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

# October 25, 2018
# 10 a.m. – 12 p.m.
# (conference call)

# MEETING SUMMARY

## Attendance

**Members Participating***:* Bill Barcellona, America's Physician Groups; Michelle Cabrera, SEIU; Paul Curtis, CA Council of Community Behavioral Health Agencies; Lisa Davies, Chapa-De Indian Health Program; Michelle Gibbons, County Health Executives Association of CA; Brad Gilbert, MD, Inland Empire Health Plan; Kristen Golden Testa, The Children's Partnership/100% Campaign; Carrie Gordon, CA Dental Association; 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; Anne McLeod, California Hospital Association; Farrah McDaid Ting, California State Association of Counties; Steve Melody, Anthem Blue Cross; Erica Murray, CA Association of Public Hospitals and Health Systems; Linda Nguy, Western Center on Law and Poverty; Gary Passmore, CA Congress of Seniors; Chris Perrone, California HealthCare Foundation; Jessica Rubenstein, CA Medical Association; Kiran Savage-Sangwan, CA Pan-Ethnic Health Network; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers; Jonathan Sherin, LA Department of Mental Health; Bill Walker, MD, Contra Costa Health Services; Anthony Wright, Health Access CA.

**Members Not Participating**: Maya Altman, Health Plan of San Mateo; Richard Chinnock, MD, Children's Specialty Care Coalition; 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; Stephanie Welch, Department of Corrections and Rehabilitation.

**DHCS Participating**: Jennifer Kent, Mari Cantwell, Sarah Brooks, Adam Weintraub, Lindy Harrington Jacey Cooper, Morgan Clair.

**Public Taking Part by Phone**: 114 members of the public attended by phone.

### Welcome and Introductions
***Jennifer Kent and Mari Cantwell, DHCS***

Director Kent welcomed the group and conducted introductions. She called attention to 2019 SAC meeting dates and invited members to provide input now to inform the agenda for future meetings.

Although this meeting is by conference call, future meetings will return to in-person meeting format.

Mari Cantwell reviewed the timing for potential 1115 waiver discussions. The Care Coordination Advisory Committee meeting is functioning as a forum for initial discussions. DHCS does not expect to advance a large new 1115 Medi-Cal waiver after 2020, given federal guidance on budget neutrality. Therefore, the waiver renewal is likely to be more limited to programs that are budget-neutral by design, such as the Drug Medi-Cal Organized Delivery System (DMC-ODS) and the Global Payment Program (GPP) for Disproportionate Share Hospitals (DSH). In addition to these specified programs, DHCS is examining how to continue other current waiver programs through other federal statutes and authorities. The Department anticipates that more significant waiver discussions will take place in 2019 after a new Administration has been established and transitioned into place.

**Questions and Comments**

*Marty Lynch, LifeLong Medical Care and California Primary Care Association*: Are there plans/thoughts about Whole Person Care (WPC) or other parts of the waiver you can mention that would go through other avenues?

*Mari Cantwell, DHCS*: Yes, other than DMC-ODS and GPP, our view is that all other waiver programs could continue via other mechanisms in some fashion. For example, WPC, Public Hospital Redesign and Incentives in Medi-Cal (PRIME) quality payments, and the Dental Transformation Initiative (DTI) may continue under other authorities. Once we see if they are successful, we would look at how to build them into the program through a SPA or other authority.

*Michelle Cabrera, SEIU*: What are the initial thoughts of how the GPP might need to be modified for a renewal?

*Mari Cantwell, DHCS*: The main change is that the size would be smaller and limited to DSH funding due to the budget neutrality requirements. The first evaluation report showed positive results and we hope the Centers for Medicare & Medicaid Services (CMS) will agree it should be continued.

*Carrie Gordon, CA Dental Association*: Do you think DTI will be continuous through a renewal? Will there be a gap or modifications?

*Mari Cantwell, DHCS*: I don’t know now. It will depend on the evaluation of impact and the fiscal situation in the state.

*Jennifer Kent, DHCS*: There will need to be a financing discussion because DTI would require backfilling from the General Fund (GF). The waiver programs currently are supported through other financing than GF for the non-federal share. We will need to identify funds for the non-federal share to continue them.

*Mari Cantwell, DHCS*: Not everything will require GF. We can use other sources of funding, but it will require different mechanisms to operate. It may need to run through health plans or other avenues. I am not clear it would mean less money in Medi-Cal, but we need to figure out how we would need to rely on non-GF and GF for the non-federal share. There are other ways we could draw down match that don't require an 1115 waiver.

