SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
STAKEHOLDER ADVISORY COMMITTEE (SAC)
Meeting #3 – Thursday, May 13, 2010
9:30am – 12:30pm
Sacramento Convention Center, Room 204

The meeting convened at 9:30 AM.

Attendance

Members attending: Kelly Brooks, California State Association of Counties (CSAC); Jack Burrows, Association of California Health Care Districts (by phone); Richard Chambers, CalOptima; Mike Clark, Kern Regional Center; Diana Dooley, California Children's Hospital Association (CCHA); Catherine Douglas, Private Essential Access Community Hospitals (PEACH); Juno Duenas, Family Voices (by phone); Teresa Favuzzi, California Foundation for Independent Living Centers; Jeff Flick, Anthem Blue Cross; Bradley Gilbert, Inland Empire Health Plan (IEHP); Sandra Naylor Goodwin, California Institute of Mental Health (CiMH); Daniel Gould, California LGBT Health and Human Services Network; Peter Harbage, SEIU; Marilyn Holle, Disability Rights California; Michael Humphrey, Sonoma County IHSS Public Authority (by phone); Ingrid Lamirault, Alameda Alliance for Health; Elizabeth Landsberg, Western Center on Law & Poverty (WCLP); Marty Lynch, LifeLong Medical Care; Jackie McGrath, California Council of the Alzheimer's Association; Anne McLeod, California Hospital Association (CHA); Santiago Munoz, University of California, Office of the President (UCOP); Bob Prath, AARP California Executive Council; Brenda Premo, Harris Family Center for Disability and Health Policy (CDHP); Sharon Rapport, Corporation for Supportive Housing (CSH); Judith Reigel, County Health Executives Association of California (CHEAC); Lisa Rubino, Molina HealthCare of California; John Schunhoff, Los Angeles County Department of Health Services (LAC DHS); Timothy Schwab, Senior Care Action Network (SCAN) Health Plan; Rusty Selix, California Council of Community Mental Health Agencies (CCCMHA); Al Senella, California Association of Alcohol and Drug Program Executives; Barbara Seigel, Neighborhood Legal Services of Los Angeles County (NLS); Stuart Seigel, Children's Hospital Los Angeles (CHLA); Marv Southard, Los Angeles County Department of Mental Health (LAC DMH); Herman Spetzler, Open Door Community Health Centers; Sarah Takahama, California Association of Physician Groups (CAPG); Richard Thorp, California Medical Association (CMA) (by phone); Anthony Wright, Health Access California.

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

Public in attendance: 60 members of the public attended the meeting in person and 91 called in on the listen-only telephone line.

Welcome and Introduction

Bobbie Wunsch, PHCG, welcomed the Committee members and the public attending in person and by phone. She reviewed the agenda and noted that public comment, at the conclusion of the meeting, would be limited to one minute per person.

Upcoming meetings of the Stakeholder Advisory Committee are as follows, with changes to the previously published schedule noted in **bold**:

- June 10, 2010, 9:30am – 11:30am **via conference call/webinar.** The meeting will include updates on waiver negotiations with CMS and on any changes to the Implementation Plan. Call-in information will be posted on the waiver website in advance of the meeting.
- **July 22, 2010**, 9:30am – 12:30pm, Sacramento Convention Center **(changed from July 8)**
- September 29, 2010, 9:30am – 12:30 pm

Highlights of the DHCS 1115 Waiver Implementation Plan

David Maxwell-Jolly, Director, DHCS presented highlights of the DHCS 1115 Waiver Implementation Plan, available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Waiver_ImpPlan_5-2010.pdf. He thanked the Stakeholder Advisory Committee members and the public for their continued attention and effort in the waiver development process, and the Technical Workgroups (TWGs) for their extensive input. (With the exception of the Dual Eligibles Workgroup, the Workgroups have concluded their meetings.) The Implementation Plan is also informed by a large number of position papers by various organizations, and that input is appreciated. David Maxwell-Jolly recognized the efforts of DHCS staff in completing the Implementation Plan, and said that DHCS is proud of the joint effort with the foundations that allowed so much of the Workgroup discussion to be included in the document.

David Maxwell-Jolly's presentation on the Implementation Plan is available at http://www.dhcs.ca.gov/Documents/DHCS%20Waiver%20Implementation%20Presentation%205-10%20gf%20dmj%20(2).pdf.

David Maxwell-Jolly said that the Implementation Plan describes an approach for improving care for populations with complex needs, and presents a coherent set of strategies in each of the target areas: seniors and persons with disabilities (SPDs), dual eligibles, children with

special health care needs and persons with behavioral health conditions. The Implementation Plan also discusses the health care coverage initiatives (HCCI) as a foundational element in implementing the federal expansion of Medicaid under health care reform (HCR), and includes strategies for hospital finance, including continuation of the safety net care pool (SNCP).

Seniors and Persons with Disabilities (SPD)

With respect to seniors and persons with disabilities (SPD), the goals of the waiver are to:

- Improve access to and coordination of the most appropriate, cost effective care for SPDs; improve health outcomes and contain costs;
- Provide SPDs with a choice of organized systems of care through which to receive these services;
- Support and strengthen the local safety net and its integration into organized systems of care;
- Align financial incentives to support providers in delivering the most appropriate care and containing costs.

The Implementation Plan proposes to begin enrollment of SPD with the Medi-Cal-only population. DHCS is proposing mandatory enrollment for this group, with a choice among organized systems. DHCS intends to make requirements for organized systems more specific in terms of care provision and coordination of with other community providers. DHCS also wants better system monitoring and increased accountability for plans, and expects increased integration of safety net systems into organized care systems.

