

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

**August 11, 2016
9:30am – 1:30pm**

MEETING SUMMARY

Attendance

Members Attending In Person: Lisa Davies, Chapa-De Indian Health Program; Sarah de Guia, CA Pan-Ethnic Health Network; Anne Donnelly, Project Inform; Lishaun Francis, CA Medical Association; Michelle Gibbons, County Health Executives Association of CA; Kristen Golden Testa, The Children's Partnership/100% Campaign; Carrie Gordon, CA Dental Association; Marilyn Holle, Disability Rights CA; Michael Humphrey, Sonoma County IHSS Public Authority; Carolyn Wang Kong, Blue Shield of California Foundation; Elizabeth Landsberg, Western Center on Law and Poverty; Sherreta Lane, District Hospital Leadership Forum; Stephanie Lee, Neighborhood Legal Services of Los Angeles County; Steve Melody, Anthem Blue Cross; Erica Murray, CA Association of Public Hospitals and Health Systems; Gary Passmore, CA Congress of Seniors; Chris Perrone, California Health Care Foundation; Brenda Premo, Harris Family Center for Disability and Health Policy; Herrmann Spetzler, Open Door Health Centers; Farrah McDaid Ting, California State Association of Counties; Richard Thomason, Blue Shield of California Foundation; Bill Walker, MD, Contra Costa Health Services; Anthony Wright, Health Access California.

Members Attending by Phone: Kim Lewis, National Health Law Program.

Members Not Attending: Bill Barcellona, CA Association of Physician Groups; Kirsten Barlow, County Behavioral Health Directors Association of California; Michelle Cabrera, SEIU; Richard Chinnock, MD, Children's Specialty Care Coalition; Bob Freeman, CenCal Health; Bradley Gilbert, MD, Inland Empire Health Plan; Marty Lynch, LifeLong Medical Care and California Primary Care Association; Sandra Naylor Goodwin, CA Institute for Behavioral Health Solutions; 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.

DHCS Attending: Jennifer Kent, Mari Cantwell, Jacey Cooper, Sarah Brooks, Sandra Williams, Alani Jackson, Adam Weintraub, Ryan Witz, Javier Portela, Morgan Knoch and Lindy Harrington.

Public in Attendance: 30 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. She reported on the DHCS efforts on the CMS Managed Care rules changes and identified the work required for compliance. An intradepartmental work group of multiple divisions and legal representatives is meeting to understand the many elements of the rules. It is a significant body of work and there are implications to incorporate into the Department's compliance efforts related to mental health

parity rules, the access rule and a new Office of Civil Rights rule involving threshold languages. We need to understand and harmonize the interactions between all of the various rules. These rules impact multiple initiatives we are working on with many of you related to managed care systems and other organized delivery systems, such as the county mental health waiver. Under federal rules, things may change due to new information or implications from the rules. We are considering some of the sections of these new programs to have asterisks around them until we complete this work.

Mari Cantwell, DHCS: We continue to see guidance from CMS to interpret the rules as they become clear about the implications, such as FAQs and informational bulletins. There will be ongoing conversation and guidance over the next several years given the ongoing implementation dates for different elements of the rules. We are participating actively with other state Medicaid programs to influence the guidance.

Steve Melody, Anthem Blue Cross: Are the FAQs between you and CMS available?

Mari Cantwell, DHCS: CMS publishes all the federal guidance on the website. On Medicaid.gov, all the state Medicaid director letters, informational bulletins and FAQs are available.

Director Kent continued with updates. The Access Advisory Group appointments are made and announced. We are looking at November/December for the first set of meetings. The meetings will be open to the public and noticed as we normally do with stakeholder meetings. They will be available for in person or phone attendance. There is no significant news related to budget. This year's budget was fairly stable with some positive change to restore an optional benefit and make changes to the Estate Recovery program. We are working now toward January 2017 and release of the FY 2017-18 budget.

Mari Cantwell, DHCS: We are working on the federal proposal for acupuncture and Estate Recovery.

Elizabeth Landsberg, Western Center on Law and Poverty: We thank you for the change on the Medi-Cal Estate Recovery program. Has the State Plan Amendment (SPA) been submitted?

Mari Cantwell, DHCS: Not yet. It will be submitted January 2017.

Anthony Wright, Health Access California: Thank you for moving forward on the Estate Recovery program changes. Is there a process to educate enrollers or others about the change? This became a significant item that enrollers and others learned about over the past few years and they will need to understand the changes to "unlearn" some previous information.

Jennifer Kent, DHCS: That's helpful feedback. We are working on submission of the SPA and the 3rd party liability staff is working to update materials and change public-facing documents to push out information to groups we work with. As we get closer to the implementation, we can work with you on who we should reach out to. We also work with the State Bar since there are attorneys who help people on this issue.

Elizabeth Landsberg, Western Center on Law and Poverty: Western Center has developed advocate information that was sent out. The language in the notice that will go out to people will also be important. Some people have gone to the Covered CA website and then got a notice from DHCS on this topic, so we appreciate the opportunity to review and comment on those materials prior to implementation.

Follow-Up Issues from Previous Meetings and Key Updates

Jennifer Kent, Mari Cantwell and Adam Weintraub, DHCS:

http://www.dhcs.ca.gov/services/Documents/Followup_SAC_081116.pdf

Adam Weintraub reported the highlights from the follow up list of questions raised in the May SAC meeting. Most of the follow up items are included in today's agenda and presentations. One item not on the agenda is follow-up on Public Hospital Redesign & Incentives in Medi-Cal Program (PRIME), however, materials related to the PRIME project were sent out to you ahead of the meeting. We will also post a link with today's meeting.

