DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
July 19, 2017
10:00am – 12:00pm

MEETING SUMMARY

Attendance

Members Attending by Phone/Webinar: Michelle Cabrera, SEIU; Lisa Davies, Chapa-De Indian Health Program; Sarah de Guia, CA Pan-Ethnic Health Network; Bob Freeman, CenCal Health; Michelle Gibbons, County Health Executives Association of CA; Bradley Gilbert, MD, Inland Empire Health Plan; Carrie Gordon, CA Dental Association; Emalie Huriaux (for Anne Donnelly, Project Inform); Marilyn Holle, Disability Rights CA; Sherreta Lane, District Hospital Leadership Forum; Stephanie Lee, Neighborhood Legal Services of Los Angeles County; Kim Lewis, National Health Law Program; Marty Lynch, LifeLong Medical Care and California Primary Care Association; Anne McLeod, California Hospital Association; Farrah McDaid Ting, California State Association of Counties; Steve Melody, Anthem Blue Cross; Erica Murray, CA Association of Public Hospitals and Health Systems; Sandra Naylor Goodwin, CA Institute for Behavioral Health Solutions; Linda Nguy, Western Center on Law and Poverty; Gary Passmore, CA Congress of Seniors; Chris Perrone, California HealthCare Foundation; Rusty Selix, CA Council of Community Behavioral Health Agencies; Richard Thomason, Blue Shield of California Foundation. Bill Walker, MD, Contra Costa Health Services; Anthony Wright, Health Access California.

Members Not Attending: Bill Barcellona, CA Association of Physician Groups; Kirsten Barlow, County Behavioral Health Directors Association of California; Richard Chinnock, MD, Children's Specialty Care Coalition; Kristen Golden Testa, The Children's Partnership/100% Campaign; Michael Humphrey, Sonoma County IHSS Public Authority; Brenda Premo, Harris Family Center for Disability & Health Policy; Cathy Senderling, County Welfare Directors Association; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers; Herrmann Spetzler, Open Door Health Centers;

DHCS Attending: Jennifer Kent, Mari Cantwell, Sarah Brooks, Bambi Cisneros, Jacey Cooper, Neal Kohatsu, Adam Weintraub, Karen Baylor, Lindy Harrington, Anastasia Dodson, Alani Jackson, Brian Hansen, Morgan Knoch.

Public in Attendance: 123 members of the public attended via webinar.

Welcome, Purpose of SAC and Today's Meeting
Jennifer Kent, DHCS Director

Welcome and introductions.

Follow-Up Issues from Previous Meeting and Updates
Adam Weintraub, DHCS:
Follow-up from previous SAC meeting
http://www.dhcs.ca.gov/services/Documents/SACFollowUps_051717.pdf

State Budget and Latest Federal Developments
Jennifer Kent and Mari Cantwell, DHCS
Slides available: http://www.dhcs.ca.gov/services/Documents/071917_SACPresentations.pdf

Director Kent reported that DHCS has released a fiscal impact analysis of the Better Care Reconciliation Act showing an annual General Fund impact of $2.6B beginning in 2020 and growing to $30.3B by 2027. The cumulative cost from 2020 through 2027 would total approximately $114B.

Questions and Comments

Anthony Wright, Health Access California: Thank you to DHCS for the analyses of both versions of bills. They were very helpful in detailing the budget hole that would be created if passed. I can extrapolate from those analyses, but has there been an analysis of the iteration that will be voted on this Monday, the straight repeal version? It concentrates on the loss of the Medicaid expansion without a per capita cap.

Jennifer Kent, DHCS: We are not planning to do that analysis, however, it should be straightforward to identify the impact since the expansion population would no longer have Medicaid eligibility and would therefore be removed from the program.

Anthony Wright, Health Access California: In addition, does DHCS have information on the federal budget process, tax cut proposal or other items where Medicaid cuts could be included?

Jennifer Kent, DHCS: We monitor federal activity from a regulatory and budgetary perspective. We go through an internal process with the HHS Agency and Governor's office and then work with DC staff to communicate concerns or work on proposed changes. Also, Mari Cantwell works with state Medicaid Directors through their national association.

Anthony Wright, Health Access California: The type of analysis done on the health bill would be very helpful if it is possible to produce those for federal budget changes. It is difficult for us outside the system to know the impact.