David Maxwell-Jolly said that enrollment of children and families in managed care has led to important improvements in care, including better access, a slower rate of growth of costs, and, ultimately, better outcomes. He said that he expects similar benefits from the enrollment of SPD beneficiaries in managed care. He acknowledged that there are many in the disability community and elsewhere who think that the state should move very slowly and carefully, and that while he understands that position, he believes that to delay enrolment forgoes real benefits. The fee-for-service (FFS) system as it currently stands does not offer many of the benefits that can be available through organized systems.

The plan includes two alternative approaches:

- Mandatory expansion of the SPD population into an existing managed care plan
- Mandatory expansion of the SPD population offering the choice of enrollment into existing managed care plans or a “County Alternative”

County alternatives will be held to the same requirements as other plans, with the exception of certain financial requirements as Knox-Keene licensure may not be required for the alternative plans.

In the near term, DHCS intends to focus on counties with existing managed care systems – the Implementation Plan does not address the care management needs of rural California, though DHCS will continue to consider that issue. Mandatory enrollment in managed care plans would begin in February 2011, except in counties that choose to develop alternative models, where enrollment would not begin until those alternative systems are fully developed.

Key performance standards against which managed care plans and county alternative models would be assessed are:

Access

- Network Adequacy
- Access to Information
- Physical Accessibility

Transition

- Outreach and Education
- Phased-In Transition
- Access to Existing Providers
- Assignment

Care Management and Coordination

- Enhanced Definitions of Care Management and Coordination
- Early Identification of a Member's Health Care Needs
- Care Management Assessment
- Cultural Competency Training
- Behavioral Health Coordination
- Coordination with Other Services

Early identification of health care needs is particularly important for members with a history of high health needs. Coordination with other services in the community is essential, and liaisons with services including behavioral health (BH) and regional centers must be explicit. DHCS expects plans to push the envelope on BH integration.

Performance Monitoring and Improvement

- Expand Required Performance Measures
- Augmented Audit Effort
- New HEDIS measures
- SPD Representation
- Enhanced Member Satisfaction Survey
- Quality Improvement projects (QIPs)
- Complaint and Grievance Procedures

The goals in the area of performance monitoring are to develop measures that inform DHCS and the public about quality of care, and to create a feedback loop to allow for care improvement and for DHCS to take action when care is not adequate. While plans already are subject to extensive performance monitoring, additional measures for SPD populations in particular are needed. In addition, active complaint and grievance procedures are important, as are QIPs specific to SPD populations.

Children with Special Health Care Needs (CSHCN)

Discussion in the CCS TWG centered on four potential models for greater integration of care for children enrolled in CCS. The four are:

- Enhanced Primary Care Case Management
- Provider-Based Accountable Care Organization
- Specialty Health Care Plan
- Managed Health Care Plan

David Maxwell-Jolly noted that these are structural approaches only – the Implementation Plan is silent as to who would deliver the various elements of care, and does not suggest that they would be outside the current CCS system. DHCS' planned approach is to develop some pilot programs, with robust evaluation, that would lay the groundwork for more broad-based approaches in the future.

Behavioral Health Integration (BHI)

David Maxwell-Jolly said that while more work remains to be done in this area, two near-term strategies include:

- Advancing integration in managed care plans and other organized systems: Promoting communication, information-sharing, and service integration between managed care providers and mental health and substance use providers

- Establishing more integrated care: Continuing to explore opportunities to develop more integrated delivery models that promote care integration, such as through coverage initiative

The first strategy would require that, as SPD beneficiaries are enrolled in managed care organizations, those managed care organizations (MCOs) deal explicitly with the question of how to coordinate medical and behavioral health services. This will include providing much more explicit direction to their organization and their providers about how that is to be accomplished.

In the HCCI context, the BHI TWG discussed opportunities for local HCCIs to develop models that would include integrated service delivery across all modalities, in effect serving as pilots for behavioral health integration.

Dually Eligible Beneficiaries

Implementation objectives for this population are to:

- Create one point of accountability for the delivery, coordination, and management of health care and long-term supports and services
- Promote improvements in health outcomes
- Maintain appropriate consumer involvement and safeguards
- Structure incentives to improve coordination of care
- Promote the use of home and community based services
- Align Medicare and Medicaid's services and financing to streamline care and eliminate cost shifting
- Slow the rates of both Medicare and Medicaid cost growth

David Maxwell-Jolly said that the Dual Eligibles Technical Workgroup has met once, and will continue to meet in the coming months. Discussions with CMS on this issue are ongoing, and DHCS does not expect details to be included in the waiver that is finalized by September. The state is, however, interested in looking at pilots for service integration where managed care plans have both Medicare and Medi-Cal contracts, and testing the advantages of that coordination.

Health Care Coverage Initiative (HCCI)

David Maxwell-Jolly provided an overview of the proposal for expanding HCCI in the context of the 1115 waiver:

- Preparing for National Health Care Reform
    - Offer enrollment of parents and childless adults up to 200 percent of the federal poverty level
    - Work to align the eligibility, benefits, cost sharing, and immigration status rules for this newly covered population
    - Prepare for seamless enrollment into mandatory Medi-Cal coverage
- Program Developments
    - Standardize benefits package over time to better align with a benchmark plan
    - Assign medical homes
    - Participation of public and private providers in provider networks
    - Outreach for increased enrollment

DHCS believes, and will argue to CMS, that HCCIs offer the best route to early expansion of Medicaid, in accordance with federal health care reform. This means that the eligibility and benefits rules in the HCCIs will have to align closely with the benefits package and rules that will be part of Medi-Cal expansion in 2014. The HCCI TWG was unanimous that county diversity should be allowed in the HCCI expansion, but DHCS believes that the HCCIs will need to become more uniform in order for the state to make the case for the proposal that is on the table.

