CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
1115 WAIVER RENEWAL
EXPERT STAKEHOLDER WORKGROUP on DSRIP 2.0

Friday, December 19, 2014
10:00am – 3:00pm
Sheraton Grand Hotel
MEETING SUMMARY

Members present: Molly Brassil, County Behavioral Health Directors Association of California; Michelle Cabrera, SEIU; Sarah DeGuia, California Pan-Ethnic Health Network; Catherine Douglas, Private Essential Access Community Hospitals; Jon Freedman, LA Care; Angela Gilliard, University of California Office of the President; Judi Hillman, Health Access; Manel Kappagoda, ChangeLab Solutions; Sherreta Lane, District Hospital Leadership Forum; David Lown, Safety Net Institute; Erica Murray, California Association of Public Hospitals and Health Systems; Kelly Pfeiffer, California Health Care Foundation; Al Senella, Tarzana Treatment Centers; Christina Ghaly, Los Angeles County Department of Health Services; Susan Ehrlich, San Mateo Medical Center; Leslie Mikkelsen, Prevention Institute; Bill Walker, Contra Costa County Health Services.

Members on the phone: Barsam Kasravi, Anthem Blue Cross; Bill Henning, Inland Empire Health Plan; Pilar Williams, DHCS; Tricia McGinnis, CHCS.

Members Not Attending: Ken Kizer, UC Davis; Anne McLeod, California Hospital Association; Richard Rawson, UCLA.

Others Attending: Neal Kohatsu, DHCS; Hannah Katch, DHCS; Mari Cantwell, DHCS; Sarah Brooks, DHCS; Betty Lai, DHCS; Wendy Soe, DHCS; Efrat Eilat, DHCS; Tianna Morgan, DHCS; Peter Harbage, Harbage Consulting; Don Kingdon, Harbage Consulting; Bobbie Wunsch, Pacific Health Consulting Group

25 Members of the public attended the meeting.

Welcome and Purpose of Meetings
Bobbie Wunsch, Pacific Health Consulting Group
Thank you to the California HealthCare Foundation, The California Endowment and Blue Shield of California Foundation for their support. Following introductions, Mari Cantwell, DHCS offered context for DSRIP 2.0 and the status of the other 1115 waiver workgroups. Delivery system reform is the foundation for the overall waiver beyond what was in the DSRIP section of the previous waiver. We will pull together the work of all workgroups for the final application.

Framework for DPH DSRIP 2.0 including Goals, Potential Domains and Criteria to Guide Selection Projects
Neal Kohatsu, Department of Health Care Services and David Lown, CAPH

Presentation Slides are available at:
http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Renewal_Workgroup_DSRIP.aspx

Neal Kohatsu provided an overview of the of DSRIP 2.0 concept. He reviewed the underlying foundations for the waiver such as the DHCS Quality Strategy. He announced that CalSIM was not awarded, however the plan is an important document for the waiver discussion. He presented the overall waiver goals and proposed domains for the waiver:

- Delivery System Transformation: Identify and specify a Patient Centered Medical Home (PCMH); specialty access; transitions of care; behavioral health (BH) integration with physical health.
- Care coordination, particularly for high utilizers: complex care management including BH and social needs; health homes for foster children; transitions from incarceration to community; pain management; advanced illness planning.
- Resource Utilization Efficiency: improve antibiotic stewardship, inappropriate imaging and pharmaceuticals.
- Prevention: Million Hearts campaign; improve cancer screening and follow up; perinatal care.
- Patient Safety: CMS safety goals; eliminate inappropriate surgical procedures.

CMS is not convinced that a DSRIP 2.0 is necessary, therefore, system transformation is a key element of a successful waiver proposal. The proposal will need to include specific measures and targets for improvement under the waiver. What are the three big things we will change?

Michelle Cabrera, SEIU: How are you thinking about the most relevant elements of CalSIM that had the most overlap with the waiver, specifically health homes? I am excited about the foster youth element as well, but wondering about now about section 2703.
Cantwell, DHCS: We will continue to move forward with health homes element and identify how it fits well within the waiver. Given how large perinatal care is within Medi-Cal (50% of births), and the fact that many are still in FFS, we will look at improving maternity care.
Kohatsu, DHCS: In addition, we are working on quality improvement strategies at the hospital related to perinatal care.