Mari Cantwell provided a state budget update including:

- Restoration of Additional Adult Dental Benefits
- Planned Restoration of Adult Optical Benefit
- Diabetes Prevention Program
- Medically Tailored Meals 3-Year Pilot
- Continue State-Only Full Scope Medi-Cal for Newly Qualified Immigrants (NQIs) and Seek Minimum Essential Coverage (MEC) Designation

DHCS staff are working on implementation of the restorations and initiatives in the state budget according to the timelines for each item. Ms. Cantwell also reported on the Proposition 56 Tobacco Tax Funding and notices of proposed State Plan Amendments (SPA) to implement supplemental payments to providers. The budget provided $325M for set dollar increments for physician service codes (new/established patient codes and psychiatric codes). Those eligible will receive supplemental payments depending on claim submissions under each service code. For managed care, the state will provide supplemental payments to plans and expect plans to pay that supplement to physicians. We are working through the approval process with CMS and

it is likely that supplemental payments won't be occurring until January 2018 with retroactivity to July 2017.

The Dental supplemental payments will follow a similar process. There will be supplemental payments equal to 40% of the current rate for approximately 250 specified dental service codes in the restorative, endodontic, prosthetic, oral/maxillofacial surgery, adjunctives, and visits/diagnostics.

Ms. Cantwell also reported on supplemental payments for specific Family PACT services that will equal 150% of the current rates and increases for abortion services. The supplemental payments for Intermediate Care Facilities for the Developmentally Disabled will be equal to what the rates would have been without the rate freeze which held rates at the 2008-09 level. Finally, on the HIV/AIDS waiver, DHCS is still finalizing the payment methodology and will be seeking an amendment to the state's waiver with the Centers for Medicare and Medicaid Services.

Questions and Comments

Carrie Gordon, CA Dental Association: When will DHCS submit the SPA?

Mari Cantwell, DHCS: We will submit in August. CMS has 90 days to respond but there are usually questions and it may not be approved in the first round.

Linda Nguy, Western Center on Law and Poverty: Thank you for the dental restoration and the immigrant wrap. Has the application for the MEC been submitted?

Mari Cantwell, DHCS: We have had conversations and are in process with CMS. It is not clear we need to send anything and hope to get this done quickly. We will follow up with specifics.

Linda Nguy, Western Center on Law and Poverty: On Proposition 56, we would like to see supplemental payments go to preventive services and adult services.

Sarah de Guia, CA Pan-Ethnic Health Network: I echo all of Linda's comments.

Chris Perrone, California HealthCare Foundation: Is the physician payment information already on DHCS website?

Mari Cantwell, DHCS: It is listed with proposed SPA and public notices listed with codes.

Adam Weintraub, DHCS: On the DHCS web page listing all the proposed SPAs, there are four on Prop. 56 grouped together.
http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Pro_SPA.aspx

Anthony Wright, Health Access California: For both dental and physician services, can you explain the methodology for the services included?

Mari Cantwell, DHCS: The choices were based on where the most positive impact would occur and what could be proposed and implemented quickly in both Fee-for-Service (FFS) and Managed Care. On the physician side, we wanted to pick basic visit codes likely to be accessed. The dollar-increment method makes the responsibility of managed care plans clear. For psychiatry, we picked three specific codes to ensure that supplemental payments would also go to them. On dental, the approach was similar, with the additional need to balance any

concerns from the Centers for Medicare & Medicaid Services (CMS) about duplication with the Dental Transformation Initiative (DTI). We chose codes that include both basic visits and restorative adult services. Because there are many codes, the money for the dental increase was done in a straightforward percentage increase as the simplest methodology. Other, more targeted, methods raised concerns about timing in the face of a one-year approach and the need to get it out quickly.

Anthony Wright, Health Access California: Can you explain the influence of the DTI?

Mari Cantwell, DHCS: The DTI focuses on kids and Prop 56 payments include kids and adults. It is too operationally difficult to do different things for kids and adults under Prop 56. Because of the concerns about duplication, we focused on different things under Prop 56 than under the DTI.

Bradley Gilbert, MD, Inland Empire Health Plan: The methodology of a flat amount on codes is a good move. Since this will have to be done retroactively, can we figure out what worked or didn't work on the previous experience with the physician payments under Section 1202 of the ACA? There will be a lag and there is the need to pay out quickly with a mix of FFS and capitated rates.

Mari Cantwell, DHCS: We want to come up with the best process and will work with you on that.

Jennifer Kent, DHCS: This also helps in that physicians will be motivated to submit encounters and we will capture better data.