Within the HCCIs, DHCS wants to include the care management structures that many HCCIs have already developed, and that are envisioned for SPDs in managed care as well.

One advantage of the HCCI proposal is that, by enrolling people now who will be eligible for Medi-Cal in 2014, health care systems will be able to start releasing the pent-up demand for health care in the population, which otherwise could overwhelm the system in 2014.

Hospital Financing

- Retain key funding features
    - Certified Public Expenditure claiming
    - Continued supplemental payments and DSH replacement funds
    - Safety Net Care Pool to support
        - Coverage Initiative
        - Other indigent care
        - State General Fund relief
- Expand Safety Net Care Pool resources
    - Increase support for existing purposes
    - Infrastructure investment to prepare for health reform

DHCS believes that an increase in Safety Net Care Pool (SNCP) resources can be used to increase funding for current purposes, but also to fund investments as part of preparation for 2014. Preparing for 2014 requires preservation of the safety net in the short-term – there are a number of financial stresses on safety net institutions, and it is important that funding is available now that will allow these institutions not only to survive until 2014, but to develop the care structures and capacity that will be needed then.

Timeline

A detailed timeline is available as slide 23 of David Maxwell-Jolly's presentation.

Questions and Comments from SAC Members

Juno Duenas, Family Voices, asked about patient choice, and specifically how to ensure that care decisions are made by families with providers, and not by managed care organizations. She said she was concerned that the Implementation Plan did not include discussion of consumer input to monitor accountability.

David Maxwell-Jolly responded that it is always a challenge to ensure understanding at the provider level of the needs of the family. DHCS' expectation is that MCOs should not get in the way of the provider/family relationship, which critical both for children and for disabled adults where family assists in managing care. He said that ongoing consumer input is a requirement for plans now, and said that consumer input into design and evaluation was an excellent suggestion, particularly in the context of CCS pilots.

Mike Humphrey, Sonoma County IHSS, commented that the proposed timeline for SPD enrollment in managed care – enrollment completed in 14 counties by January 2012 – seems extremely aggressive and in fact unrealistic. In Sonoma County, the planning process for conversion from FFS to Medi-Cal Managed Care took a year, and rate negotiation took even longer. He asked whether there would be any opt-out provisions for SPD beneficiaries. Regarding home- and community-based services (HCBS), Mike Humphrey said that the Implementation Plan is vague about the HCBS and that while there is discussion of "integrated benefits" and "inclusion of services" the language is not clear. Besides Regional Center services, about which the Plan is more specific, what kind of coordination is envisioned?

David Maxwell-Jolly said that he agreed that the timeline is aggressive, but that he is mindful of the opportunity costs of not moving forward. The Implementation Plan does not propose opt-out categories. With respect to liaison with HCBS, Regional Centers are singled out because they represent a significant institutional presence, but the point about needing more specificity regarding liaison with other HCBS is a good one.

Elizabeth Landsberg, WCLP, asked when DHCS would make available information on financial projections and detail on the process with CMS; and what the evidence is for the assertion that Medi-Cal managed care has improved outcomes. She also noted that WCLP supports a slower implementation of mandatory managed care enrollment for SPD based on the need to readiness standards and ensure that plans have met them.

David Maxwell-Jolly said that a UCSF study, published by the California HealthCare Foundation, found that avoidable hospitalizations have decreased with the implementation of Medi-Cal Managed Care for families. (The study is available at http://www.chcf.org/publications/2004/02/preventing-unnecessary-hospitalizations-in-medical-comparing-feeforservice-with-managed-care.) In addition, the rate of growth of costs is lower in managed care than in FFS. He said that some financial details would be released as part of the Governor's May Revise budget proposal, but that details on SNCP financing in particular were not yet firm, and that both the methodology and the total number were still subject to negotiations.

David Alexander, LPFCH, said that in response to a request from DHCS, the Lucile Packard Foundation for Children's Health would be convening national experts on evaluation to develop evaluation metrics to be applied to CCS pilots and to the overall CCS program.

Marty Lynch, LifeLong Medical Care, noted that the Implementation Plan does not specifically mention community clinics or Federally Qualified Health Centers (FQHCs), and that this is concerning given that these health centers have been important providers of care historically. He suggested that the Implementation Plan include a requirement that these providers be part of managed care networks and of county alternatives. He also suggested including Frequent Users of emergency care (who are often homeless Medi-Cal recipients) in discussion of the SPD population and the dual eligibles group.

David Maxwell-Jolly responded that DHCS includes community clinics and FQHCs – along with public hospitals, private hospitals that provide indigent care, and other entities – in its definition of "safety net." He said that DHCS believes that the most reliable way to target Frequent Users (FUs) is in the context of a capitated structure working in concert with community structures. Thus, while contracts may not require MCOs to have a FU program *per se*, DHCS expects that plans will focus on finding these people and finding community partners to help manage their care.

Jackie McGrath, Alzheimers Association, said she was encouraged by portions of the paper related to BHI and dual eligibles, but that she had significant concerns about SPDs. She said that the Implementation Plan contains a comprehensive problem statement on the other populations, but not on SPDs, which seems likely to allow the state to rush this group into managed care without sufficient development of standards. She suggested not only

readiness standards for plans, but that comprehensive assessments of individuals be completed before enrollment. She asked why the Implementation Plan treats SPDs differently from dual eligibles in this regard.

David Maxwell-Jolly said that the Implementation Plan focuses on those aspects that are essential to move the waiver forward. The concept paper and other documents include broad and extensive discussions of the problems and opportunities for SPD populations. The status quo is not better: people in FFS typically do not receive comprehensive needs assessments, so completion of such a process within 90 days of enrollment would be a big improvement. He said that DHCS is mindful of the need to move carefully in enrollment, and will do everything possible to preserve existing provider relationships. Still, DHCS believes that MCOs have the capacity to deliver care in a way that the FFS system cannot, and that the potential risks of the proposal are outweighed by the potential benefits.

