

**DEPARTMENT OF HEALTH CARE SERVICES  
STAKEHOLDER ADVISORY COMMITTEE**

**May 16, 2016  
9:30am – 3:00pm**

**MEETING SUMMARY**

**Attendance**

Members Attending In Person: Kirsten Barlow, County Behavioral Health Directors Association of California; Michelle Cabrera, SEIU; Richard Chinnock, MD, Children's Specialty Care Coalition; Sarah de Guia, CA Pan-Ethnic Health Network; Lishaun Francis, CA Medical Association; Bob Freeman, CenCal Health; Michelle Gibbons, County Health Executives Association of CA; Bradley Gilbert, MD, Inland Empire Health Plan; Kristen Golden Testa, The Children's Partnership/100% Campaign; Carrie Gordon, CA Dental Association; Marilyn Holle, Disability Rights CA; Elizabeth Landsberg, Western Center on Law and Poverty; 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; Steve Melody, Anthem Blue Cross; Erica Murray, CA Association of Public Hospitals and Health Systems; Sandra Naylor Goodwin, CA Institute for Behavioral Health Solutions; Gary Passmore, CA Congress of Seniors; Brenda Premo, Harris Family Center for Disability and Health Policy; Rusty Selix, CA Council of Community Mental Health Agencies; Cathy Senderling, County Welfare Directors Association; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center; Herrmann Spetzler, Open Door Health Centers; Richard Thomason, Blue Shield of California Foundation; Bill Walker, MD, Contra Costa Health Services; Anthony Wright, Health Access California.

Members Attending by Phone: Chris Perrone, California Health Care Foundation; Anne Donnelly, Project Inform.

Members Not Attending: Bill Barcellona, CA Association of Physician Groups; Lisa Davies, Chapa-De Indian Health Program; Michael Humphrey, Sonoma County IHSS Public Authority; Farrah McDaid Ting, California State Association of Counties.

DHCS Attending: Jennifer Kent, Mari Cantwell, Rene Mollow, Jacey Cooper, Sarah Brooks, Adam Weintraub, Marlies Perez, Morgan Knoch and Lindy Harrington.

Public in Attendance: 23 members of the public attended.

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

Director Kent thanked Blue Shield of California Foundation and California HealthCare Foundation for their support to convene the stakeholder meetings.

**Follow-Up Issues from Previous Meetings and Key Updates  
Adam Weintraub, DHCS**

[http://www.dhcs.ca.gov/services/Documents/SAC\\_FollowUpItems\\_051616.pdf](http://www.dhcs.ca.gov/services/Documents/SAC_FollowUpItems_051616.pdf)

Adam Weintraub reported the highlights from the follow up list of questions raised in the February SAC meeting. A complete follow up list is available via the DHCS website link and was distributed in advance to SAC members.

*Brenda Premo, Harris Family Center for Disability and Health Policy:* A Developmental Disability Health Home concept is being developed for individuals living in 4-6 bed community facilities. This is a Medi-Cal population. People with cognitive disability should be a criterion for the health home because many are living independently, are not conserved with guardianship and will need lifelong care and help with decision making. This should be included for consideration.

### **DHCS FY 2017 State Budget Revise Proposal Jennifer Kent and Mari Cantwell, DHCS**

Jennifer Kent reported that the budget proposal is moving steadily forward. SB75 is a very positive inclusion in the budget that is being celebrated. There were changes in the budget due to caseload growth and new resources included for waiver implementation. There was a General Fund increase to help individuals in DDS currently receiving Behavioral Health Treatment services, who are institutionally deemed now, but will be no longer eligible for Medi-Cal because they are over income limits. DHCS will work with a contractor to ensure they are transitioned into other coverage so their services are not dropped. The newly qualified immigrants (NQi) wrap is delayed one year. DHCS has final regulations on outpatient drugs from CMS, so the budget incorporates the federal upper limit considerations and there is a trailer bill to deal with changes in dispensing fees.

### **Questions and Comments**

*Gary Passmore, CA Congress of Seniors:* Can you highlight the reasons that the overall budget for Medi-Cal is down?

*Mari Cantwell, DHCS:* The FY16-17 budget is reduced by \$1.4 billion General Fund. There is a small impact due to the federal upper limit for drugs already mentioned but it is primarily down because the revenue from the Managed Care Tax (MCO) (\$1.1 billion) was not in the January budget.

*Elizabeth Landsberg, Western Center on Law and Poverty:* We appreciate the delay of the NQi wrap. The Governor indicated publicly that there could be hundreds of millions of cost from managed care regulations although the budget also mentioned \$5M cost.

*Mari Cantwell, DHCS:* Other than positions, there is nothing in this budget. The Governor was referencing out-years in his \$200 million comment based on estimates of impacts from AB85 down the road.

*Kim Lewis, National Health Law Program:* How many positions were you seeking in terms of Medicaid managed care regulations?

*Mari Cantwell, DHCS:* We requested 57 positions; 38 permanent staff. We won't know about these positions until there is legislative action.

*Anthony Wright, Health Access California:* Happy Health 4 All Kids Day. We appreciate the NQi wrap delay. What is the threshold for moving forward on the NQi wrap?

*Mari Cantwell, DHCS:* This was primarily about readiness and needing to have everything in place. We intend to move forward next year as we step through all the activities we need to accomplish.

*Anthony Wright, Health Access California:* On the estimate, since we met there has been a minimum wage increase and I am wondering what the impact will be on Medi-Cal enrollment? Last year there was an allocation made because of the increasing cost of prescription drugs – was that amount calculated into the base of the budget this year?

*Mari Cantwell, DHCS:* Department of Finance estimates that the impact due to the minimum wage increase evens out over time. There are increases related to rates and small savings due to decreases in number of beneficiaries. On prescription costs, yes, those costs are included. It was a total of almost \$1B in Medi-Cal, almost double the amount of the proposed January budget.

*Lindy Harrington, DHCS:* The drug cost impact was \$250M General Fund (\$1B total) because many beneficiaries are in the expansion population with higher federal sharing.

### **SB75 Implementation – Coverage for All Children**

***Rene Mollow, DHCS***

***Cathy Senderling, CWDA and SAC Member***

Presentation slides available at:

[http://www.dhcs.ca.gov/services/Documents/SB75Enrollment\\_SAC\\_051616.pdf](http://www.dhcs.ca.gov/services/Documents/SB75Enrollment_SAC_051616.pdf)

Rene Mollow provided an update on SB 75. Enrollment begins today. DHCS is monitoring enrollment to track the transition both at the county level and CalHEERS. Since the last meeting, the eligibility and enrollment plan is on the website that details the transition. Counties will be doing batch transactions to transition restricted scope individuals to full scope benefits with retroactive eligibility. The batch system does result in some exceptions and counties will work on those with a priority to get them resolved quickly. We want to ensure no one loses coverage, so some may stay in restricted scope of services for a period of time until everything can be resolved and they transition to full scope. Over the weekend, there was system testing and no problems occurred. General notices went to 123,000 kids in April in all threshold languages. The 2<sup>nd</sup> notice telling them about full scope coverage will go out now and then a third notice about plan choice. An all-county directors letter went out on May 5<sup>th</sup> with an FAQ document. The language break-out for notices was about 96% English or Spanish; 4% were the other languages. We will report back at the next meeting on final numbers.

