DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
December 3, 2014
9:30am – 3:00pm

MEETING SUMMARY

Attendance

Members Attending In Person:
Kelly Brooks Lindsey, CA State Association of Counties; Michelle Cabrera, Service Employees International Union; Anne Donnelly, Project Inform; Lishaun Francis, CA Medical Association; Marilyn Holle, Disability Rights CA; Elizabeth Landsberg, Western Center on Law and Poverty; Chris Perrone, California HealthCare Foundation; Gary Passmore, CA Congress of Seniors; Brenda Premo, Harris Family Center for Disability and Health Policy; Judith Reigel, County Health Executives Association of California; Marty Lynch, Lifelong Medical Care and California Primary Care Association; Cary Sanders, CPEHN; 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; Suzie Shupe, CA Coverage & Health Initiatives; Herrmann Spetzler, Open Door Health Centers; Kristen Golden Testa, The Children's Partnership/100% Campaign; Anthony Wright, Health Access California;

Members Attending By Phone:
Bill Barcelona, CA Assoc of Physician Groups; Kim Lewis, National Health Law Program; Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance; Stuart Siegel, Children's Specialty Care Coalition; Sandra Naylor Goodwin, CA Institute for Behavioral Health.

Members Not Attending:
Teresa Favuzzi, CA Foundation for Independent Living Centers; Bob Freeman, CenCal Health; Jim Gomez, CA Association of Health Facilities; Michael Humphrey, Sonoma County IHSS Public Authority; Mitch Katz, MD, LA County Department of Health Services; Amber Kemp, California Hospital Association; Lee Kemper, County Medical Services Program; Erica Murray, CA Association of Public Hospitals and Health Systems; Marvin Southard, LA County Department of Mental Health; Richard Thomason, Blue Shield of California Foundation.

Others Attending: DHCS staff: Toby Douglas, Mari Cantwell, Sarah Brooks, Anastasia Dodson, Karen Baylor, Rene Mollow, Marlies Perez, Don Braeger, Danielle Stumpf, Brian Hansen, Javier Portela, Hannah Katch, Wendy Soe. DMHC staff: Nancy Pheng; Scott Coffin, Anthem Blue Cross; Brad Gilbert, IEHP; Michael Harris, CenCal Health; Kathryn Kaestner, California Health and Wellness.

Public in Attendance: 19 members of the public attended.

Welcome, Purpose of Today's Meeting and Introduction of Members
Toby Douglas, Director, DHCS

Toby Douglas welcomed participants to the session and thanked the California HealthCare Foundation and Blue Shield of California Foundation for their support of the stakeholder process. He briefly reviewed the meeting agenda.

Toby Douglas noted that this was the last Stakeholder Advisory Committee (SAC) meeting he will be attending as the Director. He thanked SAC members for their service and commented that the SAC has been the center of so much important work over the last several years. He truly has viewed this as a partnership even though the group has not always agreed. He thanked the members of the group for pushing DHCS to be better and do better for California's residents.

Mari Cantwell, DHCS, introduced new DHCS staff Claudia Crist and Hannah Katch and reviewed a number of changes in roles among existing staff. She shared that DHCS had split the Medi-Cal managed care division into two divisions: 1) Managed Care Quality Division – responsible for the quality dashboards, network adequacy, etc. and 2) the Managed Care Project and Operations Division which is responsible for HCO, contracting, etc.

Gary Passmore, CA Congress for Seniors: Could someone send out a roster with an organization chart and contact information?

Mari Cantwell thanked Toby Douglas for his leadership and his work and noted that he will be missed.

Follow-Up Issues from Previous Meetings and Key Updates
Presentations can be found at:
http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

- **Follow-Up Issues From Previous Meetings: *Anastasia Dodson, DHCS***

Anastasia Dodson, DHCS, shared that the follow up items requested at the last meeting were distributed following the last meeting along with a matrix of questions and answers and accompanying documents. One of the principles that DHCS is emphasizing is effective and timely communication with stakeholders.

- **Substance Use Disorder Services Waiver: *Karen Baylor, DHCS***

Karen Baylor, DHCS, presented on the Drug Medi-Cal organized delivery system waiver. The waiver has been submitted to CMS and DHCS is awaiting an update.

Marlies Perez, DHCS, presented on the overview and goals of the Drug Medi-Cal waiver. CMS has 120 days for response. She emphasized to stakeholders that this is an iterative process and encouraged stakeholders to provide feedback. There will be another waiver advisory meeting in January to discuss county implementation plans if CMS elects to move forward.

Karen Baylor, DHCS, said the changes in Drug Medi-Cal will have an effect on other parts of the service system (e.g. criminal justice, child welfare). She encouraged stakeholders to look at this more broadly than just Substance Use Disorder services (SUD) but also as a part of a broader continuum of care.

Don Braeger, DHCS, discussed the challenges with the premium rate methodology. They have looked at developing a revised premium payment methodology. They know that the counties need the rate methodology so they can develop the implementation plan and are working with the counties to walk through the methodology.