*Marty Lynch, LifeLong Medical Care and California Primary Care Association*: There are other small programs like Community-Based Adult Services (CBAS)/Adult Day Health Care (ADHC) and Long-Term Supports and Services (LTSS) in the waiver. What are thoughts on continuing those?

*Mari Cantwell, DHCS*: Yes, I should have included CBAS as a program that can continue through the waiver because it is budget neutral. LTSS and Coordinated Care Initiative (CCI) could move to separate authorities.

*Kim Lewis, National Health Law Program*: On the process going forward, will you have a separate process or stakeholder input on all of the items that may not be included in waiver discussions?

*Mari Cantwell, DHCS*: Yes. The Care Coordination Advisory Committee has served as the place for discussion at the beginning of this process and although that committee is ending, there will be a separate process for stakeholder input and discussion that is developed. The timing and specific group is not yet developed but there will be a process.

*Michelle Cabrera, SEIU*: Can you explain budget neutrality?

*Mari Cantwell, DHCS*: Budget neutrality refers to programs that are treated as a pass-through in the waiver and are not dependent on savings. There are "with and without waiver" spending amounts. For programs that are budget neutral, the spend with or without waiver is the same. The "with waiver" is actual spending and the "without waiver" is what we would have spent. The "with waiver" savings fund the additional programs in the waiver.

*Erica Murray, CA Association of Public Hospitals and Health Systems*: I appreciate the initial discussions in the Care Coordination Advisory Committee that have happened and also want to express the extreme concern from public systems about their ability to continue to transform their systems to greater value without the waiver. The inability of public systems to draw down significant federal reimbursement has us worried.

*Mari Cantwell, DHCS*: I don't necessarily see a loss of federal funding. It is the mechanism that will change.

*Anthony Wright, Health Access CA:* I appreciate the optimism that we can continue to draw down the same funds. I am curious about the theory. For example, in WPC, is the idea that we are doing reimbursable services that will be matched?

*Mari Cantwell, DHCS*: When we think about waiver programs, like DTI, that are not budget neutral, these are reimbursable services allowable under a SPA without additional authority. It is similar for PRIME and can be done through managed care and directed payments. For WPC, it is possible to reimburse through in-lieu ability in managed care. I see a lot of potential to continue significant portions, if not all of what we are doing in waiver programs under different authority.

*Jennifer Kent, DHCS*: For all three waivers I have been part of, everyone begins with high level of concern. We think there is a path forward to continue all or most of what is included in the waiver through other mechanisms.

*Anne McLeod, California Hospital Association*: I support Erica's comments. Some of us have been through all three waivers with you and stand ready to support the process. There may be ways to expand some successful programs from the waiver to non-safety net hospitals across the state.

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

The response to the follow up items from the previous SAC meeting was distributed with the agenda, including additional information on the periodontal rates, the draft design for external quality review organization (EQRO) and clarification of the language about what is included in the Whole Child Model (WCM) notices to beneficiaries.

**Questions and Comments**

*Marty Lynch, LifeLong Medical Care and California Primary Care Association*: Two general questions. Does DHCS have plans for public charge comments and its impact on Medi-Cal? Also, what is the process for procurement?

*Mari Cantwell, DHCS*: The public charge issues go well beyond DHCS and we are working with Health and Human Services Agency and other partners on comments. There will be either a single set of combined comments or multiple input comments from different departments. We are concerned about the ability of beneficiaries to access services. The procurement timeline is published, and we are developing internal timelines to discuss later next year.

*Anthony Wright, Health Access CA*: On public charge, is the administration planning to comment program-by-program or administration-wide? Is there tracking of the negative impact from public charge on enrollment or utilization and could this be included in a future agenda?

*Mari Cantwell, DHCS*: The decision about how comments will be submitted sits with Agency and it is not clear yet how the response will be submitted.

*Kim Lewis, National Health Law Program*: We are working through the Health Consumer Alliance and with Covered CA on messages and scripted information for staff. So many people are afraid of the consequences of public charge and are getting disparate advice. We hope DHCS will participate. We need to ensure accurate information and equip ombudsmen to offer some basic information and refer consumers to advocacy organizations for follow up.