Judi Hillman, Health Access: In light of CalSIM, can you speculate how the state might partner with managed care to achieve some of the CalSIM goals, such as high utilizers?
Kohatsu, DHCS: We need to think about FFS and managed care. We are thinking about how to use the system to address the three domains of health. One small example is a current grant we have to offer TA to health plans to use existing resources with high utilizers to prioritize services. For example, CMS paying for wrap around services in housing settings.
Cantwell, DHCS: This goes directly to my introduction that the entire waiver is focused on system reforms. Do we change rate setting, shared savings? How can the managed care plans provide care better?

Barsam Kasravi, Anthem Blue Cross: We are looking at how to re-envision case management for high utilizers. How do approach hospital admissions and discharges differently?

David Lown, Safety Net Institute (SNI), presented information from the concept paper submitted by SNI. It includes a vision for the public health system for 2020. He presented ideas for how DSRIP can support achieving the overall vision and transformation. He included a focus on outcomes, greater standardization and required measures, ambitious goals, attention to ambulatory care and balancing creativity with feasibility. The SNI engaged in a process of engagement and vetting to develop DSRIP 2.0 ideas and descriptions. SNI is collaborating with DHCS to align the concepts and work on the specific metrics to be included. Metrics will include some local tailoring but will follow three areas: clinical event outcome, potentially preventable event, patient experience measures. There are 150 measures across 15 projects that will be further refined. It is unclear the degree of creativity that might be allowed by CMS with new ways to measure progress. For example, how do we measure access beyond the concept of appointment availability and face to face encounters as we redesign our systems to incorporate new ways of caring for patients?

Catherine Douglas, Private Essential Access Community Hospitals: Are you thinking of expanding the sources of IGTs for DSRIP 2.0, such as other sources from counties or cities that other states have proposed?
David Lown, Safety Net Institute: We are not currently thinking of expanding the IGTs used.

Judi Hillman, Health Access: In the feedback process, can you talk about any patient or family involvement in the process?
David Lown, Safety Net Institute: for this process, we did not formally engage patients or families due to the rapid timeline. This is the beginning of the overall engagement to get at the baseline of objectives and measures. In the local level development, there is a requirement for patient engagement as part of roll-out development, design and implementation.

Christina Ghaly, Los Angeles County Department of Health Services: While the formal workgroups he mentioned didn't include patients, the individuals involved in the process do engage locally with patients and brought that information to the workgroup. For example, in Los Angeles on foster children: we have a robust mechanism for input from patients or caregivers of foster children and they were engaged with input during the process; also the primary care workgroups have mechanisms for input from patients.

Michelle Cabrera, SEIU: I appreciate the acknowledgement of shortcomings of data inputs and metrics to capture some things. To the extent this will standardize race, ethnicity and language, it is important to have investment in the data at the plan level and provider level as a goal so that in the long run we can see who is served and what the disparities are. Can I ask for your thoughts on that? Also, how are you looking at team based care?
David Lown, Safety Net Institute: Through Meaningful Use, race, ethnicity and language are required in EHR so everyone is working with that. How might we work with this across DSRIP to get beyond a check-box way to gather patient self-reported information? On social

determinants, the National Quality Forum has changed it metrics for SDOH and the community clinics are looking at this but it is in a testing phase. It would be exciting if CMS would include this in a testing way. Team based care is the foundation of how care must be delivered in every system and setting. How do we expand the use and skills of all the team members, expand the kinds of people on the team (CHWs and others with lived experience) needs to be infused everywhere.

Al Senella, Tarzana Treatment Centers: I have a number of comments. We are not going to be as successful as we might be if we don't change and expand some thinking. The waiver concepts includes good direction and yet there are serious gaps in BH. On the hospital side, BH is in the concept paper. If you look at the enormous numbers of mental health and substance using patients in the ER, the document is thin. The primary care side of the concept paper is much richer but the hospital is not. There is no section in the document that speaks to BH impact on the whole delivery system. We need to dovetail this effort with the broader waiver and I don't think we do that for BH.

Sarah DeGuia, California Pan-Ethnic Health Network: On the metrics side, the need and desire to address SDOH is there, but the paper does not address the measures adequately. There may be information gathering across the system to learn how to address this well.
David Lown, Safety Net Institute: We have heard that CMS wants to pay for outcomes, not process. We would like to collect data but we have think of this from a CMS point of view to address the outcome. The county proposal of whole person care directly addresses the issue of SDOH and how to tackle the needs of frequent users from multiple systems.