### **Questions and Comments**

*Gary Passmore, CA Congress of Seniors:* Is the 123,000 on target?

*Rene Mollow, DHCS:* Yes, it was what we expected.

*Sarah de Guia, CA Pan-Ethnic Health Network:* Among the languages you mention, were there clusters of other languages you noticed? Chinese or others that warrant a translation?

*Rene Mollow, DHCS:* No, not that I am aware of.

*Kim Lewis, National Health Law Program:* My understanding is that the notice of actions was not translated when they went out from the county?

*Rene Mollow, DHCS:* All notices were translated. The county consortia have to program notices into their systems and some are still working on that for languages other than English and Spanish, such as Chinese. All send the explanation notice saying that if you can't understand the notice, you can call for help.

*Cathy Senderling, County Welfare Directors Association:* Within 1-3 months, all languages will be programed into the county systems.

*Anthony Wright, Health Access California:* Thank you for all the work DHCS has done to implement this and to do it on time. It is a remarkable achievement.

*Rene Mollow, DHCS:* Thank you so much and thank you to the staff in the Eligibility Division and Managed Care Division. This has been very significant for all of us.

*Anthony Wright, Health Access California:* I would like an update on how DHCS is working with local programs, Kaiser and how to transition those kids who are in programs outside Medi-Cal.

*Rene Mollow, DHCS:* There have been lots of discussions with Kaiser. They are reaching out to their members and our understanding is that they will continue to cover them for a period of time while they transition. We have longstanding arrangements with Kaiser that allow a beneficiary coming into Medi-Cal to select Kaiser as the health plan.

*Sarah Brooks, DHCS:* All of the County Organized Health System (COHS) plans contract with Kaiser and all local initiatives have Kaiser as a choice on the health plan choice form. We approved language for Kaiser to reach out to members as well.

*Bradley Gilbert, MD, Inland Empire Health Plan:* In addition, we are working with Kaiser for those who do not choose Kaiser and come into IEHP. IEHP is doing individual outreach for Healthy Kids enrollees to make sure they stay connected to care.

*Bill Walker, MD, Contra Costa Health Services:* Kaiser is a subcontractor to Contra Costa Health Plan as well and we are working to roll kids directly over once they come into Medi-Cal. On enrollment, we are hearing about those who say they won't enroll due to immigration fears.

*Rene Mollow, DHCS:* We have worked hard to alleviate those fears. This topic is in the FAQs and in the packets. We are reminding everyone that, while the information is checked in the federal data base, it is only used for eligibility. We have worked with Richard Figueroa at The California Endowment and local programs on messages related to this as well. Lots of work is being done on the ground to educate and establish trust. We hope that as people sign up, the word will go out there are no repercussions from the state from the Medi-Cal application.

*Kim Lewis, National Health Law Program:* I echo thanks for the work and the timeliness. On Kaiser, it is important to let folks know that expedited enrollment coverage is available for those who are in care.

*Rene Mollow, DHCS:* We have also let counties know they can do online applications if there is a case who falls out of coverage.

*Gary Passmore, CA Congress of Seniors:* Are you tracking the numbers for those who opt out of managed care?

*Sarah Brooks, DHCS:* This is a mandatory managed care program. They can't opt out as they can in Cal MediConnect (CMC).

*Stephanie Lee, Neighborhood Legal Services of Los Angeles County:* Thank you; we are excited in LA. Has there been discussion with local managed care plans about the need to do outreach to families about how to use the benefits?

*Jennifer Kent, DHCS:* Plans send out welcome packets which has clear explanations about how to receive care.

*Bradley Gilbert, MD, Inland Empire Health Plan:* Yes, we do send out the packets. In addition, many of the children are in families and have siblings with coverage so we hope there is some experience of managed care benefits. It is a good point though that some in this population have not been in full coverage or managed care before.

*Bob Freeman, CenCal Health:* We do welcome packets and also welcome calls. For most kids, they are changing type of coverage, but they are in our system already. Also, we have relationships with the hospitals so that if they do visit the ED out of lack of information about primary care, they will help integrate them back into primary care.

*Steve Melody, Anthem Blue Cross:* We have been educating locally for a period of time on coverage and on managed care in schools and elsewhere in the community.

*Cathy Senderling, County Welfare Directors Association:* I can offer information on some of the activities going on with counties. On May 18<sup>th</sup>, there will be a statewide, train the trainer program on SB75 with a grant from California Health Care Foundation. We will also do a regional training for county staff and local organization partners. The training will be posted on web site for public use. We have materials to hand out through local county offices. On Rene's comments about how to help those who fall out of the batch process, we sent out information about using the online MEDS system and will send out talking points so staff are aware.

*Anthony Wright, Health Access California:* There is a lot of enthusiasm for this coverage. We are holding an event on the Capitol steps today to celebrate and get the word out. Going forward, there will be some portion of the population with concerns and the more that California can send a clear signal of integration, the more that gets out into the general public.

*Sarah de Guia, CA Pan-Ethnic Health Network:* It also helps to send families to local trusted organizations.

## **Eligibility, Applications and Renewals**

***Rene Mollow, DHCS***

***Cathy Senderling, CWDA and SAC Member***

Slides and materials for this presentation:

[http://www.dhcs.ca.gov/services/Documents/SB75Enrollment\\_SAC\\_051616.pdf](http://www.dhcs.ca.gov/services/Documents/SB75Enrollment_SAC_051616.pdf)

Rene Mollow presented an enrollment update. Enrollment in Medi-Cal has increased from less than eight million in 2013 to over 13 million in December. The 14 million previously mentioned in the budget presentation is projected enrollment. Most are adults age 21-64, however 43% are children and 48% are Hispanic. Three-quarters are enrolled in managed care although a robust fee-for-service (FFS) remains. Some are in FFS as they move through the process of making a choice of a health plan and this includes those with restricted scope benefits. She also reported

on individuals with pending eligibility over 45 days – currently 23,000 individuals – and the length of time for pending cases beyond 45 days. The cases are actively being worked and the numbers are changing rapidly; this is a priority for DHCS's work with county partners. Some of this is due to changes in CalHEERS; some of the cases are duplicates. This represents 2-3% of the total applications.

*Gary Passmore, CA Congress of Seniors:* In the age break-down, do you have pending application data for the under/over age 65?

*Rene Mollow, DHCS:* We can report that.

*Kim Lewis, National Health Law Program:* Can we see this by county? Can you report on why children are reported when they have presumptive eligibility?

*Rene Mollow, DHCS:* They may not meet the requirements for presumptive eligibility and they are reported here.

*Kristen Golden Testa, The Children's Partnership/100% Campaign:* The accelerated enrollment should continue until the application gets determined.

*Rene Mollow, DHCS:* If they need to provide additional information, it would show here as pending.

*Cathy Senderling, County Welfare Directors Association:* Cheryl Davis at CalHEERS indicated that many of the 10,000 in over 121 days are duplicate applications. There are interface system glitches between CalHEERS and MEDS that are being worked on, but are still causing problems. They may have coverage through a different application. The other biggest group are those where the county is continuing to work with an individual and is waiting for information.

