

**DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
May 23, 2019**

MEETING SUMMARY

Members Attending: Maya Altman, Health Plan of San Mateo; Michelle Cabrera, County Behavioral Health Directors Association; Paul Curtis, CA Council of Community Behavioral Health Agencies; Michelle Gibbons, County Health Executives Association of CA; Kristen Golden Testa, The Children's Partnership/100% Campaign; Carrie Gordon, CA Dental Association; Barsam Kasravi, Anthem Blue Cross; Sherreta Lane, District Hospital Leadership Forum; Anna Leach-Proffer, Disability Rights CA; Kim Lewis, National Health Law Program; Marty Lynch, LifeLong Medical Care and California Primary Care Association; Farrah McDaid Ting, California State Association of Counties; Erica Murray, CA Association of Public Hospitals and Health Systems; Chris Perrone, California HealthCare Foundation; Kiran Savage-Sangwan, CA Pan-Ethnic Health Network; Linda Nguy, Western Center on Law and Poverty; Gary Passmore, CA Congress of Seniors; Jessica Rubenstein, CA Medical Association; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers; Bill Walker, MD, Contra Costa Health Services; Stephanie Welch, Department of Corrections and Rehabilitation; Anthony Wright, Health Access CA.

Members Attending by Phone: Lisa Davies, Chapa-De Indian Health Program; Anne Donnelly, SF AIDs Foundation ; Michael Humphrey, Sonoma County IHSS Public Authority; Anne McLeod, California Hospital Association.

Members Not Attending: Bill Barcelona, America's Physician Groups; Richard Chinnock, MD, Children's Specialty Care Coalition; Brad Gilbert, MD, Inland Empire Health Plan; Brenda Premo, Western University of Health Sciences; Cathy Senderling, County Welfare Directors Association; Jonathan Sherin, LA Department of Mental Health.

DHCS Attending: Jennifer Kent, Mari Cantwell, Sarah Brooks, Jacey Cooper, Karen Mark, Norman Williams, Morgan Clair, Erika Sperbeck.

Public in Attendance: 31 members of the public attended in person and 105 by phone.

Welcome and Introductions

Follow-Up Items from Previous Meetings

Jennifer Kent, DHCS

Director Kent welcomed SAC members and introduced Erika Sperbeck, Chief Deputy for Policy and Program Support, who joined DHCS about two years ago.

Update on Governor's May Revision

Jennifer Kent and Mari Cantwell, DHCS

Director Kent offered a recap of the notable items for DHCS in the May budget revisions and flagged additions. Some items are on the agenda and will be discussed. Budget additions:

- Addition of a warm line for mental health services.
- \$20 million expansion of Whole Person Care (WPC) funding to non-WPC pilots (in addition to previous \$100 million augmentation in January budget proposal).
- Proposition 56 augmentations including: restoration of optometry services, provider trauma screening technical assistance, additional value-based payments, additional loan repayment funding.
- Trauma and developmental screening implementation is delayed to January 2020 to reflect actual implementation.
- Prop. 64 funding of \$119 million to DHCS. There will be interagency agreements to CDPH (\$12 million surveillance and outreach), Education (\$80.5 million), Natural Resources (\$5.3 million). DHCS will use \$21.5 million for prevention and early intervention programs for youth. This funding will be ongoing annually.
- Coverage expansion of undocumented through age 25 is delayed to January 2020 to reflect actual implementation.
- DHCS estimated savings of \$393 million from the proposal to carve pharmacy out of managed care and return to fee for service for all pharmacy starting in 2021.

Questions and Comments:

Linda Nguy, Western Center on Law and Poverty: On the Managed Care Organization (MCO) tax, what is the rationale for not moving this forward?

Jennifer Kent, DHCS: The tax is complex to effectuate and has not moved forward, given a new administration and having many priorities moving. This is not permanently closed off, but it is not part of the budget proposal.

Chris Perrone, California HealthCare Foundation: The estimated impact of the coverage expansion was reduced. Do the reductions reflect a chilling effect of immigration?

Mari Cantwell, DHCS: No, these are updated numbers, but the take-up and other assumptions remain the same.

Anthony Wright, Health Access CA: On the expanded coverage for young adults, the Governor mentioned IT issues in the message on the delay. What is this? Will it go longer than January 2020?

Jennifer Kent, DHCS: This is primarily about the timeline for programming the eligibility and enrollment systems. They aren't any IT problems per se – it is the build-out. There is also extensive work to do with counties to re-tool the process and implement the transition.

Anthony Wright, Health Access CA: On benefits, what work needs to be done on optical benefit?

Mari Cantwell, DHCS: We are working on a State Plan Amendment (SPA) for this. From a system perspective, this will be straightforward since we have this in place for children and it is fee-for-service (FFS). Plans currently provide the exam; this is a benefit for the glasses.

Anthony Wright, Health Access CA: On prescription drugs, is there a timeline on the carve-out and the roll-out of this change?

Jennifer Kent, DHCS: There is no information to share at this time. We are working on implementation plans and released the detailed fiscal savings for the carve-out.

Linda Nguy, Western Center on Law and Poverty: We are pleased about the eye-glasses services. For this benefit, will this cease as a benefit after two years without a new SPA?

Mari Cantwell, DHCS: Yes.

Linda Nguy, Western Center on Law and Poverty: On young adults, we are hearing challenges on public charge and there may be something released soon. We appreciate the effort on the All County Welfare Directors Letter and note it may need to be updated. On managed care sanctions, I haven't seen anything out yet.

Mari Cantwell, DHCS: We have authority in oversight of physical managed care, county mental health, organized drug and other drug delivery systems and want to improve the consistency in the way we oversee plans and how this is handled.

Linda Nguy, Western Center on Law and Poverty: On sanctions, we are working on legislation. Is this about aligning with federal authority or is it about sanction amounts or something else?

Sarah Brooks, DHCS: It is not about aligning with federal authority, it is about increasing the sanction amounts and related to the other issues mentioned such as consistency.

Linda Nguy, Western Center on Law and Poverty: Is there a stakeholder process planned for the carve-out? Considering that transitions can cause unintended consequences to access to care issues, we would appreciate a stakeholder process.

Jennifer Kent, DHCS: When we have a clearer timeframe and more information, we will offer updates as we move forward.

Barsam Kasravi, Anthem Blue Cross: How can plans help collaborate with DHCS Prop. 56 options, all the coding, and the trauma supplemental screening training?