Erica Murray, CA Association of Public Hospitals and Health Systems: Just to note for the group, there was $40M allocated through Prop 56 for Graduate Medical Education (GME) payments that was to be administered through the University of California. The final budget included a $50M hit to the University, so that GME program is not happening this year. We are hopeful this funding can be restored to University of California so the GME can get up and running next year.

Managed Care Final Rule Implementation
Mari Cantwell, Bambi Cisneros and Sarah Brooks, DHCS
Slides available: http://www.dhcs.ca.gov/services/Documents/071917_SACPresentations.pdf

DHCS staff reported on:

- Final Rule Requirements by Year 2
- Grievances & Appeals
- Final Rule Contract Amendment
- Member Handbook
- Beneficiary Support Website
- Mental Health Parity
- Directed Payments

CMS released an informational bulletin indicating they are reviewing the Managed Care Final Rule. Given the July 1, 2017 effective date, CMS indicated that they will use their enforcement discretion to not penalize states that are unable to come into compliance. However, CMS indicates this discretion will not apply to the financial requirements, which are the components

we are most concerned about for July 1. This is consistent with communication with Medicaid Directors that, while CMS is open to changes in the rule, they are not very open to financing changes. We likely won't need the enforcement discretion, but it is good to have that latitude. We will continue to work with CMS and express the concerns from California on the rule.

Staff reviewed the major elements of the rule and reported on progress to implement. DHCS has implemented many of the July 2017 requirements, many through contract amendments and All Plan Letters (APL).

Staff reviewed information and progress to date on grievances and appeals. The most substantial change is that beneficiaries must exhaust local managed care plan appeals before going to state level hearing. The timeframes for filing grievances and appeals also changed. DHCS issued an APL and has revised notices on the website.

DHCS is reviewing managed care plan contracts and deliverables to prioritize updates for this year to comply with the rule. There will be additional updates for future years. A draft contract amendment was sent to the plans for comment and the boilerplate contract was submitted to CMS for review. This is the first time CMS is reviewing contracts and there has been some back and forth. We will resubmit a revised contract to CMS in August.

For the first time, managed care plans are required to use the state model member handbook. There have been several rounds of review by plans, associations, and advisory groups. Plans will be expected to use the template in their next formal submission to DHCS.

DHCS has been redesigning the website to align the beneficiary website with new rules. There is a consumer portal and links to formularies, provider handbook and evidence of coverage. This will be helpful to beneficiaries comparing and making a choice of health plans. July 28th is the deadline for comment on website although we welcome ongoing input to the following mailbox: mmcdpmb@dhcs.ca.gov. More information on the Customer Service Portal (CSP) can be found on this web page: www.healthcareoptions.dhcs.ca.gov

The states must set network adequacy standards for eight provider types effective July 2018 and California has issued a Network Adequacy proposal. There has been lots of input and comments from stakeholders and plans and the final standards will be released today.

Staff provided an update on the state's approach to parity, the CMS compliance toolkit and the state's analysis. Because mental health and substance use disorder services are carved out from managed care, the state is responsible for completing the analysis. The Parity Rule requires benefit mapping that compares medical/surgical services to mental health services, then medical/surgical services to substance use disorder services. First, DHCS developed an understanding at the state level, and then conducted a deep dive analysis. Staff surveyed managed care plans and mental health plans for treatment limitations at the plan-level that are more stringent than State guidance. Staff reviewed the timelines for APL, contract amendments and submissions to CMS.

Staff reported they are working with hospitals and health plans on the existing supplemental/directed payments to meet requirements under new managed care rules. This work has been ongoing over the last year. Staff are encouraged by discussions with CMS on the level of flexibility to be allowed to make such payments workable for states, plans and hospitals. It is not yet approved, but concepts include setting pools of funding allocated to different providers based on utilization or quality metrics and funding the pools with Inter-

Governmental Transfers (IGTs). There will be more details forthcoming, but we are on a good path for this to work for all entities and continue the flow of funding.

Questions and Comments

Bradley Gilbert, MD, Inland Empire Health Plan: Do you have a sense of the timing for the payment methodology structure? If it is utilization-based, it will be straightforward, but other proposals were more involved. Since it will be done retroactively, we would like to get moving on our internal process to prepare.

Lindy Harrington, DHCS: Next week, we should have a better sense for how long the back and forth discussion with CMS will go.

