

**SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
STAKEHOLDER ADVISORY COMMITTEE (SAC)
Meeting #6 – Wednesday, September 29, 2010
9:30am – 12:30pm**

The meeting convened at 9:30 AM.

Attendance

Members attending: David Alexander, Lucile Packard Foundation for Children’s Health; Bill Barcellona, California Association of Physician Groups (CAPG); Kelly Brooks, California State Association of Counties (CSAC); Jack Burrows, Association of Health Care Districts (by phone); Richard Chambers, California Association of Health Insuring Organizations, CalOptima; Mike Clark, Kern Regional Centers; Diana Dooley, California Children’s Hospital Association (CCHA); Catherine Douglas, Private Essential Access Community Hospitals (PEACH); Juno Duenas, Family Voices; Jeff Flick, Anthem Blue Cross; Bradley Gilbert, Inland Empire Health Plan (IEHP); Sandra Naylor Goodwin, California Institute of Mental Health (CiMH); Daniel Gould, CA LGBT Health and Human Services Network; Peter Harbage, SEIU; Marilyn Holle, Disability Rights California; Michael Humphrey, Sonoma County IHSS Public Authority (by phone); Melissa Stafford Jones, California Association of Public Hospitals and Health Systems (CAPH); 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); 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; Timothy Schwab, SCAN Health Plan; 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; Hermann Spetzler, Open Door Community Health Centers; Richard Thomason, Blue Shield of California Foundation; Richard Thorp, California Medical Association (by phone); Anthony Wright, Health Access California (by phone).

Others attending: David Maxwell-Jolly, DHCS; Greg Franklin, DHCS; Bobbie Wunsch, Pacific Health Consulting Group.

Public in attendance: 41 members of the public attended in person, and 56 attended via the listen-only call-in line.

Welcome and Introductions, Purpose of Today's Meeting

Bobbie Wunsch provided an overview of the agenda, and announced upcoming meetings: December 8, 2010, and February 10, 2011, in Sacramento.

Update of CMS Discussions, Waiver Legislation and Timeline

David Maxwell-Jolly, Director, DHCS, provided an update on the waiver.

CMS Negotiations: Discussions with CMS are continuing. The speed and clarity with which CMS processed the extension request is taken as a good sign, indicating a commitment to come to closure by October 31, 2010. CMS is putting together a draft Terms and Conditions document, which will allow the State to focus on specific points. That document is expected soon. None of the concerns raised to date by CMS are insurmountable.

The State has had intense consultations with CMS about budget neutrality in the context of the waiver. This discussion has included the approach to and calculation of the upper payment limit for hospitals. The overall budget neutrality calculation is part of a broader discussion that involves the Office of Management and Budget (OMB) as well as CMS; State staff expect to make their case in person in DC in the near future.

State Waiver Legislation: The waiver legislation is expected to be taken up again when the legislature convenes to finalize the budget. DHCS is aware of a number of requests for amendments and is in ongoing discussion with legislators and legislative staff.

- **Seniors and Persons with Disabilities (SPD):** DHCS has asked to delay implementation of SPD enrollment from February 2011 to June 2011, in order to allow for a more structured, graceful transition and additional planning time. Six counties have responded with interest in the county alternative model, and all six are continuing discussions with their local plans. CMS' Terms and Conditions are expected to require ongoing stakeholder representation in this area.
- **CCS Pilots:** A draft RFA on the CCS pilots was issued in July and has inspired many comments. David Maxwell-Jolly said that this area has turned out to be more complicated than expected, but that he is optimistic that viable solutions will be found.
- **Coverage Initiatives:** DHCS and CMS have discussed minimum benefits, rollout processes, how to avoid enrollment caps, and how to ensure coverage of lowest-income individuals first. There is an ongoing debate with some stakeholders regarding the balance between mandated benefits and the comprehensiveness of the benefit package, and DHCS hopes that this debate will lead to a reasonable balance between these goals. DHCS is optimistic that there will be strong county participation in the CI expansion.

David Maxwell-Jolly recognized the contributions of the health care foundations in moving the waiver goals and process forward, and introduced representatives from three of those foundations.

Richard Thomason, Blue Shield of California Foundation (BSCF), said that BSCF is moving forward with planning grants to counties for CI start-up and expansion, and is in conversation with another round of potential grantees.

