Senate and Assembly bills are moving in an identical fashion, and are completely in sync. When CMS provides more information regarding the overall waiver financing, the work will be to determine what the CI program looks like, how hospitals are financed, and how the safety net is protected.

David Panush emphasized that completion of the waiver is not inevitable, and the next phase will be the most strenuous. California is asking the federal government for almost \$10 billion over five years, which is more than any other state has ever received. The state has very few alternatives, given the budget situation, and the waiver may be the only way to make improvements. The waiver can be accomplished only if the legislature, administration, and stakeholders reach consensus via compromise. If stakeholders feel the need to raise objections to CMS and to the California Congressional delegation, they should know that this threatens the process. While everyone has to live with the waiver for five years, if it doesn't happen, everyone will have to live without it. The legislature is committed to completing the process, but needs help. While comments and suggestions to date are much appreciated, stakeholders should know that it will not be possible to resolve every point and still get a 2/3 vote and Governor's signature.

Bobbie asked for comments from stakeholders and legislative staff.

*Elizabeth Landsberg, WCLP*, asked about CMS' comments on duals and the CSHCN pilots, and whether stakeholders would have an opportunity to review draft Terms and Conditions. David Maxwell-Jolly said that the state's planned activities related to the duals and CSHCN pilots would be defined via RFIs and responses to those, and that the state will seek amendments to the waiver once those specifics are known. *Toby Douglas, Chief Deputy Director, DHCS*, said that the state has made it clear to CMS that the goal with regard to dual eligibles is not to restructure services to that population completely, but rather to integrate SNPs with the Medi-Cal benefit and how to integrate HCBS into Medi-Cal plans and SNPs, as discussed in the legislation. David Maxwell-Jolly said that he was unable to

commit to a specific schedule for sharing draft Terms and Conditions, given the ongoing contract negotiations between the state and CMS.

*Diana Dooley, CCHA*, asked what the consequences of not completing the waiver by the end of August would be. David Maxwell-Jolly replied that critical elements of the state budget depend on waiver financing, so without either a new waiver or an extension of the old one, the entire budget would have to be rethought. In addition, the case that the state is making in the waiver proposal is based on the idea of preparing for health reform, and that argument loses power if implementation is delayed. Sumi Sousa agreed that not having the waiver would make it more difficult to reach a budget solution. She also said that an emergency waiver extension would require significant negotiation, which would be challenging particularly since it is not clear when the legislature would reconvene.

*Al Senella, CAADPE*, asked about a conference call held on July 21 for CI counties, in which he had heard it was said that the behavioral health benefit in CIs would be limited to outpatient mental health services, with no benefits for substance abuse disorder treatment. David Maxwell-Jolly said that the question goes to the heart of the earlier discussion of tradeoffs: in the context of CIs over the next 3 years, what requirements should be on these programs and how will they be funded? What is the best balance of mandated benefits and maximum enrollment? He said he understood the concern, but was also working to ensure that a large number of counties are willing and able to participate. Al Senella replied that he did not think that excluding substance abuse treatment benefits represented any kind of balance, and that if addictions are not treated, the projected cost savings and improved outcomes would not be achieved. David Panush said that the CI program is driven by county dollars, and expectations about what can be provided must be realistic. Stakeholders must be willing to compromise in order to achieve a waiver this summer. Sumi Sousa noted that nothing stops a county from going beyond the defined benefit, this issue is better addressed by the counties, which are putting up the non-federal match for the program, than by the state.

*Marv Southard, LAC DMH*, said that he had been part of the 7/21 conference call and that neither the tone nor the approach that Al Senella reported were accurate. He said that the call included a productive discussion regarding how the benefit should be shaped. Neither the state nor the counties have funding to expand services where they haven't been provided before, but there are opportunities to be creative in the area of behavioral health. Toby Douglas said that the overall goal is for counties to move forward on provision and integration of mental health services. A single baseline for all counties will be defined, and counties that are able to provide additional services should do so. Some CIs provide inpatient mental health care already, but the focus for *all* CIs, existing and new, will be on outpatient services, integration between primary care and behavioral health, and building a baseline for 2014.