Anne McLeod, California Hospital Association: We appreciate your work to come up with a reasonable way to make this work and thank the health plans for their patience.

Linda Nguy, Western Center on Law and Poverty: Based on the recent federal guidance, are there aspects of the Mega-rule implementation you expect will be delayed?

Mari Cantwell, DHCS: No, although conversations could still reveal a barrier.

Michelle Cabrera, SEIU: Do the activities and methods on the slides address specialty mental health parity as well?

Mari Cantwell, DHCS: Yes, all the contract work and mapping has been across systems toward the October effective date.

Kim Lewis, National Health Law Program: When will the handbook be available to review and when will it be effective?

Sarah Brooks, DHCS: We are close to a final handbook and will post it on the website within a month. Health plans will use it with their next filing. Generally, the filing is January 2018, although some are in March. We will send out an announcement on this.

Kim Lewis, National Health Law Program: On the appeals process, the requirements in the APL will apply to Mental Health Plans, yet there is no guidance out to them on the obligations and there is no formal effort to be sure they are complying, other than contracts, which have not been sufficient from our point of view. Will more be sent out?

Mari Cantwell, DHCS: The right staff are not here to answer that so we will follow up with information on this.

Anthony Wright, Health Access California: On network adequacy, is this the final rule? Is there more opportunity for engagement? On the process, can you explain the proposal to do this through DHCS as opposed to DMHC?

Mari Cantwell, DHCS: Yes, the rule is final although we remain open to additional feedback. We want to get the work moving to meet the annual network certification requirement by plans and the state by next July. DMHC will continue to do Knox-Keene but per legislative guidance, DHCS has the resources to accomplish the Medicaid specific components. We work closely with DMHC, take note of plans' concerns about duplication and work to avoid this.

1115 Waiver and Other Updates
DHCS Staff
Slides available: http://www.dhcs.ca.gov/services/Documents/071917_SACPresentations.pdf

Neal Kohatsu provided an update on the **Public Hospital Redesign & Incentives in Medi-Cal (PRIME)** activity to establish baselines and report data. We are six months into the first year of quality improvement activities with the first full year of reporting to be submitted September 2017. He provided an overview of how resources are allocated across the domains (outpatient, high cost populations, resource utilization). He reviewed the PRIME Learning Collaborative, including the shared platform for learning, webinars, regional meetings and an in-person convening. He also highlighted improvements in perinatal care over the first six months. Over 80% of the systems improved performance over baseline and it is moving briskly in the right direction. In addition, more than 40% of systems are already performing above the 90% level. He reported on two examples. First, Marin General has a focus on telehealth to better serve isolated populations and is using nurse navigators to improve care. Second, Kaweah Delta focused on advancing a team-based care strategy to reduce emergency department visits for complex patients with multiple conditions. Their preliminary data shows a reduction in emergency (ED) and hospital admissions. These are small numbers but trending the right way.

Questions and Comments

Chris Perrone, California HealthCare Foundation: Is there a way to identify other PRIME participants doing telehealth?

Neal Kohatsu, MD, DHCS: We can provide that to you.

Chris Perrone, California HealthCare Foundation P: What is your perspective on the OSHPD data on emergency visits for the expansion population? There was quite a bit of press.

Mari Cantwell, DHCS: We are still looking at the data. We have our own data and provided it to the media. We had a 40% increase in the overall Medi-Cal population so our view is that the information was taken out of context. Our data shows an increase in ED, but not the headline reported. We are looking broadly at the expansion population and how they get care. We were disappointed the data we provided was not used by the media to provide the additional context.

Chris Perrone, California HealthCare Foundation: At least one reporter did reach out and report that some plans show reductions in ED use. If you are producing analyses, we would be interested in future opportunities to tell that story. We would appreciate you sharing the data.

Neal Kohatsu, MD, DHCS: It is well known in health services research that when individuals have not been in the health care system for long periods, they have pent up chronic care or other conditions needing to be managed, so in addition to learning to use the system efficiently, there is an increase in severity and acuity reported in utilization.

Bradley Gilbert, MD, Inland Empire Health Plan: This is the same pattern we saw when the Seniors and Persons with Disabilities enrolled in managed care. There was a bump in utilization initially. In the expansion population, we have had a reduction of 20% in ED utilization. These are still pretty high rates of ED use in the expansion population. We expect this will even out over time.