Karen Baylor discussed next steps. DHCS is considering a phased in approach similar to the Healthy Families transition. This would start with large counties followed by regions and then small rural areas. She noted that counties do not need Board of Supervisor approval to opt in. Immediate next steps include a waiver meeting in January and contract amendments for those counties that opt in.

Gary Passmore, CA Congress for Seniors: Five years ago, behavioral health and substance use disorder issues were on the "to do" list in the current waiver that expires next year (2015). Assuming the Drug Medi-Cal waiver starts in April 2015, would it automatically carry over to the new waiver?

Douglas, DHCS: CMS sees this as an important initiative and views California at the forefront of the effort. To the extent this is approved, it will be carried over to the next waiver. It would still need to meet the same budget neutrality requirements under the next waiver.

Brenda Premo, Harris Family Center for Disability and Health Policy: Does the plan cover SUD services for individuals who are also deaf or have other disabilities? One of the things we see is the segmenting of patients with disabilities. It is important that we have a system that acknowledges patient needs and the fact that they have dual diagnoses – whether a disability or MH/SUD issue – that they have access and that it is included in the county requirements.

Douglas, DHCS: California is creating a managed care delivery system. There are regulations in law that are similar to those requirements you laid out. So yes, the counties will have the responsibility to maintain access for patients with disabilities.

Kelly Brooks Lindsey, CA State Association of Counties: Did DHCS submitted a budget neutrality piece with the terms and conditions?

Cantwell, DHCS: DHCS initially submitted a placeholder – the minimum needed to submit a proposal. We are reviewing the budget neutrality more closely to add information and all of the information is on the DHCS web site.

Kelly Brooks Lindsey, CA State Association of Counties: What elements will require Board of Supervisor approval?

Baylor, DHCS: Because the implementation plan has not been developed, DHCS did not want the extra step of going through county boards of supervisors. However, if the plans move forward, then counties will have a revised contract that do require board of supervisor approval.

Marilyn Holle, Disability Rights CA: What happened with the attempt to get an IMD waiver? What is DHCS doing to address EPSDT needs?

Douglas, DHCS: DHCS is not seeking an IMD waiver but is going for an organized delivery system waiver that includes the continuum, including residential facilities. Under this, we expect that CMS will waive the 16 bed requirement. EPSDT is part of this system and will be included.

Baylor, DHCS: In regards to EPSDT, DHCS is anticipating that counties that opt in will be able to pull in FFP money that they cannot pull down now so we hope this will leverage existing dollars.

Anne Donnelly, Project Inform: About 50% of individuals with HIV also have co-occurring SUD/MH issues. What is being done both in terms of partnership with State Office of AIDS and HRSA to ensure appropriate utilization and use of available Ryan White funding?

Douglas, DHCS: This is a question that has not been addressed. It is something that could be discussed for the next waiver as perhaps part of the Incentives discussion.

Anne Donnelly, Project Inform: There is a behavioral health component to Ryan White that should also be considered. It is also a payer and delivery system coordination issue and she highlighted the challenge of ensuring that providers are engaged with these components.

Douglas, DHCS: Ryan White will be payer of last resort. This will be similar to LIHP.

- **Rural Managed Care Expansion – 1 year later: *Javier Portela, DHCS***

Javier Portela, DHCS, discussed the status and considerations for the rural managed care expansion. The presentation can be found at:
http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Hermann Spetzler, Open Door Community Health Centers: Can you talk more about how the State and plans are ensuring adequate primary care provider and specialist supply and how it puts primary care providers "on the ground" in communities?

Portela, DHCS: Before managed care there was very little data available to monitor access. We are now beginning to look at the standard managed care metrics to monitor access, like timely access requirements. Our efforts are not creating new providers but one of the goals is to assure that prior providers are retained and to encourage other providers to participate in Medi-Cal.

Douglas, DHCS: With the managed care expansion there is no doubt we start with some challenges in terms of provider supply and access. The first step will be looking at how plans can meet access requirements and to think creatively about strategies to do so. It is a challenge in rural areas.

Elizabeth Landsberg, Western Center on Law and Poverty: What about transportation to services for Medi-Cal members? She noted that the State's position has been that transportation for non-emergency non-required services is not a required benefit. Many members are told that they have to travel several hours to specialists. Practically, this results in a lack of access to care.

Hermann Spetzler, Open Door Community Health Centers: The reason I raised the issue is that the provider directories suggest that there is real access but the reality is that there are inadequate primary care providers and huge issues around specialist access in many communities, particularly rural communities.

Chris Perrone, California HealthCare Foundation: As a part of the one year update, I was anticipating some initial data on access. With the understanding that this is a work in progress and may take some time, the extent to which the group can examine the data and standard access metrics the more helpful it would be to the stakeholders.