Erica Murray, California Association of Public Hospitals and Health Systems: Just as the LIHP dovetailed with the current waiver, we are trying to figure out how whole person care can dovetail with the successor DSRIP. The discussion does silo individual elements of the waiver and makes it hard to see the overlap.

Kohatsu, DHCS: Absolutely agree and want to talk more about how we can enhance this. We need to identify all existing data to establish baseline data. CMS will want this upfront so we can say where we will end after this waiver.

District Hospitals' Concept on NDPH DSRIP: Goals, Program Ideas including Criteria to Guide Selection of Projects, Metrics, and Funding
Sherreta Lane, District Hospital Leadership Forum
Presentation Slides are available at:
http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Renewal_Workgroup_DSRIP.aspx

Sherreta Lane described "non-designated public hospitals", 41 district hospitals that are non-county and non-University of California. There are also 35 districts that do not have hospitals in addition to the 41 districts with hospitals. Many district hospitals are in rural areas and some are in suburban and urban areas. There was a proposal developed for DSRIP in 2012 to include

the district hospitals that was eventually pulled from the waiver but this provided some experience with the process. There are lessons and challenges from this experience. Behavioral health is a priority surfacing from district hospitals, even the smaller and rural hospitals. Many hospitals are working with local law enforcement. Other issues are access to specialty care, care coordination, population health and PCMH. There are a number of projects under development in district hospitals on these topics that are closely aligned to DSRIP 2.0 concepts.

Catherine Douglas, Private Essential Access Community Hospitals: District hospitals have unique challenges and we support the inclusion in the DSRIP. You have a wide diversity of hospitals and you are starting late. Will CMS be willing to accept a bifurcated approach that will acknowledge the new entry?
Sherreta Lane, District Hospital Leadership Forum: In addition to starting five years later than others in DSRIP, there is the issue of the diversity between very small district hospitals and larger. We hear from CMS that they want to pay for transformed care, not services.
Kohatsu, DHCS: What is clear is the CMS' approach to DSRIP is evolving. They have not committed to a DSRIP 2.0 in California or anywhere. It is hard to understand what requirements might be imposed. We are looking at other states and trying to remain focused on triple aim outcomes overall. We are all disappointed by the CalSIM award so it is hard to know about specifics. It is a long process of many months to finalize our waiver.
Soe, DHCS: To add to the context, we discussed with CMS the starting place and the unique needs of the district hospitals in the last waiver.

Michelle Cabrera, SEIU: Given the variation among district hospitals, how do we make sure we get the most value for the waiver which is a Medicaid population? Some district hospitals may not serve as many Medi-Cal patients, even if their capacity is stronger. Can all district hospitals participate even if they have lower levels of Medi-Cal? How can we balance the capacity and the return on investment to Medi-Cal where there are higher numbers of patients?
Sherreta Lane, District Hospital Leadership Forum: Your point is well taken. There are low tech projects for even the smallest hospitals to participate in and they have many Medi-Cal patients. A very small number of larger hospitals do not serve as many Medi-Cal patients.

Jon Freedman, LA Care: In terms of district hospitals, uncompensated care in hospitals should be going down because of the Medi-Cal expansion, even though cost pressures remain. Do district hospitals have a sharing program (AB85) with the state like the public hospitals?
Sherreta Lane, District Hospital Leadership Forum: No. There are public dollars in district hospitals to the extent the hospital contracts with the county to serve indigent patients. Some have taxing authority; some do not. The size of tax subsidy varies as well.

Bill Walker, Contra Costa County Health Services: How far did you get in the previous waiver? Were there numbers developed on IGT funding?
Sherreta Lane, District Hospital Leadership Forum: We did develop numbers. We were looking to fill a hole of $100 million dollars total.
Morgan, DHCS: At the time, we identified a handful of millions but we had not identified the hospital specific dollars.

Sherreta Lane, District Hospital Leadership Forum: We are public entities and have the ability to provide IGTs and CPEs. We have the ability to provide financing to draw down federal funds. There would be an array of projects and size variation. Some hospitals may choose not to participate because they are too small.
Soe, DHCS: We are looking to CMS to see if we can operationalize the DSRIP financing.