Jennifer Kent, DHCS: There will be an All Plan Letter (APL) with information on supplemental payments and the codes for screening. The provider training and technical assistance is different, and we will co-lead the roll-out of that with the Surgeon General.

Michelle Cabrera, County Behavioral Health Directors Association: On the pharmacy benefit carve-out, there is currently a limit of six drugs in FFS Medi-Cal. This will be an issue for beneficiaries who take many prescriptions, such as those with mental illness. Has there been conversation about special populations who may require approval for more than six?

Jennifer Kent, DHCS: Yes, we are aware of the issue and it is part of the conversation internally.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: As part of the pharmacy benefit transition, there is concern about elimination of the 340B program. The California Primary Care Association (CPCA) estimates a \$350 million loss of revenue to health centers that is used for case management, homeless programs, pharmacy work and other services. What are your thoughts about backfill; about how to avoid unintended consequences?

Jennifer Kent, DHCS: Consistent with what we have said, we want to see actual data from clinics and hospitals. We only have an extrapolation two-pager from CPCA based on data from 20 clinics. Once safety net providers can provide facility by facility data on expenditures and revenue, we are ready to sit down to discuss unintended consequences.

Mari Cantwell, DHCS: In addition, the \$393 million savings estimated in the budget does not include 340B information – savings from 340B would be in addition. There is not a solution that is “keep it the same way”. We need specific proposals about how the money would be spent that would otherwise be saved. Based on federal rules, in FFS we can’t allow billing to occur above acquisition cost. So, it is both the data Jennifer mentioned and proposals for how it would be spent. We assume proposals for how the money would be spent would be based on how it is currently spent so as soon as we get that information, we can sit down.

Carrie Gordon, CA Dental Association: We were disappointed to see the sunset of Prop. 56 rates for dental in 2021. Do you see the SPA extending to the 2021 dates? Also, we were excited to see the response to the loan repayments and want to give assurances that program will be there. Finally, we are wary about the Dental Transformation Initiative (DTI) going away and all the work with children’s care being lost.

Jennifer Kent, DHCS: The timeline is a discussion between the Administration and Legislature. The Administration said it planned a year by year approach. We will talk more about DTI in the waiver renewal.

Kristen Golden Testa, The Children's Partnership/100% Campaign: On the value based purchasing \$70 million for mental health integration, is that similar to the January proposal that excludes children? Will there be an additional comment period?

Mari Cantwell, DHCS: There are certain measures that apply to those over age 12 and some of the measures for BH do have age limits but those are not the only measures. We had comments already and will release that policy soon. Not all components of the behavioral health integration are driven by that metric. We will have this out as a final proposal in the next several weeks.

Kristen Golden Testa, The Children's Partnership/100% Campaign: As a follow up, I would like to see a portion of that directed to children.

Behavioral Health Reorganization and Behavioral Health Stakeholder Advisory Committee (BH-SAC)

Jennifer Kent, DHCS

Slides available:

https://www.dhcs.ca.gov/services/Documents/MHSUDSReorg_SAC_052319.pdf

Director Kent offered an introduction to organizational changes in DHCS, primarily related to a behavioral health (BH) reorganization. Going back to 2013, DHCS absorbed new programs, including Department of Mental Health and Alcohol and Drug Programs. Those divisions were shifted into DHCS without much change and have maintained staff and functions that operate independently within DHCS. For example, Mental Health has staff working on setting rates and provider enrollment that is not integrated with the staff doing the same functions for physical health. DHCS is reorganizing overlapping functions to become more consistent and efficient across all operations. Also, this is in service of integration and alignment between physical health and BH. There are many BH components - both Medi-Cal and non-Medi-Cal (e.g. Mental Health Services Act and Proposition 64). There have been months of internal conversation and review to identify the best way to organize staff and functions. On July 1, there will be consolidation of divisions as depicted in the slides presented. This will increase communication and alignment.

Questions and Comments

Chris Perrone, California HealthCare Foundation: Is there a Quality and Monitoring staff equivalent on the BH side (like Nathan Nau's position on physical health side)?

Jennifer Kent, DHCS: There are staff in the Medi-Cal BH Division (MCBHD) to oversee program policy and quality assessment reporting to Mari Cantwell.

Kim Lewis, National Health Law Program: I commend DHCS for the integrated approach. There are substantive BH content and it is important those are not lost in the transition and integration. There are areas of braiding funds and match that require expertise and coordination to ensure that rights and benefits remain consistent.

Linda Nguy, Western Center on Law and Poverty: Given the goal of better alignment, was there consideration for placing this under Health Care Delivery to allow for better care coordination?

Mari Cantwell, DHCS: Yes, that was discussed. The divisions under Sarah Brooks are massive and it was too much to put this workload there. There will be shared expertise and coordination on monitoring and oversight.

Linda Nguy, Western Center on Law and Poverty: Can you speak to new section chiefs and divisions?

Jennifer Kent, DHCS: There is one new section chief. We will open Career Exempt Appointments (CEA) for all of the new or reconstituted divisions.

Mari Cantwell, DHCS: People moved to similar positions and there was no loss of jobs. The staffing generally remains stable although we are recruiting for the 4 CEAs.

Michelle Cabrera, County Behavioral Health Directors Association: There are no changes to managed care BH or pharmacy? Where will cross-sector work happen?

Jennifer Kent, DHCS: The only changes are called out on slides. The Deputy Director of BH is a member of the senior leadership team, alongside all the 13 people and deputies and sits at the leadership table for the purpose of cross-sector discussion.

Kristen Golden Testa, The Children's Partnership/100% Campaign: How does the slide with a list of programs and projects relate to the organization chart? Where does the pediatric focus in BH show up?

Mari Cantwell, DHCS: The list we displayed is only at the level of branches under each division.

Jennifer Kent, DHCS: Also, we have renamed the work around Katie A but there is a branch in MCBHD with intensive specialty mental health, especially children in foster care. There is no separate section or division; it is interwoven.

Anthony Wright, Health Access CA: What are the dotted lines to the Behavioral Health Planning Council?

Jennifer Kent, DHCS: They are federally required to be a separate entity and are advisory to DHCS, but not a division in the same way others are.

Kim Lewis, National Health Law Program: We have struggled sometimes with confusion over disparate guidance and a lack of consistency in communication between BH and physical health. I hope that there will be single guidance letters or notices so there is less confusion going forward.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: Change always brings concern but this is an opportunity to elevate the BH fields as well as have better coordination. The history is that BH, MH and SUDS have taken a back seat, so I appreciate this change.