Chris Perrone, California Healthcare Foundation (CHCF), said that CHCF has a number of projects related broadly to Medi-Cal reform, and described three that are directly related to the waiver:

1. CCS: Paul Wise and Jeff Gould of Stanford University are working on an analysis of CCS expenditure and program data to better understand the characteristics of the population, utilization, and costs, among other issues. CHCF hopes to have results in February, 2011, and wants to make the information useful to DHCS and to entities interested in developing pilots.
2. SPD: CHCF is supporting the work of Alice Lind of the Center for Health Care Strategies related to California's waiver. Alice is working with DHCS and with the Managed Care Division in particular on activities including performance measurement, readiness assessment, and proposal evaluation. Alice also will be producing monthly updates on the status of SPD projects.
3. Exchange: CHCF has funded the National Academy for State Health Policy (NASHP) to conduct a gap analysis regarding existing state enrollment requirements and what states will have to do to meet the increased requirements for enrollment in the Exchange.

David Alexander, Lucile Packard Foundation for Children's Health (LPCFH) said that the Foundation had convened national experts to create an evaluation framework for the CCS pilots, and has sent DHCS a letter describing that proposed framework and next steps. LPCFH is also assisting the Children's Specialty Care Coalition (CSCC) and the California Children's Hospital Association (CCHA) in their joint response to the CCS RFI.

David Alexander also announced that Christy Bethell of Oregon Health and Science University will soon release a report on California children with chronic illness, based on California data from the Child and Adolescent Health Measurement Initiative (CAHMI). The headline from that report is that, while most states show only mediocre performance in serving children with special health care needs, California's performance is the worst.

Questions and Comments from Stakeholders

Dick Thorp, CMA (by phone) stated that he is concerned about the lack of Knox-Keene protection in the current legislation as it relates to the county alternative options. David Maxwell-Jolly replied that while Knox-Keene is not required in the county alternatives where they are less than a full-scope health plan, DHCS believes that Knox-Keene level protections in the areas of quality, accessibility, and care can be met via the state's contracting authority.

Anne McLeod, CHA, asked for information on the status of dual eligible integration in the waiver. David Maxwell-Jolly said that given the complexity of other areas of the waiver proposal, and because work on dual-eligibles requires negotiation with both the Medicaid and Medicare sides of CMS, specific details on duals are not part of the current waiver document. The state will wait to see what direction CMS' new Center for Innovation takes on this issue, and will work internally and in consultation with CMS to come up with a plan. The current language in SB 208 will remain as a foundation.

In the meantime, DHCS is looking at how to incorporate a broader set of home- and community-based services (HCBS) into managed care plan rates and working closely with some COHS to gauge their interest in including a more extensive set of services within their contracts. This would be important groundwork for any future integration of dual eligibles.

Marty Lynch, Lifelong Medical Services, asked about behavioral health integration (BHI) and medical home/care management demonstration projects in rural areas. David Maxwell-Jolly replied that the BHI workgroup concluded that the best opportunity for action on BHI is at the county level, and specifically in the context of county coverage and coverage initiatives. Accordingly, DHCS will be asking CIs to address BHI in their applications. Counties will not be required to provide integrated services, but to address the issue.

Care management demonstration projects are not included in the first phase of the waiver, but are on the agenda for a later phase, with discussion to begin in 2011.

Marv Southard, LAC DMH, said that creating a robust mental health benefit in the coverage initiatives is in the counties' interest, because it helps control costs on both sides. The trick is to find a minimum benefit that's acceptable to all counties, while retaining the flexibility to allow counties with more resources to create a robust package that might include coverage for co-occurring disorders, with substance abuse benefits. The CIs need a minimum benefit standard, but the expectation is that many would exceed it in the area of behavioral health.

Jackie McGrath, Alzheimer's' Association, asked which counties had expressed interest in the county alternative option. David Maxwell-Jolly replied that the six counties that have contacted DHCS are: San Francisco, Santa Clara, Riverside, San Bernardino, Sacramento

and Los Angeles. A number of those counties are concurrently talking to their Local Initiatives about delivering CI services through those plans.

Jackie McGrath, Alzheimer's' Association, also asked whether the draft Terms and Conditions from CMS would be made available to stakeholders. David Maxwell-Jolly replied that CMS has not yet sent draft Terms and Conditions, but they are expected very soon. DHCS will consult with stakeholders as needed, but will not distribute this draft widely. *Barbara Seigel, NLS*, said that giving the SAC access to the draft Terms and Conditions in advance of finalization would be prudent, based on the experience in LA.

Barbara Seigel, NLS, also asked for an assessment of how realistic it is that waiver negotiations will be completed by the end of October, given the involvement of OMB. David Maxwell-Jolly said that both the State and CMS are strongly committed to reaching agreement by that deadline.