*Marty Lynch, LifeLong Medical Care and California Primary Care Association:* How we can use health centers and other providers to help with enrollment, both with this topic of pending applications and with the kids transition? We need to get this data to offer assistance.

*Rene Mollow, DHCS:* Through TCE, counties have funding for outreach and there was funding provided for assistance on renewals. We are open to any ideas for how to help get people through the application process. I do think this may look larger than it is due to system issues.

*Lishaun Francis, CA Medical Association:* There was a slide breakdown of FFS and managed care. Do you have a breakdown of how long someone stays in FFS? Is there a group permanently in FFS or aren't in transition?

*Sarah Brooks, DHCS:* It varies, but FFS last about 60 days for most.

*Rene Mollow, DHCS:* We can get the number of ongoing FFS. There are some restricted aid codes, some Duals and some "other healthcare coverage" in FFS.

*Stephanie Lee, Neighborhood Legal Services of Los Angeles County:* Is there data on how the application was submitted to identify trends? For example, someone over 65 submitting through Covered CA online may be more complicated and it could be quickest to hand deliver an application to the county. We get questions about the fastest, easiest way to get Medi-Cal.

*Rene Mollow, DHCS:* We do have data on the different pathways people use to apply. We don't have information about the fastest way to apply. Many people over 65 have SSI/SSP and they have automatic eligibility, so it varies by the individual.

*Stephanie Lee, Neighborhood Legal Services of Los Angeles County:* Is there feedback on general trends from counties?

*Jennifer Kent, DHCS:* We do hear that there are high numbers of applications being submitted electronically. Counties are knowledgeable about this and track their applications. LA has 16 offices with different populations in different parts of the county so it would vary.

*Cathy Senderling, County Welfare Directors Association:* We know that non-English speaking individuals are more likely to come into an office in person.

*Sarah de Guia, CA Pan-Ethnic Health Network:* On enrollment by race/ethnicity, there was a large percentage not reporting data. Are there efforts to work on that?

*Rene Mollow, DHCS:* That is optional on the application so we haven't asked.

*Sarah de Guia, CA Pan-Ethnic Health Network:* Is there training to highlight this as part of the quality improvement effort?

*Rene Mollow, DHCS:* That is a good point for us to take back. Part of it is about how they apply because we are seeing increasing numbers of online applications.

*Elizabeth Landsberg, Western Center on Law and Poverty:* Perhaps the health plans have better race/ethnicity data? Do they report back to DHCS?

*Mari Cantwell, DHCS:* They get the data from us.

*Sarah de Guia, CA Pan-Ethnic Health Network:* On the commercial side, there is a requirement to do an assessment of the population. Covered CA just adopted an 80% benchmark for self-reported data.

*Bob Freeman, CenCal Health:* We collect data through some avenues, but there are numbers of 'decline to state.'

Ms. Mollow provided an update on renewal data for 2015 and first quarter 2016. This is a new report DHCS is providing. The data reflects Medi-Cal-only beneficiaries but is to offer a view of what is happening with renewals.

[http://www.dhcs.ca.gov/services/Documents/Dec2015\\_Renewals\\_SAC051616.pdf](http://www.dhcs.ca.gov/services/Documents/Dec2015_Renewals_SAC051616.pdf)

[http://www.dhcs.ca.gov/services/Documents/Jan2016\\_RENEWALSDATA\\_SAC.pdf](http://www.dhcs.ca.gov/services/Documents/Jan2016_RENEWALSDATA_SAC.pdf)

*Marty Lynch, LifeLong Medical Care and California Primary Care Association:* What would make a county lower for Continued Medi-Cal in the renewals?

*Rene Mollow, DHCS:* Lots of issues could result in that. For 2015, there were delays in processing renewals. We are working to understand the issues underneath why there are lower rates in certain places.

*Cathy Senderling, County Welfare Directors Association:* I noted that the higher the percentage of Processed cases, the lower the number of Continued Medi-Cal. Our speculation is that these represent the non-auto renewals and they are more complex. More of the complex cases may be not be eligible and drop off. We are working with LA, which has a lower percentage, to understand this. One issue for LA is the transition to a new LEADER eligibility system.

*Mari Cantwell, DHCS:* We have the same questions and are working to figure this out. The reporting is not clean yet and will improve as we go along.

*Rene Mollow, DHCS:* This is case information and there is an average of two individuals/case.

*Gary Passmore, CA Congress of Seniors:* This report does not meet accessible standards.

*Rene Mollow, DHCS:* Thank you for that. I apologize.

*Bill Walker, MD, Contra Costa Health Services:* On Marty's comment, I followed up and found that there seem to be differences between CalWIN and other systems, having to do with technology difficulties.

*Jennifer Kent, DHCS:* There do seem to be a whole set of system issues. There are differences about how they pull the data and report the data. That is why this is a preliminary report to help us understand how to provide consistent data.

*Kristen Golden Testa, The Children's Partnership/100% Campaign:* The "due" line is the denominator for the "processed" column, and the denominator for "continued" column is the "processed continued on aid"?

*Jennifer Kent, DHCS:* Using the example of Alameda, 93,402 cases were due for redetermination; they processed 86,238 so that was 92% of the work. They didn't do 7,164 but of those they processed, 63,904 were continued so that was 74% continued.

*Kristen Golden Testa, The Children's Partnership/100% Campaign:* Is this data typical?

*Rene Mollow, DHCS:* We don't know because this is the first time we have reported this data.

*Mari Cantwell, DHCS:* The renewal totals seem low. The report doesn't seem quite right yet.

*Kim Lewis, National Health Law Program:* This is annual renewal data? If there is any update from a change of information, it is a "renewal" and that resets the 12 months? That complicates the data here.

*Steve Melody, Anthem Blue Cross:* For many of the expansion population, this is their first renewal. Do you see any differences between the various aid codes in terms of staying on?

*Rene Mollow, DHCS:* That is a good point and we will be exploring that information.

*Stephanie Lee, Neighborhood Legal Services of Los Angeles County:* The aging report you mentioned would be useful. When will that be available? In the "continued" column, does this include those with a share of cost? Is there a way to know the cases transitioned to Covered CA?

*Rene Mollow, DHCS:* Yes, continued does include share of cost. I don't have a timeline for when the additional data will be available.

*Anthony Wright, Health Access California:* Has everyone in the expansion population from 2014 been through a renewal cycle?

*Rene Mollow, DHCS:* Yes, they have all come up for redetermination but they could be pending.

*Cathy Senderling, County Welfare Directors Association:* In summary, it is a balancing act. Counties are case managing the expansion population, dealing with the SB75 transition and other changes. We hope the automatic process in the ACA will capture more of the renewals. There is additional funding requested in the budget to allow for the increased work in the expansion population. The goal is for changes in CalHEERS and other systems to be done by 2018 to have the functionality changed. We are also working on a new budgeting methodology going forward. It is a roller coaster but we are proud to have 14M people covered.