Director Kent continued on reorganization. Part of the work around reorganization surfaced a realization that we have multiple advisory and specialized meetings on BH. We have terminated several smaller, issue specific work groups and are proposing a new BH-SAC group. The BH-SAC meeting will be held on the same day as the SAC. For July, SAC will be held in the morning and the BH-SAC will meet in the afternoon. Going forward, they will meet on the same day and alternate morning and afternoon. We welcome everyone to stay for both. We want a similar body to this with a standing composition that we can draw on. This is timely with discussion beginning on a waiver renewal. This means the agenda for this meeting will be shortened. There will be some overlap of members between the groups.

Questions and Comments

Kristen Golden Testa, The Children's Partnership/100% Campaign: TCP requests there be a subgroup on pediatric BH, not just representatives from children's groups.

Michelle Cabrera, County Behavioral Health Directors Association: The Youth Advisory Group (YAG) is called out on the organization chart, but I thought it was folded into the BH-SAC. How large will the BH-SAC group be? How are you conceptualizing merging the types of voices?

Jennifer Kent, DHCS: BH-SAC will be a similar size. We are collapsing the YAG into the BH-SAC. BH-SAC is not the only meeting we will have about BH issues. It will elevate and offer a forum for broad topics. Issues from the YAG are meaningful for a larger discussion and touch on other aspects of the policy discussion. What we found is that the same people in the YAG were meeting in multiple groups on similar issues. Also, the reason for public comment is to have people offer input on a specific topic.

Chris Perrone, California HealthCare Foundation: What is relationship between the BH-SAC and the BH Planning Council?

Jennifer Kent, DHCS: They have applied to be on BH-SAC. Their work and discussions are more externally focused; and not as internal to DHCS. There is more representation of families and those with mental illness. We will likely incorporate a member from the BH Planning Council in the BH-SAC.

Kim Lewis, National Health Law Program: This is an important separate group to have. I don't understand how the intersection with MHSA and other groups will happen?

Jennifer Kent, DHCS: Some of MHSA work has its own process and discussion because it is a locally driven process of funding. We have tried to ensure that BH policy broadly described will be led by the BH Deputy Director and the BH-SAC will be broadly about policy – not a funding stream focus.

Bill Walker, MD, Contra Costa Health Services: Are you envisioning changes at the local level for local audits or combining audits?

Jennifer Kent, DHCS: Some audits are required and used for cost reconciliation for specialty MH because of how they are financed and claimed; others are program related on the MHSA side. That may be a topic for waiver renewal. We try to consolidate and run joint audits with Department of Managed Health Care, but we haven't gotten there on MH side.

Mari Cantwell, DHCS: And, depending on the county, the ability to combine is a question. Contra Costa is more integrated than other places. Those divisions are moving under the same leadership. We can take that back to discuss how we go forward.

Anthony Wright, Health Access CA: The history of this advisory group was the Medi-Cal waiver and over time, it has become broadly about DHCS and Medi-Cal. Will the BH-SAC have a similar broad purview? For initial meetings, what are the topics you envision?

Jennifer Kent, DHCS: Similar to this, the agenda items for BH SAC will be informed by members. Other groups organize themselves differently related to agenda. For example, the Medi-Cal Children's Health Advisory Panel wanted deep dives on specific parts of the department. There were topics that were new to them since they came from the Managed Risk Medical Insurance Board. We will let the BH-SAC weigh in on how they want to organize themselves. I assume the waiver will be a strong topic and there are other pressing issues in the BH area.

Michelle Gibbons, County Health Executives Association of CA: Having a bird's eye view through SAC has been helpful and I hope that there will be feedback or overlap in agendas.

Jennifer Kent, DHCS: That is why they are on the same day.

1115 Waiver and 1915(b) Waiver Renewals Update

Jennifer Kent and Mari Cantwell, DHCS

Mari Cantwell offered a review of information related to waiver renewals. Both the Medi-Cal 2020 1115 Waiver and the 1915(b) [Specialty Mental Health Services Waiver](#) are expiring in 2020. In order to go forward with a more integrated approach between physical and behavioral health, DHCS will request alignment of the end dates of both waivers to December 2020, through a six-month extension of the 1915(b) waiver. Discussion has begun about what authorities (e.g. waivers, State Plan Amendments) are available and

best suited to accomplish the programmatic goals. The Care Coordination Group and DHCS have done preparatory work. This work is led by Jacey Cooper internally and involves the Governor's Office and the Secretary of HHS. The target for engaging SAC is likely October for discussion of an overall roadmap followed by 6-9 months of stakeholder engagement through small work groups, with a proposal to CMS by July 2020. The Global Payment Program and PRIME (Public Hospital Redesign and Incentives in Medi-Cal) in the 1115 waiver are on a fiscal year basis and we will need to address that timeline and gap with both CMS and hospital colleagues. We are thinking big: how do we want the Medi-Cal program to be structured if we were creating it today? We are excited to move ahead consistent with the thinking from the Governor and Dr. Ghaly of a vision of addressing social determinants and social needs, such as housing.

Questions and Comments

Kristen Golden Testa, The Children's Partnership/100% Campaign: Do you imagine linking up the 1915(b) and 1115 waivers?

Mari Cantwell, DHCS: Yes, from an overall structure and timing perspective. We will work on them simultaneously. Although these are separate funding streams and currently separate delivery systems, we want consistent value-based arrangements, alignment and better coordination for long term services, mental health, substance use and oral health as well as physical health. How do we coordinate these systems better? Beneficiaries struggle with five different delivery systems and multiple care coordinators to get the services they need. How do we create a continuum to meet needs and integrate care coordination? They may have different funding streams and authorities, but we need to link them together better.

Maya Altman, Health Plan of San Mateo: I'm glad you are including long term services and supports (LTSS). Even though the timeline for the Cal MediConnect is beyond this, it is important to consider it along with the work you are doing on the waiver.

Mari Cantwell, DHCS: Absolutely. How we look at the full spectrum long term services is one of the things we want to consider. We want a comprehensive overhaul of Medi-Cal services; who needs what; how do they get those services.

Paul Curtis, CA Council of Community Behavioral Health Agencies: With respect to upcoming waiver, are you looking at stakeholder engagement at a regional level as well as the higher level at SAC?

Mari Cantwell, DHCS: We are still developing stakeholder engagement ideas. There will be both high level and detailed workgroups. Although we have not done regional meetings, we will take that back. Also, our funding partners will weigh in about what stakeholder engagement opportunities are available.

