

**SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
STAKEHOLDER ADVISORY COMMITTEE (SAC)
Meeting #7 – Wednesday, December 8, 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) (by phone); Kelly Brooks, California State Association of Counties (CSAC); Mike Clark, Kern Regional Centers; Catherine Douglas, Private Essential Access Community Hospitals (PEACH); Juno Duenas, Family Voices (by phone); Jeff Flick, Anthem Blue Cross; Sandra Naylor Goodwin, California Institute of Mental Health (CiMH); Daniel Gould, CA LGBT Health and Human Services Network; Peter Harbage, SEIU; Michael Humphrey, Sonoma County IHSS Public Authority; Melissa Stafford Jones, California Association of Public Hospitals and Health Systems (CAPH); Elizabeth Landsberg, Western Center on Law & Poverty (WCLP); Marty Lynch, LifeLong Medical Care; Jackie McGrath, California Council of the Alzheimer’s Association; Santiago Munoz, University of California; Chris Perrone, California HealthCare Foundation; 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); John Schunhoff, Los Angeles County; Timothy Schwab, SCAN Health Plan; Barbara Seigel, Neighborhood Legal Services of Los Angeles County (NLS); Stuart Seigel, Children’s Hospital Los Angeles (CHLA); Rusty Selix, California Council of Community Mental Health Agencies (CCCMHA); Richard Thomason, Blue Shield of California Foundation; Richard Thorp, California Medical Association; Anthony Wright, Health Access California.

Others attending: Kim Belshé, CHHS; David Maxwell-Jolly, DHCS; Greg Franklin, DHCS; Tanya Homman, DHCS; Bobbie Wunsch, Pacific Health Consulting Group.

Public in attendance: 52 members of the public attended in person, and 74 attended via the listen-only call-in line.

Welcome, Introductions and Purpose of Today's Meeting

Bobbie Wunsch, Pacific Health Consulting Group, provided an overview of the agenda, and announced the upcoming meetings: February 10, 2011, in Sacramento.

Opening Comments

Kim Belshé, Secretary, CHHS, spoke about the importance of Medicaid and the Medicaid waiver to health care reform. While there is intense interest in the Exchanges, the waiver is foundational.

Health care reform holds tremendous promise for people of the state. Two million more Californians will be enrolled in Medi-Cal through the expansion. The Exchanges will enroll between two and four million more. Behind those numbers are tremendous challenges: for example, how Medi-Cal can insure adequate provider capacity for the additional enrollees with rates among the lowest in the country. The majority of the costs of implementing the ACA in California, according to the Administration's estimate, are related to increased provider rates.

The state's fiscal situation has particularly difficult implications for Medi-Cal. Medicaid Maintenance of Effort (MOE) requirements and court decisions mean that there are strong boundaries around the program in terms of reducing spending, but as the caseload continues to grow budgetary and policy tensions will become even more challenging.

California Capacity

Medi-Cal already is a fairly strong program, reaching a significant proportion of the state's low-income population. California's Medicaid program has a long history of innovation that will be useful as the state moves ahead with ACA implementation. If Governor Schwarzenegger hadn't attempted comprehensive health care reform in 2007, California would not be as far along today as it is.

The waiver recognizes that the Medicaid program is the foundation on which health care reform will be built. The Administration's effort to press the waiver in an aggressive and strategic way reflects the understanding that if Medi-Cal is not modernized and strengthened now, California will not succeed in 2014.

ACA State Implementation Challenges and Considerations: Medicaid

- 1) *The state's internal capacity.* There is a disconnect between what the public and policymakers are looking to executive branch institutions to do and the internal capacity to do that work. California needs more and different state staffing, based around technical and policy expertise.
- 2) *Culture of coverage.* The goal of comprehensive reform is to cover people, and this requires widespread engagement in order to create a community norm in which insurance is valued and expected. Medicaid has an important role to play. How the state thinks about the Medi-Cal brand going forward will be important, as will the business processes by which people connect with the program.
- 3) *Eligibility/enrollment systems.* The ACA gives states tools to modernize these systems across Medicaid, the Exchange, and the Healthy Families Program, but how the state uses those tools will be very important. California has diverse and complicated eligibility and enrollment systems: Medi-Cal at the county and state levels and the HFP system. We want to create a first-class retail experience, and how we move forward using 21st century technology and real-time eligibility is critical.
- 4) *Needs of the newly eligible.* What do we know about the newly eligible? What are their needs and how do we ensure that benchmark coverage and provider capacity, for example, align with those needs. This is a complex population with extensive behavioral health and social services needs.
- 5) *Slowing the rate of growth in Medi-Cal costs.* Delivery system reforms and innovations are a powerful tool to improve access, care coordination, and outcomes, but also to make more efficient use of the available money. Slowing the rate of growth in Medi-Cal is a fiscal necessity. California can't solve this problem on its own, but discussions with the federal government about innovation and cost containment must continue.
- 6) *People outside the coverage mandate.* Health care for undocumented people will continue to challenge the state and providers.
- 7) *Health Insurance Exchange.* As the first in the nation, California's Exchange is receiving a great deal of attention, but the focus is also on the Board's ability to be an active purchaser. This reflects California's experience in other programs as well as a focus on value as opposed to, for example, market segmentation or risk avoidance. How the board exercises its authority and the alignment of purchasing strategies and goals across the Exchange and to Medi-Cal will be very important.
- 8) *Financing of state and county programs.* 2014 will see significant shifts in the relative responsibilities of the state and the counties, particularly with regard to the medically indigent. People who the counties currently care for will become the state's responsibility, with financial implications for the state.
- 9) *Stakeholder and foundation involvement.* The 2004 Medi-Cal redesign effort did not succeed, but set an expectation of extensive stakeholder and foundation involvement in the process, which was borne out in the waiver. Secretary Belshé