*Stuart Seigel, CHLA*, noted that the existing CCS program coordinates behavioral and physical health services, and might be an interesting model for the adult population. He said that a number of stakeholders have expressed concern about the inclusion of SPD children in the mandatory enrollment effort, and that there does not appear to have been sufficient attention paid to the particular needs of children in the process. He recommended that mandatory enrollment of children be delayed in order to ensure that children are protected in the process. David Maxwell-Jolly replied that DHCS' point of view is that there are advantages to organized care across the spectrum, particularly for those with high health care needs, and that in this context it does not make sense to carve children out. Stuart Seigel responded that he was not suggesting a carve-out, but rather a separate enrollment timeline and/or process for children. Sumi Sousa said that the language that had been sent to legislative staff *does* represent a carve-out for children, and suggested that stakeholders submit alternate ideas that deal specifically with planning and process. Stuart Seigel agreed to do so.

*Anne McLeod, CHA*, said that emergency care in the CIs should be paid for within county plans, since they receive the risk payment to manage the patient. At present, there is little incentive for CI plans to manage chronic conditions, since when a patient has a crisis there is a better-than-50% chance that they will seek treatment in a non-network hospital. David Maxwell-Jolly replied that this policy also goes toward the goal of balance, in this case an adequate level of county participation to ensure a meaningful program. He said he understood the risk to some hospitals, but that CIs do mitigate emergency room use overall. The goal is not perfection but an improved system, and CI expansion offers that opportunity.

*Diane VanMaren, California Legislature*, asked for additional detail on the CMS concerns about cost-sharing. David Maxwell-Jolly said that a number of existing county CIs and the CMSP program have cost-sharing requirements that exceed statutory Medicaid cost-sharing requirements. In 2014, cost-sharing will be constrained by the Medicaid limitations, and CMS wants new CIs to conform from the beginning, and existing CIs to bring their cost-sharing into conformity. In the short term, there may be a differential while existing counties transition to meet the rules.

*Marty Lynch, LifeLong Medical Care*, said that he thought the vision paper represented a vast improvement over earlier documents in terms of safety net protections, medical homes, and care coordination. He posed two questions: 1) whether CI benefits would represent the benchmark equivalent for Medi-Cal expansion in 2014, or whether they were envisioned as less than the benchmark, and 2) whether the medical home definition would be the same across all populations. David Maxwell-Jolly declined to speculate on the first question, since there is significant ambiguity about what the Secretary of Health and Human Services will establish as the benchmark for Medicaid expansion in 2014, and what separate structures might be allowed. On the second question, he said that a number of people have

complained about varying definitions of medical home in the legislation and other places. He said that personally he does not think absolute consistency is necessary, but that he is open to that discussion.

*Rusty Selix, CCCMHA*, said that while David Maxwell-Jolly's comments about behavioral health include many of the ideas that the mental health community has been seeking, official documents do not include any specifics on these issues (although they do not preclude them, either). He said that the mental health community wants a meaningful seat at all relevant tables, and asked for written assurances that they will be part of the process. As an example, he said that some county mental health directors were part of the CI conference call on July 21 because their county CI people informed them, but others were not aware of it. Rusty Selix also said he wanted to return to Al Senella's question about the inclusion of behavioral health services as required benefits under the CI. He said that the state and many counties have tried to save money by treating MH/SA services as optional. While that may have been true in the FFS context, he said, those days are gone: in the managed care context, the costs to physical health of limiting MH/SA services might be ten times the savings. Finally, he raised two technical issues: 1) 20-40% of individuals in the dual-eligible and SPD categories have severe mental illness (SMI), and currently receive services in a system different than the one that the waiver documents speak to. People with SMI have different needs and should be considered differently. 2) Including the corrections population in county CIs could represent significant state general fund savings. Alternative treatment outside the corrections system does require general fund dollars, but represents approximately a 5:1 savings versus sending these individuals back to prison. The current CI system allows only for contracts with counties, and does not permit the current arrangement in which the corrections department contracts directly with BH providers. If this is not amended, California will leave a lot of federal money on the table and use a lot of state general fund dollars unnecessarily.

*Sumi Sousa, Assembly Speaker's Office*, said that she heard the frustration of the behavioral health community, but that it is not possible to have it both ways: for example, asking to be part of the benefit but keeping the carve-out. The state has only limited ability to tell counties what resources they must or can put up, but at the same time is negotiating with CMS for a standardized benefit. They are doing all they can with the time they have. Rusty Selix said that the issue is integration of services, not carve-out. He said he recognized that the design would have to be county-specific, given the variation in mental health resources that could be used for match. He said, however, that nothing currently requires the counties even to consider BH services, and that the BH community needs a seat at the table.

