# DEPARTMENT OF HEALTH CARE SERVICES
# STAKEHOLDER ADVISORY COMMITTEE
# May 17, 2017
# 10:00am – 12:00pm

# MEETING SUMMARY

## Attendance

Members Attending In Person: Michelle Cabrera, SEIU; Sarah de Guia, CA Pan-Ethnic Health Network; Lishaun Francis, CA Medical Association; Kristen Golden Testa, The Children's Partnership/100% Campaign; Carrie Gordon, CA Dental Association; Marty Lynch, LifeLong Medical Care and California Primary Care Association; Farrah McDaid Ting, California State Association of Counties; Steve Melody, Anthem Blue Cross; Erica Murray, CA Association of Public Hospitals and Health Systems; Sandra Naylor Goodwin, CA Institute for Behavioral Health Solutions; Linda Nguy, Western Center on Law and Poverty; Gary Passmore, CA Congress of Seniors; Rusty Selix, CA Council of Community Behavioral Health Agencies; Anthony Wright, Health Access California.

Members Attending by Phone: Bill Barcellona, CA Association of Physician Groups; Richard Chinnock, MD, Children's Specialty Care Coalition; Bradley Gilbert, MD, Inland Empire Health Plan; Marilyn Holle, Disability Rights CA; Sherreta Lane, District Hospital Leadership Forum; Stephanie Lee, Neighborhood Legal Services of Los Angeles County; Kim Lewis, National Health Law Program; Anne McLeod, California Hospital Association; Chris Perrone, California HealthCare Foundation; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers; Herrmann Spetzler, Open Door Health Centers.

Members Not Attending: Kirsten Barlow, County Behavioral Health Directors Association of California; Lisa Davies, Chapa-De Indian Health Program; Bob Freeman, CenCal Health; Michelle Gibbons, County Health Executives Association of CA; Emalie Huriaux (for Anne Donnelly, Project Inform); Michael Humphrey, Sonoma County IHSS Public Authority; Brenda Premo, Harris Family Center for Disability & Health Policy; Cathy Senderling, County Welfare Directors Association; Richard Thomason, Blue Shield of California Foundation. Bill Walker, MD, Contra Costa Health Services.

DHCS Attending: Jennifer Kent, Rene Mollow, Jacey Cooper, Adam Weintraub, Karen Baylor, Lindy Harrington, Morgan Knoch.

Public in Attendance: 20 members of the public attended.

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

Welcome and introductions for in-person and phone SAC members. Director Kent needs to leave the meeting early so she reported on agenda items out of order to address them.

**Latest Federal Developments**
*Jennifer Kent, DHCS*

There is no additional fiscal analysis after the March DHCS memo that outlines the impact to California from the American Health Care Act. There are many concerns related to the fiscal impact if this becomes law. In 2020, the first year of implementation, California would be required to add $4.5-5B General Fund (GF) revenue and that would grow to $18-19B GF required annually. This is in addition to what is already budgeted and also does not include other non-federal share sources of revenue. The proposal includes eligibility redetermination every six months, which is administratively burdensome and makes it difficult to maintain coverage.

**Follow-Up Issues from Previous Meetings and Updates**
***Jennifer Kent and Adam Weintraub, DHCS:***
Follow-Up from Previous SAC Meetings
Updates on:

- Health Homes
- Commercial Plan Procurement Timeline

On the Section 2703 Health Homes Initiative, working through the non-federal match share resulted in some delay to implementation of the initiative. We have now confirmed the non-federal share and restarted implementation efforts. We are working through the State Plan Amendment (SPA) and financing issues.

Starting in 2019, we will go through a commercial health plan procurement process for all regions and models in California. This is generally good practice and we have not gone through procurement for a number of years. The process and schedule will be posted shortly on the website.

**Questions and Comments**

*Gary Passmore, CA Congress of Seniors*: What is the specific timeline for the procurement?

*Jacey Cooper, DHCS*: We will release the RFP in late 2019 – early 2020.

*Linda Nguy, Western Center on Law and Poverty*: Are you considering a change in the roll out timeline due to the delays in the Health Homes Initiative? Would you consider rolling out all at once instead of in phases?

*Jacey Cooper, DHCS*: The posted timeline keeps the three-phase roll out to maximize funding, beginning in July 2018, then January 2019 and finally July 2019.

*Marty Lynch, LifeLong Medical Care and California Primary Care Association*: What are the phases and when will procurement finish?