Erica Murray, CA Association of Public Hospitals and Health Systems: When will the PRIME applications be posted on the waiver renewal website?

Adam Weintraub, DHCS: We distributed a summary of the projects but not the details of individual projects. We will follow up on this.

Sandra Williams, DHCS: One additional comment on the Estate Recovery program. As it gets closer to the implementation date, we will work with the County Welfare Directors Association of California (CWDA) to make a presentation to eligibility workers about the eligibility implications of the changes.

SB75 Implementation – Coverage for All Children

Sandra Williams, DHCS

Presentation slides available at:

http://www.dhcs.ca.gov/services/Documents/SB75_updates_SAC081116.pdf

Ms. Williams provided an update about the transition of children newly eligible for Medi-Cal through SB75 legislation, which expanded eligibility to all otherwise eligible children regardless of immigration status. DHCS identified approximately 121,000 children in restricted scope Medi-Cal who were eligible for the SB 75 transition to full scope Medi-Cal. MEDS data indicates that, as of July 26, 2016, full scope Medi-Cal has been granted to approximately 95% (115,692) of eligible children previously in restricted scope coverage, retroactive to May 1, 2016.

We are working with counties to transition the remaining children and are running reports twice monthly to track the progress by counties. In addition, approximately 18,000 children have been determined newly eligible for full scope Medi-Cal. This includes new applicants, not previously known to Medi-Cal, as well as adding a child to an existing Medi-Cal case. This is on track with the projections we had pre-implementation. I want to mention one follow up from the May meeting. We indicated about 96% spoke English or Spanish. The actual numbers are English 14%; Spanish 82%. We have the details for other languages (each under 1%) and will send out the details after the meeting for the break-outs. There were questions about when the SAWS system would have translation for the SB75 changes programmed into the system: LEADER, translated snippets were implemented Aug 1; CalWIN will implement during August; and C-IV will implement January 2017. She reviewed information on overall enrollment in Medi-Cal. There were 13.5 million total enrolled as of February with 10.5 million in managed care and 3 million in Fee-For-Service (FFS).

Questions and Comments

Herrmann Spetzler, Open Door Health Centers: Is this data only up to February?

Sandra Williams, DHCS: This is our report for May 2016 that has the complete data through February 2016. There is a lag of about three months to get the data to settle so we can be sure it is accurate. This allows for a more accurate version that includes retroactives and other changes.

Gary Passmore, CA Congress of Seniors: Do you have a rough figure of the next largest Medicaid program outside California?

Mari Cantwell, DHCS: New York is about 6.5 million. We are about twice that size.

Ms. Williams reported data on enrollment applications pending for more than 45 days. There are almost 20,000 total pending applications (1% of total applications). About 25% of the applications pending are children. The children do have aid but have multiple applications in the system that counties are trying to clean up to understand the true picture of pending applications. There were system enhancements implemented earlier this year that have slowed the incidence of duplicate applications. It still occurs and we are working on it.

Questions and Comments

Kim Lewis, National Health Law Program: I want to understand the duplicates. For example, how many are on presumptive eligibility? Are they applying again because of the wait for determination? Why do they have duplicate applications if they have assistance?

Sandra Williams, DHCS: We have gone in to the system to spot-check the applications. Most of the duplicates have an application with some incorrect information – wrong social security number or name – on a separate application. We want to clear this up and figure out why this continues.

Kim Lewis, National Health Law Program: What is the process for knowing these are primarily duplicates? Have they compared the actual applications or is this more about their speculation of what is going on?

Sandra Williams, DHCS: I can follow up to find out more.

Elizabeth Landsberg, Western Center on Law and Poverty: There is a way for counties to get rid of duplicates as well as changes to cut down on new, duplicate applications.

Sandra Williams, DHCS: Yes, in March, long-term negative action changes went into effect to solve for pending cases. Counties are just getting to the work of implementing this.

Stephanie Lee, Neighborhood Legal Services of Los Angeles County: Is there a way to break down data by county and age for adults?

Sandra Williams, DHCS: We can pull the county specifics and we will work on the age break down.

Jennifer Kent, DHCS: In fairness to counties, they have been undergoing multiple new programs and changes. Los Angeles has a new system conversion going on and SB 75 is a

new process. It is not a simple procedure to get the duplicates solved and I know they want this off their docket as much as we do.

Kim Lewis, National Health Law Program: The over-121-day category is more than three times the limit. I hope that you will prioritize this group for analysis and action because it is such a long time.

Sandra Williams, DHCS: Yes, we agree. We are especially concerned about the cases with the longest timeline. I am hoping the next reports will show improvements from having the long term negative action change in SAWS.

Ms. Williams reviewed renewal data for March and April provided in the meeting materials. She pointed out specifics in the data chart including the column detailing Continued Medi-Cal cases processed and percentage continued. The category of people who did not have continued Medi-Cal could be those who were discontinued or those who went onto Covered CA.

Gary Passmore, CA Congress of Seniors: Can you point out any counties that are unusually high for not renewing cases?

Elizabeth Landsberg, Western Center on Law and Poverty: LA has strikingly low percentages, 58-60% for continued Medi-Cal. Most other counties are around 80-90% cases continued.

Sandra Williams, DHCS: The long-term negative action system went into effect in March and there was a work effort in June to clean up cases and reach out to alert folks they were going to be discontinued. I imagine that the data were impacted by this clean-up of pending cases.

Kim Lewis, National Health Law Program: Is there a way to parse out the data to show the applications that were older and skewed the data because they suddenly show up in April?