Bob Prath, AARP, said that the waiver implementation requires a standard set of metrics that can be used to help monitor the transition. David Maxwell-Jolly agreed that solid metrics are the best way to report on status, and that this would require an understanding of whether milestones are being met. He took the suggestion under advisement.

Sandra Naylor Goodwin, CiMH, noted that 49% of the SPD population have disabling psychiatric conditions, and that in the FFS Medi-Cal population the annual cost of care for people with depressive conditions is \$14,000/year, as compared with \$3,000/year for people without these illnesses. Even looking only from a cost perspective, it is crucial to address mental health issues. *Brad Gilbert, IEHP*, commented that in managed care, mental health is carved out, and is largely the responsibility of the counties. He said that there is a greater opportunity to connect behavioral and medical care in the managed care context. He said that the point regarding the incidence of psychiatric illness in the SPD population was well taken, and that coordination needs are especially important for this group. IEHP has developed some successful mental health programs for the Healthy Families Program (HFP) population, and is thinking about how to apply them in Medi-Cal, although financial responsibilities are different.

Lisa Rubino, Molina, asked about the connection between county alternative options and local initiatives. David Maxwell-Jolly clarified that counties that are significant providers of health care want to continue that role, and that the county alternative option was designed to allow them to continue to serve the population as an organizational alternative to establishing a provider relationship with a health plan (either private or Local Initiative). He said that in many counties, health plans probably will eventually develop a provider relationship with the county delivery service, but that some counties may choose the

alternative structure. Lisa Rubino said that Molina would not support county delivery systems seeking differential relationships with Local Initiatives.

Melissa Stafford-Jones, CAPH, said that the county alternative that the public hospitals are contemplating has always included two structures: a separate program, or a comprehensive outpatient product that exists within the Local Initiative. DHCS's RFP doesn't allow for the latter, and there is ongoing discussion to ascertain what structures will make sense.

Small Group Discussions on CCS Pilots, SPD Enrollment, and HCCI/CEED Expansion

The Stakeholder Advisory Committee broke into three smaller groups to discuss CCS pilots, SPD enrollment, and CEED (HCCI) expansion. Detailed notes from each group are at the end of this summary. Representatives from each small group then presented highlights of the discussion to the full Stakeholder Advisory Committee.

Discussion and Feedback from Small Group Discussions Led by SAC Members

- CCS Pilots – *Stuart Seigel, CHLA*, reported.
- CCS Pilot RFA and Timeline
 - Luis Rico, DHCS, provided an update on the draft RFA/RFP process.
 - Based on responses to the draft (multiple comments as well as 14 Letters of Intent), DHCS proposed a revised timeline with staggered deadlines for the various types of pilot.
 - The group made a consensus recommendation *not* to stagger the submission dates, because of geographic as well as equity issues.
 - The group also expressed strong feelings that DHCS should be clear about its goals both for the pilots and for the post-pilot work of CCS.
 - Issues raised in comments on the draft RFA included:
 - Timeline
 - Too rigid/prescriptive
 - Medically necessary services/benefits – Medi-cal definition or EPSDT definition
 - Questions about minimum benefits
 - Opt-out v. mandatory enrollment
 - Efficiency in enrollment process
 - Inclusion of neonates
 - Evaluation process
- Data Issues
 - The Stanford evaluation funded by CHCF is ongoing. The analysis is high-level, and does not look at individual diagnoses.

- The group felt that the evaluation should look at county variability, and variability between CCS- and non-CCS centers.
- The LPFCH-proposed evaluation plan for CCS pilots includes three pieces: 1) environmental scan 2) case-control study 3) real-time quality dashboard.

Jeff Flick, Anthem Blue Cross said that Anthem is interested in working with Oakland Children’s Hospital on a CCS pilot. Their vision is to create a product that delivers high-quality health care for sick *and* healthy children, regardless of insurer. He asked that DHCS keep in mind this more expansive view as the CCS pilots are developed.

Juno Duenas, Family Voices, asked to see DHCS’ log of comments on the draft RFI. She said that, at minimum, pilot evaluation should include assessment of the family contribution to care. Mike Clark, Kern Regional Center, agreed with these remarks.

- HCCI/CEED Coverage Initiative -- *Judith Reigel, CHEAC*, reported for the group.
 - 1) How can we prioritize enrollment for those at or below 133% FPL instead of enrolling based on first come first served, to prevent need for enrollment caps?

The group discussed how to create a matrix that includes *both* poverty and medical need, and how to do that in a way that is acceptable to CMS. While the group did not reach consensus, it was noted that poverty level is a fairly reliable proxy for medical status.