David Maxwell-Jolly said that the BH community has that representation already: the July 21 convening of CIs was just one step toward engagement with the BH community. In

addition, DHCS has engaged the state DMH, and has reached out to CMHDA. Mental health and substance abuse stakeholders are represented on the Stakeholder Advisory Committee. Counties *will* be required to address behavioral health in their CI design, and a specific requirement will be part of the Terms and Conditions or other contractual document. Rusty Selix said that he was only asking for something in the legislation that confirms that this will take place.

*Anthony Wright, Health Access California*, asked about three of the vision paper's assumptions: 1) the source of estimated numbers to be covered through Medi-Cal eligibility expansion, which were smaller than he expected; 2) the stated expectation that 56 of 58 counties would participate in the CI expansion; and 3) the mention of 1 million duals entering medical homes. He also asked about other efforts to make the waiver a bridge to HCR through additional enrollment strategies, and commented that regarding the CI benefit package, it is important to know where the bridge is leading, and have a goal of what the eventual Medi-Cal package will be, recognizing that the path to get there will depend on financing and other considerations.

*Toby Douglas, DHCS*, said that based on interest in the previous solicitation and projections of new enrollment from existing CIs, DHCS had estimated that under the new waiver CIs would enroll approximately 512,000 new individuals, or approximately 45% of the total uninsured Anthony Wright said that his question was about the denominator in that equation – 851,000 uninsured, when he understood that the figure was closer to 2 million. Toby Douglas said that staff would check the numbers again. Regarding duals, Toby Douglas said that the vision statement describes duals over the full life of the waiver, during which time the state hopes to work out integration of care for *all* dual-eligibles – thus the 1 million figure. Details will be developed over the course of the waiver via amendments.

*Toby Douglas* said that CMS and DHCS view the relationship of the CI benefits to the 2014 Medi-Cal benchmark benefits as a process: it will not be reached on day one, but they expect progress over time. The areas of concern are mental health parity, out-of-network emergency care, EPSDT services for 19-20 year-olds, and non-emergency transport. CMS is particularly interested in seeing progress on mental health services, with the hope that some counties can meet parity requirements, but at minimum a floor for all counties, and non-emergency transportation. The Medi-Cal benchmark definition will come later – the state is asking for CI expansion only until the state plan kicks in. Anthony Wright said that if part of the goal is that CI cards become Medi-Cal cards, it is important to know what we are building toward. Is the goal full-scope Medi-Cal or something else? Toby Douglas replied that CMS's goal is a full-scale benchmark plan. The state option to go beyond that plan is not currently under discussion.

*Peter Harbage, SEIU*, asked whether the language in the vision document regarding dual-eligibles should be seen as a place-holder, signaling the direction that California would like to take, but requiring another process with CMS to define exactly what will happen with this population. David Maxwell-Jolly confirmed that this is the case.

### Budget Neutrality and Waiver Financing

*Toby Douglas, DHCS*, said that the goal of the waiver negotiation from the financing side is an aggressive budget neutrality to draw down a large infusion of federal funds. California is asking for \$10 billion over the life of the waiver. This figure is based on several premises:

- *Coverage expansion.* Under federal law, California can begin immediately to cover childless adults as well as parents with incomes above the 1931(b) level. Since California proposes to do this under the waiver, it should be counted outside and not under budget neutrality.
- *Hospital financing.* If California had never entered into the last waiver, the state could have expected an increase in public hospital expenditures of about 8.5% annually. The budget neutrality argument is under the waiver, the state has avoided that growth, and the difference between the with- and without-waiver trend lines is part of the request.
- *Organized delivery systems for SPD, duals, CSHCN.* Absent the waiver, California's expenditures would grow at faster rate than they will under the waiver, and that difference is part of the request.
- *Los Angeles County waiver funding that was carried forward under the last waiver.* The \$180 million in that category should be counted under both with- and without-waiver scenarios, and the state should also continue to receive the \$360 million in stabilization funds from the last year.

Toby Douglas reported that CMS agrees with the first point on coverage expansion, which is a big win, but that public hospital cost trends and assumptions regarding the rate of growth still under discussion, as are Los Angeles County and stabilization dollars. Many areas are still open for discussion.

The proposal lays out a number of ways to use the budget neutrality margin, with the goal of preserving the existing health care system within and outside DHCS. The administration proposes to expand state-only programs financed through the existing waiver, and adding other programs to that list. The new programs that the state proposes to finance include DD programs for consumers under the Lanterman Act who are not Medi-Cal eligible; workforce development programs that are focused on health; the state high-risk pool funded through Prop 99; and coverage for parolees who will be Medi-Cal eligible in 2014, among others. California wants to be part of that one-time phase-out. In addition, several states have

protocols that allow Medicaid payment for inpatient care/overnight stays of prisoners who are linked to the program via disability. California is asking for that bridge now, but, like the IMBs, this will be an uphill battle.