Sandra Williams, DHCS: They were likely processed in a timely manner but they couldn't process it in the system. They all got a notice about being discontinued.

Jennifer Kent, DHCS: It is hard for us to see into this data because this isn't cumulative data from the counties – it is month to month. DHCS doesn't run this data so we can't break it down.

Sandra Williams, DHCS: We are working closely with the SAWS systems because it has been a challenge to get this renewal data. We are looking to change the format to get the data later once it has become more accurate. For example, in October, we will get information about June renewals that will include the 90-day cure period (July, August, September). It will help us ask more relevant questions and have data that makes sense.

Kim Lewis, National Health Law Program: Can you get information about those denied to track the reasons for denial, whether they are out of coverage or have coverage through Covered CA?

Jennifer Kent, DHCS: We can check on that but I don't think so. They may be eligible for Covered CA but we don't have that information about what happens.

Kim Lewis, National Health Law Program: Can you track between CalHEERS and SAWS?

Jennifer Kent, DHCS: We will look at how accurate that data is because there is no timeline for the purchase of private insurance.

Anthony Wright, Health Access California: On SB 75, do you have information on transitions from Children's Health Initiatives or Kaiser programs? Is there a marker for that transition?

Sandra Williams, DHCS: No.

Jennifer Kent, DHCS: Some of the new applications could be coming from a CHI or Kaiser but we are not tracking the originating source. New cases include both adding a child to an existing family case and new children to the system.

Uncompensated Care Report and GPP Funding for Waiver Years 2-5

Lindy Harrington, DHCS

Presentation slides available at:

http://www.dhcs.ca.gov/services/Documents/UC_GPP_SAC081116.pdf

Ms. Harrington provided a report on uncompensated care. In the past, counties funded uncompensated care through the safety net care pool (SNCP). As part of Medi-Cal 2020, we transitioned the Disproportionate Share Hospitals (DSH) and SNCP into the Global Payment Program (GPP) for public hospitals. We are required to conduct two independent reports on uncompensated care. The main purpose was for CMS to determine the size of the GPP for years 2-5 of the five-year waiver. For 2015-16, the GPP was \$236 million in federal funds, equivalent to the amount in the final year of the previous waiver. Thank you to Blue Shield of California Foundation (BSCF) for the contract to Navigant for the first report. There were tireless efforts from California Association of Public Hospitals and Health Systems (CAPH) and the report was submitted to CMS May 15th.

Components of the first report are: 1) Costs at Designated Public Hospitals (DPHs) for providing care to Medi-Cal and the uninsured in FY 2013-2014; 2) Payments to DPHs for services provided to Medi-Cal and the uninsured; 3) The ratio of payments to costs; and, 4) The level of overall uncompensated care, charity care and bad debt.

Findings:

DPHs provided about \$3.15 billion in uncompensated care in FY 2013-14 before accounting for DSH and SNCP payments of about \$2.9 billion (federal and non-federal share provided by the DPHs). The total FY 2013-14 uncompensated care exceeded payment by more than \$1.65 billion (\$1.18 billion in charity care) for DPHs participating in GPP. Given the uncompensated care demonstrated, DHCS believed maintaining the same level of funding for the uncompensated care component (\$236 million per year) was justified. In July, CMS approved the continuation of \$236 million of federal funds for each year of the GPP under Medi-Cal 2020.

Questions and Comments

Gary Passmore, CA Congress of Seniors: Does this mean that we were not compensated for the difference between \$1.65 and \$1.18 billion?

Lindy Harrington, DHCS: Not exactly. The hospitals provided uncompensated care of \$1.65 billion and part of this is bad debt instead of charity care. The \$1.18 billion qualifies as charity care by CMS.

Mari Cantwell, DHCS: This is important because CMS only allows charity care in qualifying uncompensated care pools. We had said, and the report demonstrates, that the vast majority of uncompensated care did qualify in these hospitals.

Anthony Wright, Health Access California: Is the definition here for charity care the same as in nonprofit hospitals?

Mari Cantwell, DHCS: Yes, the definition is the same but the data was a challenge for us. The definition CMS used was from Florida. Each hospital has varying rules in their counties for qualifying what is uncompensated care.

Anthony Wright, Health Access California: So it could be an even bigger number?

Mari Cantwell, DHCS: Yes.

Anthony Wright, Health Access California: There were different numbers in different accounts of this part of the waiver. I want to confirm that there is no drop off over the out years? It is \$236 million for every year?

Lindy Harrington, DHCS: Yes, some reports include state and federal funds of \$472 million, which is the total computable funds. CMS always speaks in this total number and this may be confusing.

Anthony Wright, Health Access California: This does not include DSH funds, is that right?

Erica Murray, CA Association of Public Hospitals and Health Systems: Yes, this is only referring to the SNCP, and because DSH does decline, that is why you see decreases in the overall, combined numbers reported for DSH and SNCP.

Anthony Wright, Health Access California: Some thought there were also declines in the SNCP. This is really good news. We hope this encourages counties to do more for undocumented, now that they have more financial security about these funds. There is some belief in counties that they can draw down most or all the dollars if they do what they already are doing today. I was under the impression they need to do something more, take some additional steps to draw down their portion of the funding. What do counties need to do?

Lindy Harrington, DHCS: The thresholds were set on their doing a lot already, however, there is point value change as they move through time in GPP. If they do what they are doing today, they will not hit the point value because points for unnecessary emergency visits go down and primary care goes up over the timeline of the waiver.