*Mari Cantwell, DHCS*: Yes, we are working on scripts and information we can provide so we can communicate accurately and refer to consumer organizations for additional help.

*Jennifer Kent, DHCS*: We are coordinating FAQs for county eligibility and social services staff. We are sensitive to the need to offer appropriate information without giving legal advice. We are also coordinating with other departments and entities across the state to respond to the regulations.

**Proposition 56 Payments and Loan Program Update**
***Jennifer Kent and Mari Cantwell, DHCS***

Mari Cantwell provided a review of Prop. 56 supplemental payment programs. Three supplemental payment programs continued in year two as they were in year one: Women's Health Services, HIV/AIDS waiver and Intermediate Care Facilities for Developmentally Disabled (ICF-DD). For one-time, non-federal match payments to Program of All-Inclusive Care for the Elderly (PACE) and CBAS, the payments have gone out. One-time pediatric subacute payments that are federally matched will go out in January, retroactive to July 2018. The programming for this was more difficult than we hoped, and payments have been delayed. Physician payments have been flowing prospectively since September and the retroactive payments for July - September will flow in November. The 2017-18 directed payments are approved and payments are going out. For FY18-19 directed payments, we are still waiting for CMS approval. Health plans will continue FY17-18 payments for now and we will go back to do retroactive payments when we receive approval for FY18-19. Some plans are doing FY18-19 payments as if approved to avoid retroactive reconciliation. Dental payments continue for items not requiring approval. In December, we will begin payments prospectively and in January, the retroactive payments for new codes should begin. The payments for home health and pediatric day health centers are approved and will begin in January, retroactive to July.

**Questions and Comments**

*Carrie Gordon, CA Dental Association*: Can you speak to the delay in dental payments? Provider feedback is that it is hard to plan with the uncertainty.

*Mari Cantwell, DHCS*: It is taking longer to do the programming with a new fiscal intermediary and get new rates in the system. This should be a one-time issue.

*Jennifer Kent, DHCS*: Unlike the physician codes, the dental fiscal intermediary has to change hundreds of codes and it is taking longer than expected.

*Carrie Gordon, CA Dental Association*: Are there specific accountabilities for a timeline with the fiscal intermediary? How long do they have to get the retroactive payments out?

*Mari Cantwell, DHCS*: I can have the team follow-up. I think it is the complexity, not a failure of the fiscal intermediary.

*Steve Melody, Anthem Blue Cross*: We are paying the FY18-19 rates. Any chance CMS will not approve?

*Mari Cantwell, DHCS*: It can never be 100 percent guaranteed but I am confident it will be approved. We anticipate paying these in April following their approval.

Director Kent reviewed the Proposition 56 loan repayment assistance program. There is $190 million for physicians and $30 million for dental to establish a targeted loan repayment program. DHCS is working with Physicians for a Healthy California to oversee the selection and administration of the program. They will open the application in Spring 2019 and have loan assistance flowing by 2020 for both types of loan repayment. There will be a maximum of 125 slots for physicians and 20 dentists, with each provider receiving up to $300,000 in loan repayment based on their actual loan amount. In exchange for the loan repayment assistance, the applicant must have completed residency within five years, be licensed and in good standing, not be receiving any other loan repayment assistance and have at least 30 percent current Medi-Cal beneficiary caseload that is maintained for five years. They must also have employment, or a job offer; be participating in Medi-Cal through fee-for-service (FFS), CCS, managed care and/or public and safety net systems. We are agnostic about where they graduated medical school or dental school (e.g. international), the type of practice, the type of specialty or California geography. We expect more applications than slots and will use additional criteria to choose finalists, such as fluency in a language other than English, a specialty that is high need, or a higher level Medi-Cal caseload.

**Questions and Comments**

*Brad Gilbert, MD, Inland Empire Health Plan*: it sounds like there are overarching criteria, then sub-criteria that will prioritize the applications?

*Jennifer Kent, DHCS*: Yes, there are basic criteria to qualify and then additional criteria to balance the final selection across the state. As examples, there are specific workforce issues in the Central Valley, the North State and specialties such as child psychiatry.

*Marty Lynch, LifeLong Medical Care and California Primary Care Association*: The federally-qualified health centers (FQHCs) throughout the state struggle with workforce and we applaud this program. We hope that willingness to do a higher amount of Medi-Cal

will be a prominent criteria. You mentioned working with the safety net, and I imagine a large number of applications will be received from health centers. We hope this program will help with FQHC workforce challenges. What are your thoughts on the best ways for health centers to benefit?