The waiver proposes a global payment program for public hospitals, with a goal of reducing the cost of care and improving outcomes, and preparing for 2014. Hospitals would have to live within a set limit of funding, and the payments would be above cost. The waiver also proposes an improvement pool, through which hospitals could use IGTs to invest in their delivery systems in order to move toward better care management and delivery improvements.

In contrast to the last waiver, everything in this one must be accomplished without new General Fund dollars. Maintenance of Effort (MOE) requirements also make it difficult to use the funds in different ways. Toby Douglas said that DHCS is aware of the argument that this approach does not help the private safety net, but said that the state is not able to go beyond the areas already laid out.

*Melissa Stafford-Jones, CAPH*, said that from the public hospital perspective, the current (2005) waiver is extremely challenging due to hard caps which make it difficult to sustain the system, and because that waiver made hospitals almost entirely self-financed via CPEs (with “cost” actually meaning “50% of actual cost”). Public hospital sustainability in the last round is not due to the waiver itself, but rather a result of the enhanced FMAP under ARRA. Public hospitals cannot sustain services and prepare for 2014 under an extension of the current waiver. Critical issues under the proposed waiver, from a public hospital perspective, include increasing the total dollar amount available, and also increasing the 50 cents-on-the-dollar ratio. The “above cost” payments that Toby Douglas refers to might get to 75 cents on the dollar – still limited but moving in the right direction.

*Catherine Douglas, PEACH*, said that her organization appreciates the work that they have been able to do to date with the Department and the Agency. However, the waiver proposal doesn't go far enough for private safety net hospitals, which see themselves in the same place as public hospitals, though in a different way. The waiver proposal puts private safety net hospitals at 50 cents on the dollar from 2010-2015, and they will probably implode. Public hospitals are of course critical, but there should be recognition that private DSH hospitals provide 40% of the care to the SPD population. From 2006-2008, care for the uninsured increased 30%. Over the life of the waiver, an estimated \$6-7 million will go to public hospitals and \$4 million will go to the state, while private DSH hospitals get nothing. This reverses a 20-year partnership between the state, public hospitals, and private DSH hospitals, which have together shared resources to sustain the public and private safety nets. Catherine Douglas said that her organization looks forward to continuing to work to improve hospital financing, but that she is disturbed that in the current iteration they are

excluded from all funding. Regarding the CIs, she said that Los Angeles County has said that only county systems can be included in the CI network. Without some access to waiver funding, many private DSH hospitals won't be here in 2015.

*Barbara Seigel, NLS*, said that the timeline for SPD enrollment includes a number of unrealistic expectations, including beginning enrollment in October 2010. She asked when plan assessment will be completed, and whether that information would be available before people had to begin choosing plans. She also asked for more information on the EPDST waiver and reasonable promptness waiver requests. The first question was held for later discussion, and regarding the second question, Toby Douglas said that existing CIs don't provide EPSDT services, and the Department's goal is to continue that. CMS has not raised questions about that yet. CMS has asked for additional information from counties about due process, and the state is collecting that.

*Jeff Flick, Anthem Blue Cross*, asked whether the idea that CMS would ever allow a state like California to take responsibility for Medicare administration for dually-eligible beneficiaries was realistic. Toby Douglas replied that while the state has had some conversations with CMS about duals, other states have put it on the table, and CMS has a new Innovations Center that is working on exactly this issue, neither CMS nor the state is fully ready to address these issues.

*Marilyn Holle, DRC*, asked for clarification on the CI benefits packages. If a county elects to provide services beyond the defined minimum, can they still draw down federal dollars and are there any limitations on the services? Toby Douglas replied that standard limitations on allowable services would apply, unless a county went to a capitated arrangement in which case they would have far more flexibility.

*Michael Humphrey, Sonoma County*, asked about the transition of duals over the life of the waiver. Given that the pilots and their evaluation will take time, is it envisioned that dually-eligible individuals would be transitioned before the results of pilot evaluations are in hand? David Maxwell-Jolly replied that DHCS will be taking that timeline into consideration. The 1 million figure is the outer limit, and what can be accomplished practically in terms of transitioning dual-eligibles remains to be worked out.