Elizabeth Landsberg, Western Center on Law and Poverty: I agree and suggest sharing what the DHCS Ombudsman calls have been for in the 28 expansion counties to get a sense of what complaints they are seeing.

Suzie Shupe, CA Coverage & Health Initiatives: The issue of pediatric specialty care continues to be a big issue, particularly in rural areas. I would like to review data on pediatric specialty access.

Gary Passmore, CA Congress for Seniors: The state rate structure discourages new CBAS programs. Does the transition to managed care ever envisioned the concept of promoting more CBAS programs as an alternative to big nursing homes?

Cantwell, DHCS: The recently approved CBAS amendment provides more flexibility for how the plans can contract with the providers for something beside a standard per day reimbursement. The CCI counties hold the potential for plans working to delay nursing home placement.

Gary Passmore, CA Congress for Seniors: At some point in the State's planning process, it will be important to look at CBAS as a service statewide, and not just in the seven CCI counties. We have lost 20% of the CBAS statewide.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: The issue is not necessarily about nursing home avoidance but about providing improved care and cost management for the very complex patients. There are different models in county expansion areas. Can we look at Medi-Cal managed care expansion patient satisfaction data with comparisons between COHS, local two-plan models and commercial plans?

Brooks, DHCS: In terms of the rural counties, we have conducted a survey of member satisfaction before the Medi-Cal managed care transition and will be conducting the same survey 18 months later.

Cantwell, DHCS: The CBAS amendments were approved by the legislature last week and are posted on the web site.

1115 Waiver Renewal Expert Stakeholder Process
Mari Cantwell and Wendy Soe, DHCS

Wendy Soe presented on the waiver renewal process and highlights from the meetings thus far. The presentation can be found at:
http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Kristen Golden Testa, California Children's Partnership: We have a proposal put forward that does not seem to fit in with any of the initiatives but does seem to align with the overall waiver goals. It involves taking children, particularly those with asthma and partnering with some of the home evaluators who actually do the home assessments to identify mold and other environmental causes. There is evidence this creates savings.

Cantwell, DHCS: It might be challenging from a CMS concept in terms of being something that they have the ability for Medicaid to pay for.

Brenda Premo, Harris Family Center for Disability and Health Policy: I support the proposal and recommended categorizing this service as a home and community based services. She supported the goal of keeping people healthy instead of just paying for clinical services.

Marilyn Holle, Disability Rights CA: This idea is similar to the lead abatement that is currently done. Medicaid pays for remedial care so I am not sure there is a CMS barrier if California thinks about categorizing it in the existing baskets that CMS already accepts.

Douglas, DHCS: These are examples of things that have been done in other states or other ideas that DHCS encourages stakeholders to share.

Rusty Selix, CA Council of Community Mental Health Agencies: It feels like the behavioral health issue is the same conversation happening in multiple workgroups. It is challenging to figure out which conversation should happen in different workgroups.

Cantwell, DHCS: Behavioral health integration is a part of many of the workgroups. The incentives and DSRIP workgroups might be workgroups to prioritize attending.

Anne Donnelly, Project Inform: I also have a question of fit. One issue that could be included is the use of preventive medications that could end the HIV epidemic.

Stuart Siegel, Children's Specialty Care Coalition: I have the same question about where do we fit in? My understanding is that the Ryan White question fits into the incentives workgroup.

Douglas, DHCS: Behavioral health (and other topics) can fit into multiple workgroups. He encouraged stakeholders to send ideas to DHCS so they can incorporate suggestions into multiple groups.

Chris Perrone, California HealthCare Foundation: How would Medi-Cal per member per month costs have grown over the last three years (excluding growth in costs resulting from expanded membership)? Are state general funds on or off the table as a source of reinvestment in new services or as the non-federal share for DSRIP?

Cantwell, DHCS: The California proposal is focused on leveraging federal savings to improve care and reduce costs, which is a type of re-investing although it is not general funds, per se.

Chris Perrone, California HealthCare Foundation: To the extent that health plans invest in other services, they don't get credit for that as a cost in their rates? Are different states approaching capitation rate setting differently and if they are able to include non-Medicaid covered services?

Cantwell, DHCS: We can include those services as part of the capitation but currently, those costs are not included in the rate setting for managed care plans. We are thinking about how we can look at that based on sharing of savings and move away from cost-based and experience based rates.

Chris Perrone, California HealthCare Foundation: I would encourage that course. The field is increasingly focused on whole person care and that to the extent that we are constraining ourselves we are doing a disservice to ourselves.

Cantwell, DHCS: The incentives workgroup is discussing this and how, to the extent the plans have efforts that meet the three metrics of reduced cost, improved quality and outcomes, how

the savings can be shared. One of the challenges is that we have a MH/SUD financing system that is separate from our medical financing system so for counties that invest more in MH/SUD, the benefits are on the medical side.

Gary Passmore, CA Congress of Seniors: To the extent the plan exceeds the available services allowed, how is that included in the rates?

Cantwell, DHCS: if it is a Medicaid-reimbursable service, it would be included in the costs – unlike what Chris asked regarding additional services.