### **CCI Comprehensive Strategy**

***Sarah Brooks, DHCS***

Slides are available: [http://www.dhcs.ca.gov/services/Documents/CCI\\_SAC\\_051616.pdf](http://www.dhcs.ca.gov/services/Documents/CCI_SAC_051616.pdf)

Sarah Brooks provided a summary update on CCI enrollment and policy decisions. There are 122,000 enrolled across the seven counties. Enrollment in Orange County is ongoing. Thanks to the SCAN Foundation for funding evaluation of the program. The Department is pursuing a two-pronged approach in its CCI Comprehensive Strategy. One prong focuses on quality improvement; the other on sustainability. On the quality side, DHCS is looking at Long Term Services and Supports (LTSS) and how to strengthen referrals to services. A standardized set of LTSS Health Risk Assessment (HRA) questions is out for comment. We are also aligning the Medicare continuity of care period to Medi-Cal, increasing it to 12 months. We reviewed opt-out data in a more detailed level than previously and will share this with health plans so they can reach out in a more targeted manner to providers with high opt-out rates. We are also implementing best practice meetings. On sustainability, we are operationalizing mandatory MLTSS enrollment. The choice book is going through beneficiary testing. We are pausing on passive enrollment and instead trying voluntary enrollment. We are implementing streamlined enrollment, which allows the health plan to talk to beneficiaries to "enroll" individuals interested in Cal MediConnect, then sending information to Health Care Options to conduct the actual enrollment. Health Care Options will follow up by phone to validate that the beneficiary chose to enroll.

### **Preliminary Results from an Evaluation of Cal MediConnect: The Beneficiary Perspective** ***Carrie Graham, Ph.D., MGS Principal Investigator UCSF, Community Living Policy Center UC Berkeley, Health Research for Action***

Slides are available:

[http://www.dhcs.ca.gov/services/Documents/CalMediConnect\\_SAC\\_051616\\_FINAL.pdf](http://www.dhcs.ca.gov/services/Documents/CalMediConnect_SAC_051616_FINAL.pdf)

Carrie Graham reported an overview of the Cal MediConnect (CMC) evaluation from provider and beneficiary perspective. There were 14 focus groups in four languages in six counties to gain qualitative input directly from beneficiaries in different target populations and services. The focus groups informed the randomized phone survey to over 2,000 individuals to drill down on those in CMC, those who opted out and those in counties without CMC. Those in CCI are more likely to be white, English speaking and high school graduates. Those opting out were more likely to have difficulty with daily activities. About 50% opted out overall but a surprising feature

was that 43% were unaware they had opted out. If this were about recall, we would expect 18-20%. Top reasons for opting out included uncertainty, choice satisfaction, continuity and disruption. Overall satisfaction for those in CMC is high. Over one third said their care is better since switching to CMC. Only 4% have filed any type of complaint or grievance. Reasons for high satisfaction included: better quality of care, simpler with one card, easier to speak with someone and more access to specialists. On care coordination, 92% of CMC beneficiaries were very or somewhat satisfied with their care coordinator but 40% of CMC beneficiaries did not know they could get care coordination. The only predictor of getting care coordination was receiving behavioral health services. Ms. Graham reported in detail on other factors of care coordination, challenges experienced and integrating LTSS and IHSS. The next step in the evaluation is to conduct a follow up survey in 2017 to measure differences over time and to produce case studies.

### **Questions and Comments**

*Gary Passmore, CA Congress of Seniors:* Are the opt outs people those who enrolled and then dropped out?

*Carrie Graham, UCSF:* They are primarily people who never enrolled.

*Gary Passmore, CA Congress of Seniors:* When you asked if someone from CMC talked to the opt outs about LTSS, who are they are talking to since they are not enrolled in a plan?

*Carrie Graham, UCSF:* That may be a better question for the plans. We do see some getting care coordination from the plan on the Medi-Cal side. Are they offering care coordination to those who opt out?

*Marty Lynch, LifeLong Medical Care and California Primary Care Association:* I assume those who opt out do so for continuity of care to keep their doctors and they also tend to have more disability. This is an irony since we speculate that they would benefit most from care coordination. Did you tease out more about this dichotomy?

*Carrie Graham, UCSF:* We want to follow up on this. In focus groups, people mentioned that they heard they would lose IHSS if they joined CMC. We also heard from them that they coordinate their own care.

*Marty Lynch, LifeLong Medical Care and California Primary Care Association:* If in fact some people would benefit from care coordination who opt out, can we think about a care coordination benefit that doesn't come through the CCI plan?

*Sarah Brooks, DHCS:* It is a good question to ask. The difficulty is that most of the care would be happening on the Medicare side and we don't have full control of that part.

*Marty Lynch, LifeLong Medical Care and California Primary Care Association:* Perhaps a conversation with CMS about a joint benefit?

*Bill Walker, MD, Contra Costa Health Services:* The survey reminds me of the SPD (Seniors and Persons with Disabilities) experience. We struggled for years to overcome the doubts. Do you really think that more education, better letters will change the opt out number? Or do we just move them into managed care? I think the SPD experience indicates that when it was mandatory, it worked out over time.

*Mari Cantwell, DHCS:* It is a good question, it is more difficult with Duals because it involves the Medicare side.

*Brenda Premo, Harris Family Center for Disability and Health Policy:* First, there were big problems with the SPD transition but I do think they are getting resolved because of work with DHCS. I think managed care will be good for most people, but this is a vast array of people. We found there is a view of disability based on who you see and it is not one population. We need a variety of options; we can't just say "those people need to go into managed care". Those with developmental disability or traumatic brain injury will need coordinated care for their lifetime. We can increase these expensive individuals joining if we introduce them to care coordinators and build trust. This is important as we begin to think of policy. I see plans doing a great job; others struggling with basics. This evaluation is a way to begin that discussion. We need to talk to a number of different populations and their families to understand the issues. The state has done a good job of improving the process and as I listened to this report, it seems clear that it is time to look at the next level.

*Marilyn Holle, Disability Rights CA:* It was interesting to see the differences for those with DME or wheelchairs because of the stronger benefits in Medi-Cal.

*Carrie Graham, UCSF:* Those with DME were not more likely to have care management through CMC, but were more likely to have disruptions.

*Stephanie Lee, Neighborhood Legal Services of Los Angeles County:* It seems the two factors to stay are continuity with specialists and care coordination. Given the difficulty plans have had in reaching contract agreements with specialists, the more realistic thing to focus on is the care coordination. Can you speak to improvements with the plans on care coordination?

*Sarah Brooks, DHCS:* Certainly care coordination is a key component of Cal MediConnect, but not everyone needs a high level of care coordination. There are opportunities to work with the health plans to strengthen different elements of the program based on the diversity of the population. We need to dig into the data to identify those opportunities. When we dig into the data on SPDs with higher acuity, we see different changes than those with lower acuity. We do want to work on it but it is early to say what will make sense to do.

*Michelle Cabrera, SEIU:* Was there a reason not to break out the non-LTSS data?

*Carrie Graham, UCSF:* We will be cutting the data in different ways as we drill down over time. This is just a first cut of what seemed interesting. Also, it was not sampled to look at each different segment separately, so there are sample size issues with some break downs.

*Michelle Cabrera, SEIU:* The benefits of this are that health plans can identify those with risk, do health assessments. If they are not using data to target those who will benefit from care coordination, will there be an expectation from DHCS that health plans will do more targeting?