Jennifer Kent, DHCS: We are acutely aware of the financing. CMS has indicated interest in waivers such as the Institutions for Mental Diseases (IMD) exclusion. It has to pencil out

with budget neutrality, but we have heard strongly from counties and others they want us to do this. Stakeholder topics will break out more detail around ideas we are pursuing.

Carrie Gordon, CA Dental Association: I want to voice concern about the carry-over of the DTI. There is a unique opportunity for dental to be included in integrated approaches of the waiver, such as the work we are doing with Health Plan of San Mateo. There is discussion federally and we want California to be a leader in dental.

Mari Cantwell, DHCS: Part of what is on the agenda is how we take the lessons of DTI and integrate components into the larger delivery program, rather than operating separately or in certain regions. How do we look at continuity of care, caries risk management and look at ways to spread these across the state?

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Where does Community-Based Adult Services (CBAS) and Adult Day Health fit as you go forward?

Mari Cantwell, DHCS: There are some items for which we must have a waiver, such as CBAS. Other programs currently in the waiver are a pass-through and we may use a different authority going forward. We won't have an overarching 1115 waiver for the whole program but we will look at waivers where they are needed.

Anthony Wright, Health Access CA: A year ago, the tone about what was possible sounded different to me. It would be useful to hear your broad ideas and theory about what you can do, so we can be thinking along the same lines. What are the guardrails? What is doable?

Mari Cantwell, DHCS: We are not talking about the money going away and we are not talking about the kind of large waiver we have had in the past. We are looking at what we are currently doing; what authorities we can use to continue; where are there authorities with flexibility? How do we integrate WPC into payment mechanisms? How do we think of it system wide – not as separate programs? Most things are possible under different authorities if we have the funding for it. The funding issue is critical because some ideas have not advanced in an 1115 context because we didn't have funding. State Plans and 1915(b) have broad flexibility. We have nonfederal share concepts to work through and how those impact our funding partners – not just federal approval.

Chris Perrone, California HealthCare Foundation: Given that many of these programs in the future will run through managed care and that procurement will be released next year, how does that timing relate to the submission and approval of the waiver? It seems that some of what would go into procurement would mirror the waiver.

Mari Cantwell, DHCS: Yes, that is part of the internal conversation. Procurement needs to reflect what we are doing in the waiver. We are committed to the timeline published on procurement. In some cases, we will need to make changes prior to procurement through contracting as well as other changes that will happen as part of the waiver.

Chris Perrone, California HealthCare Foundation: The FQHCs are shining stars on social determinants of health and they are handcuffed under the current payment methodology. Do you see payment reform as a lever in achieving integration and social determinants of health?

Mari Cantwell, DHCS: The fundamental issue remains; the willingness to move beyond the prospective payment system (PPS) as being the structure of financing. We want integration but will there be a change in PPS?

Jennifer Kent, DHCS: Just to be clear, DHCS is not proposing a change.

Sherreta Lane, District Hospital Leadership Forum: The District Hospitals have learned a lot and are eager to make changes based on our lessons from current waiver.

Bill Walker, MD, Contra Costa Health Services: I am reassured to hear about money not going away. The IMD exclusion could be done separate from the waiver.

Mari Cantwell, DHCS: We intend for that to be part of waiver renewal discussion, not a separate waiver.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Will DHCS roll out a proposal followed by the stakeholder process? Are the ideas for the waiver those that were developed by the Care Coordination group?

Mari Cantwell, DHCS: It will be similar to 2014. DHCS will bring forward general ideas and use the Fall-Spring stakeholder process to develop the specific details. Yes, we hope to build from the concepts from the Care Coordination group – but not limited to those ideas.

Michelle Cabrera, County Behavioral Health Directors Association: I am hearing there will be one process for all authorities or waivers that move forward. We have 1915 for waiving rules and the 1115 for financing. Since we are financing the system via the 1115 waiver, is it your opinion we can remain at the net-same financing overall?

Mari Cantwell, DHCS: This is our third state-level 1115 waiver (since 2005) and there was no waiver prior to that at the state level. First, what do we want to do; what is best pathway for federal approval to do that? We used different mechanisms prior and may use them going forward. We can use the 1915 waiver for financing as long as match is available and there is no specific limit.

Kim Lewis, National Health Law Program: There are very specific rules associated with each type of waiver. Are you thinking a 5-year timeline?

Mari Cantwell, DHCS: Yes, in general.

Erica Murray, CA Association of Public Hospitals and Health Systems: We have appreciated the DHCS spirit of problem solving. CAPH is hopeful and nervous because the stakes are high. The expiration of PRIME, GPP, and WPC are huge. There are looming Disproportionate Share Hospital (DSH) program cuts set to take effect in October. And add to this, that the waiver is masking a structural financing challenge of a lack of general fund that is causing growing shortfalls. We are looking at a \$3 billion shortfall. It is essential that we get the GPP renewed, continue WPC and prevent DSH cuts from taking effect. And it is important we continue the changes in public health systems. Over the course of multiple waivers, there has been significant change in the paradigm of care in public safety net and there is more to do.

Update on DHCS Care Coordination Initiative

Jacey Cooper, DHCS

Slides:

https://www.dhcs.ca.gov/services/Documents/Care%20Coordination_SAC_052319.pdf

This presentation is to refresh the Care Coordination Initiative we have talked about in previous meetings. Last year, DHCS engaged across the state in a deep assessment, site visits and key informant interviews as well as discussion with the Care Coordination Advisory Committee. We used a set of Guiding Principles as we developed ideas for discussion, with value and consumer experience at the center. We took a wide variety of ideas to Care Coordination in three main buckets:

- Reduce Variation and Complexity across the System
- Identifying and Managing Member Risk and Need through Population Health Management Strategies
- Improve Quality Outcomes and Drive System Transformation through Value Based Payments, Incentives and Shared Savings

Next steps for the process:

- Internally vetting policy recommendations
- Stakeholder Engagement starting in fall 2019
- 1115 and 1915b Waiver Planning
- Contract language
- Roadmap for multi-year changes

Questions and Comments

Michelle Cabrera, County Behavioral Health Directors Association: Our members will be excited to see payment reforms and integration included. When we talk about integration, it means different things. It's different at plan level, state level and delivery level. Delivery system integration will require a whole level of support separate from the other integration efforts. It will be important to ground the group going forward as to what is waivable, what flexibility is available, which federal rules are rigid.