- 2) What indicators should be used to determine the degree of success in integrating mental health services with the physical health services through the expansion of county-based CI?

The group identified several indicators:

- How well are patients being screened for BH problems when they come in for physical health concerns?
- Does the treatment plan address all the patient’s needs?

The group also discussed co-location of services, saying that while it is desirable, it does not guarantee service integration or replace discussion of integration in the treatment plan. The group also thought it would be appropriate to gather data on the provision of substance abuse services in CI evaluations, although such services won’t be required in CIs.

3) What results should the evaluation of CI focus on or target?

The group's discussion was based on the recognition that this round of coverage initiatives is different from the last, and represents preparation for 2014. With that in mind, the group said that CI evaluation should include:

- Percentage of the poverty population enrolled
- Behavioral health integration
- Cost savings
- EMR (recognizing that not all providers are similarly situated)
- Provider networks and access to primary care
- Delivery system changes, including assignment to and effectiveness of medical homes
- Maintenance of enrollment
- Scope of benefits, including comparison to the Medi-Cal benefit package
- Patient satisfaction

Marty Lynch, LifeLong Medical Care, said that while he agreed that co-location does not guarantee service integration, it remains important. He noted that a SAMHSA study showed that co-location was critical in the rate of uptake for elder patients. *Sandra Naylor Goodwin, CiMH*, noted that treatment plans and integration should be evaluated bidirectionally.

Sharon Rapport, Corporation for Supportive Housing, said that evaluation of need shouldn't be only medical, but should look to issues such as homelessness, frequent ER use, and others.

Brenda Premo, Harris Family Center, noted that many in the CI population will move into Medi-Cal through an SPD eligibility category: many are on the "SSI treadmill," awaiting decisions on their disability status. They may need as much in the way of coordinated services and access services as the SPD population.

Marilyn Holle, DRC, asked whether the State could get budget neutrality credit for non-progression of disease between now and 2014, when costs of new Medi-Cal enrollees will be 100% federally funded. New York booked savings for intervening early with people with HIV< for example. David Maxwell-Jolly replied that California has used the argument but not quantified it, and will look into it.

- Seniors and Persons with Disabilities

Elizabeth Landsberg, WCLP, reported for the group, which first heard a report from Tanya Homman on the status of MMCD's work on SPD integration. The group then addressed the following questions:

- 1) How can CBOs and other community groups get more involved in educating their constituencies about this change?
 - The group identified a long list of organizations that should know about the upcoming changes in order to be prepared to answer beneficiaries' questions.
 - DHCS resources are limited. The Department will do one presentation in each of 16 counties, so providers (Regional Centers, Area Agencies on Aging, etc.) will be critical sources of information for beneficiaries, as will individual doctors' offices. Outreach should include local medical societies as well as state organizations.
 - State presentations should also be made available via local cable stations.
 - Official notices will be sent March 1, 2011, for enrollment beginning June 1, 2011.
- 2) How can we measure success in the transition of SPDs into managed care?

The group identified two specific questions:

- *Did the transition work?* This should be evaluated by measuring default rate, rate of plan switch, numbers of people who received risk assessments, complaints to ombuds and HMO lines, etc.
- *Was the overall result accomplished?* Alice Lind has done some of this work and is doing more. The group suggested that Alice Lind and DHCS present a draft evaluation plan to the SAC at or around the December SAC meeting.

Hermann Spetzler, Open Door Community Health Centers, expressed concern that provider availability be assessed, and that evaluation not be limited to the enrollment process. Elizabeth Landsberg replied by noting DHCS's provider crosswalk, which compares provider participation in FFS and managed care, as well as DMHC and DHCS's work on provider availability standards. Hermann stated that point of service has to be an eligibility access point, or providers would be lost. *Lisa Rubino, Molina*, noted that two rounds of the provider crosswalk, with imperfect data, still showed 60% overlap between FFS networks and plans, and said that plans have many more specialists in some of the categories.

Chris Perrone, CHCF, said that Tanya Homman/MMCD's presentation to the SPD group was excellent, and suggested that that template be used for future updates. Others agreed that the presentation was very helpful.

Diana Dooley, CCHA, noted that her organization had asked that language be added to the waiver stating that children in SPD categories are not required to change providers unless a plan can show that there is adequate provider access, including an adequate network of children's providers.

Juno Duenas, Family Voices, asked again that children in SPD categories be allowed to opt out of managed care altogether. She noted that many users of pediatric specialists are technically adults – requiring them to switch to the adult system will be difficult for adult providers and will put these individuals at risk. *Stuart Seigel* noted that this issue was raised again in comments on the CCS pilot draft RFI, and that he expects to see responses from DHCS soon.