Bobbie Wunsch, Pacific Health Consulting Group: How are you thinking about the domains laid out by DHCS? Would you participate in all the domains or only some? How will you approach the data infrastructure to support the metrics?
Sherreta Lane, District Hospital Leadership Forum: The only domain that poses a problem is the patient safety domain because the number of events is so small and could skew the results. The metrics are a challenge as well. We are looking at collaborative efforts at the association level because individual hospital efforts may not be feasible.
Kohatsu, DHCS: We have learned how difficult data is. We can't underestimate the importance of this capacity. It would have been impossible without centralized data collection through SNI so a central entity is essential.

Susan Ehrlich, San Mateo Medical Center: There are some small public hospitals as well. We are a large ambulatory system but the hospital average daily census is only 30. The data collection is a challenge but we are participating in all elements including patient safety

Judi Hillman, Health Access: Given CMS expectations of solid outcomes based on data and baseline data, can you speak to how far district hospitals have come on meaningful use?
Sherreta Lane, District Hospital Leadership Forum: I don't have specifics on this – they have come a long way. I will follow up at the next meeting with information.

Erica Murray, California Association of Public Hospitals and Health Systems: We have shared some observations with Sherreta. When we set up the DSRIP, we intentionally set it up to be ambitious but feasible. Now that some hospitals are meeting 98% success with targets, we received comment from CMS that the target must not have been ambitious enough. That seems unfair. It will be important for the district hospitals to set targets that are ambitious. It is not clear what CMS wants.

Bill Walker, Contra Costa County Health Services: I sit on governing board of Doctors Hospital and it seems that many of the DSRIP measures could be achieved on the inpatient setting Given that DSRIP is moving to incorporate the outpatient systems, I have difficulty understanding how we would meet the ambulatory care targets given the structure of the physician practices.
Sherreta Lane, District Hospital Leadership Forum: We are grappling with this. This is the way care is being provided and there will have to be changes. In many rural areas, they have moved to more connected systems of care and provide many services through ambulatory systems.

Manel Kappagoda, ChangeLab Solutions: If the district hospitals are included, are there implications for the existing hospitals in terms of the funds they would receive?

Erica Murray, California Association of Public Hospitals and Health Systems: The waiver must have budget neutrality room and you must commit to policy goals under the waiver demonstration. Provided there is enough budget neutrality room, the district hospitals have a way of providing non-federal share and are thinking about aligned goals.

Sherreta Lane, District Hospital Leadership Forum: In some communities with both a district and public hospital, there are discussions of working together – both inside and outside DSRIP.

Targeted Framing Questions for Stakeholder Feedback and Discussion

1. How do the goals of DSRIP 2.0 fit within broader waiver goals of delivery system and payment reform and achievement of Triple Aim?
2. How can projects under DSRIP 2.0 support the goals of other waiver concepts and other statewide initiatives?
3. Sample national metrics look at NCQA/NQF measures; are there other metrics for consideration?
4. The framework lays out 5 domains to drive improvements. Are there other domains of focus for consideration?
5. Does establishing measurable goals across hospital systems for DSRIP make sense? Is there alignment across systems and metrics?

Peter Harbage, Harbage Consulting: The domains are thoughtful. There is a level of innovation compared to other states in terms of ideas. There is precedent from other states but it is new and creative as well. We don't know much about what CMS is thinking and we need to engage them to understand more.
Kohatsu, DHCS: All the states are in the same place. The discussions back and forth has included change over time with new thoughts that emerge in the negotiations. Cindy Mann is leaving CMS and she has been very involved.
Soe, DHCS: Many are hearing uncertainty. Ours is the first 2.0 and I am optimistic. How do we develop the overall cohesive story about how to change the delivery system?

Bill Walker, Contra Costa County Health Services: I think trying to develop additional domains to be attractive for CMS is not feasible. The domains here include huge projects within them that encompass care improvements. I agree with Wendy, we should proceed and make the case.

Christina Ghaly, Los Angeles County Department of Health Services: I think the discussion with CMS will be less about the goals and domains and more about the metrics and outcomes. How do we push things forward in a way that shows progress and demonstrate that progress?

Manel Kappagoda, ChangeLab Solutions: People have mentioned the denial of CalSIM. Are there lessons from that to keep in mind for the waiver?
Soe, DHCS: That effort was statewide, beyond DHCS with partner agencies and others. We are in reaction mode, so it is too early to know.