Erica Murray, CA Association of Public Hospitals and Health Systems: The Safety Net Institute put out an issue brief on PRIME that includes an overview of the projects on our website.

Lindy Harrington provided an update on the **Global Payment Program (GPP).** For Year One, services were provided primarily (81%) in traditional outpatient settings. She reviewed the budget and payout. All funds were distributed. There was some re-distribution from hospitals that didn't use their full allocation to those which exceeded their targets. She also reviewed Year Two budgets for the GPP. Money is distributed quarterly and adjustments are made in final quarter every year.

Questions and Comments

Anthony Wright, Health Access California: This is year to year. Can hospitals who are under in Year One make adjustments?

Lindy Harrington, DHCS: Yes, each year is separate.

Anthony Wright, Health Access California: Are there any common elements among those who didn't meet their budgeted threshold?

Lindy Harrington, DHCS: No, it is Year One and this represents a change in the way funding is allocated.

Erica Murray, CA Association of Public Hospitals and Health Systems: This is a good question to ask my team. We have reached out to those who did not meet 100% threshold for Year One. There are challenges with data reporting and we do offer technical assistance support to get accurate data and tracking to report thresholds.

Chris Perrone, California HealthCare Foundation: Can you describe the significance of the reporting on service categories? Is this a big or an incremental shift? What is the take away? Is this units-of-service to the remaining uninsured only?

Mari Cantwell, DHCS: This data establishes a Year One baseline to assess change. Does setting this funding methodology help hospitals make changes? Do we begin to see the intended change to decreased ED and move to outpatient care? Year Two will be exciting to tell the story and understand if we are moving away from cost-based care.

Karen Baylor reported on the **Drug Medi-Cal Organized Delivery System (DMC ODS)** element of the waiver. Seven counties have implemented, including Los Angeles, and we are hearing good feedback. A total of 34 counties have submitted implementation plans. Partnership Health Plan (PHP) submitted a plan for eight counties. We are working on contracts and expect a large number of additional counties to implement this year.

Questions and Comments

Rusty Selix, CA Council of Community Behavioral Health Agencies: Is there a deadline to submit a plan for the remaining 24 counties or they can't participate?

Karen Baylor, DHCS: Yes, there is a September 1 deadline for counties to submit a plan. This does not include the Indian Health Service. All Phase 1 (Bay Area) and Phase 2 (Southern

California) counties have submitted. We are receiving more Phase 3 (Central Valley) county plans and we expect Phase 4 to be primarily the PHP plan. There are some small northern California counties we have not heard from.

Rusty Selix, CA Council of Community Behavioral Health Agencies: What can people do about the counties who are not coming forward?

Karen Baylor, DHCS: It is a voluntary county choice. We are open to regional models and the small counties can submit as a region.

Kim Lewis, National Health Law Program: How would counties let consumers know what is available and when it is available?

Karen Baylor, DHCS: Counties must have a 24-7 800 phone line for access to services. We think Riverside County has a good model. There were originally about 140 calls on the access line per week and when they implemented Drug Medi-Cal they had 6,000 calls in the first week.

Sarah de Guia, CA Pan-Ethnic Health Network: What are the concerns from counties not planning to implement?

Karen Baylor, DHCS: The concern is infrastructure for small counties; that it is too difficult to implement given the lack of providers for some benefits and other challenges like the Katie A services and Mega-Rule changes. That is why we are encouraging a regional model.

Karen Baylor reviewed the **Medication Assisted Treatment (MAT) Expansion Project** funded through the federal CURES Act. California received $90M over two years and there may be additional expansion beyond the two years. The focus is on the highest opioid overdose rates to increase the availability of buprenorphine through a hub/spoke model. Some physicians are uncomfortable with the induction phase so the hub offers the high-level expertise connected to physicians for additional support. We have reserved about $6M for native populations. We had 62 applications and will announce awards soon. This funding will help with counties that do not have MAT in their county.

Questions and Comments

Emalie Huriaux, Project Inform: We are happy about this effort and want to highlight the requirement to offer HIV and Hepatitis C testing in the hub/spoke models. Are there opportunities to link opioid efforts in an integrated approach for the overlapping epidemic of HIV/Hepatitis C, given high rates of both?

Karen Baylor, DHCS: It would be great to work together on these efforts.

Bradley Gilbert, MD, Inland Empire Health Plan: Traditionally, there is not much of a link between primary care/Federally Qualified Health Centers (FQHCs) and substance abuse providers, so linking them is important for multiple reasons. Most folks in MAT also have other health issues. A link back to the health plan and building the connections to primary care would be a step forward that doesn't exist now.