recognized David Maxwell-Jolly's work on the waiver along with that of Melissa Stafford-Jones and the California Association of Public Hospitals.

In sum, the Medi-Cal waiver is a bridge to reform that gives California an opportunity to strengthen the foundation on which ACA will be implemented and brings not only coverage but also value to the people of the state.

Update of CMS Waiver Approval and Special Terms and Conditions

David Maxwell-Jolly, Director, DHCS, thanked Secretary Belshé for her leadership, and said that California owes her a debt of gratitude.

Waiver Update

The waiver was approved on November 1, 2010, and the webinar presented on November 4, 2010 presented some information. A policy brief from CAPH is available on the waiver website at

www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/policybriefnov2010.pdf.

David Maxwell-Jolly's presentation is available at

http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/SAC_12-8_Presentation.pdf.

Key Programmatic Elements

- Expand coverage to more uninsured adults;
- Support uncompensated care costs;
- Improve care coordination for vulnerable populations including Seniors and Persons with Disabilities (SPD); and
- Promote public hospital delivery system transformation.

New Features

- Low Income Health Program (LIHP) has two components
 - Medicaid Coverage Expansion (MCE)
 - Health Care Coverage Initiative (HCCI)
- Beneficiary protections: CMS was very interested in Medicaid-like protections for low-income adults up to 133% FPL who will become Medi-Cal enrollees in 2014.
 - Grandfathering existing beneficiaries
 - Due process requirements
 - Expanded benefits
 - Provider timeliness standards

- Planning for 2014
- LIHP will also include the Health Care Coverage Initiative which will also allow counties to expand to individuals up to 200% FPL. Counties can retain existing beneficiaries, but due to CMS' interest in enrolling lower-income people first, counties will be required to establish income thresholds that may or may not allow expansion into the 133-200% group. This is an opportunity for counties to develop the systems they will need in 2014, and represents the best opportunity to advance behavioral health integration, since both responsibilities rest with the counties.

Safety Net Care Pool

- There is continued support for uncompensated care under the waiver, including a reduction in the discount that is applied to these funds relative to undocumented people being served in hospital systems.
- Support for additional state programs
 - County mental health programs
 - Developmental services
 - Workforce development

Delivery System Reform Incentive Pool

- Four categories of investment:
 - Infrastructure Development
 - Innovation and Redesign
 - Population-Focused Improvement
 - Urgent Improvement in Care
- There are incentives in this area to take some chances. CMS is interested in these innovations.
- California continues to work closely with CMS on specifics in each of these areas, specifically about the sorts of projects that will be approved in each area.

Elements not in the Waiver

- Dual Eligible Integration was left out of the waiver in a strategic decision based in part upon time pressures and in part on the fact that CMS is still developing its strategy in this area.
 - Next steps:
 - Understand innovation opportunities offered by CMS

- Continue local discussions of options regarding expanded rate structures, to try and incorporate a broader array of HCBS into COHS rates)
 - Develop detailed proposal to identify the specifics of duals pilots
 - Pursue waiver amendments
- All managed care activities are included in this waiver for the first time. This provides a big financial advantage, and also allows for innovation under a single waiver structure.
- Organized care in rural areas is not part of the waiver. David Maxwell-Jolly said that DHCS would continue to look at this issue in the lead-up to 2014.
 - Behavioral Health Integration (BHI) is only partially realized in the waiver. The Coverage Initiatives are relevant to this topic, and should include good evaluations, but more is needed. Discussions on this issue will continue with CMS, as will DHCS' analysis of results from Washington State on expanded access to substance abuse services.