PEACH Concept on DSRIP: Goals, Program Ideas, Metrics and Funding
Catherine Douglas, PEACH
Presentation Slides are available at:
http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Renewal_Workgroup_DSRIP.aspx

Catherine Douglas presented background and opportunities for community DSH hospitals to participate in DSRIP 2.0. They are not included in the current waiver but would like to be included in DSRIP 2.0. Community DSH hospitals provide one third of all inpatient care to Medi-Cal patients, 66% of all Medi-Cal mental health inpatient days, one third of all hospital care to Duals and 44% of the Medi-Cal care to seniors and persons with disabilities. She offered three snapshots of community hospitals. All community hospitals are greater than 100 beds.

We want to participate in DSRIP 2.0. We support the public hospitals receiving the same funding under the new waiver as the past and we believe that including community DSH hospitals demonstrates the state's interest in transforming the whole system in California. Some post-ACA reductions are a challenge for us. The largest is the Medicare DSH cut mandated in ACA resulting in $389 million to California hospitals plus other ACA cuts of $63 million this year. There are a number of projects community hospitals are interested in developing that align with DSRIP 2.0. Funding for participation is the biggest challenge. It appears from our review that budget neutrality room is there. The state is looking to provide general fund savings and reinvesting in transformation. It would take $500 million total funding to create a robust program. We have heard that other states are including participation of other hospitals. Health equity requires high performing systems of care no matter where Medi-Cal beneficiaries access care.

Susan Ehrlich, San Mateo Medical Center: How many hospitals are there and what is the definition of a PEACH hospital. Does you association represent all community DSH members?

Catherine Douglas, Private Essential Access Community Hospitals: There are 70 core members. For participation in DSH, the hospital must provide 25% of care to Medi-Cal or provide more than 1% over the standard deviation. We do not represent all private DSH hospitals. Our goal is to ensure that all have access to DSH, we would not limit this to our members.

Kohatsu, DHCS: What is the relationship between the hospitals and physician providers?
Catherine Douglas, Private Essential Access Community Hospitals: We cannot employ physicians but have relationships with community providers and there are good relationships with community clinics and solo physicians. Hospitals are organizing 1206 hospital owned clinics.

Judi Hillman, Health Access: Can you describe PEACH or other hospital participation in SPD or CCI pilots? Would it be possible to amend those initiatives?

Jon Freedman, LA Care: CCI has many elements and many SPDs are already in managed care. Many community hospitals are under contract with Medi-Cal plans. There are special features under Cal MediConnect, such as continuity requirements, shared savings agreements. That network is narrower than our Medi-Cal network but it does include many of the hospitals

presented here. As part of CCI, we were required to take all partners, such as IHSS. Until we can get better alignment of all the financial elements, we can't access the savings.

Brooks, DHCS: Where are the hospitals located?
Catherine Douglas, Private Essential Access Community Hospitals: Wherever there are pockets of poverty. There are many community DSH hospitals in LA, San Diego and Orange. Many are in communities with other public hospitals or UC Hospitals. Methodist here is Sacramento,

Leslie Mikkelsen, Prevention Institute: Can you talk about the population health improvement projects you mentioned. Boyle Heights has walkability projects, San Bernardino and Loma Linda Hospital, and you described projects you are involved in to improve health. Do you see an opportunity in the 1115 waiver to support that kind of community collaboration and action?
Catherine Douglas, Private Essential Access Community Hospitals: Community needs assessment is a critical part of any DSRIP project. We need more discussion among all the partners needed to accomplish connections to social services. One hospital in LA sees 86 homeless individuals per month in the ED and they work with LA County. The van LA County runs is too busy and so some are in beds for many days because there is nowhere to send them.

Bobbie Wunsch, Pacific Health Consulting Group: What is your sense of the infrastructure for reporting and data collection?
Catherine Douglas, Private Essential Access Community Hospitals: We can absolutely do that? The clearinghouse element would be a challenge. We need opportunities for sharing and learning, but in terms of EHR and data collection, we are there.

Brooks, DHCS: Would all want to participate or a subset?
Catherine Douglas, Private Essential Access Community Hospitals: All PEACH hospitals would want to participate. For some others, it would depend on the metrics. CMS has been willing to pay for planning upfront for a year and that could be important. We would want this to be voluntary and some hospitals, particularly small ones, will gauge their ability to participate.

Bobbie Wunsch, Pacific Health Consulting Group: At our first meeting, the issue was raised as to whether private DSH would use the quality assurance fee as part of the financing.
Catherine Douglas, Private Essential Access Community Hospitals: The great thing about DSRIP is that it is not for direct services. It is outside of DSH, it is for transformation. There are more than 300 hospitals in the quality assurance fee and only 30-45 community hospitals in DSH and there would be political issues to redirect those funds.