Maya Altman, Health Plan of San Mateo: What other states did you speak to?

Jacey Cooper, DHCS: There have been many states: WA, OR, AZ, TN, NM and NC come to mind. There has been a lot of outreach on various questions.

Kim Lewis, National Health Law Program: One challenge that I hope will be part of the conversation is the need for better data. Other states have done a good job of showing impact because they invested in data and did a good job of telling the story.

Jacey Cooper, DHCS: We agree. We are focused on getting better data; encounter, MH/SUD data, quality performance – data is a big part the roadmap to make good decisions.

Barsam Kasravi, Anthem Blue Cross: There is a bullet on annual member open enrollment. Is value payments at the plan or provider level?

Jacey Cooper, DHCS: Yes, we talked about annual enrollment with the Care Coordination Advisory committee. The department is considering value payments are at all levels.

Anne Donnelly, SF AIDs Foundation: On annual member open enrollment, does that mean beneficiaries can't change at will? We would have concerns about some populations under that policy we would want to make you aware of.

Mari Cantwell, DHCS: We haven't landed on any particular proposals, but it was discussed at the Care Coordination Advisory meeting.

Anne Donnelly, SF AIDs Foundation: We would have concerns and input on that topic. There are vulnerable populations that have difficulty finding an appropriate provider, such as transgender and HIV + populations. Perhaps for follow up, we would like to discuss the care management and coverage navigation system through CDPH for those with HIV through Ryan White. We know there are better outcomes with this system, and we would want to talk about integrating those further.

Kristen Golden Testa, The Children's Partnership/100% Campaign: What was the mandatory vs FFS, was that discussion including CCS?

Jacey Cooper, DHCS: That had to do with the listing of aid codes that are voluntary, excluded or mandated managed care. We didn't discuss CCS with Care Coordination because we have just rolled out the Whole Child Model and we will want to evaluate the success of that.

Update on DHCS Access Assessment Required under 1115 Waiver ***Sarah Brooks, DHCS***

The Special Terms and Conditions require an External Quality Review Organization (EQRO) assessment of primary, core specialty and facility access. Also, we are required to have an Access Committee. We submitted the Access Assessment to CMS in August

2017 and CMS approved it more than a year later. We received the EQRO Assessment draft recently. It will go to the Committee early next month. It will be updated and posted for external review and a 30 day comment period, then submitted to CMS after 90 days. Given it is an independent review, comments may not change the content. The approved plan is posted on the website.

Proposition 56 Payments

Mari Cantwell, DHCS

Mari Cantwell offered information on Prop. 56 budget items. DHCS will be continuing existing Prop. 56 programs including physician, dental, HIV, home health and Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) in the same manner as 2018-19. There are four additional Prop. 56 benefits for this year: 1) optical restoration of eyeglasses and other aids (paid FFS), 2) \$70 million for value based payments on behavioral health integration, 3) three years, \$60 million, for provider training for trauma screening, and 4) \$120 million for loan repayment (\$100M for physicians and \$20 million for dentists).

Trauma screening is important to identify and offer services prior to poor health outcomes. Given that child trauma screening tools include sensitive information, it is important that providers and their staff understand how to deliver the screening and that beneficiaries and their families understand why the screening is happening. DHCS is working with the Surgeon General and Agency on a plan to roll this out. Payments won't begin until January to allow time to implement training. Providers will have to attest to taking training to get the increased payment for screening.

There were over 1,200 loan repayment requests totaling \$300 million. Approximately 1,000 applications for physicians and close to 300 applications for dentists. Review and prioritization of the applications is moving ahead, and we will make awards by June 30. The funding will be spent over five years in annual cohorts of recipients.

In other Prop. 56 programs, we are continuing to monitor impact through data submitted and are starting to see some impacts. It is still too early to report out specific data trends. By next year, we hope to have more complete data to inform decisions on Prop. 56.

Questions and Comments

Kristen Golden Testa, The Children's Partnership/100% Campaign: Is there trailer bill language for Prop. 56?

Mari Cantwell, DHCS: This is in the budget bill; there is trailer bill language only for value based payments.

Jennifer Kent, DHCS: The money is appropriated through budget language and we have latitude over implementation and methodology for payments.

Barsam Kasravi, Anthem Blue Cross: On Prop. 56 provider education, I think there is a need for additional communication to let providers know the funding is available, going through provider organizations or other methods.

Mari Cantwell, DHCS: We generally notify through provider notices but would appreciate hearing any ideas.

Linda Nguy, Western Center on Law and Poverty: What is the break-down of loan repayment applications by provider type?

Jennifer Kent, DHCS: We don't have that specific break-down with us. Also, some applicants are medical students or early residents. We are mindful of location in the state, taking more than 30 percent Medi-Cal, culture/language and specialty. Once we see the analysis, we will also need to include consideration of where the applicant falls in the 5 year timeline and how that balances. If they are in the 5th year, this will be the only year they are eligible. In general, we are agnostic as to specialty, with a very few exceptions such as child psychiatrists. We do have some data on specific regions where there are shortages of other specialties, so we have to be mindful of the nuance.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Those are big numbers of applications. How many can you fund?

Jennifer Kent, DHCS: Originally, we could fund 125 providers per year based on applicants having maximum debt (\$300,000). The budget has increased, and the average debt of applicants is lower. The original budget was \$190 million for physicians and \$30 million for dentists. The May revision increase provides an additional \$100 million for physicians and \$20 million for dental.

Jessica Rubenstein, CA Medical Association: Do you have an update on when the APL on Prop. 56 will be released? There was a draft a month ago.

Mari Cantwell, DHCS: We will follow up to get that.

Jessica Rubenstein, CA Medical Association: In terms of impact on access to care, I want to reiterate the importance of getting a multi-year SPA. The delays in getting federal approval have impacted the ability to see improvement.

Kristen Golden Testa, The Children's Partnership/100% Campaign: In the loan repayment, are you targeting geography?

Jennifer Kent, DHCS: No, our decision point is increasing providers taking Medi-Cal.

Carrie Gordon, CA Dental Association: My understanding is that over the last 18 months, there has been an increase of 900 providers in Medi-Cal. This is the first net gain in providers in a decade. The momentum under Prop. 56 is working and the length of the SPA is important.

Jennifer Kent, DHCS: On dental, there are a few applicants who are applying for relocation to places with very few dentists to address access issues. This is a specific experiment related to dental we are trying to see if we can fill underserved areas.