Public Comment

Carolyn Ginno, CMA, said that the provider community is willing to help with SPD enrollment outreach. One important data point for evaluation is ER utilization in private and public hospitals, contracted and not, for Medi-Cal patients. CMA has noted increasing utilization of ERs and wants to continue tracking that trend.

Terri Cowger Hill, Cowger and Associates, speaking on behalf of the Hemophilic Council, said that it is important that patients have direct access to hemophilia centers within the CCs pilots. She also said she supported Diana Dooley's comments regarding provider access for the 153,000 children who are enrolled in Medi-Cal through SPD eligibility categories.

Tim Madden, California Chapter of the American College of Emergency Physicians (CAL/ACEP), raised concerns about the lack of a Knox-Keene requirement for the county alternative option. Fair and timely payment is critical for emergency physicians, and to the extent that patients are not contracted to emergency departments, physicians depend on Knox-Keene requirements to ensure payment. These payment requirements should be part of the county alternative options.

Next Steps, Next Meetings and Adjourn

Bobbie Wunsch, PHCG, thanked SAC members and the public for their participation. Additional SAC meetings will be held from 9:30am – 12:30pm at the Sacramento Convention Center on:

- December 8, 2010, Sacramento
- February 10, 2011, Sacramento.

The December 8 meeting will include discussion of the future meeting schedule and the role of the Stakeholder Advisory Committee.

The meeting was adjourned 12:20 PM.

Notes from Small Group Discussions

CCS Pilots

Update on RFA Progress and Feedback

- Luis Rico, DHCS, provided updates on the RFA progress to date
 1. Released draft RFA for comments 7/22/10
 2. Comment period extended to 9/10/10
 3. Originally planned that RFA/RFP would then be developed over 6 weeks, with release 10/18/10 and submissions due 12/12/10
 - Steve Holley, Chief of Operations, Children's Medical Services
 4. Received 14 letters of intent: 10 for specialty health care plan, 9 for MMCP, 7 for ACO, 6 for PCCM (some LOIs referenced multiple models)
 5. Also received multiple comments -- 57 pages of tabulated responses. Areas of comments include:
 - Timeline
 - Too rigid/prescriptive
 - Medically necessary services/benefits – Medi-cal definition or EPSDT definition
 - Questions about minimum benefits
 - Opt-out v. mandatory enrollment
 - Efficiency in enrollment process
 - Inclusion of neonates
 - Evaluation process
 6. LOIs assumed to be non-binding, so final tally could include more or fewer proposals than the 14. Some CCHA members are interested in pilots but did not submit LOIs.
1. Timeline for RFA Process
- After reviewing all the comments, DHCS is proposing extending due dates in order to incorporate some suggested changes.
 - Proposal: release RFA/RFP 12/1/10, with staggered due dates: MCO submission 2/1/11, specialty MCO 3/1/11, EPCCM 4/1/11, ACO model 5/1/11.
 - Staggered due dates allow DHCS to ramp up how they review, support, etc. Begin with MCO because it's a model that DHCS already knows.
 - Comments:
 1. What about hybrid models?

- DHCS: When we get to final proposals, will have some defined parameters, but there are opportunities for more creativity depending on the vehicle.
 - 2. Will there be a specific opportunity between now and 12/1 to affect the final RFP? CCHA recommended that specialty care plan and EPCCM hybrid be allowed, for example.
 - DHCS: Will go out and talk to stakeholders prior to 12/1. Public process not necessarily required.
 - Bidders' conference after RFP is final would be helpful.
 - RFA/RFP process handled through Office of Medi-Cal Procurement. Staff review, document review, and protest period, etc. will take approximately 90 days from submission of proposals to contract.
 - 3. Would be fairer to have all proposals evaluated at the same date.
 - 4. What's DHCS's goal? One pilot for each model? Five best pilot proposals? Geographic spread? If committed to trying all models, then it makes more sense to push the whole thing out and then see how you're going to distribute the resources. If the goal is to see which works best, doing more than one of each is better.
 - DHCS: Would like to test all four models, but have to consider regional provider network, and multiple proposals for the same area may be is a problem.
 - 5. Need to be clear about goals. CCHA asked DHCS to clarify what they will do with the results of the pilots: bring it back to a single integrated system, or might there be multiple models?
 - 6. How many pilots can DHCS realistically support?
 - 7. Geography is complicated. Area depends on the style of the model. If you have overlapping geographic areas on different submission schedules it's going to be difficult to deal with.
 - 8. Would like to see something about rural areas in these pilots.
- Consensus recommendation from the group that a single deadline is preferable.
 - Anthem Blue Cross interested in moving ahead with Oakland Children's Hospital. Ready to move forward, and hope there isn't a long delay. Part of the vision is to create something that works for sick *and* healthy kids, where a whole family will want to work with Anthem and CHO.
 - Marilyn Holle: Have tried to include DME coverage and appropriate assessments for DME – most plans cut off at \$2500. Have a lot of clients who are on CCS for DME purposes, and would like to see DME requirements spelled out in RFP. Lab quality requirements also need to be spelled out.