Richard Chambers, CalOptima, asked how DHCS sees the waiver negotiations with CMS playing out, particularly given the upcoming change in state Administration. Does the Department expect that on some of the issues there will be agreement in concept only? David Maxwell-Jolly said that in the area of dual eligibles, he expected agreement in concept, and possibly some milestones. For CCS, the state expects to propose specific pilots, while in the area of BHI the work will be included as part of the HCCI and SPD proposals.

Rusty Selix, CCCMHA, noted that the Implementation Plan includes a county-by-county count of SPD beneficiaries, and asked that this be broken out to specifically identify beneficiaries who are disabled due to severe mental illness (SMI), since these individuals will have very different needs from others, including coordination between MCOs and specialty mental health agencies. Many of these people are eligible for Medicare as well: currently there is no incentive for county mental health agencies to enroll them as dual eligibles, but as the parity law is implemented in Medicaid that will change.

Herrmann Spetzler, Open Door Community Health Centers, said that the only discussion of financing in David Maxwell-Jolly's presentation was focused on hospital financing, and called for investment in the primary care safety net as well. David Maxwell-Jolly responded that one of the state's key strategies to provide more stability in the primary care safety net is HCCI – engagement of additional resources will replace some of the losses that the primary care safety net has experienced.

Marv Southard, LAC DMH, said that he supported casting the waiver as preparation for HCR implementation, and that bringing a variety of BH stakeholders together in the context of the BHI TWG would help with eventual implementation as well. BHI integration as part of HCCI is a good preparatory step.

Stuart Seigel, CHLA, commented that the Implementation Plan is inappropriately negative about the current CCS program, implying that the program is a hindrance to the care of CSHCN. This was not the consensus of the CCS TWG. He also said that, given the lack of comparative effectiveness data and the complications of designing appropriate pilot models, the proposed timeframe for CCS pilots might be too aggressive. David Maxwell-Jolly said that staff would look at the Implementation Plan and potentially revise the characterizations of the CCS program. DHCS is very interested in ensuring that the CCS pilot evaluations are concrete and well-designed, and since the data question is model-specific, implementation timelines might vary by model.

Melissa Stafford-Jones, CAPH, asked whether the state planned to use this document for state-level dialogue or as the basis for a proposal to CMS, since the Plan lacks detail on a number of issues. David Maxwell-Jolly said that the primary audience is the state community. The Implementation Plan does provide the majority of the information that CMS would want, but does not include complete discussion of cost-neutrality, HCR and other issues. DHCS will be preparing a comprehensive summary informed by the Implementation Plan and including other issues.

Sandra Naylor Goodwin, CiMH, said she approved of the decision to delay implementation of specific BHI projects, given the lack of clarity about the best way to proceed and the significant BH issues that occur in all the other proposals. She said she was pleased to see the requirement for coordination with BH in the SPD proposal and in HCCI expansion. She raised several concerns: 1) The terms “medical home” and “health care home” are used throughout the document but are never defined. Behavioral health should be a required component of a medical or health care home. 2) The Plan does not include any mention of the federal option for 90% FFP for people with chronic conditions or SMI. David Maxwell-Jolly replied that DHCS is definitely interested in taking advantage of that option, and is tracking it as it is developed at the federal level. DHCS will be looking at developing a better definition of health care homes in terms of what that means for MCOs.

Barbara Seigel, NLS, asked why the Plan was silent on simplification and restructuring of Medi-Cal enrollment administration, given that many problems are caused by people coming on and off the program. David Maxwell-Jolly said that the opportunities for Medi-Cal simplification are not addressed in the waiver, but are still possible. 2014 will bring a new income threshold for the program that will greatly simplify income calculations, as will the elimination of categorical distinctions. Barbara Seigel noted that there are actions that the state can take in advance of 2014 to ensure that people maintain their eligibility.

Anthony Wright, Health Access California, said that he appreciated elements of the Implementation Plan, especially the bridge to HCR. He asked for more detail on the Department’s plan to get ready for 2014, including consumer protections, plan readiness

standards, and other ideas proposed in the HCCI Workgroup and elsewhere. For example, the Plan mentions "network adequacy" as an important concept, but does not define it. He asked what the public should assume in areas that lack detail. David Maxwell-Jolly said that it will be important to discuss the Implementation Plan in the context of the specific proposals and suggestions that were accepted as well as those that were not included.

Discussion and Feedback by SAC Members on the DHCS 1115 Waiver Implementation Plan

The SAC divided into five smaller groups, to discuss the following Key Questions for Discussion

- What elements of the Implementation Plan need to be strengthened?
- What is missing from the Implementation Plan?
- What is the feasibility of the timing and process for implementation? What suggestions for improvement would you suggest?

Notes from each group are included here; the reports to the full SAC from each small group are discussed below.

CSHCN/CCS

Participants: Mike Clark, Kern Regional Center; Diana Dooley, California Children's Hospitals Association (CCHA); Marilyn Holle, Disability Rights California (DRC); Judith Reigel, County Health Executives Association of California (CHEAC); Stuart Seigel, Children's Hospital Los Angeles (CHLA); Luis Rico, DHCS Staff Lead.

- Missing elements
  - MTP (Medical Treatment Program) is not addressed: who is referring, paying, providing?
  - CCS/HF and CCS state-only: how will they be integrated into the pilot financially?
  - No discussion of Multi-Disciplinary Team being preserved.
  - The evaluation design is critical in order to really answer whether the model is better for kids.