Anthony Wright, Health Access: As a result of President Obama's recent immigration executive action, the categories that California has a long and proud tradition of covering (e.g. deferred action) will be expanded in the future. DHCS has said that they are reviewing the order. Is there is a timetable or any insights on this process? How might the safety net financing workgroup be adjusted to include this discussion?

Douglas, DHCS: I do not have a more specific answer other than that they have begun the process to assess these questions. It will be part of the budget process.

Cantwell, DHCS: For those legal immigrants under the 5-year bar, California offers state-based Medi-Cal. We claim emergency services funding from the federal government. If coverage were expanded, we would continue to claim these funds. We would not lose this.

Kristen Golden Testa, California Children's Partnership: What the rough percentage was of how much of the per capita costs were claimed for emergency room services.

Cantwell, DHCS: About 50-60% of the ER costs are claimable.

Marilyn Holle, Disability Rights CA: My recollection is that San Mateo County elected to provide full scope coverage on the theory that doing that was the same or more of the emergency costs for meeting their needs.

Anne Donnelly, Project Inform: This discussion may not be appropriate for the waiver, but California needs to start a discussion about Medi-Cal's role in providing high cost curative access drugs related to Hepatitis C. There are more of these drugs coming down the pike.

Douglas, DHCS: This fits into the bigger conversation, such as CalSIM and others, which is looking more broadly at care efficacy, efficiency and cost.

Meeting the Needs of the Medi-Cal Population: Timely Access and Network Adequacy
Sarah Brooks, DHCS and Nancy Pheng, DMHC

Nancy Pheng, DMHC presented on SB964, which has a lot of implications for timely access requirements and monitoring. The presentation can be found at:
http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Gary Passmore, CA Congress for Seniors: Do DMHC and DHCS intend to collect data on long-term care, and if so what process will be used to develop the reporting formats?

Pheng, DMHC: We do not collect that right now can consider that for 2016 collection. We are ramping up to provide this.

Gary Passmore, CA Congress for Seniors: I encourage DMHC to include this data now that this is state law. Does SB 94 specifically include instructions that the results of investigations need to be shared with the legislature?

Pheng, DMHC: Section 1367.03 requires DMHC to post annual findings online. This is a new requirement.

Gary Passmore, CA Congress for Seniors: Is the only expectation is that they put the information on the website?

Pheng, DMHC: Yes.

Anthony Wright, Health Access: I thank DMHC and DHCS for the work and Senator Hernandez for proposing the legislation. When is the soonest stakeholders can expect to start seeing data results, particularly for Medi-Cal?

Pheng, DMHC: We will receive the first set of data from plans on March 31, 2014. DMHC has not yet figured out the strategy or timing for reporting out findings and noted that there are several different sets of data that need to be analyzed, including access data on primary care, specialty, ancillary and hospital services. Though it is hard to say, we hope to get some findings out in 3-4 months so we can work with the plans to improve results in the following year. That suggests a likely release in late summer.

Suzy Shupe, California Coverage and Health Initiatives: Can you explain how the new requirements get to the issue of physicians who are engaged in Medi-Cal but cap the number of patients they see? What we often see is that there are a number of providers involved in the program but the experience in the community is that members try to make an appointment but there is not enough availability because providers are only accepting a few Medi-Cal patients.

Pheng, DMHC: One of the fields for each provider is the number of assigned enrollees in each line of business. The struggle that DMHC has had in the past is that if you are collecting data for just one line of business (e.g. Medi-Cal), you do not know how other lines of business (e.g. Medicare, commercial) are impacting a provider's capacity.

Gary Passmore, CA Congress for Seniors: Is there anything in the Medicare data collection requirements that correspond with SB94?

Pheng, DMHC: I don't have the answer but we can contact Region 9.

Rural expansion network adequacy

Sarah Brooks, DHCS and Javier Portela, DHCS, presented on the rural expansion timely access and network adequacy issue with Javier Portela, DHCS. The presentation can be found at: http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Elizabeth Landsberg, Western Center on Law and Poverty: Are there were any "alternative access standards" approved for the County Organized Health Systems (COHS)? How do those standards apply to them?

Brooks, DHCS: My understanding is that DHCS did not approve any alternative access standards for COHS.

Portela, DHCS: It is not solely DMHC's responsibility, but we consult with DHCS since they are jointly reviewing network adequacy. Any alternative access standards approved are public and can be shared with the group. We review both COHS and other plans for access standards.

Gary Passmore, CA Congress for Seniors: Why is podiatry listed as a core specialty if it is not a covered service for Medi-Cal?

Brooks, DHCS: Podiatry is covered for certain circumstances and for children under 21.

Gary Passmore, CA Congress for Seniors: Are pediatricians considered primary care providers and not specialists? If you add many children into a plan, would you monitor the number of pediatricians differently? What standard is used to assess if there are an adequate number of pediatricians in the plan?