*Michael Humphrey* also asked whether the amendments would be included in the next iteration would include an opt-out provision. David Maxwell-Jolly replied that, at this point, there is no concrete opt-out provision.

## 1115 Waiver Implementation Steps Taken So Far

*Greg Franklin, DHCS*, said that Department staff had been very busy on work related to the SPD transition and to CCS pilots, and introduced Tanya Homman and Don Fields to provide details.

*Tanya Homman, Medi-Cal Managed Care Division*, detailed the Department's work to date on SPD transition:

- Provider crosswalk – comparison of current treating providers and plan provider networks is underway
- Aggregate data provided to plans – will also be posted on DHCS website
- De-identified individual member data – raw data (de-identified) representing all the services that FFS patients received in calendar year 2009 was shared with counties and plans this month
- RFI for county alternative model – released 7/20/10, questions due 8/2/10, final responses/feedback due 8/18/10, will be used to develop the RFA process
- Outreach and education –
  - SPD sensitivity training, through a contract with Western University of Health Sciences, will be provided to everyone in January 2011
  - UC Berkeley is developing informing materials, and will be seeking stakeholder input on these and providing 16 presentations statewide. Notifications are scheduled to begin 10/10 but no later than 1/11, allowing 90 days for the informing process. (Counties that develop alternative models won't get this informing notice.)
- Revised facility site review tool – being developed through a contract with Western University of Health Sciences. A revised tool has been drafted and stakeholder meetings are scheduled for August/September.
- SPD Network Adequacy – DHCS is working with DMHC on this issue and investigating how other states conduct this assessment.
- Member Specific Data at Time of Enrollment – DHCS solicited information from plans in June regarding what information they would want on incoming members, and is working on how to identify, format, transmit and protect that information.
- Provider linkage for non-choosers – DHCS is working on a new default process for this population, using information about current providers and with a goal of maintaining continuity of care.
- Phased-in Enrollment – The current plan is to phase in based on member's month of birth, which will mean enrolling approximately 26,000 members/month. Beneficiaries will receive a 90-day informing letter, followed by an outbound call and

presentations. At 60 days prior to enrollment, they will be sent informing materials and a choice packet. At 30 days, they will receive a letter of intent to default, but there will be another outbound call before the default takes place.

- Stakeholder Workgroups – Ongoing workgroups include:
  - SPD default process (begins in August)
  - UCB stakeholder discussions (begins in August)
  - WUHS facility site review (begins in August)
  - Culture and sensitivity training meeting was July 6
- DMHC – Will have a more explicit role regarding specific processes for the SPD population.

Upcoming activities related to SPD transition include:

- Reassessment of provider crosswalk by October
- FFS member data sent again to plans in September '10 for the period April 2009-March 2010
- Stakeholder groups as described above
- RFA for county alternative option by end of September
- Finalize SPD network adequacy
- Finalize informing materials

*Barbara Seigel, NLS*, asked whether the enrollment packet for SPD is the same as the one used now. Tanya Homman replied that while the actual enrollment forms are essentially the same (excepting changes to format and type size), the informing materials are different. Barbara Seigel noted that the existing packet is too big to fit in many mailboxes, meaning that some people never receive it.

*Don Fields, DHCS*, provided an update on activities related to the CCS delivery pilot models:

- Data analysis
  - CHCF is contracting with Stanford University to assist DHCS with decision-making process for CCS redesign
  - DHCS providing Stanford with data related to claims, demographics, utilization patterns, etc. for this analysis
- Evaluation
  - Lucile Packard Foundation for Children's Health held a meeting on evaluation strategies in June.
  - Recommendations from that meeting include:
    - Compare between models
    - Compare models to the existing system

- Use a contractor to perform the evaluation
  - Create a final design with input from providers and stakeholders
- RFA
  - DHCS is ready to release a draft RFA to potential bidders
  - SAC and CCS Technical Workgroup members will receive copies
  - One month comment period
  - Final RFA early fall
  - Letter of Intent request (not required)

*Chris Perrone, CHCF*, asked Tanya Homman whether DHCS intends to amend plan contracts with regards to medical home requirements. He also asked how the Department intended to handle plan readiness: if in a single county one plan is ready but another is not, will enrollment move forward? Tanya Homman replied that staff are looking at more than 25 amendments to plan contracts. Plan readiness assessments are slated to begin in September, in coordination with DMHC. If a plan isn't ready, the goal is to proceed with mandatory enrollment with an opt-out option.