- Pilot design
  - Plan suggests too many pilots. Even 2 would be ambitious. A single pilot with in depth analysis would be more appropriate than the approach in the document.

  - Pilots and the waiver are the way to get additional federal money, but the point is really to improve the program: treat the whole child and fix fragmented payment system.
  - Medical homes should meet some established criteria, such as AAP definition
  - The options in the Implementation Plan are not presented as they were discussed in the CCS TWG. The group's consensus was that managed care is premature given the lack of available data.
  - Children's Hospitals' position is that CCS should not be in managed care.
  - What is "local support for evaluation" on page 18?

- Maintenance of existing CCS program
  - The idea that there is something wrong with current tertiary teams is upsetting. Coordination with tertiary care is not detailed, which is a big issue.
  - Credentialing and getting doctors into the CCS pool is important. Even if the waiver is not the place, we have to try and take care of this. The process of credentialing should not reduce standards, and should not be the responsibility of pilots.
  - State must continue to set CCS standards – this is not clear.

- Timeline
  - Too aggressive: need to strengthen the financial data before moving forward. Need to know what financial risk exists before the proposal is submitted, not after.
  - The RFI shouldn't go out in June as described.
  - Baseline status quo needed.
  - There are complex financial interactions with counties that need to be worked out prior to a pilot. Some of the models have the potential to further fragment care, not create a whole child approach.

- Financing
  - The statement in paragraph 3, pg 14, that about 60% of CCS kids in areas of the state where Medi-Cal managed care exists receive their Medi-Cal services through plans seems wrong.
  - COHS are not really at risk as stated on page 14, the state is.
  - The statement that costs will not be increased over current levels seems dangerous.

BHI

Participants: Sandra Naylor Goodwin, California Institute of Mental Health (CiMH); Ingrid Lamirault, Alameda Alliance; Sharon Rapport, Corporation for Supportive Housing (CSH);

Rusty Selix, California Council of Community Mental Health Agencies (CCCMHA); Al Senella, California Association of Alcohol and Drug Program Executives; Marv Southard, Los Angeles County Department of Mental Health (LAC DMH); Barry Handon, DHCS Staff Lead.

- Missing Elements
    - The Plan lacks detail, and does not include much of the BHI TWG input
    - Target population definition is missing, as are the procedural steps for selection. Can counties identify populations and can the populations vary county to county?
    - Health Information Exchange is not covered at all

- Financing
    - Need financial incentives from the state, and in particular some shared savings given that increased BH services should lead to hospital/ED savings, which will accrue to the state.
    - Shared savings based upon improved outcomes must be quantified, and a portion of the savings shared with counties. This should include savings from improved criminal justice outcomes.
    - The current rate setting methodology lumps many risk groups together so that savings can't be teased out. Capitation should be outcomes-based rather than purely cost-based, particularly to allow the return of shared savings to county systems -- cost-based reimbursement doesn't lend itself to this effort
    - Medicaid rules should be waived to allow reimbursement for certain "rehab" or other providers
    - The expectation that MCOs can work more effectively with BH providers without systematic financial and program incentives is not realistic
    - Some pilots will require more state funding than others

- Program design
    - Counties should have flexibility in designing pilots, including designing different benefit packages
    - Limiting efforts to HCCI leaves Medi-Cal MCOs out of the developmental process.
    - Care coordination and the health care home can't be limited to primary care – BH providers must have a role, and be reimbursed

- HCR
    - Implementation plan should include the 90% FMAP option for SMI, as well as other options in HCR

- Substance abuse benefit should be included

HCCI

Participants: Kelly Brooks, California State Association of Counties (CSAC); Anne McLeod, California Hospital Association (CHA); Santiago Munoz, University of California, Office of the President (UCOP); Melissa Stafford-Jones, California Association of Public Hospitals and Health Systems (CAPH); John Schunhoff, County of Los Angeles, Department of Health Services (LAC DHS); Hermann Spetzler, Open Door Community Health Centers; Anthony Wright, Health Access California; Barbara Siegel, Neighborhood Legal Services of Los Angeles County (NLS); Jalynne Callori, DHCS Staff Lead.

- Financing
    - According to the Implementation Plan (page 27), there will be no cap on the federal funding for providing health care services to those individuals with incomes at 133% and below the Federal Poverty Limit (FPL), and that the federal funding for providing health care services to those individuals with incomes at 134% - 200% of the FPL will be provided under the Safety Net Care Pool (SNCP). The amount of the federal funding under the SNCP will be determined through negotiations with the Centers for Medicare & Medicaid Services (CMS). County certified public expenditures (CPEs) for health care services and intergovernmental transfers (IGTs) will provide the non-federal share of the federal reimbursement. The only rate limiting factor is the amount of CPEs available at the local level to dedicate for this purpose.
    - Implementation Plan needs strengthening in identifying how many individuals are likely to be eligible for the program with incomes at 133% and below the FPL. (Based on estimates of individuals with incomes at 133% and below the FPL in the counties with designated public hospitals, about 300,000 – 350,000 may be eligible for the program. The eligible individuals within the counties under the County Medical Services Program (CMSP) and the remaining counties may be able to add additional individuals to the program, but not to any large degree.)
    - Los Angeles County does not have the CPEs to dedicate to expansion of this population. There may not be a large increase in the number of individuals enrolled in the expansion program because it would require a massive amount of local dollars to provide services to them.
    - County participation in the program is voluntary, and every county that has CPEs can participate. Since every county has a Section 17000 obligation to provide health care services to low-income individuals, this program creates a new opportunity for counties to receive federal reimbursement for their costs

during the period prior to full implementation of the Medi-Cal expansion program.