Questions

Marty Lynch, LifeLong Medical Care, asked about incentive pool funds, specifically whether there is room in the incentive pool for partnerships with safety net providers other than public hospitals. A comprehensive delivery system will have to involve all of public hospitals' private and public partners, and investment is needed in all parts of the system.

Melissa Stafford-Jones, CAPH, responded that the incentive pool does not exist in isolation from the rest of waiver, but rather is connected to the expansion, and that is where partnerships are made manifest. Technically, the incentive pool money has to be earned via a series of milestone plans (if hospitals meet the plan goals they get the federal monies, which require a self-funded match). The funding is also available to PEACH hospitals in some situations.

Bob Prath, AARP, asked whether there were any incentives available to ACO organizations that coordinate with social services. *David Maxwell-Jolly* responded that the Department's goal is to get plans to set up the right kind of liaison with social services. Tim Schwab, SCAN Health Foundation, noted that just because social and medical services are paid together does not mean that the integration occurs. There are models for successful integration with cost savings, but it takes a great deal of communication, and adequate rates. *David Maxwell-Jolly* agreed that financial restructuring alone does not make anything happen, and that California has a lot to learn in this area.

Jeff Flick, Anthem Blue Cross, said that his plan is interested in innovation as a means to savings. Blue Cross is engaged in experimental work in other states, for example

subsidizing the purchase of cell phones in order to give the plan a means of communicating with patients. There are many opportunities for innovation in California, as long as plans receive actuarially sound rates. *David Maxwell-Jolly* said that the rates DHCS is proposing are actuarially sound, built on careful analyses of existing rates for the voluntarily-enrolled SPD population and of FFS expenditures. DHCS expects a negotiation with the plans about these rates, and will look at their suggestions. He emphasized that calculations are not driven by the budget situation and do not represent artificial budget savings.

Update on Implementation Efforts on SPDs, LIHP and CCS

Greg Franklin, DHCS, and Tanya Homman, DHCS, provided an overview of the implementation timelines for different elements of the waiver.

Greg Franklin discussed CSHCN and LIHP:

Children with Special Healthcare Needs

- The CCS RFI is being revised to respond to comments from the September 29, 2010 SAC meeting and work with David Alexander of the Lucile Packard Foundation for Children's Health.
- RFI to be re-released in January 2011.
- Continuing to work with LPFCH on evaluation methodology to be included in the final RFI.
- *David Alexander, LPFCH*, said that the plan is to suggest a traditional pilot project evaluation, with a control group, but also some real-time metrics to allow for evaluation of the pilots and the CCS program generally.

Low-Income Health Program

- A request for information that must be submitted by the state to CMS by January 1, 2011, has been sent to counties.
- A county application is also scheduled for release in the first week of January.
- The LIHP Expansion Discussion will provide additional detail.

Tanya Homman provided an update on MMCD Waiver Implementation activities:

- Plan Readiness
 - To be complete January 2011
 - Network adequacy assessment is underway, with plan responses and comments due back 12/20/10

- Contract changes and revisions, developed in consultation with plans, to be finalized by the end of December 2010.
- Outreach and Education
 - 90-day materials are complete
 - At least 16 outreach events (led by UC Berkeley team) will be scheduled for April and May
 - SPD awareness/cultural sensitivity training will be finalized in early January, with two trainings with health plan master trainers to be held that month.
- Facility Site Review Tool
 - MMCD has revised the tool and shared it with the advisory group on November 23, 2010.
 - Policy letter and tool itself will be issued in December, with training in January and use of the tool in place by February 2011.
- Risk Stratification and Assessment
 - MMCD is working with plans to develop the risk assessment tool
 - Policy letter to be released January 2011, with submissions expected by March 2011 for approval by April.
 - Tool must be in use by all plans by June 2011.
- DHCS/DMHC Interagency Agreement
 - Agreement is drafted but language still being finalized
- Draft SPD Rates
 - Meeting was held 12/3/10 to discuss draft rates
 - Analyzing feedback to determine whether changes are necessary
 - Drafts finalized by February 2011

Small Group Discussions on SPD Enrollment and LIHP (Coverage Initiative) Expansion

SAC members broke into two smaller groups, focused on SPD enrollment and LIHP expansion. Notes from each group follow.

SPD Enrollment

Moderated by *Elizabeth Landsberg, WCLP*.

Tanya Homman and Rita Marowitz, DHCS, presented a report on the status of DHCS's implementation of mandatory SPD enrollment. This information was also made available as a handout

(http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/SPD_Implementation_Monitoring_SAC.pdf). MMCD's second Implementation Update is available at

http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/SPD_Update2_Dec3.pdf.

DHCS is currently developing the components of its monitoring of the implementation of mandatory enrollment of SPDs into Medi-Cal managed care. Below are a few suggested approaches for discussion.