*Jennifer Kent, DHCS*: Go-live of the plans will be final in late 2021. In the event that a contractor is exiting, there is extensive work in the turn-over process.

*Chris Perrone, California HealthCare Foundation*: Are there any other objectives for this procurement, such as alignment between Covered CA and Medi-Cal or alignment with other public purchasers' quality measures? Is there a role for the stakeholder advisory committee?

*Jennifer Kent, DHCS*: It is still unknown if there will be any new requirements. We are using the previous procurement documents as a starting point. This will be run through the procurement office. We may send a draft document out for comment but it is unlikely we will have any other means beyond the procurement office itself involved in the process. These are large contracts and we need to adhere to our process.

*Kim Lewis, National Health Law Program*: On the federal analysis, thank you for doing that – it was very helpful. Are you planning to do any additional analysis of changes on the AHCA congressional proposal?

*Jennifer Kent, DHCS*: We are not analyzing every tweak or proposal discussed, but if there is any proposal that is moving forward and there is time, we will try to provide an analysis. The models are complex and require significant staff resources to understand and analyze, but we will try to accomplish it, time permitting.

**State Budget: May Revision**
*Lindy Harrington and Rene Mollow, DHCS*

Lindy Harrington offered a FY 2016-17 state budget update. DHCS is showing a $1.2B shortfall, which is $600M below projections issued in January, as a result of lower caseloads, changes in managed care payments and increased drug rebates. For FY2017-18, GF is lower by $50M in a total budget of $108B.

Rene Mollow provided additional budget updates. The Newly Qualified Immigrant Medi-Cal affordability wrap is not included in the May revise budget and we are not pursuing this. We are working with CMS to determine what is needed to secure a designation of minimal essential coverage (MEC) for our state only programs – we are unsure of the process but believe it may be similar to what occurred when they designated the pregnancy only coverage as MEC. . The other change is the 340B (drug) pricing and billing proposal. This is not the same as the item in the January budget. We are in discussions with the hospital associations and California Primary Care Association about this proposal. The May revision covers only contract pharmacies for Medi-Cal. The use of 340B contract pharmacies is creating inappropriate billing and claiming because those drugs are unknown to DHCS. We are working on the specifics to clarify this and avoid the billing issues in the future.

**Questions and Comments**

*Marty Lynch, LifeLong Medical Care and California Primary Care Association*: Health centers go through audits with the federal government to ensure we do not duplicate any rebates in the 340B program. We are working to report accurately to DHCS through Medi-Cal Managed Care plans. The work will offer assurance of accuracy for the state.

*Rene Mollow, DHCS*: There is a three-way contract required (state, health plan, 340B entity/ clinic/hospital) and we have one in place signed in 2014. We are aware there are other arrangements in place but recognize there is no state approval for such; under our proposal, we would be seeking CMS approval.

*Michelle Cabrera, SEIU*: Is this related to the current year Medi-Cal shortfall?

*Rene Mollow, DHCS*: No.

Rene Mollow also reported that DHCS is working on drug pricing rules from federal government on pricing and dispensing fees. We are moving to a new pricing and dispensing methodology policy to be operationalized in FY 17-18. It requires system changes and a SPA. We worked through a stakeholder process and put out the report of alternatives.

Jacey Cooper reported budget updates on the California Children's Services (CCS) program. A trailer bill clarifies that Occupational/Physical Therapy Services (OT/PT) claimed through CCS need to be medically necessary. If they are educationally necessary, they will not be covered by CCS ($1.6B to cover services not medically necessary).

**Questions and Comments**

*Kristen Golden Testa, The Children's Partnership/100% Campaign*: Can you offer an example?

*Jacey Cooper, DHCS*: Through the Individual Education Plan (IEP), some physical therapy services may be recommended by schools that do not meet the medically necessary criteria.

*Lindy Harrington, DHCS*: There may be physical therapy or occupational therapy to allow a child to hold a pencil to write that is educationally necessary, but not medically necessary. This would be covered by school funding, not CCS.

*Marilyn Holle, Disability Rights CA*: Holding a pencil may be consistent with EPSDT and not with CCS. Can you clarify LEA billing and whether schools can draw federal match for the IEP recommendations not covered by CCS? I want to be sure nothing hinders school financing.

*Jacey Cooper, DHCS*: It is our understanding it must be medically necessary to draw down federal match. We would need to work with education to know if LEA billing can draw down.