- Timeline
  - More time is needed for implementation based on the experience of current HCCI programs.
  - County expansion depends on the availability and flow of federal funding, but the current timeline in the Implementation Plan is reasonable. Timeline for implementation in new counties could be earlier than September 2011.
  - It may be more difficult for new counties to implement because the program rules are not defined. These counties should have staggered implementation dates and small enrollment milestones that increase over time.

- Program Structure
  - Even though county participation is voluntary, it can be interpreted as a goal to transition the population of individuals at 133% and below the FPL to the Medi-Cal program in 2014. However, counties could implement the program and then lose the enrollees to the Medi-Cal program or managed care in 2014. This situation would deflate the county infrastructure. Nevertheless, the program gets the people used to the public health care system and wanting to stay in the system for ongoing health care services. This factor helps to strengthen the viability of the safety net system in the counties after 2014.
  - The opportunity to invest in strengthening the public safety net structure may encourage non-HCCI counties to participate.
  - There are structural problems for program participation in those counties that do not have a public hospital or community clinic system. This situation may prevent some counties from participating regardless of the federal reimbursement opportunity.
  - A network of private and public providers has to happen in the program to ensure portable health care coverage for program participants. A fully compensated structure that ensures cross-county reimbursement is necessary in order to ensure that all private and public providers are reimbursed for services provided to program enrollees that are outside of their county provider network.
  - Health care coverage in this program should not be considered insurance. There would need to be additional funding provided from another source other than local funding to pay for portable health care coverage for program enrollees. Furthermore, portable health care coverage would not be feasible to implement under the current health care structure in the counties.

- Additional funding to support portable health care coverage could be negotiated with CMS, and suggested that that it may be feasible to be implemented within the current health care structure in the counties.
- (There was no consensus on the issue of insurance coverage.)

- Transition
  - It will be difficult to structure an eligibility and enrollment simplification effort to enable all enrollees to transition smoothly to Medi-Cal in 2014. We need to identify what we can do to align Medi-Cal as the care program in 2010 - 2013, and to not allow current Medi-Cal beneficiaries to age out of the program.
  - Los Angeles County uses a one-year eligibility determination process to help alleviate this problem and to minimize the administrative cost in conducting more frequent Medi-Cal eligibility redeterminations.
  - A phase-in period is important to allow the other 37 counties to come into the eligibility system for this program.
  - CMSP has a good eligibility determination structure that may enable the counties in this program to transition into the system more easily.

- Benefit package
  - There should be a pathway to the benchmark package that is required in 2014. Priorities for HCCI benefits should be defined and prioritized.
  - CAPH is completing a comparison of benchmark benefits to the Medi-Cal managed care plan benefits.
  - A phase-in approach is preferred. The goal of the program is to achieve a full benefit package as provided under managed care plans that meets Knox Keene requirements and then add substance abuse and other services to the package.

- Home- and community-based services (HCBS)
  - Most counties try to get individuals who are disabled into the Medi-Cal program. Only a small group of these individuals would be in the HCCI program.
  - Terms and conditions under the current waiver require that HCCI enrollees be ineligible for the Medi-Cal program. A structural approach is needed to identify the individuals needing HCBS and get them into the HCCI program or the Medi-Cal program.

- Substance Abuse and BH Services
  - Integration of County Mental Health Services Plans with the HCCI program is limited by what is allocated by the state to the Plans. Counties with designated public hospitals receive federal reimbursement under the SNCP

for mental health services provided to low-income, uninsured individuals not eligible for the Medi-Cal program.

- It will be difficult for the counties to implement the program if the necessary workforce does not exist in the counties.

- Future of HCCIs (after 2014)
    - Counties should develop a local initiative that will continue the public safety net system and encourage providers to participate.
    - In large counties, the structure could look like a managed care contract, but this structure may be difficult to develop in small counties.

SPD

Participants: Catherine Douglas, Private Essential Access Community Hospitals (PEACH); Teresa Favuzzi, California Association of Independent Living Centers; Jeff Flick, Anthem Blue Cross; Brad Gilbert, Inland Empire Health Plan (IEHP); Elizabeth Landsberg, Western Center on Law and Poverty (WCLP); Chris Perrone, California HealthCare Foundation (CHCF); Lisa Rubino, Molina Healthcare

- Missing Elements
    - The Plan lacks specificity overall
    - Coordination of care requires better definition. The medical home sounds more like a primary care provider (PCP) –requires a clear definition and a discussion of who does what

- Timeline
    - Unreasonably aggressive
    - Disagree with timeline, “people’s health will be impacted”
    - The volume of SPDs transitioning into plans and timing is concerning
    - Concern with trying to prepare for readiness in two (2) months in the Timeline, when this component may likely need six (6) to eight (8) months for providers to respond to readiness standards (develop readiness tools, access, care coordination, ancillary services, facility needs, etc.)

- Provider network
    - Some medical groups/individual providers are more prepared than others to absorb SPDs.
    - Plans need additional time to reach out to safety net providers.
    - Health plan provider network needs increased depth and broader range of specialist and board certified MDs, public hospitals, and safety net providers

- County Alternative Option
    - A County Alternative Option without Knox-Keene Act licensing is "frightening"

- Enrollment
    - There is insufficient detail on the enrollment process, particularly the default process for people who do not choose a health plan/provider
    - No opt-out option:
        - Relying on existing Medical Exemption Request (MER) is insufficient, need broader MER process for SPDs
        - People with FFS providers have complex medical needs and there are situations when the FFS provider not a plan network provider
        - Lack of opt-out is not good for plans *or* beneficiaries
    - Need more robust education and outreach information
    - Plans need risk assessment data, member specific claims data, diagnosis codes in order to prepare for enrollment

- Consumer protections/monitoring
    - Concern about enforcement of consumer protections and monitoring of access
    - The Plan lacks details on performance standards

- HCBS
    - There is discussion of liaison with regional centers, but no requirement for liaison with other community providers
    - What is the status of IHSS? Will those services become the responsibility of plans?