✓ - Identifies a current monitoring activity

1. Enrollment Patterns (monthly):

- Number of members choosing plans ✓
- Number of non-choosers being defaulted to plans on the basis of FFS provider linkage
- Number of members defaulted in accordance with the regular quality-based default algorithm ✓
- Monthly changes in plan enrollment and current totals ✓

2. Outreach Results (monthly):

- Number of packets sent each month ✓
- Number of beneficiaries reached in first outreach call (vs. number of attempted calls)
- Number of beneficiaries reached in 2nd and 3rd calls (vs. number of attempted calls)
- Number of completed METs returned to HCO and forwarded to plans

3. Medical Exemption Requests/Expedited Disenrollment Requests and Continuity of Care Approvals (monthly or quarterly)

- Number of MERs and EDERs requested and approved/denied for SPDs each month or quarter (reported by HCO) ✓
- Number of enrolled members who requested “continuity of care” with FFS provider through plan; number of with plan approvals and number of denials with reason categories (as reported by plans)

4. Risk Assessment Results (monthly and/or quarterly)

- Number of new SPD members for which FFS utilization data was provided to plan and number of new SPD members with no available utilization data
- Total number of records provided to each plan each month
- Monitoring to assure plans retrieve utilization data timely each month
- Number of members identified as high-risk by plan in 1st 45 days each month
- Number of high-risk members that plans were able to reach and complete care coordination plans for vs. number of members who could not be reached

5. Member Concerns (monthly and quarterly)
 - Number of calls to MMCD Office of the Ombudsman re: physical accessibility and access to care; number of State Fair Hearings in these areas (monthly) ✓ (current monitoring activity except for physical accessibility)
 - Number of plan grievances re: physical accessibility and access to care (quarterly) ✓ (current monitoring activity except for physical accessibility)
6. Utilization Data – Note that utilization data for newly enrolled SPDs will be extremely incomplete until 18 months after the end of the 12-month roll-out. Utilization data reported before that time will simply be incomplete “snapshots” of utilization by SPDs which may or may not be meaningful.

Initial utilization data **under consideration**

- Number of new SPDs receiving inpatient and/or outpatient services each quarter
- Types of services most commonly accessed
- Most common diagnosis codes

Expanded utilization data reporting to begin **no earlier than six months after phased-in enrollment begins and perhaps later**

- Hospital usage (inpatient) ✓
 - Avoidable hospitalizations – this will be extremely challenging to report; data specs need to be developed in collaboration with plans
 - Hospital readmissions – also challenging; specs to be developed
 - Emergency room use ✓
 - Prescriptions (per 1,000 member months and/or top drugs used) ✓
7. Quality Measure Reporting (annual) – Performance measure reporting (such as HEDIS or other measures) for SPDs re: quality of care (quality, access and timeliness) will be incorporated into existing annual performance measure reporting
 - Required performance measures for reporting year 2012 (reflecting 2011 data) will include some new measures focused on SPDs and initial provisions for stratified reporting for selected measures. Due to continuous enrollment requirements and timing of reporting, 2012 scores will not reflect the newly enrolled SPDs. ✓ (current monitoring activity except for stratified reporting)
 - Required performance measures for reporting year 2013 (reflecting 2012 data) will begin to reflect outcomes for both total population and SPD members. ✓ (current monitoring activity except for SPD members)

DHCS will engage stakeholders in discussion regarding the selection of 2012 Performance Measures by spring 2011.

Members of the group then posed a number of questions and offered comments related to SPD enrollment. DHCS responses were by Tanya Homman and/or Rita Marowitz:

Enrollment Process

- Will there be a different enrollment process for those with a primary behavioral health condition? DHCS: No – individuals with behavioral health conditions will receive a packet like anyone else. Default enrollment does not take the mental health provider into account. DHCS is reaching out to mental health plans and providers.
- What about children? DHCS: For both adults and children, the phase-in begins on June 1, 2011, based on their month of birth. Children are not treated differently than adults in the phase-in, with the possible exception of foster children if they can be identified.
- Is there a benchmark by which the default rate is determined to be too high? This would be a signal that the communications to beneficiaries aren't working. DHCS: This is a good idea, but we will need to determine how to identify that benchmark, which may vary from plan to plan.
- Every year DHCS reevaluates the measures it uses in its default algorithm. Is DHCS planning to use HEDIS measures or factors around health outcomes and interventions that are more specific to seniors in determining this algorithm? DHCS: We evaluate the default measures every year, usually beginning in May. However, the choice of default measures is driven by the overall performance measures DHCS requires plans to submit, which also is evaluated annually. We expect to add to and modify the currently required performance measures for 2012 in order to begin to integrate some SPD-specific measures. That decision for 2012 will be made by August 2011. At that point we also will consider making changes to the default measures and will involve plans and other stakeholders in both processes.
- Will DHCS track plan switches? DHCS: Yes, and we will also track the reasons for plan changes.
- Alternate formats for outreach are needed. Many in the deaf community, particularly non-English speaking deaf people, will not respond to any paperwork unless it comes from the deaf community. Brokers need to inform people that they will supply materials in alternative format for vision impaired. The number of phone calls to beneficiaries (outreach results measurement) is not helpful for those populations. An ASL video showing how to apply, enroll, and choose a plan would be useful. DHCS: Excellent input, and we will look into this.
- Can benchmark percentages be included in all reporting so that we can gauge what people consider high or low results? DHCS: We will be working on determining the monitoring measures for which we can develop benchmarks.
- Can monitoring data be stratified, e.g. by age groups? DHCS: Yes.
- A survey of beneficiaries might be useful since there is much that is difficult to understand from the quantitative data. UC Berkeley is willing to do this if funding is available. DHCS: We will be considering this.