Karen Baylor, DHCS: That is the vision for the spokes. We are basing the hub/spoke model on information from Vermont we heard the physicians were hesitant about MAT until they implemented this model. We agree the links are critical.

Sarah de Guia, CA Pan-Ethnic Health Network: It is important not to forget other drug use and other populations. What are the ways we can also look at other drugs and look at youth especially? We need a system to address the full continuum of concerns and populations.

Karen Baylor, DHCS: These are very timely comments. We agree and want to remember alcohol abuse in addition. We believe this is the benefit of the ODS expansion. CURES and its focus on opioid is a companion to ODS.

Emalie Huriaux, Project Inform: In addition, there is a clear increase in syphilis with methamphetamine use in California and we need coordinated efforts between physical health and ODS.

Jacey Cooper reported on the **Whole Person Care** (WPC) pilots. Round One and Two applications are approved. Round Two includes some new counties and some expansion of previous applications (listed on the website). The new applications include one city and a collaboration of counties. She highlighted the systems being put in place such as information sharing; care management software; bi-directional data sharing; data warehouse development; and real time alerts of inpatient admission. There are a large number of innovations, short implementation timelines and ambitious goals for transformational change. Some pilots will not complete all of the deliverables for 2017 or may want to make adjustments to 2018 budgets. DHCS will begin posting enrollment numbers on the website. DHCS will release guidance on making mid-course budget corrections and rollover of deliverables and funding to the extent possible. There is a learning collaborative and DHCS will contract to UCLA for an evaluation of WPC. The evaluation design will be posted when CMS approves.

Alani Jackson and Anastasia Dodson reported on the **Dental Transformation Initiative (DTI)**. All four domains are focused on children. Under Domain 1, DHCS provided $22M in payments in January with the next payment on July 31st to cover any additional 2016 services. Payments for 2017 will be made in January and July of 2018. Domain 2, Caries Risk Assessment and Disease Management Pilot includes 84 providers in the 11 participating counties and continues to grow. We are doing outreach to expand the number of providers participating in Domain 2 and working to be sure we maximize the payments. Under Domain 3, Increasing Continuity of Care, there are 17 counties participating and promising early results. There are 15 approved pilots under Domain 4, Local Dental Pilot Projects. We are working on an evaluation plan with CMS and other ways to share information across the domains.

Questions and Comments

Carrie Gordon, CA Dental Association: Do you anticipate the next payments will be closer to the levels projected for the DTI? We want to be sure we are tracking to fully utilize the resources.

Anastasia Dodson, DHCS: Yes, we have a shared goal in that and will have more information for 2016 in the fall.

Brian Hansen provided an update on **Health Homes Program**. DHCS posted a revised implementation schedule on the website describing the three phases to begin July 2018, January 2019, and July 2019. DHCS is continuing to work through the SPA and 1115 Waiver approval process with CMS and rate development process. We are working with Harbage Consulting on provider outreach. He reviewed timelines for next steps, including the timing for DHCS to provide beneficiary lists to the plans.

Questions and Comments

Chris Perrone, California HealthCare Foundation: Can you update us on the status of the FQHC Alternative Payment Methodology (APM)?

Mari Cantwell, DHCS: We are working with CMS to get approval. At the leadership level, they want to find a way forward, but the legal interpretation has been problematic. We are working through this with the California Primary Care Association and the California Association of Public Hospitals to figure out how to make this work.

Chris Perrone, California HealthCare Foundation: Is the principal concern that it puts clinics at risk? The federal budget?

Mari Cantwell, DHCS: No, they have trouble with the methodology for attesting that the capitated rate is equivalent to the Prospective Payment System (PPS). They are not clear this is allowable under the law although we did this through the Low-Income Health Program.

Public Comment

Amber Kemp, California Hospital Association: Will the Mental Health APL be shared with the Advisory Committee?

Mari Cantwell, DHCS: Yes

Catherine Douglas, Private Essential Access Community Hospitals: Do the numbers on slide 31 of the GPP presentation include services that enrollees may be getting from out of network providers? Is there a way to track that?

Mari Cantwell, DHCS: No, this is for services at public hospitals for the remaining uninsured. It would not capture any services to other providers unless there was a contract in place.

Next Steps and Next Meetings 2017

Next Meeting will be October 19, 2017.