Bobbie Wunsch, Pacific Health Consulting Group: Would standardized metrics apply to all groups of hospitals in DSRIP?
Kohatsu, DHCS: We would want to see standardization across all participating hospitals. It can look easy to do this but the way data is collected is different and defining the methodology can be difficult. CMS will want to look system wide performance or even population health may be required – not just within a hospital. For example, reducing smoking statewide might be desired.

Catherine Douglas, Private Essential Access Community Hospitals: in NY, I understand there is a funding pool that only county hospitals participate in; also in Texas. I think it is possible there could be a hybrid in CA. All of us participating in Medicare national data and providing data for some standards like hospital acquired infections.

Peter Harbage, Harbage Consulting: There is a need for standardized metrics, regardless of the configuration of the DSRIP plan. In regard to PEACH, it is up to the state as to how they want to proceed.

Bobbie Wunsch, Pacific Health Consulting Group: What is the challenge for participation by private DSH hospitals in DSRIP?
Catherine Douglas, Private Essential Access Community Hospitals: State match.

Additional comments from morning discussion and preparation for Meeting #3
Facilitated by Bobbie Wunsch
Al Senella, Tarzana Treatment Centers: I ask that BH be on the agenda with specific time allotted for the next meeting early in the day. To recap some earlier points, in reviewing the concept paper, what we say about BH in the hospital setting is not tied to the response to BH. What is said about primary care and BH is right on. Finally, the terms and conditions in the current waiver required that BH must be addressed, including an in-depth needs assessment. We have done some work, but not a lot on that issue.

Susan Ehrlich, San Mateo Medical Center: When I think about domain 1 and 2 projects and the 75,000 people we care for, it is mostly about BH. Even when the project description doesn't specify that, the people are largely those with mental health and substance abuse issues.

Al Senella, Tarzana Treatment Centers: The patients have mental health and substance use issues, but the infrastructure to meet their needs is lacking.

Susan Ehrlich, San Mateo Medical Center: Yes, however, in order to meet the outcomes specified, you must address the needs of those with BH issues.

Al Senella, Tarzana Treatment Centers: I completely agree.

Don Kingdon, *Harbage Consulting*: Harbage is willing to assist with the BH conversation for the next meeting. The current 1115 waiver does have significant terms and conditions and the results have been submitted. We can provide that background for the group.

Christina Ghaly, Los Angeles County Department of Health Services: I hear your point, Al and I second Susan's comment. We need to make it more explicit in the document and there may be other places where it is missing and we could enhance the document. But we cannot succeed with the concepts without addressing issues of BH.

Kohatsu, DHCS: We would like you to offer input, welcome language or models to make it more explicit.

Jon Freedman, LA Care: Perhaps the state team can talk about what is happening in other workgroups. I am having difficulty figuring out the anchor to this. Much of the CA framework is a pre-ACA framework and I think it is a mistake to think from a pre-ACA world. It is wrong from a system point of view; we have people in Medicaid for the first time; we have expanded Substance Abuse benefit; and we need to put ourselves into that framework. The difficulty is that we still have substance abuse and mental health carve out with a responsibility between the county and the plans to wire these together. It will do us a disservice to think pre-ACA.

Soe, DHCS: I agree and the intent of the overall waiver is delivery system transformation. The waiver we have laid out is to address the landscape now and 5 years from now. Initiatives like housing and work force are concepts to expand our ability to provide access and serve new beneficiaries better. We will be putting together a cohesive proposal with that framing you lay out for how the system can handle the needs over the long term.

Brooks, DHCS: We do have multiple workgroups. Monday, we had the plan-provider incentive workgroup, looking at opportunities for many structures. Specific to BH integration, we have a proposal to incentivize the plans and we are also looking at P4P, the quality strategy and treating the whole person. We will pull from Let's Get Healthy and other constructs to find metrics tied to quality overall and linked to technology and integration. We can discuss the connections more on the next agenda.

Judi Hillman, Health Access: As we tee up the BH discussion, there may be groups missing. If this is the time to look at transformation, we could include the Integrated Behavioral Health Project, CA Mental Health Services Authority or County Mental Health.

Bobbie Wunsch, Pacific Health Consulting Group: Molly Brassil represents county mental health programs. Al represents substance abuse providers. On other work groups, we have MHSA and some other programs.