Critical Issues

- Network adequacy is required by the Statement of Terms and Conditions. What is DHCS' plan? DHCS: Network adequacy reviews will be conducted through DMHC on a quarterly basis. Plans that do not meet network requirements will be suspended from mandatory enrollment. We will post the network adequacy submission package provided to plans on the website.
- Is there an age-based assessment of network adequacy? DHCS: We have reviewed network adequacy based on access to the 24 specialty groups used by this population. We also looked at specialty types in COHS plans to inform other plans about our expectations.
- Will there be any new contract language regarding home and community-based services? Are any quality measures for HCBS built in? DHCS: Any changes to HCBS, such as enhancements, would have to go back through the waiver.
- Enhanced HCBS coordination/linkage is required: HCBS have to be connected to plans through some well-established process. DHCS: There is contract language regarding coordination with carve-outs, and David Maxwell-Jolly is currently in discussion with plans about increased inclusion of HCBS.
- Qualitative assessment of network adequacy is essential.
- Plans and DHCS should keep track of calls documenting client problems. DHCS: We will be doing this.
- In documenting problems with primary care access and PCP linkage, the number who did not receive any care is also a useful measure. DHCS: We are looking at how to report this.
- It would be useful to see the boilerplate for modified plan contracts as soon as possible. DHCS: We will share when finalized.
- It is important to focus on providers and on the social network, and to survey them for their view of SPD enrollment.
- CHCF reiterated its offer of support to help DHCS with outreach.
- Health plans need incentives to deal with special groups. Plans should be encouraged to partner with stakeholders. DHCS: There is a requirement that plans work with stakeholders, but in reality plans *want* to have good relationships with stakeholders, as that helps them too.
- HEDIS measures are not so relevant to SPD, and the state must find alternate measures. DHCS: We will begin modifying the required performance measures to better reflect the SPD population as of the 2012 required measures, which are determined by August of the previous year. Additional measures will be added in subsequent years as more utilization data becomes available to help provide focus on quality improvement "opportunities."
- Data is crucial, and the data set should be comprehensive, e.g. including mental health drug data and mental health service use, CCS information, etc.
- Actuarially sound rates are important to managed care plans – there is an expectation that managed care enrollment will reduce ED use and hospitalization rates, and increase generic drug use. If provider performance standards are too tough, all plans will have to narrow their networks.

- The criteria for identifying individuals as high-risk are critical and will drive a number of other issues. DHCS: Dr. Sherie Smalley, Chief of MMCD's Medical Policy Section, is working with health plans on this issue, which also needs to be vetted with stakeholders.
- There are no well-organized integrated institutions in Northern California. Rural issues are a problem. DHCS: Implementation will only be in 14 managed care counties.
- A member of the SAC commended DHCS staff for its work in this area.

LIHP Expansion (formerly the Coverage Initiative and identified as CEED in waiver legislation)

Moderated by *Kelly Brooks, CSAC*.

Participants reviewed a handout on the Low Income Health Program (LIHP) prepared by DHCS (available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Low_Income_Health_Program_Discussion.pdf).

Greg Franklin, DHCS, said that the LIHP is the fastest-moving piece of the waiver, with information due to CMS beginning in January and implementation in new and continuing counties during the spring of 2011. DHCS will be reaching out to create small advisory groups as the process moves along.

Bob Baxter, DHCS, presented a draft timeline for new and continuing counties, beginning with the release of applications on January 3, 2011, and continuing through the application process with a June 1, 2011 deadline for county authorization to implement the LIHP programs. Greg Franklin noted that the application will not be complex: DHCS is looking at developing something that doesn't require a great deal of work from counties but meets CMS' needs. March 1, 2011, is the date on which the counties' applications will be due to CMS.