Erica Murray, CA Association of Public Hospitals and Health Systems: I would characterize this as a large demonstration on the design of incentives. We will see if the way the point values are structured do actually result in what we hope to see. It is true that in the early years, before the relative values shift, we are focused on meeting the thresholds because we have experienced declines in uninsured – and that is a good thing.

Mari Cantwell, DHCS: The end result of changing the values was less significant than we originally planned. We are decreasing the value of patients in the ER, but we did not go with the significant increases in primary care and decreases to inpatient. When we modeled it, there

were counties doing lots of outpatient and they could have met the thresholds by actually doing less.

Anthony Wright, Health Access California: Any assistance to counties from CMS or DHCS about what they can do to receive the maximum point value if they make their program more inclusive would be very useful. Counties are looking for guidance about what they can do.

Mari Cantwell, DHCS: I want to thank Lindy and Ryan at DHCS as well as CAPH. It was not a difficult negotiation with CMS, but that is because the report was so thorough and completed in a very short time period.

Jennifer Kent, DHCS: The Navigant report was really helpful. We would have struggled without the support from the foundation.

Dental Transformation Initiative Update

Alani Jackson, DHCS

Presentation slides available at:

http://www.dhcs.ca.gov/services/Documents/DTI_SAC_081116.pdf

Ms. Jackson offered updates on the dental initiative including specifics for each domain.

Domain 1 waiver amendments include: 1) A revision to the methodology to the baseline metrics for incentive payments to new and existing dental service office locations; and, 2) authority to provide partial incentive payments to provider locations partially meeting the increases.

Domain 2: The Caries Risk Assessment (CRA) tool has been finalized and will be released following the pilots, anticipated to be October 2016. CRA training will be required. Caries-arresting treatments have been added to the protocol. This is an opt-in process.

Domain 3: Data for Fee-For-Service (FFS) and Managed Care providers has been collected. The collection of Safety-Net Clinic data is in progress.

Questions and Comments

Herrmann Spetzler, Open Door Health Centers: I have concerns that the state-level data does not include FQHCs because of how we bill. We bill medical or dental but you don't see the granular level. For our county, it showed something like 37 children's visits when actually we saw thousands. We may be missing the most important access point for this if the FQHC isn't included. The private sector is carrying very little of the population.

Alani Jackson, DHCS: We agree and we need that detailed data. That is why we established the small workgroup to identify how to get that data.

Jennifer Kent, DHCS: In all of our work with legislature, we have acknowledged that there are large numbers of children being seen in FQHCs. We don't get credit and you don't get credit for the huge level of care provided. We hope the DTI is one way to get the data in a better way.

Herrmann Spetzler, Open Door Health Centers: I am not concerned about the fairness, but I am concerned about how we are seen by the feds. FQHCs have focused on children for a long time since adults were not covered for dental.

Brenda Premo, Harris Family Center for Disability and Health Policy: Another group with large numbers of children are the dental schools. Out of 1,000 visits/month, our school sees 20% under age 18. We want to be sure the students are trained to care for children and use Denti-Cal to accomplish this. I think if we include dental school data and the clinics, the data picture will be more accurate. I know you have to follow a model for this data but I suggest we look at the full level of data available.

Jennifer Kent, DHCS: If they are billing Denti-Cal, we have the data. The FQHCs don't bill Denti-Cal and that is the issue.

Alani Jackson, DHCS: The dental school sites are included in the claims data.

Kim Lewis, National Health Law Program: On the CRA tool, is this the AAP tool or another tool? What is the plan for who can implement the tool – only dentists?

Alani Jackson, DHCS: There is a workgroup of clinicians, including state Dental Director, Dr. Kumar, leading the process and the tool is not final. It is being piloted now and won't be shared until after the pilot. We will post the final tool.

Jennifer Kent, DHCS: It will be open only to Denti-Cal providers in pilot counties and that includes dentists and dental hygienists.

Ms. Jackson then reviewed the timeline and process for local dental pilot projects (LDPP). DHCS received 25 letters of intent (LOIs) to participate. Applications are due September 30, 2016 and programs commence February 15, 2017. All updates and FAQs are posted on the web site.

Questions and Comments

Lisa Davies, Chapa-De Indian Health Program: Are tribal health programs participating in the safety net work group? On the CRA tool, where is it being disseminated?

Alani Jackson, DHCS: The work group includes the California Primary Care Association (CPCA) and rural health clinics but I will check on tribal and get back to you. On the tool, some of the small workgroup clinicians have taken this back to their locations to test and inform any changes before its implementation.

Lisa Davies, Chapa-De Indian Health Program: It would be important to include some tribal health programs in this work.

Mari Cantwell, DHCS: We can make sure we understand where they fall in the billing today and circle back to you to be sure we aren't missing something.

Carrie Gordon, CA Dental Association: Overall, this is a significant opportunity to look at dental differently and to track and understand if beneficiaries are getting what they need through data instead of anecdotal report. It is important to get this data out so we can make improvements. Specifically, on Domain 1, what is the detail of the change in the methodology? We want to get a better idea of the distinctions about who the kids are and what care they receive.

Alani Jackson, DHCS: For Domain 1, office locations will be sent a letter indicating their baseline from 2014 and what the benchmark is for what they need to do to reach the 2%. It will be sent by the fiscal intermediary to all service locations, including those recently disenrolled in the hope that they re-enrolled.

Carrie Gordon, CA Dental Association: Is there work being done on streamlining the provider application? Will that be done for the implementation?

Alani Jackson, DHCS: The streamlined application is being worked on and will happen during the demonstration, but perhaps not for the start.