2. Data needed to implement pilot projects

- Still don't have good data from MCOs, and still have a lot of trouble with referrals and DME in some plans. Without better data we don't know what protections we need.
- Stanford data use the CCS data set and OSHPD data set. Mostly financial data – useful for people who may be taking on risk.
- There may be some data on carve-in and carve-out from Stanford that gets to the questions of what care is being received and what is still missing, but this data won't show where things aren't paid for, where DME is not provided, etc.
- Evaluation has to be part of the pilots from the beginning. LPFCH recommendations for evaluation include a tri-part evaluation
 1. Pre-implementation evaluation to understand the ecology of the pilots going in
 2. Traditional case-control evaluation (5 years, costly, has to be done, but not the most useful)
 3. Real-time quality dashboard, which LPFCH thinks should be applied to CCS statewide. 100% death review, 100% complaint review – maybe fundable.
- Stanford data will serve as the control data for the pilots – there will not be a concurrent matched evaluation.
- Need basic data before taking on risk. In the case of Alameda/Contra Costa for example: How do costs in those counties compare to the state? What are the admission rates, lengths of stay, readmission rates, ER visits/1000, etc. (all with comparisons)? All that is needed in advance of a proposal submission.
- Need to ensure that Regional Center clients are appropriately catalogued for reimbursement as disabled or non-disabled – many of them are currently enrolled as 1931b although they are actually disabled. Need to look at it honestly and not pretend that there's a bright line between people with and without disabilities. Aid codes can be misleading
- Important to note that there is huge variation in costs at baseline due to the rare nature of the diseases involved. Know that how things are distributed can be different year to year.
- Evaluation should include expenditure of family time? The harder the system is to manage, the more time families have to put in, and this is part of the success (or not) of the pilots.
- Will there be a comparison of non-CCS and CCS centers in the Stanford evaluation?
- DHCS: Data will be posted on the DHCS website data library, in aggregate, for the RFP process, to be followed by the Stanford work.

CEED/HCCI

1. How can we prioritize enrollment for those at or below 133% FPL instead of enrollment based on first come first serve to prevent need for enrollment caps?
 - Clarifying comments: CMS doesn't want waiting lists for CI, but funding is county-generated.
 - "Enrollment cap" is not the right term– should say "waiting list" instead.
 - Greg Franklin, DHCS: How do we ensure that the neediest are not on the waiting lists? How can we monitor the list to ensure that the lowest income individuals are enrolled? This will require counties to monitor the waiting list and enrollment by income and have policies to move certain people into the CI.
 - What about enrolling people currently in indigent programs first?
 - CMS rejected that proposal because they want CI to be Medicaid-like – not targeted.
 - Greg Franklin: CMS wants the priority on FPL – not being in 17000.
 - If there is point of service enrollment, we can triage by going with who is showing up for care. This does not have to be exclusive of other criteria. All providers should have access to enrollment.
 - What about setting priority based on extent of illness, plus FPL – would this be acceptable?
 - Could create a priority matrix with conditions on one axis and income on the other.
 - Have to keep conditions list simple in order to predict severity.
 - What priority should income have? Up to 50% FPL? 50-100%? CMS wants priority on lowest income.
 - Can we make this invisible to consumers so as not to create artificial barriers that make life even more difficult for very poor consumers?
 - Could have the understanding between provider/clinic and county about what resources are available without creating a patient eligibility nightmare.
 - Each county program will set its own size based on county resources – this is acceptable to CMS. The state must have criteria but not dictate the size.
 - Can't create a seamless program to client unless the same services exist under CI and 17000.
 - Continuous eligibility should be a criterion.
 - Poverty level may be enough of a criterion. In LA, when poverty level was investigated it accounted for all other issues (health status, etc.).

Summary of Question 1:

- The group is interested in a matrix of need and condition that would include more than just medical conditions (homelessness, frequent user status, etc.).
- Eligibility should be transparent/seamless to users.
- Focus on those to be enrolled in 2014.