Greg Franklin, DHCS, clarified that counties with existing CI programs could begin claiming earlier than July 2011. The LIHP website will post the timeline and framework for the process, which will be transparent.

Marty Lynch, Lifelong, asked whether counties could get retroactive approval for services. Greg Franklin said that at county option, individual beneficiaries can receive retroactive approval for up to three months. It is not clear whether a county would claim this as a CI or MCE benefit.

Judith Reigel, CHEAC, asked whether the deadlines were the same for both CI and MCE applicants, and whether there would be a second opportunity for counties that cannot meet

the deadline. Bob Baxter replied that applications will be accepted on a rolling basis, but that those counties that join later risk missing access to the HCCI allocation.

Kelly Brooks then moderated discussion on the following questions:

What are the advantages and/or disadvantages of basing eligibility solely on income? How would you use acuity or medical status to help determine eligibility?

- Base eligibility on income and then stratify it by acuity. A plan might do different things about immediate care, but income should still be the standard. The goal is first to get people in as quickly as possible, and then to provide care to the neediest first.
- This was discussed at the last SAC meeting, and the group circled around to a decision that income level can be used as a proxy for medical need.
- It appears that CMS wants income to be used as the eligibility tool.
- If there is room only to look at income, is it possible to stratify by how low the income is? People with incomes below 50% FPL have higher acuity than those at 133% FPL.
- Prioritization is an important issue but simplicity is also a high value – we want to get people in via the quickest, easiest way. Slicing and dicing may itself create a barrier.
- All these people are very poor. Outreach and enrollment can be targeted, but not eligibility and enrollment.

How would you target outreach for these populations?

- Start with the criminal justice system and emergency departments.
- Find people in shelters and on the streets (before they go to jail).
- Once you enroll people, to keep them in you need to put services in places they can find them – and include the services that Corporation for Supportive Housing provides or it won't work.

Financial mechanisms: LIHP offers an opportunity to move away from CPEs and toward capitated rates. What are the challenges for new counties in developing a capitated rate?

- In the past there has been difficulty putting these populations in a capitated system – counties need help to do it right.
- What are the actual costs of stabilizing these people? Washington State's experience may be helpful, but it may be that nobody knows the answer to this question.
- While there's a minimum benefit package, counties might want to invest more in behavioral health in order to reach this population and that will affect the rate.

- The MCE population also includes healthy people, who may never have been to the hospital, and these people also need outreach.

The group discussed the mental health benefit under MCE at length. *Rusty Selix, CCMHA*, asked whether a county that wants to provide comprehensive mental health services to someone has to provide those services to everyone enrolled in the program. A comprehensive program for an individual could cost \$10 - \$20,000/year, and this could scare counties away. Greg Franklin clarified that the benefit package can't be designed for one individual. *Marty Lynch* asked whether there could be a narrowly defined minimum benefit with the exact service package driven by need. *Sandra Naylor Goodwin, CiMH*, asked whether a combination of medical necessity and avoiding the risk of hospitalization could be used as a criterion for a higher benefit level. Greg Franklin said that the Statement of Terms and Conditions doesn't appear to allow for that. *Melissa Stafford-Jones* noted that medical necessity was not waived, and would be the avenue to think through this issue.

The group also discussed whether federal parity rules apply under the waiver. Some argued that it did, others that the 10 days/year of inpatient and the 12 outpatient visits included in the waiver imply that CMS does not envision parity rules as applying.

Existing Medi-Cal carves out mental health services: what would be the benefit of including mental health packages in the capitation rate?

- If the goal is managing care, it should all be included.
- Many in this population will have high acuity physical conditions, and while they may have mental health issues they do not have Severe Mental Illness that would qualify them for services through the county. These individuals should have access to some services through the MCE.
- Different populations require different approaches. There will be at least three different levels of outpatient mental health services: 1) tied to the primary care provider or center; 2) via individual therapists in the community; and 3) through the county mental health system. Someone with SMI needs the third level.
- When mental health was carved out in 1994, plans didn't have the capacity to provide the services that people with SMI needed, and that is still the case. It would be ideal if the health plan had some money for mental health as part of their capitation, but they contract with county mental health or with their providers to collocate services in the primary care center. A carve-in could work for 97% of the population, but the people with SMI will end up costing 70% of the money.
- Whether it's carved out or carved in, the critical issue is that comprehensive services are available in one location. For some people, that means the community mental

health center, where both a mid-level primary care provider and medication management should be available.

The Statement of Terms and Conditions requires some reporting from LIHPs. The current plan is to model the LIHP assessment process on that for managed care plans, which requires some encounter data. Will counties be able to provide this?