Carrie Gordon, CA Dental Association: That will also be important to getting new providers into the program.

Jennifer Kent, DHCS: That is a different project and it is an IT project. The automated applications begin in October and dental is in a phase behind physicians and allied providers.

Carrie Gordon, CA Dental Association: Do we have data on how long it is taking for dental providers to enroll?

Jennifer Kent, DHCS: We don't know specifically for dental. Based on information from the overall program, the time to enroll is related to how complete the application is upon submission.

Carrie Gordon, CA Dental Association: The application is a complex process that dentists report can take up to a year. I have a number of items I want to mention here. First, as a complement to the dental caries risk assessment, we are offering the Treating Young Kids Everyday (TYKE) program that will train providers to be comfortable caring for young children. Next, maybe for future discussion, there is the alternative treatment we are looking to test in this domain, silver diamond fluoride. We are excited to have this opportunity. We need to educate parents and providers about the benefits.

Carrie Gordon, CA Dental Association: What will happen if the local pilot applications don't match what you want?

Alani Jackson, DHCS: Based on LOIs, I don't think a lack of applications will be a problem. We will only approve up to 15 projects. As to specific questions, we will communicate directly with applicants.

Carrie Gordon, CA Dental Association: Is there any concern about the transition of the fiscal intermediary – any news about bumps that may occur?

Jennifer Kent, DHCS: No.

Herrmann Spetzler, Open Door Health Centers: Has the data collection tool been disseminated?

Alani Jackson, DHCS: No, much of the information for domain 2 is not yet public and will come out in the write up.

Herrmann Spetzler, Open Door Health Centers: Sometimes what happens for clinics is that a new OSHPD data request comes to us with a retroactive request for data not collected during the year. We don't need to be involved in the data tool, but we do need a heads up so that we craft the collection of the data for the future. I agree we need more granular information but it is really hard to do this after the fact.

Jennifer Kent, DHCS: I don't think we will change the FQHC billing data. We struggle with how we collect it but are not planning to ask for new data.

Herrmann Spetzler, Open Door Health Centers: I am not concerned about the billing side, but with whether we are keeping data to give you a complete picture of care what is happening with children.

Alani Jackson, DHCS: The members of the workgroup reported they are collecting the data. It is just not reported to the state.

Marilyn Holle, Disability Rights CA: Are there any incentive elements in the DTI for kids with disabilities?

Jennifer Kent, DHCS: The entire DTI focuses on children and continuity of care. There are no incentive elements specific to disabilities.

Marilyn Holle, Disability Rights CA: There are unique access problems for this population and additional time required for their care. Some will need to be in hospitals to receive services.

Brenda Premo, Harris Family Center for Disability and Health Policy: The university where I am purchased a dental facility created by parents for those with disabilities – all ages. We are expanding from 4 to 8 chairs and receiving lots of referrals from health plans. The facility can provide sedation and work with physical disabilities that require special care. I will be encouraging students to do research on workforce needs and health improvement. We hope to collect data on what it takes to work with those with disabilities and come up with solutions.

Jennifer Kent, DHCS: That is great.

Sarah de Guia, CA Pan-Ethnic Health Network: I think the LOI information is great. Are there targeted, high priority areas or criteria for the LDPP? Sometimes, counties that have high needs may not have capacity to submit the application.

Alani Jackson, DHCS: We did take that into consideration in selection of counties for Domain 2 and 3. For the LDPP, we are looking for innovation.

Jennifer Kent, DHCS: For the LDPP, we are not setting the local priority. The local community will set that based on local needs and we hope to see new ideas.

Sarah de Guia, CA Pan-Ethnic Health Network: I raise it because if there are high priority populations and high needs in certain counties, it would be a way to identify them.

Data from Medi-Cal Managed Care Ombudsman System

Javier Portela, DHCS

Presentation slides available at:

http://www.dhcs.ca.gov/services/Documents/Ombudsman_SAC081116.pdf

Mr. Portela offered an overview of the ombudsman phone program and system updates that occurred in September 2015. He reviewed the authority for the program and the goals for assisting members navigate managed care. He reviewed the challenges of the old system and how the newer system has improved response. For example, the old system could only handle 30 calls in the queue, sent waiting members to voice mail after 18 minutes and did not provide data. The new system allows for 80 lines, the number that can actually be handled by staff. There is a self-service menu and a call-back feature to handle calls when there is a wait to speak to a representative. They are working to eliminate the need for call-backs by lowering the wait time. He also reviewed data from the call center, such as the number of call-backs, self-serve menu calls and abandoned calls. The center handles an average of 12,000 calls per month and this represents a 151% increase in calls handled since the new system was implemented. Self-service represents almost 5,000 calls per month and the most utilized self-service menu option is FFS. Staff receive emails as well as calls and handle requests from county staff. There are 16 permanent and 5 temporary staff.

Questions and Comments

Steve Melody, Anthem Blue Cross: How do you define resolution?

Javier Portela, DHCS: For us, this means they got to an actual agent to talk since we don't have data on resolution of the case itself.

Elizabeth Landsberg, Western Center on Law and Poverty: Where are the folks sent who choose FFS from the self-service menu?

Javier Portela, DHCS: They are sent to the FFS hotline vendor for DHCS.

Chris Perrone, California Health Care Foundation: Some of these self-service choices are outside DHCS, like Covered CA. Some of these seem to be inside DHCS. For example, if I have a question like mental health, are you saying this is self-service because you are sending them off to a different team? Including those sent to someone within DHCS?

Javier Portela, DHCS: That's right. They are self-serving within our definition because they picked a choice and were not handled inside the center.