- Rates and financing
    - Lack of transparency in how rates are developed is a concern
    - Implementation plan does not contain information to analyze costs and cost savings

Dual Eligibles

Participants: Richard Chambers, CalOptima; Richard Thorp, California Medical Association (CMA); Daniel Gould, California LGBT Health and Human Services Network; Marty Lynch, LifeLong Medical Care; Bob Prath, AARP; Tim Schwab, SCAN Health Plan; Sarah Takahama, California Association of Physician Groups (CAPG); Paul Miller, DHCS Staff Lead

- Missing elements
    - Overall, plan is a work in progress – details are missing. (In the area of dual eligibles, this is partly due to the fact that only one dual eligibles TWG meeting has been held.) The Implementation Plan can be strengthened with additional detail.
    - Recognize that things can be done without specific 1115 waiver authority. There should be placeholder language in the 1115 waiver application that says 1915 waivers will be sought for certain provisions of implementation.
    - There is $10 billion federal money. The clock is ticking for California's administration to get this authority to do all these things, especially the pilots in Orange County and San Mateo.
    - Rural counties are missing from the Implementation Plan. It would be tough to get managed care in those counties. Plans could exist for a coordinated care program that doesn't go all the way to managed care. EPCCMs and Team San Diego are examples of systems that have some care integration.
    - Conflict between pages 5 and 9 about integration versus coordination.

- Model design
    - Expand the possible models to include more than just the 4 presented in the Plan. There are other successful models out there.
    - Need more detail on pilot design: Is this COHS only? Or SNPs as well? Is HCBS integration purely in the pilots? Since this is a waiver, it needs to be addressed more in the paper.
    - The 4th concept has the state taking over responsibility for dual eligibles. There are 70,000 dual eligibles in Orange County. CMS would ask how the state would envision taking care of that population. Do they want to mandate enrollment in a commercial HMO?
    - There isn't a strategy to expand PACE, as the Plan is written. The Implementation Plan should clearly and explicitly spell out the state's intention to expand the PACE model.
    - There is brief mention about expanding SNPs, but no in-depth discussion.
    - There must to be safeguards to opt out to Medicare fee-for-service.
    - It isn't clear that the county alternative couldn't evolve to include dual eligibles. The challenge would be on the Medicare side because Knox-Keene licensure would be needed.
    - The county alternative model should be applied to rural counties as well.
    - The state should keep the Technical Workgroup meetings going until full implementation. It appears that the state is committed to this effort.

- Financing
  - Long-term care savings seems to be underestimated, and the reduction in the quantity of acute care hospital savings is especially underestimated.
  - The shared savings model doesn't have language further exploring this option.
  - The state should look at the Medicare savings carefully. Setting up the structure may cost the state in the early years, with savings generated in out years. Take the acute savings from Medicare and spend on home and community-based services and supports. Home care takes resources.

- HCBS/Other Services
  - SPD section of the Implementation Plan talks about integrated benefits (the full range of HCBS) but this isn't mentioned in dual eligibles section.
  - Is the state pushing to blow up ADHC, IHSS, and MSSP into an integrated funding stream? This can be done outside of the 1115 waiver process. The state can create a 1915 b or c waiver to do this.
  - Where do aging services, homelessness, HIV, and housing fit into these integrated models? County services are different, and county-level integration may be a good option. The county could provide MSSP, Meals on Wheels, etc. What about the county infrastructure to do this? Service capacity must be in place for these services on day one of managed care.

Summary/Report Out of Small Group Discussions

CSHCN

Diana Dooley, CCHA, reported for the group.

The two primary objectives in changing the current CCS system are 1) treating the whole child and 2) resolving fragmentation of financing and authority. Accordingly, the group's comments on CSHCN in the Implementation Plan are:

- Timeline – an RFI by June 2010 is too ambitious
- Four pilots are too many – there should be some prioritizing of the models, and one or two pilots as opposed to four
- Moving this population into traditional managed care is not viable without standards for quality and access
- Maintenance of state standards is important – pilots should not panel providers
- The Implementation Plan lacks discussion of the relationship between the state and the counties, and of the Medical Therapy Program (MTP)
- "Medical home" is not defined

- The group had significant concerns about evaluation and the lack of baseline data, such that any pilot's ability to be compared to the current-state or to a comparison county is inadequate.

BHI

Sharon Rapport, CSH, reported for the group.

- The plan is too general, and needs more discussion of the specifics of BH both in HCCI and throughout the other sections.
- The group was concerned about BH only applying to HCCI, and discussed choosing specific target populations, including homeless and Frequent User populations, SMI with other conditions, and people leaving institutions
- Counties should be allowed to choose a design for dealing with those populations.
- Counties need financial incentives from the federal government and the state, particularly as regards care coordination
- Funding and incentives for care coordination funds must be available to BH as well as primary care providers.
- Mental health and substance abuse should be addressed individually, not combined into behavioral health. More discussion of access to MH and SA services, particularly the latter, is needed.

HCCI

Barbara Seigel, NLS, reported for the group.

- The population from 133-200% FPL will be difficult to finance. The significant limiting factor is county fund availability – and as a result, coverage initiatives may not be able to be implemented statewide.
- CMSP counties should come together for a coverage initiative.
- BH issues should be strengthened in the HCCI proposals.
- *Coverage* is missing from the Implementation Plan. The HCCI expansion as described is really access to care, but not coverage. There should be a phase-in such that, by 2014, the HCCIs provide real coverage that is portable across counties.
- What happens to the HCCIs in 2014? Can they maintain the viability of the safety net and public health safety net? They must be competitive in the market for Medi-Cal and the exchange.
- The timeline proposed for the current counties is acceptable, but the timeline for HCCI expansion is too optimistic: counties must know what the benefit package would be, and then will need 9 – 12 months to implement.