*Jennifer Kent, DHCS*: Applicants need to show employment or job offer. We are not looking at practice setting in the basic qualification. We will review what we get and then balance the final selections across geography, practice type, modality and amount of Medi-Cal as a second-level review. We will be refining how we calculate the 30 percent. For example, if you are willing to offer double appointment times for Medi-Cal consumers because they are more complex and require more time, then we may calculate considerations like this into the percentage of caseload.

Director Kent said the dental loan repayment will follow the same criteria as physicians and will also be operated by Physicians for a Healthy California. The department is also considering a practice re-location option, for those willing to go to areas where there are fewer than five Medi-Cal practicing dentists, in return for a 10-year commitment. Other additional criteria are similar to physicians such as higher caseload, language or certain specialty categories. We are working with CDA to refine this program and gathering information from other states that have tried this.

**Questions and Comments**

*Linda Nguy, Western Center on Law and Poverty*: Can you speak to how you arrived at 30 percent caseload requirements? The Steven M. Thompson Loan Repayment program requires 50 percent participation in Medi-Cal.

*Jennifer Kent, DHCS*: Medi-Cal covers about one third of the state, so we chose 30 percent. As graduating physicians make business decisions, we hope to encourage them to care for Medi-Cal beneficiaries.

*Linda Nguy, Western Center on Law and Poverty*: I appreciate there will be additional consideration for those who will take larger caseloads of Medi-Cal. On the five years, if a provider does not see 30 percent Medi-Cal across the full five years, do they repay the amount or drop out of the program?

*Jennifer Kent, DHCS*: Our understanding from other repayment programs is that the failure rate is very low. We will pay in arrears and they will demonstrate they met the requirements prior to a payment.

*Brad Gilbert, MD, Inland Empire Health Plan*: Our program is a three-year program with a subsidy concept and we have had virtually no drop-off.

*Marty Lynch, LifeLong Medical Care and California Primary Care Association*: Are you expecting a stakeholder process to finalize the criteria?

*Jennifer Kent, DHCS*: Once the administrative contract is in place, we will publish criteria for feedback and suggestions. We are generally settled on this for its feasibility and reasonableness to retaining providers over the long term.

*Jonathan Sherin, LA Department of Mental Health*: Will indigent caseload be a factor?

*Jennifer Kent, DHCS*: The program refers to Medi-Cal because that is in statute, but applicants could certainly include indigent as an additional benefit.

*Anne McLeod, California Hospital Association*: Is this on the DHCS website?

*Jennifer Kent, DHCS*: Not yet but once we finalize the contract, we will list this on the website.

*Carrie Gordon, CA Dental Association*: On the limit of five providers in a county for relocation, would you consider locations where the number of providers is far below the need but there are more than five providers?

*Jennifer Kent, DHCS*: We are focused on the fact there are places where there are no or very few providers. Since the pool is small, we want to focus on the highest priority.

*Carrie Gordon, CA Dental Association*: This is exciting. We have some experience through the CDA Foundation using a different structure than the one proposed and the impact has been extraordinary. We are happy to offer more about our experience and serve as a resource.

*Anthony Wright, Health Access CA*: I support the opinion that the standard for Medi-Cal should be higher than the average caseload amount. I appreciate the additional prioritization criteria cover this. On physician supplemental payments under Prop. 56, how close are the new rates to Medicare rates?

*Mari Cantwell, DHCS*: The website includes the methodology. Our target is 85 percent of Medicare for Evaluation and Management codes and 100 percent for the ten preventive codes. On managed care side, the Medicare comparison is less certain.

*Brad Gilbert, MD, Inland Empire Health Plan*: Yes, when we put the supplement on top of existing rates, the rates are at or above Medicare

*Anthony Wright, Health Access CA*: Is there utilization or other information on the impact of the supplemental payments.

*Mari Cantwell, DHCS*: We are currently working on an analysis of the FY17-18 services in managed care and FFS. We will be ready to share that in the next month. One caution about the data is the lag time for submission of claims and encounter forms, especially on the managed care side. We typically receive claims six months beyond the end of the year. Also, part of the challenge is that the money didn't go out until mid-year and it is

unclear whether providers were anticipating those payments and increasing services or not. We should see better data and results for FY18-19.

*Anthony Wright, Health Access CA*: I would like to have this for discussion at the next meeting.