*Sarah Brooks, DHCS:* On risk stratification, there was work to determine the high/low acuity. From the learnings, we can now update the policy and procedures to revise the process and who is targeted.

*Gary Passmore, CA Congress of Seniors:* Did you, or could you, survey them about benefits they would like to have and that would draw them into managed care?

*Carrie Graham, UCSF:* Mostly we saw that people have a limited idea of what a plan can do – it's just about a doctor. They aren't thinking about the range of services. Dental did come up.

*Gary Passmore, CA Congress of Seniors:* Has anyone spoken to beneficiaries about the protections in managed care compared to FFS like timely access, continuity of care, filing grievances? That seems a tangible benefit. Also, what happened to the universal assessment tool?

*Carrie Graham, UCSF:* In the SPD survey a few years back, we asked about their understanding about that. I don't think we asked about specific rights. In the qualitative data, when people said it was better and we followed up, they said there was someone to talk to and follow up.

*Sarah Brooks, DHCS:* We are still working on the universal assessment tool with Dept. of Social Services and Dept. of Aging.

*Rusty Selix, CA Council of Community Mental Health Agencies:* Thank you. I am pleased and not surprised to see this led to better behavioral health care. Can we look at the penetration rates in different plans? That should translate into better outcomes in physical health and savings. We also expect the flip side – better physical health care for those with mental illness. Is there data on that?

*Carrie Graham, UCSF:* We don't have access to information when we call them about whether they are seriously mentally ill. We do ask 'do you use mental health services?'

*Rusty Selix, CA Council of Community Mental Health Agencies:* We could figure that out with you and would want to figure out how to get data.

*Sarah Brooks, DHCS:* There are specific data measures tied to the SMI population through CMS and the NORC (NORC at the University of Chicago/research center).

*Lishaun Francis, CA Medical Association:* When physicians think about patients and the best way to improve health outcomes -- in my own case, I think I am coordinating my health care quite well, but my doctor would say something different based on actual health. Is there an appetite to look at health outcomes for those in vs opted out?

*Mari Cantwell, DHCS:* We are moving to work on data like that now. We need to get the complete data from Medi-Cal and Medicare.

*Bradley Gilbert, MD, Inland Empire Health Plan:* I am confused overall and am wondering if this is an issue of definitions. For a Med-Cal-only beneficiary, we do limited care coordination. It doesn't make sense to me, that number of 35% of CMC LTSS duals said "yes" and 34% of opt outs said "yes". We do HRA for most everyone; we do care plans for everyone; we do transitions of care; we run algorithms for high risk patients and we do care plans for high needs in HRA. They may not think a care plan is care coordination.

*Carrie Graham, UCSF:* Yes, it is hard to talk to people about care coordination. We have extensive definitions and probes about that, but it is not perfect. We say is there, "someone from the health plan that helps you with your care". We talk specifically about IHSS and we use the managed care plan name.

*Bradley Gilbert, MD, Inland Empire Health Plan:* Plans don't do IHSS, counties do. So, I wonder about confusion on who is talking to them. When we did focus groups, there was confusion about the benefits. I agree with Brenda that not all belong in managed care but the vast majority do. A piece is giving them information, making sure they know the options. But, care coordination at its core is getting them from inpatient to home or other activities they may not see as care coordination.

*Carrie Graham, UCSF:* Some know, others no. We ask things like, has the plan done anything to make it easier to live in your home? Another point is that there is so much happening behind the scenes that a beneficiary won't know about on care coordination.

*Bradley Gilbert, MD, Inland Empire Health Plan:* We have almost 1000 measures. Many are not mature but we do monitor the population and we are looking at how they are doing in the plan.

*Michelle Cabrera, SEIU:* One thing I noticed is that folks in CMC said they were having trouble finding specialists. The plan is supposed to be helping find specialists. Does that raise flags about a disconnect?

*Carrie Graham, UCSF:* It was not about a specialist or not; there were other subtleties. The specialist is far away; doesn't know me; other distinctions.

*Bradley Gilbert, MD, Inland Empire Health Plan:* Plans will never get every Medicare specialist but it is our job to find a not-far-away specialist.

*Sarah Brooks, DHCS:* We need to go back to the point that beneficiaries who are new to managed care may not understand how to navigate it at first.

*Gary Passmore, CA Congress of Seniors:* It is important for all of us to reset our thinking. We have brought in four million childless adults into Medi-Cal and they are mostly in managed care. We have struggled for two years to get those in Medicare to have more managed care. Soon, those who are already in Medi-Cal managed care will age into Medicare and have experience in managed care. I try to keep in mind that these current problems understanding managed care and opting in/out will disappear.

*Marilyn Holle, Disability Rights CA:* My clients tend to not understand the difference between the plan and the IPA. The IPA is a not the plan and you have options beyond that IPA.

*Carrie Graham, UCSF:* We saw that in the focus group as well. The plan says I don't need authorization but the medical group says I do.

*Stephanie Lee, Neighborhood Legal Services of Los Angeles County:* We see this issue for those beyond CMS. It is important to work on that for all Medi-Cal populations.

## **New CMS Rule on Managed Care**

### ***DHCS staff***

Director Kent began with the context that DHCS is at a high level of analysis on the new CMS rules on managed care. Mari Cantwell offered feedback about the final rules and comments and issues raised about the draft rules. There was some movement by CMS on some issues to make them more workable although it will be a challenge. Two key financing issues were raised related to how CA funds the nonfederal share of payments and bolster the safety net that we

refer to as the rate range. States have the ability to choose where to pay within the actuarial range. The draft and final regulations are very similar – the state must pay a specific rate. A slight modification was made related to the rate certification, but it does not impact the requirement to pay a specific rate. The challenge will be in working with partners prospectively to see if we can continue to pay more. The rate range did not change but operationally it will be more difficult. This financing supports public hospitals, county clinics, fire districts and others. Certifying rates begins in FY18-19 so we have time.

The second issue is the supplemental payments paid to designated public hospitals that is “up to costs” for particular aid groups. Similarly, there is the hospital provider fee for non-public hospitals rates. The original regulations made continuing this impossible. The final regulation softened this to allow directed payments to a class of providers with a minimum or maximum fee schedule or value-based payments. All of those are things we will explore but it will require a change to current payments. CMS included a 10-year phase down for California related to hospitals and pass-through payments. California can continue through FY17-18 as we are now and develop a phase-out of 10% per year over the balance of time.

The third item relates to provider enrollment. The draft regulations said all providers must be enrolled through the FFS enrollment system. Many states raised issues with this. CMS modified the requirement so states can delegate the responsibility. We must ensure that what managed care plans do meets the requirement. HR 3716 is a bill in Congress to implement the original regulation that has bipartisan support. Perhaps this will still be a problem if the bill becomes law.

The fourth issue is partial disallowance of FFP and this was changed.

Many other items we commented on remained the same in the final rule and will require significant work by DHCS and health plans, such as network adequacy certification, the star rating system, rate setting process changes and other standards. This is a key reason for the budget request for additional positions in DHCS.

## **Questions and Comments**

*Bill Walker, MD, Contra Costa Health Services:* What is the federal rationale for the legislation?