Manel Kappagoda, ChangeLab Solutions: Jon made an important comment about this being a post ACA world. It has been difficult to understand the big vision. My orientation is prevention but what I see in the domains and categories is piecemeal. We can plug in some elements, but I don't see how this connects to LGHC. I think we are missing an opportunity to link to those larger visions.

Soe, DHCS: The overall waiver will tie together all the workgroups. That work is still emerging so it is early to go beyond the bigger picture buckets we laid out to target the delivery system. We are thinking about how to evolve the waiver concept to drive to payment and delivery system reform.

Kohatsu, DHCS: We all use the triple aim phrase but it is difficult to define and to bring together under one funding scenario. The waiver is complex and that is why we have separate workgroups. CMS will require that we work very specifically on each area listed to identify exactly how we will accomplish the outcomes, establish the metrics and collect the data.

Jon Freedman, LA Care: The DSRIP is either a necessity or an opportunity. There has to be a calibration of its magnitude in program and financing. Depending on the answer, it could be narrow or the whole Medi-Cal program. I tend to think CMS doesn't really know – they have a framework and they are at a wholesale level. The faster we can get ideas to DC for feedback, the better off we will be. This workgroup needs to help crystalize the ideas to get feedback.

Bill Walker, Contra Costa County Health Services: I think CMS is looking at DSRIP as pre-ACA effort. Contra Costa health plan has the same goals as this DSRIP. We have to create recognition of managed care in the waiver and how we set up our goals and measures.

Christina Ghaly, Los Angeles County Department of Health Services: The themes that come to mind for me include: leveraging integrated delivery systems across the full spectrum of care; building long term access for Medi-Cal and the ability of the delivery system. We need to emphasize that value of care. What is that value and how do we use DSRIP to get more value.

Judi Hillman, Health Access: One question I would raise is that we are not ready to move on. The LIHP got us more paying patients and we have cut our uninsured rates but we have a ways to go. How much more work is there to do on the Bridge to Reform?

Bobbie Wunsch, Pacific Health Consulting Group: The next meeting is to hear from advocates about how SDOH and prevention can be woven into DSRIP and to talk about metrics. We will add BH and how to drive integration. Are there other ideas to address in the next two meetings?

Barsam Kasravi, Anthem Blue Cross: We need to be more granular. I don't hear specifics and I worry we are running out of time. Especially on financing – should we have a shared savings program? Should funding be tied to collaboration?

Bobbie Wunsch, Pacific Health Consulting Group: There are six other workgroups and there will be a one day meeting on shared savings. Each workgroup looks at a specific element of the waiver. It is difficult to think about how to talk about what each workgroup is talking about in each meeting. At the next meeting, we can offer a high level overview of what is being discussed in the other workgroups. This workgroup needs to focus on what will be in DSRIP 2.0. This is the only place that clinical issues are being focused on – and we will dig in into metrics in the upcoming meetings. This is the hardest part of the process because everything is partially formed and still evolving. It will be the state's job, following the workgroup to specify what will be in the waiver and negotiate with CMS.

Erica Murray, California Association of Public Hospitals and Health Systems: One topic not covered in any workgroup is data. The ability to collect and report meaningful data to drive system wide transformation is essential. We have not successfully wrestled with that as a state.

Susan Ehrlich, San Mateo Medical Center: It is a heavy lift to implement an EHR and it is an equally big lift to analyze that data. It can require additional software, etc. Beyond that, it is difficult to report externally and to put the data in the hands of those doing the work. It takes time and big investments.

Erica Murray, California Association of Public Hospitals and Health Systems: We heard from NY about their waiver. They have regional HIE and other data systems in place.

David Lown, Safety Net Institute: NY is building a statewide data system. We need to be thinking about this capacity.

Christina Ghaly, Los Angeles County Department of Health Services: There are challenges getting the data and putting it in a repository, there is also the issue of risk stratification. When we talk about outcomes, we have to be able to do risk stratification.

Public Comment
There is no public comment.

DSRIP 2.0 Expert Stakeholder Meeting Dates:

- Meeting #3: January 13, 2015: USC State Capital Center, 1800 I Street, Room E
- Meeting #4: January 26, 2015: DHCS Training Room A, B, C, 1500 Capitol Avenue
  Meeting #5: February 3, 2015 (if needed): Sheraton Grand Hotel, 1230 J Street