Anthony Wright, Health Access CA: Can you say more about value based payments (VBP)?

Mari Cantwell, DHCS: The revised measures will be released in the next two weeks. There will be a July 1 effective date for the measurement period. We are working through payment mechanisms for how we will get this into managed care rates and then to providers. Payments will not be in place as of July 1, but the metrics will be finalized.

Sarah Brooks, DHCS: There will be a webinar for providers announced tomorrow to explain VBP.

Anthony Wright, Health Access CA: We have so many variables in payments now. Do we have a sense of how Medi-Cal payments compare to Medicare?

Mari Cantwell, DHCS: This is a difficult question because Medicare is FFS and Medi-Cal is managed care (both from the state to plans and plans to providers). We can look at FFS and the codes in Prop. 56 are up to or over Medicare. On the managed care, there is a supplemental payment, but it is not possible to judge the comparison.

Comprehensive Quality Strategy Update

Dr. Karen Mark, DHCS

Slides are available: https://www.dhcs.ca.gov/services/Documents/CQS_SAC_052319.pdf

Dr. Mark joined DHCS as Medical Director moving to DHCS from CDPH last summer. She provided an overview of the quality strategy. SAC previously offered input to the quality report released June 2018 that covers all managed care programs in compliance with the managed care rule. Also, DHCS has been preparing an annual quality report, last released March 2018, that covers FFS and managed care, and reports on the DHCS Strategic Plan commitments and aligns with national efforts, such as the National Quality Strategy. Having two different quality strategies is confusing and going forward, DHCS will merge the two approaches to cover both managed care and FFS delivery systems through a single DHCS Comprehensive Quality Strategy Report. Part of this effort has involved building DHCS department-wide infrastructure for quality, including:

- Office of the Medical Director
- DHCS Clinical QI Learning Collaborative (across the department)
- CMS Core Set Measure Workgroups (including coordination across behavioral and physical health)
- Program Quality Improvements Efforts
- External Stakeholder Engagement
- Workforce Development

- Monitoring and Reporting Data on QI: Data and Performance Dashboards

There are four goals for the strategy to produce an integrated report across all programs: 1) Improve Health Outcomes, 2) Improve Health Equity, 3) Address Social Determinants of Health and 4) Improve Data Quality and Reporting. Dr. Mark reviewed the individual sections of the report. The draft will be released in fall 2019 for stakeholder comment, and the final report in early 2020.

Questions and Comments

Barsam Kasravi, Anthem Blue Cross: I encourage DHCS to think about the provider in the stakeholder process. There is lots of pressure on providers related to coding and other reporting. There is also a tension between access and other expectations. I encourage DHCS to ask providers about how they see quality in Medi-Cal and what they would expect from health plans and DHCS on collaboration, education, tools or other support.

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: Will the disparities report still be separately produced?

Karen Mark, DHCS: Yes, that is put out by managed care and it will continue. There are many reports we will use to inform this comprehensive report. We will not repeat that work but will draw on it.

Chris Perrone, California HealthCare Foundation: Do you see adding measurable targets over time that will allow for retrospective reflection on progress in a quantitative way? Are there constraints on doing that?

Karen Mark, DHCS: It's a great question. It is quite difficult to determine how to set useful targets – at what level should we set them.

Jennifer Kent, DHCS: And, it depends on the part of the program we are talking about. In dental, we have definite targets. In some areas we will want to set specific metrics.

Kim Lewis, National Health Law Program: How do we pull together disparate programs with different measures under the overarching goals you outlined? The metrics are specific to individual elements of the program; how can we be clear about the overarching themes and the targets we are after. It is easy to get lost in the individual sections and not see the overall program.

Karen Mark, DHCS: It is a challenge. By defining goals across every program, all programs are working to improve health outcomes although the specifics of the outcomes will vary. And, yes, it is challenging to pull together the entire program.

Michelle Cabrera, County Behavioral Health Directors Association: I appreciate the call-out of the lack of standard quality and outcome measures for mental health and substance use disorders. The standard tools, like HEDIS, are only beginning to look at these

services. There is no entity overseeing provider quality and there are no commonly understood goals or metrics. There are people looking into whether providers are doing the right thing, but we need to bring lessons from medical side to this. Currently, these are largely process measures. We need to start from scratch and look at what will be valuable to measure and understand.

Carrie Gordon, CA Dental Association: There are also measures on the medical side for dental quality. For example, looking at referrals and the quality of oral exams. We need to get serious about dental quality on the medical side.

Anne Donnelly, SF AIDs Foundation: We support provider concerns about reporting burdens and appreciate this effort to look at quality. Do you envision a quality dashboard to report out at the plan level? What is the vision for that?

Sarah Brooks, DHCS: The intent is to significantly expand the existing quarterly managed care dashboard. In June, you will see encounter data and how plans are individually performing.

Karen Mark, DHCS: Many programs have a dashboard that are in different stages of being refined. Yes, this is an overall focus.

Anne Donnelly, SF AIDs Foundation: We don't have a good measure for Hepatitis C care that is approved. Will this be a living effort and can we add items at a later date?

Karen Mark, DHCS: Yes, it can evolve over time. Even CMS core measures are revised annually.

Anne Donnelly, SF AIDs Foundation: Do we have plan level data on HIV viral suppression?

Karen Mark, DHCS: Yes. I will follow up with you.

Strengthening Oversight for Managed Care Plans

Mari Cantwell and Sarah Brooks, DHCS

- **Children's Preventive Health**
- **Group Needs Assessment**

Slides available:

https://www.dhcs.ca.gov/services/Documents/ChildPreventiveHealth_SAC_052319.pdf

Mari Cantwell introduced this presentation and indicated that DHCS wants to improve and hold plans accountable for higher performance. This includes both increasing minimum performance levels and also setting real targets for performance that are not based on improvement over past reports.

Sarah Brooks reviewed slides beginning with the Governor's focus on children and request of all health plans:

1. Partnership and collaboration as California increases the commitment to early childhood development
2. Asked all California health plans to review their current networks, processes, outreach and metrics for pediatric screenings and services
3. Directed DHCS to review its data in regard to pediatric measures and identify areas that require improvement

Ms. Brooks reviewed current measures and how accountability will be measured going forward. There will be a managed care accountability set that incorporates all child and adult CMS core set measures. In the past, DHCS contracts required plans to perform at least as well as the lowest 25% of Medicaid plans in the US; going forward DHCS will require their performance to be at least at 50% of Medicaid plans. She presented the 19 measures with benchmarks that health plans will be held accountable to. DHCS will develop an alternative method for measures with no NCQA benchmark. In the future, DHCS will impose sanctions immediately if a plan is not meeting benchmarks. DHCS is planning to implement these changes in rate year 2020, for care that is delivered during 2019.