*Mari Cantwell, DHCS:* Program integrity is the rationale. There is concern states don't know about providers who aren't coming through the state provider enrollment system. It is to make tracking fraud easier.

*Lishaun Francis, CA Medical Association:* To add to that, our legislative staff say they are finding that providers are changing states after a finding of fraud and there is no tracking. The goal is to pinpoint providers committing fraud so they are known.

*Anthony Wright, Health Access California:* The ten year phase out is based on our current system? If we move to value-based payment, that will meet this requirement?

*Mari Cantwell, DHCS:* Yes, we have 10 years to change the way we do this.

*Sherreta Lane, District Hospital Leadership Forum:* On the rate range requirement, will this upend the way the program works today?

*Mari Cantwell, DHCS:* There are many more detailed discussions to have with all of you but I wouldn't say it will upend. It will change the program and there are challenges to work through.

*Marty Lynch, LifeLong Medical Care and California Primary Care Association:* Does this include the whole intergovernmental transfer structure?

*Mari Cantwell, DHCS:* Yes. It moves everything to prospective.

*Michelle Cabrera, SEIU:* Are there implications for the supplemental payments on the nursing home quality assurance since that is on a different timeline?

*Mari Cantwell, DHCS:* My view is that we are in compliance today. The plan pays nursing homes on a fixed schedule.

*Lishaun Francis, CA Medical Association:* What are the next steps?

*Mari Cantwell, DHCS:* I don't have exact next steps. We are currently assessing impact in each area of DHCS and creating work plans. We will need to have discussion on the financing with public hospitals and decide timelines and where we need to engage with stakeholders.

*Lishaun Francis, CA Medical Association:* Is there a plan to loop in Dept. of Managed Health Care (DMHC)?

*Kim Lewis, National Health Law Program:* I am excited about some items. This is the first time network adequacy and access rules will affect Prepaid Inpatient Health Plans (PIHPs) – the mental health plans in California. This will provide some consistency with rules at DMHC on the Knox-Keene side. On grievance and appeals, there are positive changes. The rule will be that you have to exhaust internal appeals before going to fair hearing. Also it will require continuing benefits during appeals.

*Elizabeth Landsberg, Western Center on Law and Poverty:* Do you anticipate any statutory changes you need to make this year?

*Mari Cantwell, DHCS:* That is one of the things we are assessing; where are there conflicts and how that needs to be resolved.

*Anthony Wright, Health Access California:* Our review is that there are adjustments on network adequacy that will need to be made. It seems there will be interaction with DMHC and engaging with stakeholders on that.

*Mari Cantwell, DHCS:* Yes.

*Kristen Golden Testa, The Children's Partnership/100% Campaign:* Will SAC be the forum for the ongoing discussions? It would be helpful to have a schematic of the changes.

*Mari Cantwell, DHCS:* That is still unclear. We will bring updates here but don't know yet how we will engage with stakeholders. We have other venues as well so we will be figuring that out.

## **SUDS Waiver Implementation**

***Karen Baylor and Marlies Perez, DHCS***

Slides available: [http://www.dhcs.ca.gov/services/Documents/SAC\\_ODSWaiver\\_051616.pdf](http://www.dhcs.ca.gov/services/Documents/SAC_ODSWaiver_051616.pdf)

Marlies Perez provided an update on roll-out of the Drug Medi-Cal Organized Substance Use Delivery System waiver. Counties are rolling out in five phases by region through 2016. DHCS is providing technical assistance throughout the implementation and has been releasing guidance to clarify different issues. Blue Shield of California Foundation (BSCF) and California Health Care Foundation have been very helpful in supporting the implementation. There are nine plans submitted and posted on DHCS website. This is the first External Quality Review that has occurred for substance use organizations so DHCS is offering support for this process to go well. She reported on progress related to network capacity.

There are several regional models under discussion including 1) Coordinating with managed care plans; 2) Establishing a Joint Powers Authority; and, 3) County-to-County collaborations. We will submit plans to CMS in October for how we will integrate care through coordinated, co-located or integrated models. We have approved an implementation plan for San Mateo and are close in other counties. CMS and DHCS reviews each plan and works with the county to clarify any questions and issues. CMS will issue approval to the county. Ms. Perez also reported on a number of innovations that go beyond the requirements.

Ms. Perez also reported on opioid overdose data. The highest eight counties with overdoses do not have any treatment programs (NTP). There are a number of projects through DHCS to overcome barriers, improve training and increase access to services.

She reported on a survey among managed care plans about the implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) and coordination with substance use services. She also reported that California is providing support to other states interested in developing a similar waiver.

## **Questions and Comments**

*Bradley Gilbert, MD, Inland Empire Health Plan:* One of the big barriers is federal law on sharing information. They are developing new policy for many entities such as health information exchanges but don't mention managed care plans. Separately, are the credentialing applications for individual providers? Clinics? I hear you talking about having more structure for SUD and a critical piece is credentialing.

*Marlies Perez, DHCS:* I was speaking to increasing applications for residential services. We haven't seen expansion in license requests for narcotic treatment facilities. At the provider level, the federal agencies are looking at allowing physician assistants to dispense medications, but it is highly regulated at the federal level. With the opioid epidemic, the federal government is reviewing policies on medication assisted treatment. At the state level, California mirrors federal guidance.

*Bradley Gilbert, MD, Inland Empire Health Plan:* And at the counselor level?

*Marlies Perez, DHCS:* There are about 36,000 alcohol and other drug counselors in the California system now. There are three certifying organizations and we oversee those organizations.

*Bradley Gilbert, MD, Inland Empire Health Plan:* On medication assisted treatment (MAT), one issue is the big investment required on training versus the limitations on the number of people

you can bring through. There is an economy of scale problem although there is interest on the physical health side to coordinate more with substance treatment centers.

*Marlies Perez, DHCS:* The maximum served by a (Data 200 waived) physician is limited to 100 (30 in the first year) and that is a federal requirement. They are considering moving to 200 to increase access. In narcotic treatment program (NTP) settings, we don't have individual physician limits on the numbers to prescribe because it is federally regulated. Some counties are looking at outpatient settings and coordinating with the NTP settings as a hub to overcome the barriers you describe.

*Sarah de Guia, CA Pan-Ethnic Health Network:* We are doing some work to engage consumers in this area to overcome stigma. How are counties and providers addressing these issues and how can we work together?

*Marlies Perez, DHCS:* BSCF is helping roll out cultural competency and other communication with beneficiaries as well as learning collaboratives. We haven't had beneficiary engagement in the past. We are having webinars with counties about engagement and will release guidance from DHCS.

*Sarah de Guia, CA Pan-Ethnic Health Network:* There is emphasis on the opioid epidemic but there are other issues in many communities and want to be sure other issues aren't lost.

*Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center:* There is a tremendous amount of work and progress has been made. However, some of what I want to speak to is the negative. First, I feel urgency to get this up and running that I don't see with others. I say that because of what we know about the opioid epidemic, Hep C being the highest mortality infectious disease. I was forwarded a voice mail recently from a father who couldn't find detox services because there were no beds available. He put his son in a hotel until the next day when a bed might be available and when he arrived, he found his son dead from an overdose. I am looking for a timeline and milestones that hold us accountable to get this implemented so it does not continue to be pushed forward. For every month it bleeds forward, people are dying. Can you speak to the detox issue? Can you speak to residential treatment benefits? I am being told that what was expected to be two months of care becomes two episodes – maybe a few days each. That isn't care for a chronic disease. Can you speak to the requirement that no care is approved unless/until there is a face to face assessment? There are not the resources to do this for everyone who needs care. Today's waiting lines will extend around the block if we roll this out with a whole new barrier. Those are some of my issues.