Brooks, DHCS: They are considered primary care providers.

Portela, DHCS: There is consideration of pediatricians, OB/GYN, family practice and other providers. We look to ensure that all of those different spectrums are available but do not have a set standard of how many of these different types of providers they need to have. We do assess when there is a robust number of transitions whether standards are met.

Gary Passmore, CA Congress for Seniors: When there are transitions that add large numbers of seniors, do you look at the number of geriatricians in the network.

Portela, DHCS: I do not recall but they can look into this question.

Suzy Shupe, California Coverage and Health Initiatives: Access to pediatric dental surgery is a huge access issue in Medi-Cal and in commercial plans across the state, but an especially challenging problem for children on Medi-Cal in rural areas. Many families have to travel several hundred miles if they are even able to secure an appointment. How carefully are you looking at this and uncover where new services are needed? I encourage a strong focus on this issue.

Brooks, DHCS: It is a very important issue and something that is on their radar. DHCS is meeting weekly with dental partners and stakeholders, not just on this issue but on dental issues more broadly.

Lishaun Francis, CMA: Can you explain your role in network adequacy and the accuracy of provider directories, particularly in light of recent issues with Anthem and Blue Shield in regards to inaccurate Covered California directories?

Pheng, DMHC: SB 94 does not address provider directories. Plans are supposed to update them quarterly and are required to note that they can change at any time. In the future, we can reach out to the plans to request they confirm how they ensure accuracy. Other ideas include a portal where provider information can be provided directly to consumers.

Douglas, DHCS: On the Medi-Cal side there is a Bureau of State Audits that will look at Medi-Cal directories. Plans do update them quarterly and we check the information.

Portela, DHCS: There is a longstanding pilot in LA and Sacramento called the personalized provider directly. It updates data monthly and has been successful from a fiscal and member communication strategy.

Hermann Spetzler, Open Door Community Health Centers: On the issue of the primary care continuum (e.g. family practice, pediatrics, geriatrics), the hardest part for family practice trained individuals is when you age out the patients they are allowed to see. Because of the broken mental health system, this means they are burdened with some of the most complex issues. In one of our clinics with a pediatric wing, we have a hard time keeping because family practice doctors end up caring for only highly complex patients.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: I need some more explanation about the Covered CA requirements in terms of plan network adequacy.

Pheng, DMHC: The only difference between Medi-Cal and Covered California is the 10/30 vs. 15/30 requirement. In specialty care the standard is "reasonable access". There are no time or distance requirements.

Kristin: The pediatric specialties appear to be tucked into adult specialties so it is hard to distinguish.

Brooks, DHCS: This is true on the readiness side but in terms of monitoring the providers, the plans submit files with a much more expanded list of specialties to both DHCS and DMHC. Based on inquiries at the last meeting, we are following up.

Marilyn Holle, Disability Rights CA: It might be helpful if the directories included whether or not the provider was CCS empaneled because that is a way to know if they are able to care for children.

Cary Sanders, CPEHN: Will DMHC will be tracking differences in access to care by language when they look at network adequacy?

Pheng, DMHC: For the first year it is not incorporated. We do, however, look at this issue when a plan is initially licensed.

Brooks, DHCS: We do look at language issues when we review plan grievance data. We issued an all plan letter and can send that out to the members.

Cathy Senderling, County Welfare Directors Association: County eligibility workers often get complaint calls when members cannot find a provider nearby. This is a big deal in rural areas. Do the alternative access standards mean the 10 mile standard isn't adequate? What type of guidance should eligibility workers give individuals when they feel that the network adequacy or access standards are not being met? Should we make a complaint?

Portela, DHCS: The first thing to do is to make sure they call the health plan. A second option is to link them to the DHCS Ombudsman. Overall, the alternate standards are about access to hospitals not primary care.

Kim Lewis, National Health Law Program: Does DHCS have patient to provider ratios that are used?

Brooks, DHCS: It is 1:2000 for primary care.

Kim Lewis, National Health Law Program: One issue is the EPSDT specialty care access for patients under 21. Are there different standards for that population and/or are there different tools that are used to measure network adequacy for pediatric populations?

Brooks, DHCS: There are not special tools. We are exploring this right now.

Kim Lewis, National Health Law Program: Is there any more detail that can be provided on what you do during these reviews, the results of network reviews and if any information is provided publicly.

Pheng, DMHC: Individual follow up letters are not posted at this time.

Brooks, DHCS: We are looking at what information can be pulled together both for our network adequacy dashboard and also timely access standards.

Marilyn Holle, Disability Rights CA: One of my concerns is recognizing that specialists are not fungible and the failure of plans to vet a particular referral to see if the specialist is the appropriate one. There have been many cases of members being referred to a specialist and traveling long distances to see them, only to find out that this was the wrong specialist. There is a failure of the plans to vet fully a specialist before making a referral.

Brooks, DHCS: This is something we do look at through Medi-Cal audits. I would like to follow up and speak to you offline so we can learn more about the specific issues.