2. What indicators should be used to determine the degree of success in integrating mental health services with the physical health services through the expansion of county-based CI?

- This is not about the minimum benefit of MH. This is about making progress beyond this to work on real integration.
- Look at bi-directional integration.
- Don't focus on system indicators – focus on consumer/health care indicators. Look at diagnoses and measure whether they get services/whether they are getting better.
- The measure in LA includes a metric for co-occurring disorders. They track assessment and diagnoses for substance abuse in the plan, and whether services are received. Treatment can be tracked.
- Should track the number of systems the patient needs to move through. Is there real integration or does the patient have to go from system to system?
- Co-location does not mean integration.
- The goal is integration – bi-directional integration between MH/BH and physical health care.
- Track that physical health services are occurring in mental health system.
- Screening is baseline requirement to set up the identification of needs and services.
- Need standards – this is being worked on in the pilots.
- SA treatment is not a required service in CI. How can we ensure integration when SA is not included? Without this, cost and health conditions probably will not improve.
- Some counties might consider including SA. Federal parity laws may help this.
- Can we require collection of data in any county that does include SA, even if it is not a required service? Even if SA treatment is not required, can we add a screening requirement? Can we evaluate the cost at the end of the waiver in counties where SA treatment is included compared to where it is not included?
- When patients present in a non-county ER, can this data be included? What is the warm hand-off process? Otherwise, we can't get true indicators/metrics for services that happen out of network.

3. What results should the evaluation of CI focus on or target?

- % FPL eligible individuals that are actually served/enrolled
- Degree of integration of BH/physical health services

- Cost savings for those in the program (compared to previous costs)
- Data collection will be difficult. Need to make sure we can collect the required data from our existing systems. Use the existing data systems as baseline for what we can collect. May have to compile it manually, but don't add new data points.
- Number of providers and some indicator of actual access to provider service/primary care
- Have the programs created medical homes/care coordination? Patients assigned to medical homes? Effectiveness of medical home based on ER use?
- Patient satisfaction
- Coverage: How long are people maintaining coverage? Who is churning? Improve the understanding of what coverage means and how to keep it. Develop best practices for keeping people on.
- Evaluate seamlessness of transition to 2014.
- How close the scope of benefits is to Medi-Cal
- Align CI evaluation data with meaningful use requirements.
- The integration element makes this difficult because the MH side does not currently collect/do anything on medical side.
- Look at the CMSP behavioral health integration pilot: the data was not accurate because the number of CMSP patients was very small. CI enrollees may similarly reflect only a small number of those in need.

SPD Enrollment

1. Tanya Homman presented current waiver implementation activities:
 - Provider Crosswalk:
 - Overlap analysis, comparing the providers DHCS under contract to serve seniors and persons with disabilities (SPD) in fee-for-service (FFS) to those under contract to managed care plans.
 - In June, FFS provider data was shared with plans. Plans found 46% overlap of providers in first run. After doing follow-up with providers to build up network, the plans resubmitted the analysis, and by August, 60% of FFS providers were found in health plans. DHCS will do a follow-up with plans in October.
 - Health plans explained that they find even higher rates of overlap when they look at the data, because there are some differences in provider ID's (some only report as their group, e.g.).
 - FFS Member Data:
 - Aggregate data on SPD clients provided in June. The data is de-identified but shows unique beneficiaries.

- New snapshot will be provided in October. Numbers, providers, ethnicity, aid code by county.
- Utilization data is CY 2009 data – raw – for all FFS beneficiaries. Includes inpatient, diagnosis codes, etc. The data is provided to health plans, for the plans to analyze as see fit.
- Plan readiness:
 - DHCS is developing criteria for access and adequacy. DHCS is reviewing plans' policies and procedures. DHCS is in the process of revising contract language. DHCS will review the good standing of plans, e.g. from ombudsman, finance – any deficiencies will be addressed before implementing enrollment of SPD as mandatory population.
 - Will discuss new requirements in October with health plans.
 - Will be new/revised requirements.
- Rates:
 - Developed through Mercer. Available by end of October and shared by November. Rates go in to CMS by January (with contracts) for June 1 start.
 - What method will be used? Similar to risk adjustment methodology used today. Medicaid Rx based methodology. CDPS – is there enough attention to people who do not use Rx?
- Network adequacy:
 - Specialty providers, analysis of historical data and projected care.
 - DHCS is meeting with DMHC on standards. The interagency agreement between DHCS and DMHC to perform medical, financial, and network activities is under review.
- Access/facility review tools:
 - Had stakeholder meetings in August; draft in September.
 - Will revise and issue all-plan letter in November. FSR will be revised. Will include input from advisory group. Train plans by January 2010. Require use by June 2011.
 - Questions about whether plans are already meeting these requirements. Many plans are already addressing these issues.
- Risk assessments
 - Plans need to submit risk assessment tool to DHCS for approval.
 - DHCS will issue all-plan letter by January. Plans will submit tools by March. Plans will begin to use the risk assessment tool by June.
 - Member-specific risk assessment data will be provided at the time of enrollment. Everything approved by HIPAA. Will test data sharing through early 2011. Extremely useful for plans to receive historical data.
- Outreach and Education
 - Sensitivity training – input finalized in January and training finalized by February