- *Greg Franklin* noted that the encounter data could be useful in assessing utilization, access, and the provider network, and in shaping the state's thinking regarding the future of ACA. It would also allow for more targeted technical assistance, and permit comparative analyses.
- This data will be important for implementation in 2014.
- Quantifying care coordination and related topics is very difficult. Medical procedures and visits are easier to count.
- If the encounter data includes reporting on how plans meet timeliness standards, particularly with regard to specialty care and the initial health assessment, then it could be very useful – but is DHCS really going to take an oversight role in this?
- It would be very helpful to collect data that allows for quantification of outcomes, not only contacts.
- Currently, basic demographic data does not include gender identity, sexual orientation, or family status. If assessment procedures are being revised, this information should now be included.

How should the state proceed in developing rural access standards? Are there models elsewhere that might be helpful?

- *Greg Franklin* noted that there is a provision in the waiver requiring the state to develop access standards for rural areas.
- Current DMHC standards have a variety of provisions to accommodate rural areas. They are not perfect, but provide a starting point.
- It's important to be clear about what's being offered. We can't pretend to provide coordinated care where we're not.

Budget Neutrality in the Waiver

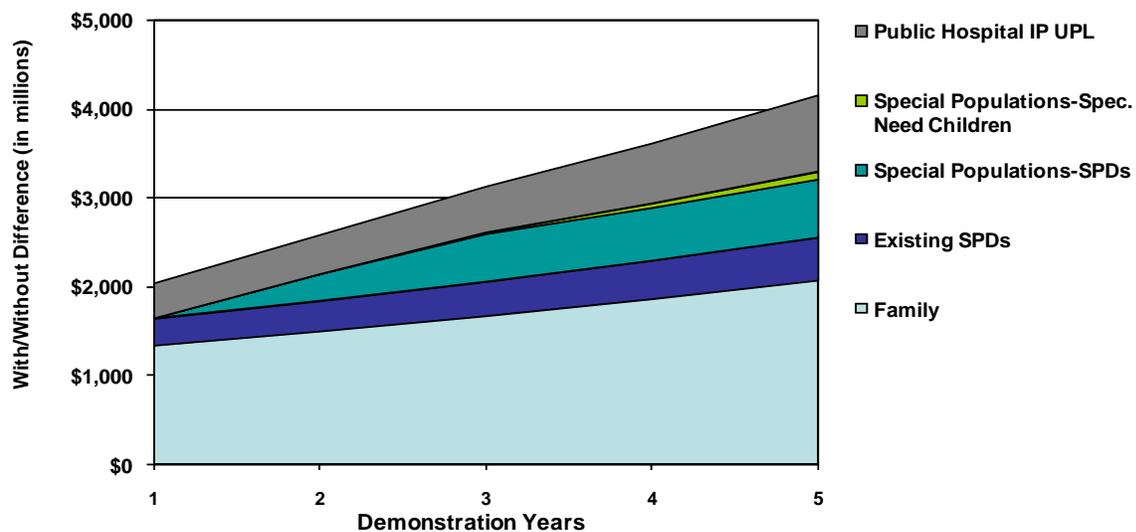
David Maxwell-Jolly and Gregory Franklin, DHCS, presented a high-level discussion of budget neutrality as calculated for the waiver in order to show how California justifies the additional investment of federal funds.

In an 1115 you compare expenditures with/without waiver, and if you save with you can use some of those savings for other things. This is a new approach for CA.

Budget Neutrality Approach

- Justification for additional federal funds for:
 - Safety Net Care Pool
 - Low Income Health Program – Health Care Coverage Initiative (the Medicaid Coverage Expansion funding is open-ended in this waiver and does not count toward the budget neutrality limit.)
- Based on two elements
 - Inclusion of managed care under the waiver – the entire program, including families and voluntary SPDs, is included
 - Consideration of unexpended room in Public Hospital Upper Payment Limit – gap between inpatient hospitals' actual spending and their UPL -- is part of the budget neutrality calculation

Budget Neutrality Sources



- *Family*. In Year 1, family enrollment generates about \$1.3 B in savings compared to FFS, and that savings is projected forward. In this waiver, California has been credited for and achieved budget neutrality cost savings based on cost savings measures that are ongoing allowing reinvestment in SNCP.
- *Current SPD*. Current voluntary SPD enrollment in managed care plans is credited with approximately \$300 million in savings.
- *Special Populations – SPDs*. The savings from enrolling current FFS SPDs in managed care is counted as 0 in first year, growing to approximately \$400M annually by year 5.
- *Special Populations – Special Needs Children*. The waiver assumes a very small amount of savings for CSHCN as CCS pilots roll out.
- *In-Patient Upper Payment Limit (IP UPL)*. This amount, unlike the others, is locked in for the course of the waiver.
- The graph represents total funds amounts, so the federal share of these amounts is what can be reinvested for the purposes of SNCP.