Brad Gilbert, Inland Empire Health Plan: A few comments in response. 1) Podiatry is a covered benefit for adults when medically necessary. 2) We do allow our family practice doctors the full age range as a retention issue because that is important. 3) Marilyn, sometimes this happens because of a change; it is a moving target to keep up on the specialists and it is not in our interest to send people to the wrong place but you raise an important point.

Solutions to Improving Access – Comments from Health Plans and Providers

Several health plan representatives presented separately on network adequacy monitoring and expansion efforts at their health plans. This included:

- Brad Gilbert, (IEHP)
- Michael Harris, CenCal
- Kathryn Kaestner, California Health and Wellness
- Scott Coffin, Anthem Blue Cross

Presentations can be found at:
http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Marty Lynch, LifeLong Medical Care and California Primary Care Association: I have an interest in IEHP's efforts to fund entry of new primary care physicians and asked if other plans are doing this. Are these costs can be built into plan rate setting?

Brad Gilbert, IEHP: I am not aware of other plans with similar efforts. It is not built into rate setting and has been structured as a grant program.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Managed care plans can pay more than FFS rates for specialty, but is there a thought of increasing the FFS specialty rates, which would then increase plan rates?

Douglas, DHCS: At this point it is fair to say, more than likely the answer is no. The State wants to look at alternative approaches for expanding access through the waiver such as incentives as well as other vehicles. We are looking at this from the regulatory side and incentives.

Anne Donnelly, Project Inform: On current Hepatitis C treatments, do plans have the authority to limit prescribers only to provision by hepatologists. She stated that there may be a much broader set of providers that could provide these treatments and increase access to patients. She questioned if these restrictions had been placed to restrict costs.

Brad Gilbert, IEHP: IEHP has been working with the Desert AIDS Project in the Coachella Valley and sent them a contract, because we do agree, they should be able to prescribe this treatment. He asserted that the Hepatitis C treatment regimen was actually very complex and that there is specialized training needed by providers in order to prescribe this. Not every gastroenterologists should be prescribing this.

Brooks, DHCS: As long as plans ensure timely care and meet the network adequacy requirements they can restrict their networks.

Hermann Spetzler, Open Door Community Health Centers: How has California Health and Wellness approached establishing access points in border areas? Do you contract across state lines?

Kathryn Kaestner, California Health and Wellness: We do contract with willing providers in Nevada.

Lishaun Francis, CMA: We recently supported legislation that would have required plans to pay for phone and some other services but it was not successful. Do the plans see phone and telemedicine as a tool to reduce access burdens?

Douglas, DHCS: From the DHCS perspective this is in the same vein as their efforts to be involved in the FQHC payment reform model, which is about providing flexibility for providers to provide more responsive and cost-effective approaches to care. In the waiver we are also looking at bundled payments to providers to give flexibility. These are the approaches we are looking to incentivize these approaches.

Michael Harris, CenCal: The additional services can clearly benefit the provider and patient but said it is important to find a way to be able to continue to enhance services with a reasonable pay structure.

Hermann Spetzler, Open Door Community Health Centers: Open Door has been providing very active telemedicine since 1996. The single biggest learning is that it is just another tool. It is integrated into our sites. The other lesson is that that providers are very interested in telemedicine but they will quickly get bored if you stick them in a room for four hours at a time and make them do only telemedicine. Instead, telemedicine is just a part of providers' day.

Chris Perrone, California HealthCare Foundation: I want to tie together the earlier discussion of standardized methodology for timely access relationship to the health plan comments about using appointment surveys to monitor timely access surveys. Are these used to monitor access voluntarily and are surveys part of the DMHC and DHCS standardized access monitoring requirements?

Nancy Pheng, DMHC: We have not yet defined the standardized methodologies for 2015 but for 2014 they listed a best practice methodology that included timely access surveys. They are not required yet, but most plans have been conducting some form of timely access surveys of providers for a long time.

Brad Gilbert, IEHP: The best practices efforts did encourage more standardization and improved practices to the plans on how to conduct these surveys.

Elizabeth Landsberg, Western Center on Law and Poverty: California Health and Wellness mentioned you pay for patient transportation below 200 miles, can you explain how members are informed of this benefit and what options are available to patients traveling more than 200 miles?

Kathryn Kaestner, California Health and Wellness: This benefit is printed on member and provider materials and the benefit is utilized actively. If members need transportation more than 200 miles it will generally be provided but does require a pre-authorization.

Scott Coffin, Anthem Blue Cross: We do not have a mileage limit.

Douglas, DHCS: Can the plans provide more information on how frequently this benefit is utilized?

Anthony Wright, Health Access: Could the plans share your perspectives about how useful a tool the provider ratios are in realistically determining network adequacy. For example, with IEHP's statement about having 1,100 PCPs in the network, it is assumed that those are not exclusive arrangements and that they have other competing lines of business. He asked if the plans had figured out a better metric for measuring network adequacy.