Marilyn Holle, Disability Rights CA: Where do you send mental health requests? Is it specialty mental health or is there is differentiation of the mild-to-moderate mental health cases that receive care through the health plans?

Javier Portela, DHCS: I think the calls are sent to county specialty mental health. We have their numbers programmed by county.

Sarah Brooks, DHCS: I think also if they don't choose a county option, they are referred to the DHCS Mental Health Ombudsmen.

Elizabeth Landsberg, Western Center on Law and Poverty: It is important how we are distinguishing between the mild to moderate who should be talking to you because they are handled within managed care or those who should talk to specialty mental health at the county.

Kim Lewis, National Health Law Program: You said the mental health questions are going to the county where they live? Are they transferred to the DHCS Mental Health Ombudsman?

Javier Portela, DHCS: I will follow up with the tree for identifying where each of the self-service options sends people.

Kim Lewis, National Health Law Program: I am interested in what happens at the DHCS Mental Health Ombudsman and how the data from the mental health ombudsman data gets rolled in.

Javier Portela, DHCS: I can share what my office does but I don't have that data.

Sarah Brooks, DHCS: The Mental Health Ombudsman is under Karen Baylor.

Kim Lewis, National Health Law Program: I am interested in seeing how people get helped and what the overlap is between the two systems.

Anthony Wright, Health Access California: Is there a warm hand-off? Do they receive a number?

Javier Portela, DHCS: We give them a number and we forward them through to where they want to go. They are going to the queue at the forwarded number.

Anthony Wright, Health Access California: They are forwarded but there is no assurance they reach a live person? If there is a long wait time, they go into the queue?

Javier Portela, DHCS: Correct. We don't have a back door into the referral.

Marilyn Holle, Disability Rights CA: Is there a live person in your office they talk to? I am concerned people get lost in the system.

Javier Portela, DHCS: They are given options to speak to us in person or use the self-service menu. If they do not choose the self-service menu, they talk to a live person. If they do choose the self-service, they hear a description for each option.

Anthony Wright, Health Access California: Is there any tagging so that you know about how many calls are abandoned after being forwarded?

Javier Portela, DHCS: Once it leaves our system, we don't have the call and we can't track it.

Brenda Premo, Harris Family Center for Disability and Health Policy: I may have some folks on my staff try this out. This also needs to get to the deaf community to help us understand how this works with the relay service. NorCal could disseminate the information in a way that the deaf community will be able to use it. I get many calls about health issues.

Javier Portela, DHCS: I appreciate that. We are also looking at other language issues.

Gary Passmore, CA Congress of Seniors: Do you train ombudsmen about Knox Keene provisions? Many of us see a lack of understanding about the benefits and protection people have in managed care. It seems that should start with your staff.

Javier Portela, DHCS: We focus on contractual requirements that health plans have, which in many cases are more expansive than Knox Keene. We have an internal training team and they

handle on-boarding new staff as well as ongoing. We have quarterly contract meetings to update ombudsman staff so they stay on top of changes.

Gary Passmore, CA Congress of Seniors: Do you include secret shopping as oversight?

Javier Portela, DHCS: We include monitoring by state staff, but do not use secret shopping. We listen in on calls as part of monitoring.

Stephanie Lee, Neighborhood Legal Services of Los Angeles County: As someone who runs a consumer hot line, I know it is difficult. We receive feedback about our scripts and periodically revise them. What mechanisms do you use to adjust scripts and menu options, such as greetings or the description of options? Do you use surveys or receive feedback? With the call-back feature, do you have data on the success of that option?

Javier Portela, DHCS: We do have information on completed call-backs and are working to understand this better. Yes, we have changed our scripts multiple times based on feedback and trends we notice. We are looking to incorporate surveys in a future phase. We are open to feedback and we get input all the time that we do incorporate.

Sarah de Guia, CA Pan-Ethnic Health Network: Can you walk through the language options for non-English speakers? Is the self-selection menu in Spanish? What is the process for them to get to a person to help? Do you track data for language requests?

Javier Portela, DHCS: We provide English and Spanish through the system and they can choose either language. We also have staff for English and Spanish language. For other languages, they choose the "other" option and we use the AT&T line to connect to a person to offer services. The way it works is that we have options to choose for English, Spanish and "other language". If they choose "other", they go in the queue and wait for someone to help them. We do track the data of "other". We want to enhance this so that they go directly to a person.

Sarah de Guia, CA Pan-Ethnic Health Network: For the calls that are not self-service, are you tracking trends for what issues you are helping people with to inform outreach?

Javier Portela, DHCS: That is part of our case management system, however, it is older and we need to enhance it. We do share the data through the managed care advisory group.

Sarah Brooks, DHCS: We utilize the data in health plan monitoring. For example, if we get higher prevalence of calls from a certain geography or health plan, we go back and follow up.

Lishaun Francis, CA Medical Association: How confident are you that beneficiaries know about this phone line? Would you consider putting it on the BIC card?

Javier Portela, DHCS: The number is on everything printed that a beneficiary receives. The first stop should be the health plan and that number is on the BIC card. We come in when they have additional issues.

Lishaun Francis, CA Medical Association: Is there an ability to report why people are calling?

Javier Portela, DHCS: We have categories on calls that we report but we are trying to offer more detail.

Chris Perrone, California Health Care Foundation: Is the VoIP system available to the other DHCS units that offer assistance, like the Mental Health Ombudsman? Has DHCS contracted with this VoIP for all the assistance options or only for managed care?