Overall, the budget neutrality calculation:

- 1) Shows how the state recaptures savings for program innovations that are in place now saving program costs.
- 2) Is based on assumptions about growth rates/spending that are very reasonable and very obtainable.
- 3) Grows over time. The level of spending of SNCP can exceed the savings in the early years, and this will require careful monitoring so that the state can justify expenditures over the course of the waiver. If savings aren't actually generated and SNCP spending exceeds actual savings, the state may be required to pay those funds back.

Jeff Flick, Anthem Blue Cross, asked whether enrollment of duals in managed care would have changed the graph. *David Maxwell-Jolly* replied that while there are great opportunities in that area, DHCS did not develop those arguments or quantify potential savings. The savings calculations in the graph are real-time calculations, based on real FFS costs, and primarily represent savings from avoided hospitalization.

Elizabeth Landsberg, WCLP, asked for clarification on total amounts for which the state is eligible. *David Maxwell-Jolly* said that the \$10 billion in federal funds that is often cited represents a combination of the amounts in this chart (which totals approximately \$14 - \$16 billion, of which the federal share is \$7 - \$8 billion) and estimates of the dollars California will claim via an open-ended LIHP (approximately \$2.3 billion). The webinar presentation

from November 4, 2010, provides more detail and is available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Waiver_Approval_Webinar_11_41.pdf.

Chris Perrone, CHCF, applauded the administration and stakeholders for the budget neutrality calculations, particularly for achieving savings from program innovations that are currently in place. He asked whether the incentive pool falls within SNCP.

Rusty Selix, CCCMHA, asked what projected enrollment in county LIHP programs was and how close that comes to projected new Medi-Cal enrollment in 2014. *David Maxwell-Jolly* recalled that the Administration's LIHP enrollment estimates were 500,000 by 2014, or approximately 50-60% of projected newly eligible Medi-Cal beneficiaries.

Public Comment

Gary Passmore, California Congress of Seniors, said that managed care plan rate negotiations are structured such that the Department first negotiates with the plans, and the plans subsequently negotiate with providers. There is no role for consumer advocates, and as California moves toward 2014 DHCS should consider opening up the rate discussion to the public, since the assistance of provider and consumer groups will be needed to create the political will to adequately fund the program.

Beth Abbott, Health Access, had the following comments related to the SPD breakout discussion. First, information on enrollment patterns for SPDs should be made publicly available, as it represents an important public measure of performance. Second, the Office of the Ombudsman should be fully staffed and functioning in order to handle the increased demand for service that can be anticipated with mandatory SPD enrollment. There are other avenues for grievance and redress within the plan and state structures, but it is still important that the Office of the Ombudsman is functioning robustly with adequate training. *David Maxwell-Jolly* replied that the comment echoed a conversation he had recently had with Tanya Homman of MMCD, and that Ombudsman office staffing is a high priority.

Jordan Lindsey, California Association for Health Services at Home, said that coordination and communication between medical services and HCBS should be improved. He provided an example from Solano County in which a child's care was complicated by a lack of communication between CCS, the plan, the home health provider. Mr. Lindsay suggested that DHCS require post-event evaluations in order to determine what went right and wrong in situations like this. Outreach to home health providers is important. Home health and hospice workers would like to be involved in financing and policy decisions that affect these services.

Lydia Missaelides, California Association for Adult Day Services, noted that at the same time that the waiver is designed to achieve better care coordination, Adult Day Health Care (ADHC) is being proposed for elimination. ADHC already provides the coordinated, integrated care that the waiver envisions, and could help plans in their management of SPD individuals, but should budget battles lead to the elimination of ADHC a Medi-Cal benefit the ADHC centers would be unable to survive and would close. There is not comparable service that could be substituted, meaning significant impact on beneficiaries and on rate discussions.

Randy Hicks, CA Disability Rights, said that many SPDs don't yet know about the managed care transition, and recommended that the Department conduct outreach at Regional Centers. One important question will be how enrollment affects TARs.

Next Steps, Next Meetings, and Adjourn

Bobbie Wunsch thanked Elizabeth Landsberg and Kelly Brooks for facilitating the small group discussions. She acknowledged the participation on the SAC of Jackie McGrath of the Alzheimer's' Association, who is retiring in December 2010, and Diana Dooley, California Children's Hospital Association, who has been nominated as Secretary of Health and Human Services.

She announced two additional meetings also to be held on December 8:

- Update on dual eligibles at 1:30pm – 2:30pm in room 202.
- Meeting for counties interested in LIHP at 2:00pm – 4:00pm in this room.

The next meeting of the SAC will be on Thursday February 10, 2011 from 9:30 AM – 12:30 PM at the Sacramento Convention Center.