Tom Harris, CenCal: I don't think it is necessarily one measurement that you want to look at. CenCal is lucky to have pretty good provider relationships. A provider taking on 500 members that is in a desperately needed area that is a relationship issue. Overall, the best approach is to use multiple measurements from appointment wait times, number of members they have and what they think is the most important – that relationship.

Brad Gilbert, IEHP: The ratio is a requirement from DMHC and DHCS but it is really dependent on the doctor. So at the doctor level, you are looking at grievances, wait times, etc. I think of the ratios more as a limit and not a ratio.

Gary Passmore, CA Congress for Seniors: People tell us that with Telehealth a big issue is the lack of broadband access. Have the plans have addressed this or thought about it?

Kathryn Kaestner, California Health and Wellness: From the perspective of our Telehealth pilot, broadband is an issue. We looked at where broadband is available and in some areas installed it.

Toby thanked the group for the robust discussion. He said that the State and stakeholders are now putting much more of an emphasis on how much they are monitoring access but are also hearing from plan partners how much they are doing to monitor access already.

Gary Passmore, CA Congress for Seniors: I really appreciated having someone from DMHC at the SAC meetings. It is helpful to see how the two agencies are interacting.

Coordinated Care Initiative: Enrollment and Care Coordination:
Mari Cantwell, DHCS

Mari Cantwell, DHCS, reviewed progress of the CCI. The presentation can be found at: http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Gary Passmore, CA Congress for Seniors: I recall that about 51,000 individuals enrolled into CCI but what was not reported on was how many people chose not to enroll.

Cantwell, DHCS: I don't recall the number but one of the follow up items from the last meeting was to get an understanding of the opt-out data. CMS is still defining how they want states to report opt out data in a standardized way, so DHCS is waiting for that guidance to be issued.

ACA Section 2703 Health Homes:
Brian Hansen, DHCS

Brian Hansen, DHCS, presented on the ACA 2703 Health Homes. The presentation can be found at: http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Has the State come up with some form of tiered case management reimbursement to allow for different levels of acuity?

Hansen, DHCS: We have not settled on one but understand the need for it. The population is frequent users but there are different levels of need even within this population. DHCS has begun discussing this methodology but have not settled on anything. More information will be available at the next meeting.

Cary Sanders, CPEHN: PTSD is one of the chronic conditions that would make someone eligible for this program - how do you define PTSD. In some communities men and boys of color experiencing, gun-related violence suffer from PTSD. Would these individuals be eligible?

Hansen, DHCS: This falls into the next level of policy development and DHCS does not yet have a specific definition so stakeholder ideas and thoughts are encouraged.

Elizabeth Landsberg, Western Center on Law and Poverty: Can DHCS clarify the target counties for the health homes initiative?

Hansen, DHCS: As a first stage of targeting in January, we are starting with CCI Counties. The thinking is that the care coordination and other groundwork from CCI prepares them for the health homes. We continue to look at readiness so it will become more broadly available.

Douglas, DHCS: Another thing is that the federal rules require that the health homes initiatives have to serve duals. It is not limited to duals counties but must include them.

Elizabeth Landsberg, Western Center on Law and Poverty: I want to echo the point about tiered payment. Our organization also encourages different levels of payment for different acuity levels. I have heard that DHCS is considering targeting up to 5-10% of the Medi-Cal population. From our perspective, this is too big of a population to ensure a targeted and effective program.

Hansen, DHCS: This is also a next level policy discussion that will need to be addressed in the future.

Cary Sanders, CPEHN: It is important to look at encounter data by key demographic characteristics to make sure the needs of the full population are being met.

Gary Passmore, CA Congress for Seniors: I'm particularly interested in the MSSP waiver and wonder if those services that you call MSSP-like, do they fall under this?

Douglas, DHCS: Most of the requirements do go to meeting care coordination needs in CCI - – not necessarily through MSSP.

Enrollment Updates, Rene Mollow

Rene Mollow, DHCS, provided a Medi-Cal enrollment update. The presentation can be found at: http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Gary Passmore, CA Congress for Seniors: Will DHCS continue to track over time those individuals that came in through presumptive eligibility. I want to understand how many of these individuals move into full scope coverage and how many lose their eligibility.

Rene Mollow, DHCS: We have the capability to track by aid code. There is a requirement for hospital presumptive eligibility to monitor how well these people are doing in completing the application and getting into full coverage. By far, the primary access point is "unassisted".

Suzy Shupe, California Coverage and Health Initiatives: Are those primary access points are for all applications?

Mollow, DHCS: Yes, applications through the portal can be broker, consumer, health plan, county as well as others.

Cary Sanders, CPEHN: Do you have numbers for all applications or only CalHEERS for open enrollment?
Mollow: Yes, Only CalHEERS, open enrollment.

Gary Passmore, CA Congress for Seniors: Do these the numbers include those people that are newly eligible or aging into just MLTSS for Medi-Cal and might be getting their medical care through Medicare.