*Marlies Perez, DHCS:* You are highlighting what a huge lift this is for the system. In some cases, there is misinformation and confusion about program requirements. The only service where a face to face is required is for group counseling - all others can be done by telehealth. The medical necessity determination requires a physician or licensed practitioner, face-to-face or via telehealth; the ASAM assessment and paperwork can be done by a counselor. That has come up on our county calls and we added it to our FAQ. On the residential benefit, there has been confusion, so we are releasing a documentation manual as additional guidance to indicate how to document services. I will make sure the issue you raise about two non-contiguous stays is clarified. Finally, the detox reimbursement will be changed to become part of the organized delivery system structure rather than FFS. We will be releasing this guidance soon.

*Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center:* At the bottom line, Jennifer, you asked why it matters if it is paid by the county or the

state? It doesn't matter if the care is made available, except that it has created a whole new barrier and delay.

*Bill Walker, MD, Contra Costa Health Services:* You mentioned credentialing organizations for counselors. Is there a move to license substance use counselors?

*Marlies Perez, DHCS:* There is no license for substance use. There is a bill pending, SB1101, to create one.

*Brenda Premo, Harris Family Center for Disability and Health Policy:* Abuse is a disability. However, we don't come with one disability. Some are deaf and addicted; blind and addicted; veterans who are addicted. I believe this must be covered with the same access standards as other services. I have had many denied access to treatment because there was no ability to serve a disabled consumer, no physical access. I don't see attention to that in the plan. The facility site review would be one way to deal with this requirement. We need to apply the same standards to this system that we have applied to primary care and other physicians.

*Jennifer Kent, DHCS:* As Marlies referenced, this waiver represents a total change in a benefit. It is not with managed care plans. Counties will be in the role of the health plan. Counties have financial responsibility for behavioral health through realignment. There is an emerging process and although we are working with best intentions, it is taking a long time. Brenda, your points are well taken that we need to attend to. San Mateo is first but still doesn't have a cost claiming process with CMS. We will continue to update you as we get down the path.

*Brenda Premo, Harris Family Center for Disability and Health Policy:* Physical and communication access are not new. They are law and are a requirement for state and federal funding. They should be part of the planning as you put this together.

*Marlies Perez, DHCS:* We need to do more, however, we are reviewing plans for access requirements around all kinds of issues. We have sent some implementation plans back to include more detail about access. We are not where we want to be. We are looking at access as a part of the review process.

*Sandra Naylor Goodwin, CA Institute for Behavioral Health Solutions:* California is the first state to even try this. It is important we are doing it and these problems have been around for a long time without anyone creating a full continuum of care. Other states are anxious to have a similar effort.

*Rusty Selix, CA Council of Community Mental Health Agencies:* On the issue of integration with mental health, we surveyed our community mental health providers and 90% acknowledged providing lots of substance use treatment. But fewer than 20% are participating in Drug Medi-Cal. To participate, they need cost-based rates that match the rates they currently receive in mental health. The other issue is site certification and provider certification. Where there is already approval for mental health certification, I wonder if through federal waivers, you can fold these providers in without additional federal approval. Without that, integration will be very slow.

*Marlies Perez, DHCS:* Because of Drug Medi-Cal fraud and abuse, this is considered high risk so it must come through the state.

*Rusty Selix, CA Council of Community Mental Health Agencies:* I have had discussion with CMS and there was willingness to look specifically at this group of providers.

*Marlies Perez, DHCS:* We discussed this with CMS but they are closed at this point. It will have to be in a different phase.

*Jennifer Kent, DHCS:* They have indicated that county governmental providers may not need to go through a full certification. Now, there is no flexibility and we have to go out to do onsite reviews. Once it settles into implementation and we can lift the high risk we can talk about changes. It will be at least a couple of years.

*Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center:* Can you speak to the State Plan Amendment (SPA)?

*Jennifer Kent, DHCS:* You are referencing the SPA to add specific drugs to narcotic treatment programs like naloxone and buprenorphine. These are FDA approved drugs in the Medi-Cal program and formulary and so we don't believe we need a SPA to add those drugs. We need other changes to pay narcotic programs for the drugs. The SPA is not required for prescribing, the change is required for reimbursement because of the difference between the county financed system and the FFS Medi-Cal side. It also depends on whether a county opts in. Currently, we cover buprenorphine without a TAR anywhere in the state. It is about who is prescribing. In the non-opt in counties, we are discussing whether there will be county distribution of funding for individuals who travel to counties with NTPs. It will be a discussion for when the waiver is up and running.

*Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center:* Thank you.

*Anne Donnelly, Project Inform:* We are hearing that for stand-alone methadone clinics, there is no way to be reimbursed for Hep C or HIV screening or to link people to care. How can we engage to solve this? This is a key that the capacity for this be available.

*Jennifer Kent, DHCS:* This has not been raised before. The Short-Doyle system does not allow claims for medical health services. If the provider is in Medi-Cal it could potentially be billed FFS but that would depend on managed care contracts. It is probably better to discuss offline because it is complex.

### **Medi-Cal 2020/1115 Waiver** ***Mari Cantwell, DHCS***

Mari Cantwell provided a short update on Medi-Cal 2020 approval for Whole Person Care and PRIME. PRIME plans are submitted and we are on track to approve all of those soon. On Global Payment Program, we are developing a webinar with details on point values. Thanks to BSCF, we worked with Navigant and our public hospital colleagues to submit the uncompensated care report. It does a great job of laying out the significant, continuing levels of uncompensated care and the rationale for continued global payment program financing. We are looking forward to more discussion with CMS. On the Dental Transformation Initiative, we have fleshed out how the various domains will work and are moving forward to begin the program.

*Anthony Wright, Health Access California:* Are there ways for us to be helpful with CMS on the uncompensated care pool?

*Mari Cantwell, DHCS:* There may be a way for support. I will think about it and let you know.

*Elizabeth Landsberg, Western Center on Law and Poverty:* There is an STC requiring UC hospitals to contract with at least one managed care plan. There is a concern about beneficiaries not being able to access services through the UCs. Here in Sacramento County, only Anthem has a contract with UC and it seems to be limited. Even when there is a contract, it may not work the way it should.

*Mari Cantwell, DHCS:* Yes, we share the same goals.

*Steve Melody, Anthem Blue Cross:* It is a full service contract just like any other hospital, so I would be happy to work with you if there are access issues.