*Sarah de Guia, CA Pan-Ethnic Health Network*: I want to be sure this is communicated clearly to education in a way that ensures no interruption to services.

*Marilyn Holle, Disability Rights CA*: I am concerned about the benchmark being CCS because they do not use the same medically necessary requirements as EPSDT. I want to ensure that schools can draw down federal match as the LEA.

*Kim Lewis, National Health Law Program*: We want to ensure Medi-Cal kids get all EPSDT services and that we draw federal match. I am concerned to hear that CCS uses a different medically necessary standard than EPSDT. Can you report back on this?

*Jacey Cooper, DHCS*: We can follow up off line.

Lindy Harrington, DHCS, continued with budget updates. In collaboration with public hospitals, we are proposing a Graduate Medical Education supplemental payment to hospitals to offset costs of teaching associated with beneficiaries in managed care. The non-federal share is from public hospitals, not GF. It will bring in $800M in additional federal funds. The May revise also includes costs for repaying funds for dual eligibles inappropriately in expansion aid codes.

**Questions and Comments**

*Steve Melody, Anthem Blue Cross*: Is there is consideration of trailer bill language for the duals item? It is complex – there are downstream issues and we are not sure how far back it goes.

*Lindy Harrington, DHCS*: We didn't believe trailer bill language is necessary but there is active discussion on this point.

*Erica Murray, CA Association of Public Hospitals and Health Systems*: As background, California used to participate in a Medicaid GME reimbursement program that was phased out. This is an attempt to resurrect that program. We are one of only four states without a Medicaid GME program. We worked on this with the political challenges of introducing a new Medicaid stream in California at this time. It will be especially wonderful if this is approved.

*Marty Lynch, LifeLong Medical Care and California Primary Care Association*: There are a number of Teaching Health Centers training residents and new physicians. Is there a way that the IGT (Inter-Governmental Transfer) methodology can be used in health centers as well as hospitals?

*Lindy Harrington, DHCS*: IGTs are only allowed through governmental entities. The program is not currently contemplated to go beyond public hospitals, but I can take that back. It would depend on the type of facility providing the teaching service. We are not currently looking at expanding this, but may in the future.

*Anne McLeod, CA Hospital Association*: The program is for the designated public hospitals only – not other hospitals.

*Kristen Golden Testa, The Children's Partnership/100% Campaign*: Is this related to increasing residency slots?

*Erica Murray, CA Association of Public Hospitals and Health Systems*: There are two related policy ideas. There was a program of $40M in the budget that UC would administer through Prop 56 to increase the number of residency slots and that was zeroed out by the Governor. We hope it will be reinstated to increase slots because it was misunderstood as an education item. The program we are discussing here is to offset the cost of teaching for current residency slots.

*Linda Nguy, Western Center on Law and Poverty*: We had proposed language to address the UC funding issues. Going forward, funding should consider the Medi-Cal population served.

*Anne McLeod, CA Hospital Association*: This line item was in the education budget. The Department of Finance noted the line item as new funding for UC and they took out the $40M. We are looking to fix this.

Karen Baylor, DHCS, reported on working on the performance outcome system and will implement two performance tools through County Mental Health Plans. There is money in the budget to train and report data to DHCS. Related to the CURES Act, California received $44.7M funding and will expand medication assisted treatment in California focused in places where there are no treatment facilities. We are adopting a Vermont model of hub-and-spoke where a central location does the initial Medication Assistance Treatment service and then refers to local facility for ongoing care. We will expand to 15 locations across state. We are requesting an exemption from procurement and modified RFA process to begin the program in September.

**Questions and Comments**

*Rusty Selix, CA Council of Community Behavioral Health Agencies*: Is there a map of locations?

*Karen Baylor, DHCS*: We are in the RFA process now and will have a map after awards.

*Rusty Selix, CA Council of Community Behavioral Health Agencies*: This is a comment on a budget item not related to DHCS, but very important to mental health services. The May revise includes a cut to mental health as part of giving IHSS back to the counties. The DOF cut mental health by $36M this year and $30M next year and Vehicle License Fee growth, totaling $150M over five years. This will impact crisis services and emergency services.

*Kim Lewis, National Health Law Program*: Will the tools you mentioned be used statewide?