SPD

Jackie McGrath, Alzheimer's Association, reported for the group.

- The document is less an implementation plan than a concept paper – many details are missing.
- The timeline is not workable. While it might be possible to enroll some individuals on this timeline, large-scale implementation requires significantly more time for plans to develop readiness with respect to provider networks, disabled access, training, education, and other issues. One suggestion was to begin enrollment with newly eligible individuals, allowing more time for transition of existing beneficiaries.
- There should be an opt-out process from mandatory enrollment.
- The Plan is not clear about who will provide IHSS and other HCBS.
- There was concern about a County Alternative Option that is not Knox-Keene licensed.
- Plans need more information about who the population is and what they need.
- Risk adjustment requires more science.
- There is nothing in the Plan for FFS counties
- "Medical home" must be defined.

Dual Eligibles

Marty Lynch, LifeLong Medical Care, reported for the group.

The group discussed how Medi-Cal integration could be accomplished under 1915 (b) and (c) program waivers, and noted that the Obama Administration has some interest in demonstration projects, which could be a way to integrate Medicare on a smaller scale.

With regard to the Implementation Plan:

- The Plan presents only the options outlined in the SCAN paper, but there might be others, such as coordinated care, or a County Alternative growing into a dual plan.
- There is little discussion on coordination versus integration: is DHCS promoting one versus the other?
- The Plan doesn't address services not in Medi-Cal funding stream that should be considered
- There is no detail about two of the options in the SCAN issue brief – a PACE expansion and shared savings concepts.
- Integration of funding would not necessarily mean putting dual eligibles in managed care. That whole area will be politically sensitive.

- The timeframe is not such a problem in this area, but there is a long-term question of acute care savings – everyone hopes for it, but the state shouldn't try to capture Medicare savings and use them immediately to pay for HCBS.

Melissa Stafford-Jones, CAPH, clarified that the HCCI group was not unanimous that HCCIs do not provide coverage: some felt that, while limited, it is still coverage.

Lisa Rubino, Molina Health Care, and *Jeff Flick, Anthem Blue Cross*, clarified that they were concerned that the SPD enrollment timeline was too aggressive, but supported the general concept of moving SPDs into managed care.

Questions and Comments from SAC Members

Marilyn Holle, Disability Rights California, said that she does not see sufficient enforcement capacity at the state level. She also asked about the presumption that the current contractor for Health Care Options could manage the assessment piece of enrollment, versus some in the MSSP program or elsewhere who have better contact with this population.

Sharon Rapport, CSH, asked about the definitions of medical home and of patient-centered health care home (in the BHI section), and whether these were intended to be the same thing. She also asked for more detail on the definition of care management: can it be provided telephonically or only face-to-face, for example. Regarding David Maxwell-Jolly's earlier comment that plans have an incentive to deal with Frequent User populations, she said that she is concerned about plans' readiness without promotion of in-plan or out-of-plan options/programs to deal with this population.

Catherine Douglas, PEACH, said she was encouraged by the discussion of HCCI, and the desire to build on public and private safety nets. In certain parts of the state, the same specificity that is included in the Plan for public hospitals is missing for private hospitals, which are also cornerstones of the safety net. In Los Angeles, private hospitals provide about 40% of the care to the SPD population. They will need to evolve their clinics and physicians to be ready for 2014, and will need upfront state investment to do that. PEACH is very concerned that HCR will fail in places like LA without a strong public *and* private safety net.

Bob Prath, AARP, suggested that each of the workgroups pick out key evaluation statistics that could be tracked over time.

Public Comment

Gary Passmore, Congress of CA Seniors, said that his organization shares many of the opinions expressed by SAC members and will be sending written comments on the

Implementation Plan. He said that the state needs to stop going down separate and conflicting paths (waiver and budget) with respect to the SPD population, and asked that DHCS come back to this group to address how it plans to implement the SPD waiver proposals in the same year that people will be cycling through institutional settings due to loss of HCBS, ADHC, and other programs. The state must go forward with a single conversation.

Laurie Soman, CRISS Project, said that she thought the comments of the CSHCN breakout group were very good. Before implementing a traditional Medi-Cal managed care model for children, it is important to have a robust evaluation of the experience of children in those plans in which CCS is carved in. In addition, the SPD discussion does not include specific mention of *children* in those aid codes. This is a serious deficiency. Children should be exempt from mandatory enrollment unless there is specific attention to how they would be included. At minimum, specific performance measures for CSHCN in plans are needed.

SAC Comments

Al Senella, CAADPE, said that is appropriate to talk about care management if you can provide care. In the area of substance abuse, the system does not have the capacity to provide care. This is true for mental health as well, but the crisis is more severe for SA. The waiver should address this specifically, and not only in discussion of pilots or HCCI. Parity laws apply in the case of mandatory managed care enrollment.

Brenda Premo, CDHP, said that there are three criteria for success in moving SPD populations to managed care. 1) Readiness: The document proposes 30-60 days, but there is no tool to help plans get ready. Without such a tool, the plan cannot succeed. 2) Rates: People coming in may need things that they were denied in FFS, and these must be seen as an investment rather than an expense. 3) Access for people with significant complex disabilities: Plans and providers must be physically ready, and have sufficient provider networks, knowledge, materials, and preparation. This cannot be achieved in 60 days, and DHCS must carefully assess a realistic timeframe for plan readiness.

The meeting was adjourned at 12:40 pm.