**Pediatric Palliative Care Waiver Status**
***Sarah Brooks and Jacey Cooper, DHCS***
Slides are available:
https://www.dhcs.ca.gov/services/Documents/SAC_Presentations_102518.pdf

The Pediatric Palliative Care (PPC) Waiver (a home and community-based waiver) was first approved by CMS in December 2008. It began as a three-year demonstration pilot program April 1, 2009, and renewed for additional five-year terms in 2012 and 2017. The PPC Waiver was approved for 1,800 slots and approved to operate within 12 counties. There are currently eight participating counties and counties have been dropping off. The participating counties: Alameda, Los Angeles, Marin, Orange, San Francisco, Santa Clara, Santa Cruz, and Sonoma. The enrollment has been historically low and there are currently 228 enrolled beneficiaries. Given the low enrollment and challenges in renewal approval with CMS, we will be ending enrollment January 2019. A majority of these children are already enrolled in managed care and the PPC services are covered under Early Periodic Screening Diagnostic and Treatment (EPSDT). There is a workgroup for the transition. Timelines and notices to beneficiaries were discussed by the workgroup and will be mailed soon. There will be data-sharing of enrollment files and utilization data for these children with Managed Care Plans (MCPs) prior to the transition date. All Plan Letters and Numbered Letters are out for comment and will be final soon. Ongoing monitoring will include:

- Palliative care reporting template will be updated for post-transition operations.
- Daily check-ins with plans will occur after the transition for two weeks.
- Weekly and monthly monitoring will occur as needed. Given the small number of beneficiaries, it will be possible to discuss individual needs.

**Questions and Comments**

*Kim Lewis, National Health Law Program*: Of the 228 children enrolled in the waiver program, how many are in managed care?

*Sarah Brooks*, *DHCS*: There are fewer than 50 children in FFS.

*Kim Lewis, National Health Law Program*: Will the existing waiver providers continue to offer services through FFS for those 50 children?

*Sarah Brooks*, *DHCS*: A key part of the transition discussion and outreach is to help providers continue services or transition to managed care. We want to maintain services to the extent we can. I will follow up to let you know how many of the providers are enrolled in plans.

*Kim Lewis, National Health Law Program*: I am concerned about the ability to access these services in a FFS system.

*Sarah Brooks*, *DHCS*: We have provided a list of providers to the plans, so they know providers and can offer a contract.

*Michelle Cabrera, SEIU*: What is the overlap with this population and CCS?

*Sarah Brooks*, *DHCS*: There is some overlap between CCS and PPC but I don't know the extent.

*Brad Gilbert, MD, Inland Empire Health Plan*: I would expect most of the beneficiaries are enrolled in CCS, but some of the PPC services are not covered in CCS.

**Update on Network Adequacy Compliance for MCPs and MHPs**
***Mari Cantwell and Sarah Brooks, DHCS***
***Slides available:***
***https://www.dhcs.ca.gov/services/Documents/SAC_Presentations_102518.pdf***

Mari Cantwell provided an update on network adequacy compliance since the July SAC meeting.

- There were eight dental managed care plans under corrective action when submitted. All have resolved the issues and have come into compliance.

- For DMC-ODS, six county plans were under corrective action. Five remain under corrective action, primarily for issues of timely access and language. The plan due date for coming into compliance is March 1. We think all plans will come into compliance.

- For Mental Health Plans, there was a change in methodology for determining network adequacy based on input received from counties and providers about how ratios are calculated for adequacy. We had assumed all medication support services were provided by physicians. We have learned they are often provided by non-physician providers and therefore we adjusted the ratio numbers of required providers to beneficiary. Of the 56 Mental Health Plans, 54 were under corrective action last July. There are 26 plans that have come into compliance and 28 remain under corrective action. Of these, 15 are related to provider ratios for psychiatry, 14 for provider ratios in outpatient mental health, 10 for mandatory inclusion of Indian health facilities, 10 related to the mandatory inclusion of home-based service providers, and, a few additional issues such as language line or grievance/appeals. There is more work to do, but we are seeing positive direction and collaboration to bring all into compliance. The target for completion remains December. Some may not be complete, and we will consider potential sanctions.

- Managed Care Plans: Eight were under corrective action at the time of the July certification (32 rating regions). Now there are three plans (Aetna, Health Net, CA Health and Wellness) that continue under corrective action in 12 rating regions. We continue to see progress coming into compliance. Some of the reason for corrective action was our ability to review requests for alternative access requests. We continue to work through those. We think all will be in compliance by December. If not, we will consider potential sanctions.