*Karen Baylor, DHCS*: Yes, it will be required statewide. CANS is a tool completed by the clinician and the PSC tool is completed by the caregiver. This will offer more reliable information on progress in treatment. The tools will be utilized on a regular basis and results will be reported to the state.

*Linda Nguy, Western Center on Law and Poverty*: We want to express appreciation for not moving forward on NQI wrap. It would have had serious implications for immigrants.

*Adam Weintraub, DHCS*: There was a question to follow up from the last meeting on dental services in community health centers. We have gathered more reliable data, although it is not detailed as to services.

*Carrie Gordon, CA Dental Association*: Can we get multiple years of data to identify trends?

*Adam Weintraub, DHCS*: I will look into the resources required to accomplish that.

*Rene Mollow, DHCS*: We have been providing dental program data on the DHCS website.

*Marty Lynch, LifeLong Medical Care and California Primary Care Association*: On the FQHC data, I understand there is concern about going back and recreating claims for the Dental Transformation Initiative to report this data. If we can provide this in spreadsheet format, it will be much easier to report and more reasonable for health centers.

*Rene Mollow, DHCS*: Yes, this is in relation to incentive payments to clinics. We required a specific format. We have had difficulty with spreadsheet format but we are working on this.

**Mental Health Parity Managed Care Rule**
*Jacey Cooper, DHCS*
Slides available: http://www.dhcs.ca.gov/services/Documents/MentalHealthParity_SAC.pdf

Ms. Cooper walked through aligning mental health parity rules in Medi-Cal. One significant change is that it applies across delivery systems (mental health plans, managed care plans). General parity rules require that financial requirements and quantitative treatment limitations on mental health (MH) and substance use disorder (SUD) benefits cannot be more restrictive or be applied more stringently than medical/surgical (M/S) benefits. In addition, non-quantitative treatment limitations on MH or SUD benefits in processes, strategies, evidentiary standards, or other factors must be comparable to, and applied no more stringently than, limitations applied to medical/surgical benefits in the same classification. Ms. Cooper detailed the state responsibility to assess parity compliance across the delivery systems such as fee-for service pharmacy,

mental health, substance use disorder and medical/surgical. She provided information on the four components of parity compliance:
1. Benefits Mapping and Classification
2. Financial Requirements and Quantitative Treatment Limitations
3. Nonquantitative Treatment Limitations
4. Disclosure Requirements

Finally, she offered details and timelines for the state responsibility:

- Provide an assurance of compliance with parity requirements to the Centers for Medicare & Medicaid Services (CMS)
- Ensure compliance of the MCPs, MHPs, and DMC delivery systems via State guidance and review of deliverables
- Implement any needed changes via amendments to State Plan, waivers, contracts, statutes, regulations, All Plan Letters, County Information Notices, Medi-Cal Provider Manual, policies and procedures to meet parity requirements
- Monitor for continued compliance
- Post documentation of parity compliance on its website

**Questions and Comments**

*Marty Lynch, LifeLong Medical Care and California Primary Care Association*: What is the alternative benefit plan you spoke about?

*Rene Mollow, DHCS*: That is the benefit package made available to the expansion population. It is the same scope of services in California, but we had to file a SPA (State Plan Amendment) on this.

*Marty Lynch, LifeLong Medical Care and California Primary Care Association*: Community Health Centers have a same-day restriction on providing mental health services on the same day as physical health. Would parity requirements raise a new discussion of this?

*Jacey Cooper, DHCS*: We did look at this issue. We don't have the final recommendation yet, however given that all costs are built into the Prospective Payment System (PPS) rate for FQHCs, we think it is compliant.

*Karen Baylor, DHCS*: The reminder is that mental health can't be more restrictive. We often hear about issues that do not meet this baseline test. It is not a lens of equal across the board, but only "more restrictive."

*Marty Lynch, LifeLong Medical Care and California Primary Care Association*: We can argue about whether the payment is included already, but it seems that not allowing people to have a visit on the same day is more restrictive. We can discuss offline.

Jacey Cooper, DHCS: The restriction for payment is for both mental health services and physical health, both are equally restricted to same day billing regardless of what service is provided first.

*Rusty Selix, CA Council of Community Behavioral Health Agencies*: It sounds like there were many meetings and written materials over the course of this process. Is there a draft plan that will go out for comment and input from beneficiaries?

*Jacey Cooper, DHCS*: We have presented at the Managed Care Advisory Group and wanted to discuss here with SAC. We will post some areas for comment. I don't know if we will post the entire compliance plan for comment because of the timeline.