She discussed the Group Needs Assessment (GNA). This is currently done as a member survey by plans every five years to report how a plan will address member needs, such as culture and language. DHCS is evaluating the process and how it might be improved.

Issues include:

- 1) Frequency – more frequent than every five years
- 2) GNA Report and Annual Reports not well linked by data or objectives
- 3) Unclear what should be in Report; DHCS receives summary
- 4) There is no template/format required for the every-5-year GNA Report
- 5) Non-validated GNA Surveys; data have never been successfully aggregated
- 6) How to gather and use information in a meaningful way to impact identified member needs

In addition, going forward the EQRO plan-specific evaluation report will include the GNA and plans will be held accountable to the action plans in the GNA with sanctions imposed if a plan does not come into compliance.

She also discussed the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey. Changes going forward include doing CAHPS every two years. DHCS is evaluating the questions to be included, in particular incorporating standardized questions on health disparities. She also discussed the outreach campaign tied to children's services. DHCS will mail notices to beneficiaries about preventive services.

In addition, they will contract with a consultant who will conduct varying activities such as focus groups, developing the website and other outreach to gather beneficiary input. Finally, she listed various reports that are being implemented.

Questions and Comments

Linda Nguy, Western Center on Law and Poverty: Is DHCS planning to use only CMS core measures? Is there opportunity to add other measures?

Sarah Brooks, DHCS: We will use the CMS child and adult core set. There is not an opportunity to change them at the state level, but input to CMS can be provided so that measures can be changed at that level.

Linda Nguy, Western Center on Law and Poverty: It seems that the data would be continuous since some data is collected through encounter data. It should be available on a rolling basis.

Sarah Brooks, DHCS: It is a combination of encounter and other data reported to us annually.

Mari Cantwell, DHCS: These are annual measures and what is happening over the period of enrollment. There are other inputs than encounters, including EQRO chart information.

Linda Nguy, Western Center on Law and Poverty: On GNA frequency, what is annual update?

Sarah Brooks, DHCS: We will ask health plans to review and update the GNA through a quality improvement type process. What worked, what didn't.

Chris Perrone, California HealthCare Foundation: What is the thinking behind holding everyone to the same 50% standard? Not everyone can be above average; why hold San Joaquin to the same level as San Francisco? I thought I heard an interest in holding plans to an absolute benchmark.

Mari Cantwell, DHCS: Yes, we are setting absolute benchmarks for those measures where it is possible. Relative marks are problematic because you could be higher than everyone else and still at a poor level. The 50 percent standard is a national comparison, so we will use this, but we do see that moving to an absolute standard is a better method.

Sarah Brooks, DHCS: For example, you could be at 90% percentile but if the benchmark is 20%, then you are at 90% of a very low level (e.g. alcohol/drug screen is at 20%). This is why we are looking at alternatives that will be absolute. On the slides, it mentions measures where there are absolute benchmarks.

Chris Perrone, California HealthCare Foundation: So, you are holding plans accountable and setting absolute benchmarks?

Linda Nguy, Western Center on Law and Poverty: it's also important to continue to improve.

Maya Altman, Health Plan of San Mateo: It makes sense to go in this direction and it will be challenging for plans. I am most worried about providers, not plans. We have lots of small practices and it will be a huge lift for some of them, especially the additions of facility reviews, etc. I am concerned that we don't reduce access.

Barsam Kasravi, Anthem Blue Cross: As you look at improvement, think about how plans can collaborate to improve. As providers, it is tough to improve on all 40 metrics equally. Can we prioritize measures to focus on across the state?

Sarah Brooks, DHCS: What we have noted in audits is that where we did not have measures, there was no focus on those areas.

Kristen Golden Testa, The Children's Partnership/100% Campaign: When is all of the guidance and the measures going out?

Sarah Brooks, DHCS: The plans will have information next week on the final measures and there has been discussion already at the Medical Directors meeting and input along the way from stakeholders. We have the facility site review process out for review now.

Jennifer Kent, DHCS: We have announced what the measures will be. There is no comment period or input to the measure because they are established.

Sarah Brooks, DHCS: The process is set up and formalized. For those that are NCQA benchmarks, they are settled. For others we develop a methodology, we will have stakeholder input on those.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Is there discussion of incentives as well as sanctions?

Sarah Brooks, DHCS: We are focused on holding plans accountable to these measures for now.

Erica Murray, CA Association of Public Hospitals and Health Systems: This situation of the lack of national benchmarks is similar to early days in the PRIME program where we were trying to find measures. I think dialog with our clinical leaders could be useful.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Is there consideration for an upside, a bonus in addition to sanctions?

Mari Cantwell, DHCS: Not in the immediate timeframe but we are looking for ways to be innovative with payments in the future.

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: Can you speak to how you will use the information in the health disparities report in the GNA?

Sarah Brooks, DHCS: The intent is to provide data to the plans and they will use the disparities report to inform their GNA. They will prepare an action plan with milestones and need to demonstrate they are accomplishing the milestones or there will be sanctions.

Anthony Wright, Health Access CA: What is the action you will take? Will measures be different in COHS or two plan counties?

Sarah Brooks, DHCS: We have financial sanctions for all plans.

Anthony Wright, Health Access CA: With respect to the metrics, providers won't see 40 metrics since the measures are for children, OB and other populations.

Karen Mark, DHCS: There are some practices with all populations, but many providers will only have a limited set.

Kim Lewis, National Health Law Program: What is included in the preventive services report? Is this related to the outreach effort?

Sarah Brooks, DHCS: It is annual ongoing. We will work with plans to develop actions and monitor their progress on those milestones. It is not related to outreach at the moment, but we can work with the contractor for any regional needs.

Kristen Golden Testa, The Children's Partnership/100% Campaign: What is your thinking about how the utilization report can be used for underutilization as well as overutilization?

Maya Altman, Health Plan of San Mateo: We are all required to look at data for over- and under- utilization. When we cap providers, there is always a danger of underutilization

Kristen Golden Testa, The Children's Partnership/100% Campaign: On outreach, is there a stakeholder process for the outreach campaign, especially longer term?