*Jackie McGrath, Alzheimer's Association*, reiterated her concern that member-specific data be transmitted as soon as a plan is selected, so that the plan can begin to assess the complexity of the case. She also asked how the algorithm for determining high-need cases will work. Tanya Homman replied that she agrees that data should be made available to plans as soon as possible. Regarding the algorithm, she said that staff will be working with plans on this issue beginning in August. She also corrected her earlier statement that approximately 26,000 SPD beneficiaries would be enrolled each month, based on birth date. This number represents the SSI population who do not have annual determination dates. The total monthly number is closer to 32,000.

*Lisa Rubino, Molina HealthCare*, asked when the state would know whether a county intended to develop an alternative model. Tanya Homman said that they hope to have a sense from the RFI responses, and a final accounting in September or October.

*Juno Duenas, Family Voices*, thanked DHCS staff for amendments to date. She asked that the legislation be amended to include opt-in and opt-out for both SPD and CCS populations, in order to allow the program to start small and build up. If this does not happen, she asked that organized care include patients and families as central decisions makers, establish quality of life as central goal, and ensure timely access to appropriate specialists. Children should be mandatorily enrolled only when medical homes conform to AAP standards.

### Public Comment

There was no public comment.

## Additional Stakeholder Discussion

*Sharon Rapport, CSH*, asked whether the ability to provide care coordination would be considered as part of plan readiness. Tanya Homman replied that this would be one of the contract amendments: plans will have to show how they intend to provide care coordination before they can be approved. Sharon Rapport asked if DHCS would be checking not only for processes, but for actual infrastructure. Tanya Homman said that the provider network would be evaluated through facility site review as well as site visits, but that DHCS would also be looking to see that policies and procedures are in place, and then will monitor plans to ensure that the care coordination takes place.

*Sharon Rapport, CSH*, also asked how the enrollment process would work for homeless individuals. Many in this population don't have phones and have difficulty receiving mail, and will be defaulted in large numbers. Many will also fall into high-risk categories. What happens when they walk into an out-of-network clinic or provider? Tanya Homman said that currently mail for people without addresses goes to the county. When they swipe their Medi-Cal cards, wherever they seek care, information about their assigned plan and provider will come up. The ombudsman office as well as health care operations will be available to people who need to find a provider or switch providers.

*Stuart Seigel, CHLA*, said he echoed Juno Duenas' comments, and that he hopes DHCS pays close attention to the needs of pediatric patients. Access to pediatric providers should be part of network adequacy assessments, and plans should not be allowed to say that a cardiologist is the same as a pediatric cardiologist. CCS financial analysis should look at risk category subsets. He also raised concerns about the timing of the CCS RFA issuance and response due dates.

*Elizabeth Landsberg, WCLP*, said that she is very concerned that the DHCS is considering starting enrollment before all standards are met, and also about specialist access. Tanya Homman said that DHCS staff are meeting regularly with DMHC regarding provider network standards. They intend to meet the deadline for plan assessments, but Tanya said that if plans' provider networks are not ready, they won't come up. If only one plan in a county is ready, only one plan will enroll members.

*Peter Harbage, SEIU*, asked if there would be an opportunity to provide input on the informing materials and process. Tanya Homman said that staff are using the SPD Technical Workgroup list as well as the Medi-Cal Managed Care advisory members to assemble a group to review these materials and processes.

*Brenda Premo, CDHP*, acknowledged DHCS staff for their hard work. She noted that readiness includes not only medical offices, but also clinics and hospitals. Physical access

is critical – if there is no accessible mammography or MRI machine in the network, that network isn't ready. This equipment won't be at every site, but it has to be accessible within the system. She suggested that most plans will have trouble meeting that standard.

#### Next Steps and Next Meetings

*Bobbie Wunsch, PHCG*, thanked the California HealthCare Foundation, the Blue Shield of California Foundation, and The California Endowment for their support of the five SAC meetings to date.

Going forward, the proposal is that in Year 1 of implementation, presuming the waiver goes forward on time, the SAC will meet 3 times in person (on September 29, 2010; February 10, 2011; and in summer 2011), and in Year 2 will meet twice. She asked for feedback from members regarding the number and length of meetings, whether the format should be altered, and what specific issues related to implementation are of interest.

Bobbie Wunsch thanked SAC members, David Maxwell-Jolly, Toby Douglas, Greg Franklin, DHCS technical staff, and legislative staff presenters Sumi Sousa and David Panush for their participation.

The meeting was adjourned at 12:33 PM.