**Questions and Comments**

*Chris Perrone, California HealthCare Foundation*: Is the methodology published anywhere for network adequacy? On the challenge of counting the time for part-time physicians, we discussed previously that there was not an alternate way to calculate their time in Medi-Cal – did this get revised? For Plans using telehealth, how are those providers counted?

*Mari Cantwell, DHCS*: Yes, we have the method on the network adequacy website. We continue to work on the full-time equivalent (FTE) issue – some of this is that we don't have data required to be more precise. We want to refine this going forward. Telehealth is used to meet network adequacy, so if a plan is using it, it was recorded in the filings. Some of the plans are meeting adequacy requirements through telehealth.

*Chris Perrone, California HealthCare Foundation*: If a plan contracts with a telehealth company that has 1000 providers, do they count all of those as FTEs in the network? How do you calculate?

*Mari Cantwell, DHCS*: There may be a slight difference between the calculation on the mental health and physical health plans, however, in general the telehealth calculation is based on the time they commit to visits. We have information on time committed via the contracts with the health plan so the providers are not counted as an FTE for network adequacy. We look at contract for minutes (MH) or services (others) and we calculate based on that information.

*Anthony Wright, Health Access CA*: For the three plans out of compliance, is it correct that if they resolve the compliance issues before December they will not be sanctioned? Are sanctions monetary?

*Mari Cantwell, DHCS*: Correct. We work with the health plan for a time prior to monetary sanctions to see if they can comply.

*Anthony Wright, Health Access CA*: How are you coordinating with corrective actions under the Department of Managed Health Care (DMHC)?

*Sarah Brooks*, *DHCS*: We are responsible for certifying Medi-Cal networks and DMHC is not doing that. We have talked with them about FTE calculations and consistency of information.

*Brad Gilbert, MD, Inland Empire Health Plan*: These are very separate processes and there are separate measurements. We respond differently to DHCS and DMHC.

*Anthony Wright, Health Access CA*: To the extent there are deficiencies, is that communicated?

*Mari Cantwell, DHCS*: Yes, we share information both ways.

**Update on Care Coordination Committee and Next Steps**
***DHCS Staff***

The update was offered earlier in the meeting. There is one meeting remaining for this committee.

**Questions and Comments**

*Marty Lynch, LifeLong Medical Care and California Primary Care Association*: Do you have an update on Health Homes as to roll-out by counties?

*Mari Cantwell, DHCS*: We are on track with our timeline and expect the roll-out to be on track.

**Update on AB 340 – Trauma screening**
***Jennifer Kent, DHCS***
***Slides available:***
***https://www.dhcs.ca.gov/services/Documents/SAC_Presentations_102518.pdf***

Director Kent reviewed the progress of the trauma screening expert workgroup that has met several times to develop recommendations to DHCS and the legislature by May 2019. There is a broad stakeholder group represented. Previous meeting materials and minutes are available on the DHCS website. Likely, the group will recommend adding questions to the Staying Healthy Assessment that is currently used for all populations in Medi-Cal. Additional questions will cover exposure to community violence, household dysfunction, incarceration, mental illness and food insecurity. We will share the recommendations with SAC. Kim Lewis is a member of the AB 340 trauma workgroup and SAC. She commented that the process has been a good one and the group will bring forward recommendations for screenings in Medi-Cal.

**Public Comment**

*Wendy Soe, California Association of Health Plans*: On the public charge rule, our plans' feedback is that it would be helpful to have caseload or cost estimate impacts from DHCS or the administration. Is that underway and will that be shared?

*Mari Cantwell, DHCS*: I am not certain if that is happening, but if we have that we will share publicly.

*Chris Perrone, California HealthCare Foundation*: One comment on Care Coordination. There was a discussion whether payment models are better done at the plan-provider level or the SPA level? I would note that there are reasons to see the two approaches as mutually reinforcing.

*Mari Cantwell, DHCS*: Yes, that is not intended to be mutually exclusive.

**Next Steps and Final Comments**
***Jennifer Kent, DHCS***

Please send your comments or ideas for agendas for upcoming meetings. The dates for 2019 are:

- February 13, 2019
- May 23, 2019
- July 10, 2019
- October 29, 2019