**PRIME Planning and Implementation for District and Municipal Hospitals**  
***Sherreta Lane, District Hospital Leadership Forum and SAC Member***

Presentation slides are available at:

[http://www.dhcs.ca.gov/services/Documents/DHLF\\_PPT\\_SAC\\_051616.pdf](http://www.dhcs.ca.gov/services/Documents/DHLF_PPT_SAC_051616.pdf)

Sherreta Lane presented an update on the non-designated hospital participation in PRIME. There are 40 non-designated hospitals in 28 counties throughout the state. We began discussion in 2012 and although it was not finalized, it built enthusiasm and some hospitals did go ahead to implement what they had been planning. The hospitals will put up \$110M for IGTs, with 110 projects among 37 hospitals/system. The projects were chosen to meet specific community needs and gaps in services for both primary and specialty care; some are related to behavioral health; many are beginning preventive programs and many are working on post-acute transitions (most popular project). We are learning from public hospitals and others and continue to collaborate to overcome challenges and participate in PRIME.

**Questions and Comments**

*Bradley Gilbert, MD, Inland Empire Health Plan:* We have spent lots of time in discussion with California Association of Public Hospitals, but we have not spent time on this to align and partner. Can we get a list of hospitals and projects?

*Mari Cantwell, DHCS:* We can make that available to SAC.

*Anthony Wright, Health Access California:* I am curious if there was engagement with communities or consumers during the process of developing projects?

*Sherreta Lane, District Hospital Leadership Forum:* There was no formal process but all reached out and included interaction with stakeholders. The larger hospitals all have regular engagement with community partners. They also used their community needs assessments.

*Anthony Wright, Health Access California:* It would be helpful to have contact information to understand the projects. Is there any reporting of the projects, other than to the state?

*Mari Cantwell, DHCS:* We will post all reports – twice yearly – on the PRIME part of the website. The first report is September 2016.

**Status of Whole Person Care RFP and LOIs**  
***Sarah Brooks, DHCS***

Presentation slides are available at:

[http://www.dhcs.ca.gov/services/Documents/WPC\\_SAC\\_051616.pdf](http://www.dhcs.ca.gov/services/Documents/WPC_SAC_051616.pdf)

Sarah Brooks provided an addition to the update on the overall waiver in relationship to the access assessment required in the STCs. DHCS issued a public application period and received about 87 applications. Over the next month, we will screen them and the committee membership. She presented slides on the Whole Person Care (WPC) program. This is a collaborative project of the waiver to focus on high risk, high utilizer consumers in order to:

- Build infrastructure to integrate services among local entities that serve the target population.
- Provide services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target population, such as housing components.
- Implement strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.

She reviewed the roles and responsibilities for lead and participating entities. There is emphasis on collaboration across systems and partners. DHCS issued a letter of intent and received 29 letters with a balance of urban and rural areas and different lead agencies. She offered examples of activities and services included in the letters of intent which are posted on the website. There has been great interest in housing services and there are many questions about how this might work. She clarified some housing supports and tenant services that are eligible (or not) for reimbursement. All WPC pilots will report on a set of metrics – universal and pilot-specific metrics. She reviewed implementation to date and next steps to review applications and approve final WPC pilots. Pilots will begin in November.

### **Questions and Comments**

*Marty Lynch, LifeLong Medical Care and California Primary Care Association:* Some of the homeless population are dually eligible. Has there been any work to secure Medicare data?

*Sarah Brooks, DHCS:* Not specific to this project, but Linette Scott has been having discussions about accessing Medicare data and once it becomes available, we will share it with the pilots as appropriate.

*Rusty Selix, CA Council of Community Mental Health Agencies:* The metric being used for mental health is depression questionnaire and suicide risk, but I think the most important population to target will be schizophrenics and I am not sure those metrics are useful for them. I wonder if the metrics will create a problem?

*Sarah Brooks, DHCS:* We can use additional metrics as well.

*Kristen Golden Testa, The Children's Partnership/100% Campaign:* Can a county lead entity submit multiple projects or have two pilots within their applications?

*Sarah Brooks, DHCS:* We are not encouraging multiple applications but they can cover multiple populations within the application.

*Kristen Golden Testa, The Children's Partnership/100% Campaign:* Are the full letters of support listed with contact information included on the web site?

*Sarah Brooks, DHCS:* Letters are posted. We are happy to share other information as needed.

*Bradley Gilbert, MD, Inland Empire Health Plan:* To clarify the housing dollars, if I have \$50 from county and \$50 from feds and if I want to provide housing, I create a separate fund and that can include health plan dollars, right? On recuperative care, we have a way-station for those coming out of hospital on the way to housing. Is that reimbursable?

*Sarah Brooks, DHCS:* Yes, on both.

*Michelle Gibbons, County Health Executives Association of CA:* Do you have a sense of how many awards you will give out? Is there a minimum award? We are getting questions from small counties in particular about whether there is a minimum threshold to participate.

*Sarah Brooks, DHCS:* We don't know this yet. The STCs only specify that no more than 30% can be awarded to a single county. Beyond that, we need to see the applications before we have more information.

*Jennifer Kent, DHCS:* We are excited to see many letters of intent from small and rural counties. We will fund as many as we can and are encouraging small counties to put in the application.

*Mari Cantwell, DHCS:* Both DHCS and CMS have interest in seeing there is a rationality across counties and we can't see that until we have the applications.

*Anthony Wright, Health Access California:* You said you might introduce additional standardization if you see themes across counties?

*Mari Cantwell, DHCS:* It is both the menu and the payment. CMS has concern about whether the money will accomplish something. It will require an iterative process.

*Marilyn Holle, Disability Rights CA:* Will assistance dogs be included as an option?

*Sarah Brooks, DHCS:* We haven't looked into this as of yet.

*Elizabeth Landsberg, Western Center on Law and Poverty:* There were 29 applications for 28 counties? Which county had two?

*Sarah Brooks, DHCS:* In San Diego, both the county and a tribe applied.

*Brenda Premo, Harris Family Center for Disability and Health Policy:* You can't deny access to any service animal. It is not a question of the payment but there are required policies for service animals that should be attended to. I have trouble with paying rent with health dollars – HUD should pay rent.

*Kristen Golden Testa, The Children's Partnership/100% Campaign:* There was a list of services on the housing pool and a goal of keeping people in their home. Can you access the flexible pool for pest remediation?

*Sarah Brooks, DHCS:* You can use federal funds for that so the pilot can pay for that. You can put anything you want in the pool. The benefit to not putting it in the pool is that you can draw down funding but you can put the service in the pool. The money for the pool is generated from savings or local entities.

*Anthony Wright, Health Access California: Who submits the application; does it need a Board of Supervisors' vote?*

*Sarah Brooks, DHCS: We don't require a vote, it is up to the county's policy.*

**Public Comment**

There is no public comment.

**Next Steps and Next Meetings**

Next meeting dates:

August 11, 2016, Room 313, Convention Center (**new room**)

October 24, 2016

A few announcements:

SAC will not be scheduled on Mondays in response to member comments - following the October date that is already set. You are all invited to the May 24<sup>th</sup>, 50<sup>th</sup> anniversary party for Medi-Cal. BSCF and TCE have generously funded the celebrations.

There was lots of interest in CMMI applications for Accountable Health Communities that required a letter from DHCS in the application. This was difficult for us because there were Medicaid requirements and it required data capacity at DHCS we were worried we couldn't meet. DHCS will work with two applicants, Contra Costa and Inland Empire/Kaiser, to move forward with applications. That program similarly focuses on integration and whole person care.