Sarah Brooks, DHCS: We will share the letter or notice and call script for comment initially. For phase 2, there will be engagement as well.

Anne Donnelly, SF AIDs Foundation: On the prevention utilization report, how will the set of services for the measures be decided?

Sarah Brooks, DHCS: We will engage with stakeholders about this and are just beginning that work. There is more to come.

Michelle Gibbons, County Health Executives Association of CA: Do you overlay your data with overall issues trending, such as obesity or sexually transmitted diseases?

Karen Mark, DHCS: Yes, that goes to our overall quality strategy where we do look at the bigger picture.

Jennifer Kent, DHCS: There will be continuing updates and work on this area.

Public Comment

Deborah Kelch, Insure the Uninsured Project: We want to make you aware that ITUP regional workgroups for 2020 will take up care coordination and many of the issues you discussed today. There is a schedule in the back of the room. These are important meetings in local communities with a broad range of stakeholders. I want to let your members and their constituents know about these meetings and encourage them to attend. The process is to hold the open meetings, followed by an overall annual report, and culminating in a pre-conference half-day session in February that brings together all the input on the topic. Today was very helpful and we want to offer this as an additional opportunity for additive discussion.

Douglas Dunn: I am a Contra Costa Mental Health Commissioner and member of National Alliance of the Mentally Ill. Because of the crisis of exploding statewide Incompetent to Stand Trial (IST) cases and the related dearth of state hospital and LPS Conservatorship facility beds, Contra Costa's Behavioral Health Services (CCBHS), like many other county behavioral systems, is in real crisis. As one of the top 15 IST counties in the state, CCBHS has been paying between \$1,100-\$1,500 / day for over 180 days and counting for numerous patients for whom an IST or LPS Conservatorship bed is not available. Like many other counties, this situation is seriously affecting its service capability and behavioral health budget.

As required by this up to 30 day federal waiver, CCBHS has several current and proposed community based programs that would very nicely link to this waiver. Furthermore, CCBHS is willing to promptly send to DHCS these programs plans which would clearly demonstrate:

- Very innovative community based program linkages to returning IMD clients.
- Overall Medi-Cal "cost reimbursement" neutrality.
 1. Will DHCS leadership promptly accept these program proposals and quickly file for this up to 30 day limited IMD Waiver? It would really help our loved one and Contra Costa Behavioral Health Services (CCHBS).
 2. Is DHCS leadership really listening and ready to take prompt action to apply for this limited waiver which could begin to open many badly needed services doors for more consumers here in California?

If not, DHCS is leaving at least \$55 million up-front money "on the table" for the federal Health & Human Services (HHS) Dept. to use elsewhere.

Amanda McAllister-Wallner Director, CA LGBTQ Health and Human Services Network: We are excited to see the ways DHCS is streamlining BH services and excited to engage in the BH-SAC. We are also happy to see the quality updates and will watch the roll-out of these going forward.

Wendy Soe, California Association of Health Plans: Appreciate the focus on quality and we welcome the challenge to make improvements. Thanks to the SAC for comments and want to emphasize the case for an incremental approach with health plans, such as what has been useful in PRIME. We also want to request consideration of using the current year as a threshold year. There are some new measures to us, and we don't know where plans or providers stand. Additionally, for some measures, we don't know why the measure is at the current level. Whether there are quality issues or reporting issues. We could use this year to make that meaningful target investment.

Kym Flores, Senate Office of Research: With the expanded group of children's measures, are you getting data from anyone else beyond primary care?

Sarah Brooks, DHCS: For some measures, for example follow up on mental health hospitalization, we have information from Short-Doyle and encounter data and we can administratively report a rate. There are other measures of performance where the plan does not have data and is not accountable, such as dental.

Kym Flores, Senate Office of Research: On the HEDIS measures you have done so far, can you separate the quality issues? Have you discussed with plans what the issues are? Are individuals not coming in or are there other issues? Is that what you doing further analysis?

Sarah Brooks, DHCS: Yes, we will be doing additional analysis on those.

Leila Towry, Senior Director of Strategy and Business Development: We have a new office opening in Los Angeles and thank you for the opportunity to provide comment for the committee today. The Primary Care Development Corporation (PCDC) is a national nonprofit organization and a U.S. Treasury-certified community development financial institution dedicated to building equity and excellence in primary care. Our mission is to create healthier and more equitable communities by building, expanding, and strengthening primary care through capital investment, practice transformation, as well as policy and advocacy. We have leveraged close to \$200 million in affordable and flexible financing in low-income communities, increased capacity to add over 300,000 medical visits, and trained more than 2,000 health care providers to increase and improve the delivery of primary care and other vital health services.

PCDC would like to take this opportunity to highlight the 340B Medi-Cal Savings and implications of Executive Order (N-01-19) to this critical program. While PCDC shares in Governor Newsom's vision to transform the health care system and promote affordable and accessible health care for all, we are gravely concerned about the unintended implications of the executive order, which would eliminate critical 340B savings that enable health care providers who serve California's low-income communities to operate

and provide services for the most vulnerable. Chronic underinvestment – and the undervaluing – of primary care and other critical health services have forced primary care providers to depend on every dollar and means of cost savings to continue their essential programs. 340B discounts allow community health centers, critical access hospitals, and other safety net health providers to obtain life-saving medicine at a reduced cost and, according to the Health Resources and Services Administration (HRSA), enable safety net providers “to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.” Since Congress created the 340B Drug Pricing Program in 1992, safety net providers such as Ryan White HIV/AIDS-funded organizations have counted on 340B to reduce drug costs and help offset the high unreimbursed costs of delivering comprehensive care services to the medically underserved. Because 340B providers by definition see the most vulnerable populations, elimination of the program will jolt and diminish the overall health of these communities. Repercussions are also economic. We trust many members of the committee share in our concern and commitment to sustaining and increasing primary care and continuing the program as it is today.

Jean Shanley, Planned Parenthood Affiliates of California: Can you let us know the release date of new telehealth policy revisions?

Mari Cantwell, DHCS: It should be final in the next month, before the end of spring.

Next Steps and Final Comments

Jennifer Kent, DHCS

Thank you for your participation. Please send your comments or ideas for agendas for upcoming meetings. The SAC meeting will be in the morning and the BH-SAC will be in the afternoon. The dates for 2019 are:

- July 10, 2019
- October 29, 2019

The Stakeholder Advisory Committee agenda and meeting materials can be [viewed on the DHCS website](#).