*Rusty Selix, CA Council of Community Behavioral Health Agencies*: We have learned there is a difference between parity on paper and in the real world. For example, what happens when you are released from hospital and the discharge plan is three days of medications and the name of a doctor? When people need specialty care who are in primary care setting, the PCP will help find services. If you need mental health, good luck. There is a need to put out detailed guidance.

*Karen Baylor, DHCS*: Much of that is oversight and monitoring of compliance. That is the next step in this process. The questions you raise are the ones we are discussing and it is a work in progress. We will update all of you as we develop this work.

*Jacey Cooper, DHCS*: There are issues within parity on how we come into compliance and then additional issues on monitoring we will need to address.

*Kristen Golden Testa, The Children's Partnership/100% Campaign*: Is this tied to workforce as well? The waiting times must be the same and it seems the parity requirement of "availability" is tied to adequacy?

*Jacey Cooper, DHCS*: Network adequacy is part of parity. We are using the network adequacy proposal released by DHCS to demonstrate compliance with network adequacy.

*Kristen Golden Testa, The Children's Partnership/100% Campaign*: How can there be compliance if there is no workforce?

*Karen Baylor, DHCS*: I understand the concern although I don't know that there is a parity requirement specific to workforce. There is a national shortage of some mental health professionals. DHCS will be looking at whether you have access to those services and level of care. Access is the level we will monitor, not workforce per se.

*Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers*: On the hospital detox benefit, there is also nonexistent access.

*Karen Baylor, DHCS*: The detox benefit is under FFS and therefore is not covered by parity or this review.

*Rusty Selix, CA Council of Community Behavioral Health Agencies*: Does this only apply to those enrolled in physical health managed care? If they are in specialty mental health care but FFS physical health, this rule does not apply?

*Jacey Cooper, DHCS*: Yes

*Rusty Selix, CA Council of Community Behavioral Health Agencies*: How will people know whether this rule applies for what happens after a hospital stay?

*Jacey Cooper, DHCS*: Mental Health parity applies to individuals in a physical managed care. Mental health plans will come into compliance through contracts with the state and that will cover part of what you are refer to.

*Kristen Golden Testa, The Children's Partnership/100% Campaign*: How do you look at compliance in EPSDT?

*Jacey Cooper, DHCS*: EPSDT is deemed in compliance by CMS based on the existing rules in the program. If you are in compliance with EPSDT, you are in compliance with parity.

*Sarah de Guia, CA Pan-Ethnic Health Network*: While you may not be able to share the full report, DMHC is sharing high level findings and it would be great if you can share high level findings also. Are there ways you can streamline processes across the delivery systems?

*Jacey Cooper, DHCS*: Yes, we can share high level findings. Yes, this is an opportunity to standardize across delivery systems and align policies.

*Sarah de Guia, CA Pan-Ethnic Health Network*: You said plans will have the opportunity for comment on the All Plan Letters?

*Jacey Cooper, DHCS*: Yes

*Anthony Wright, Health Access California*: Can you walk through what has been the interaction with DMHC and let us know the timetable for high level findings?

*Jacey Cooper, DHCS*: We reached out to understand DMHC's approach and we learned from their process. However, one difference is that they were looking within one plan at a time; we are looking across multiple delivery systems and plans. We will have high level findings in the Fall.

*Kim Lewis, National Health Law Program*: Can you clarify that it doesn't apply to MH plans? You also said they need to comply with access and other standards, including time and distance?

*Karen Baylor, DHCS*: This does apply to MH plans. It also applies to counties that opt into the Drug Medi-Cal system.

*Jacey Cooper, DHCS*: Once you are in managed care, parity applies even if you receive a service through FFS.

*Kim Lewis, National Health Law Program*: What tools you are using for assessment? Can we see the tools?

*Jacey Cooper, DHCS*: We looked at CMS and DMHC surveys and we tailored them. We will get back to you about providing copies of the survey tools.

*Sarah de Guia, CA Pan-Ethnic Health Network*: Can you talk more about the plan for ongoing monitoring?

*Jacey Cooper, DHCS*: We are required to address this in the compliance plan.

*Sarah de Guia, CA Pan-Ethnic Health Network*: We would be interested in hearing more on this and providing feedback here.

**Public Comment**

There was no public comment.

**Next Steps and Next Meetings 2017**

July 19, 2017
October 19, 2017