Jennifer Kent, DHCS: It is only for managed care. We contract for each assistance system and they are handled on different platforms. They may be similar but they don't connect. The external systems are the county offices, Covered CA, Denti-Cal, the FFS hotline run by Xerox, State Fair Hearing run through Department of Social Services, Health Care Options run by Maximus and Medicare. The only internal units are Mental Health Ombudsman and state fair hearing. I would need to check on what system the internal units are using.

Anthony Wright, Health Access California: I appreciate the investment to improve this system. Is there capacity to do analysis similar to Covered CA, such as how many people wait for different amounts of time?

Javier Portela, DHCS: Yes, we have that capacity. We can tell you there is an average of 25-28-minute wait time but not why they are calling. We don't have information on why people are calling so we can direct them to the right person. We don't know why they are waiting.

Mari Cantwell, DHCS: We can provide more data in follow up.

Anthony Wright, Health Access California: We are interested in seeing more data on the actual resolution of the case. Also, what is the interaction with DMHC and their call center on complaints?

Javier Portela, DHCS: We do have some information, such as health plan tracking, for the calls handled by us. As far as DMHC, we can involve them, however we resolve most issues related to managed care. We are the right support to help with things like PCP choice, getting access to services or resolving problems with Medi-Cal. We send health plan complaints and grievances to DMHC. I can share more data after this meeting as to the calls we receive.

Sarah Brooks, DHCS: Also, we have revamped the quarterly data we collect from health plans on their call centers and what they are hearing. There are new elements in the managed care rules and we will need to incorporate them going forward. In the past, we heard concerns on wait time and touches and wanted to present the system changes.

Anthony Wright, Health Access California: Does the recent Office of the Patient Advocate report include these changes?

Jennifer Kent, DHCS: No, it doesn't. The next report will include it.

Elizabeth Landsberg, Western Center on Law and Poverty: It would be helpful to drill down and see any data you do have about who is calling, what health plan they are in and why people are calling. It is a challenge to get information out to people and there are many who do not know about this line. We would be interested in how DHCS sees its role in solving problems related to managed care plans. What are the differences between DMHC and DHCS oversight and resolution of problems? If there is a problem, how are you referring internally to health plan managers? What is the oversight role?

Gary Passmore, CA Congress of Seniors: How does the 21 staff compare to previous staffing when there were 7 million people in managed care?

Javier Portela, DHCS: We had 5 staff before. Now we have 21.

Michael Humphrey, Sonoma County IHSS Public Authority: I commend you and appreciate the analysis. I remain concerned about wait time. Do you have a standard wait time you want to work toward on wait time and queue? I assume 25 minutes is not optimal.

Javier Portela, DHCS: There is not a standard we have set for wait time.

Jennifer Kent, DHCS: We have been waiting for the system to get stabilized and see the month to month view. If we continue to see persistently high wait times, it would be on us to raise it to the administration for budget changes. We have gotten some additional resources in the last year's budget. In addition, this is augmenting other call centers and the health plans also monitor and run call centers. People get helped through multiple channels.

Michael Humphrey, Sonoma County IHSS Public Authority: I am also concerned about the 20% abandonment rate. Have you looked at other systems of this scale to see what the standard might be for the abandonment rate? Is it 20%?

Jennifer Kent, DHCS: There is huge science around call centers. The call-back feature is helping significantly with wait time.

Carrie Gordon, CA Dental Association: I want to echo the comments about the next level of value we might get from additional information and how we can make recommendations to change and improve the program.

Brenda Premo, Harris Family Center for Disability and Health Policy: We have worked with the health plans to emphasize that it is important to really talk to people and not rush with a time limit for calls. What about combining DMHC and this assistance with two levels of help: easy calls and more difficult calls? You are handling the same people. We have helped managed care plans to transition in ways that benefit the members. Maybe we can think about how to innovate with the resources we have.

Gary Passmore, CA Congress of Seniors: Medi-Cal has changed so much and I think it is time for a re-think about the overlap between DMHC and DHCS. There may be both efficiencies and member advantages.

Kim Lewis, National Health Law Program: I want to echo the need to look at the substantive data and how we are handling and triaging cases with DMHC. I agree that the overlap with DMHC is important. We want to help people at the first place they call if possible.

Jennifer Kent, DHCS: Great.

FQHC Alternative Payment Pilot Project

Ryan Witz, DHCS

Presentation slides available at:

http://www.dhcs.ca.gov/services/Documents/FQHC_APM_SAC081116.pdf

Ryan Witz introduced himself and provided an overview on the FQHC Alternative Payment Methodology Pilot (APM). An important context for the presentation is that there is state legislation in place but DHCS has not yet approached CMS for approval of the pilot. Mr. Witz provided specific information about the pilot project including goals, the existing and proposed payment structures and timelines. There has been extensive stakeholder involvement to date in developing the pilot. DHCS is working on the concept paper to be followed by a SPA. DHCS will work with Mercer to develop the actual rate payments.

Currently, FQHCs are reimbursed at cost for visits. The APM pilot will move away from a FFS payment model to a capitated payment model for an assigned group of members. Instead of clinics receiving 1) plan payment, 2) wrap around payment, and 3) reconciliation adjustment, they would receive monthly capitation payments for specified managed care members. The PMPM would be equivalent to the Prospective Payment System (PPS) rate for beneficiaries assigned to the clinic for primary care (children, non-disabled adults, seniors and people with disabilities, expansion population). The capitation could include behavioral health and specialty if the clinic provides that service. This structure would provide clinics the flexibility to provide services in the best manner for the beneficiary without needing to worry about the particular billing rules that trigger a traditional FQHC billable "visit" (e.g. only with billable providers, limit to 1 visit per day). The new process would mean there would not be a need for the reconciliation process, however there is a process to mitigate risk due to high or low utilization. Finally, Mr. Witz reviewed the timeline for submission of the SPA and implementation in October 2017.