- Informing materials have been developed with input from stakeholders.
 - DHCS – will issue all-plan letter in March.
 - County presentations March-April 2011. 16 presentations by UC Berkeley – one in each county. How CBOs can get involved (discussed in more depth below).
 - Health Plan linkage for FFS Non-Choosers
 - All SPD's will receive 90 day notice. 60 days prior to enrollment, will receive packet and choice material.
 - Phase in based on month of birth.
 - First will enroll based on provider seen most often. Will default enroll only if utilization of providers is unclear or no care is received.
 - CMS Approval (contract language and rates)
 - Need to tweak language, will make available in October.
 - Allow time for discussion with health plans, finalize in December.
 - Hope for approval by February 2011
 - CAM(County Alternative Model):
 - RFA being finalized and to be released in October.
2. How can CBO's and other community groups get more involved in educating their constituencies about this change? (Suggestions from the group brainstorm follow.)
- Use county TV systems – includes translation – all metro areas have their own TV station.
 - If DHCS can identify the primary providers (providers who serve large numbers of seniors and persons with disabilities), enlist them in education.
 - Train medical offices and other providers so they can help answer questions.
 - AAA, regional centers, independent living centers need to be included: they have benefits counselors.
 - Include agencies for the deaf (only 7). Have sign language interpreter at meetings.
 - People come to these agencies for services.
 - Outreach will involve HCO and UC Berkeley.
 - Don't have DHCS resources to reach all of these sites.
 - Hold big meetings in a few locations. There are networks of the providers. Tape presentations for later broadcast.
 - Voice mail message that could be sent out to all members?
 - County Mental Health will be a critical partner.
 - Where to hold the 16 county presentations is an issue. (People are used to coming to IEHP, e.g., but may not be a big enough space. Need large spaces.)

- Need to have a packet of information for people to take away with them (train the trainer).
- Timing is important: 12 – 2 p.m. for providers?
- Tip sheet for office managers. Brenda – creating these already.
- Suggestion to separate providers and beneficiaries. Very different presentation for providers and beneficiaries.
- Train the outreach groups? Enlist people already working on this.
- Is there something CAPG could do? Need to train providers all together or coordinated across health plans.
- Focus on recruiting new providers as well as explaining to existing providers.
- CMA also has a network through county organizations.
- DHCS has limited resources – please let Tanya know how you can help.
- March 1 – simple beneficiary informing notice goes out.
- Need a list: key community orgs, consumer advocacy can help. Training focused on the people who will help beneficiaries; providers need a separate campaign.
- Outreach in multiple languages, sign language, etc.
- Family caregivers also important.

3. How can we measure success in the transition of SPD into managed care?

- Default rate of enrollment. By aid code, etc.
- Health outcomes
- Two big topic areas for evaluation: Measure transition process as well as measure effectiveness of care delivered.
- Transition: did everyone end up in right place, success of risk assessment tool, how successful were the plans in reaching people?
- Establish benchmarks and then track over time.
- Satisfaction/process measures
- Extent to which people switch plans
- Access and availability
- Complaint rate of people not able to access providers
- Ombuds office data, other sources of complaint data (HMO help line?)
- Wait times for procedures, e.g., hip replacement
- Timely access standards start in January.
- Send suggestions for measures to Tanya.
- Suggestion for process: DHCS and CHCS will put together a draft and share with stakeholders at December meeting. Need to decide if that is part of this stakeholder advisory meeting or a separate meeting (maybe on the same day).
- How good are plans in getting to people who need care the most? Advocates worry about people in crisis falling through the cracks.

- Need to share information about what other states have done (CHCS).
- General question about how stakeholders can give input and get updates on SPD enrollment implementation: Medi-Cal Managed Care Advisory Committee meeting? Waiver Stakeholder Advisory Group? People need guidance on what will be discussed in which venue.