Mollow, DHCS: We do not drill down to this level

*Cathy Senderling, County Welfare Directors Association: S*ince so many counties work so closely with the clients and providers on that and counties do not use CalHEERS, I do not believe that many MLTSS patients are coming through CalHEERS.

Mollow, DHCS: All of the individuals coming through CalHEERS are not known to CalHEERS or Medi-Cal and have never come through the CalHEERS system.

Elizabeth Landsberg, Western Center on Law and Poverty: On the mail notice, what do they receive?

Mollow, DHCS: We are using the same notices used before with some improvements. We are working on some of the issues regarding multiple notices.

Elizabeth Landsberg, Western Center on Law and Poverty: If the online version says that they are eligible for Medi-Cal but then later get a paper notice that they are probably eligible it can be confusing for the applicant.

Rene Mollow, DHCS: That is the process now. We can always work together on improvements.

Anne Donnelly, Project Inform: What the timeline was for sending out notices? Our folks have to apply for Medi-Cal to show they are not eligible to receive other insurance products.

Mollow, DHCS: I don't have the exact timeframes (that will be part performance reporting) but emphasized that the CalHEERS-SAWS communication is at or below one minute. The information is moving quickly and they are getting into coverage. Then the information is posted in MEDS and they get the BIC card.

Cathy Senderling, County Welfare Directors Association: The numbers pending past 45 days are down significantly. There are some that remain because we are going back and forth with people. The backlog is down. You are trying to let people know they are NOT eligible? A small number of your folks may be those who require a manual denial and counties can't do a manual denial. We can work with you individually until this issue is worked out.

Anne Donnelly, Project Inform: Yes, people who are on the borderline need to understand if they are eligible.

Suzie Shupe, CA Coverage & Health Initiatives: Do you have a sense the ratios of those that discontinued versus those that renewed?

Mollow, DHCS: We do not but are working on the analysis right now.

Suzie Shupe, CA Coverage & Health Initiatives: Do the notices include information about the 90 day cure period?

Mollow, DHCS: We do not have that information now. DHCS is working on reprogramming the system so that information will be included. Just as a point of reference, she reminded the group that DHCS has never included this information on the notices.

Katie Murphy, Neighborhood Legal Services: We had heard that in many cases the counties were just starting to effectuate the discontinuance notices. Do you have a sense of where counties are with that?

Mollow, DHCS: Counties began working the renewals in June and when they started seeing the return rates as low they started additional outreach. This is really anecdotal as to what we have heard from the counties on what their experiences have been historically versus what they are seeing now.

Anthony Wright, Health Access: What was the historical attrition rate for Medi-Cal?

Cathy Senderling, County Welfare Directors Association: I estimate about 20-30% was the attrition.

Kristen Golden Testa, California Children's Partnership: When will the first report will come out?

Mollow, DHCS: January 2015 and then it will be released on a quarterly basis.

Cary Sanders, CPEHN: Besides the December 17, 2014 meeting, will there be other opportunities to comment on the ABX1 report.

Mollow, DHCS: We will send out materials and will host a call for stakeholders to provide feedback.

Gary Passmore, CA Congress for Seniors: Many things have changed in Medi-Cal over the last year. How do the changes compare to what was projected? What are the issues or factors that will affect the Medi-Cal budget?

Cantwell, DHCS: There are many factors that will affect budget planning and that they cannot say how it will affect the budget yet.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: What percentage are having ex parte review using last year's beneficiary information?

Mollow, DHCS: I don't have that yet. It is too early.

Suzie Shupe, CA Coverage & Health Initiatives: It appears that grants for counties are going pretty well in some counties and like some of the enrollment payments are going through and that is good. Some stakeholders are concerned about how long this will continue. How long do you see that the enrollment payments can last? What do you see as the future of these payments?

Mollow, DHCS: We have a process for reconciling and paying Covered California and Medi-Cal application payments. We have verified about 480,000 applications thus far eligible for payments. I can get more information as a follow up.

Suzie Shupe, CA Coverage & Health Initiatives: How would a phase out of Covered California enrollment counselor payments affect continued Medi-Cal payments in the coming years?

Mollow, DHCS: This is something we are currently discussing with Covered California because they have been leveraging the Covered California enrollment counselor payment process. The intent of the grant funds is to continue those payments.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: When you find that there are members that need paperwork completed to renew, it would be great to work with the provider so that the providers can support patient efforts to retain coverage?

Cantwell, DHCS: We are working with the health plans to make sure that they are aware of renewal efforts so that the health plans can work with their providers.

Public Comment

Adam Francis, California Academy of Family Practice: The end of the ACA provision that raised Medi-Cal payments is approaching. Is there any report or meeting to talk about how these funds were used and what kind of impact they had on achieving its stated goals?

Cantwell, DHCS: We can provide an update on this at the next SAC meeting.

The meeting was adjourned at 3:00pm.