Questions and Comments

Gary Passmore, CA Congress of Seniors: How are you accommodating the different costs based on the population differences between seniors or children?

Ryan Witz, DHCS: They are currently paid the same for all populations. The utilization will be different based on population needs.

Mari Cantwell, DHCS: The capitation rates will be different because certain populations have more visits.

Steve Melody, Anthem Blue Cross: Great presentation. This is a complex economic model. There is also complexity related to Independent Physician Associations (IPAs) who take risk and then need to pass on the correct rates to FQHCs. It is important to work out the many incentives related to utilization, quality and other elements.

Elizabeth Landsberg, Western Center on Law and Poverty: Is it only primary care? Is there mental health? What is the scope of services?

Ryan Witz, DHCS: We are not proposing new services - it depends on the services provided by the clinic.

Jennifer Kent, DHCS: Each clinic comes to DHCS with a defined set of services. Dental or pharmacy are services that could be outside a clinic's scope. It is based on the clinic.

Mari Cantwell, DHCS: Anything that is included in their PPS is required to be in the APM pilot and will be included in the capitation.

Ryan Witz, DHCS: There is an annual increase from Medicare that is also included in annual rate setting.

Anne Donnelly, Project Inform: I understand that FQHCs can't bill Drug Medi-Cal? Are there plans to change that?

Jennifer Kent, DHCS: There is legislation pending, but this does not change that.

Lishaun Francis, CA Medical Association: Does this pilot include rural health clinics?

Ryan Witz, DHCS: Yes.

Anthony Wright, Health Access California: Would a patient know they are included in this? Are all patients included from a clinic?

Lindy Harrington, DHCS: All beneficiaries assigned to the clinic for primary care will be included. It will be seamless to beneficiaries.

Mari Cantwell, DHCS: For most clinics who do not provide specialty care, it is likely that the vast majority of their patients will be included in the pilot. If they provide specialty care, that patient may receive primary care elsewhere.

Anthony Wright, Health Access California: It isn't important for patients to know these details but I am interested in how we can track whether the care is better.

Ryan Witz, DHCS: There is a full evaluation of this pilot that will be conducted.

Lindy Harrington, DHCS: Part of the evaluation will be to determine improved outcomes for patients.

Jennifer Kent, DHCS: This is not just about payment to the clinics, the plans want to participate because they would like data to know that their population is being served well.

Carrie Gordon, CA Dental Association: For clinics providing dental, how does this change that?

Mari Cantwell, DHCS: This does not change anything for dental. It is only those services that are the responsibility of health plans.

Erica Murray, CA Association of Public Hospitals and Health Systems: Thanks to Ryan for being the engine to drive this forward. We have been working with CPCA and DHCS for two years on this. The foundations have supported this pilot as well. There is great synergy between this pilot and the waiver that will have long term implications. We will all be working together to manage patients better and that is a key goal of the waiver. There is a lot more work to do but we are excited to be working with CPCA.

Herrmann Spetzler, Open Door Health Centers: It is clearly where we want to go. The way we are getting there is complex and it is not clear we are simplifying or having less bureaucracy. I fear we are using yesterday to project tomorrow and that this is not where we need to be 5-10 years out. The greatest part of this plan is giving more flexibility to care for populations in the best way to improve health. We need to maintain flexibility to tweak the system going forward so we improve it. At Open Door, we have been morphing into new ways to care for people. For

example, the building has pods now. A few years ago, we had six nurses and now we have 52. We have challenges ahead and I would like to see a few more people involved who are thinking forward.

Gary Passmore, CA Congress of Seniors: What is the number of people cared for?

Chris Perrone, California Health Care Foundation: Over 40% of primary care in Medi-Cal managed care is through clinics.

Gary Passmore, CA Congress of Seniors: Are you anticipating increases in the number of people because of the changes?

Jennifer Kent, DHCS: The pilot only contemplates 15 counties and 60 clinics – a small number of the total clinics. This is really to identify how the economics work and whether it delivers on better care to patients.

Mari Cantwell, DHCS: One of the results is that it could help expand capacity through flexibility to not have a person seen by a provider.

Steve Melody, Anthem Blue Cross: It will not be just any clinic that will participate. There are readiness requirements and it will be a small number of the overall clinic sites.

Ryan Witz, DHCS: DHCS will make the final selection based on input. There is an evaluation and we want it to be representative of the whole state.

Richard Thomason, Blue Shield of California Foundation: I want to echo thanks to DHCS and Ryan for the work on this pilot. We are excited about the possibility to improve care and expand services through FQHCs. Can you describe the selection criteria and process?

Ryan Witz, DHCS: There will be a formal application process for clinics. Metrics include reporting capacity. This pilot will alleviate some existing reporting but they will need to demonstrate the ability to report because that will be used for future rate setting. It's important there is a wide array of both historical and forward-looking data.

Lindy Harrington, DHCS: We aren't setting selection criteria in a vacuum. We are working with clinics, CPCA and others to get this right.

Gary Passmore, CA Congress of Seniors: I would like a future presentation to include a two year look ahead at what you will be doing through the balance of this administration.

Jennifer Kent, DHCS: Yes, that is a fair question. There are some high level goals about what we are trying to accomplish and we are happy to share that.

Public Comment

There is no public comment.

Next Steps and Next Meetings

Next meeting date:
October 24, 2016