DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
February 16, 2017
10:00am – 3:30pm

MEETING SUMMARY

Attendance

Members Attending In Person: Bill Barcellona, CA Association of Physician Groups; Michelle Cabrera, SEIU; Lisa Davies, Chapa-De Indian Health Program; Michelle Gibbons, County Health Executives Association of CA; Carrie Gordon, CA Dental Association; Marilyn Holle, Disability Rights CA; Sherreta Lane, District Hospital Leadership Forum; Stephanie Lee, Neighborhood Legal Services of Los Angeles County; Marty Lynch, LifeLong Medical Care and California Primary Care Association; Anne McLeod, California Hospital Association; Steve Melody, Anthem Blue Cross; Erica Murray, CA Association of Public Hospitals and Health Systems; Linda Nguy, Western Center on Law and Poverty; Brenda Premo, Harris Family Center for Disability & Health Policy; Rusty Selix, CA Council of Community Behavioral Health Agencies; Cathy Senderling, County Welfare Directors Association; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers; Richard Thomason, Blue Shield of California Foundation.

Members Attending by Phone: Lishaun Francis, CA Medical Association; Bradley Gilbert, MD, Inland Empire Health Plan; Sandra Naylor Goodwin, CA Institute for Behavioral Health Solutions; Emalie Huriaux (for Anne Donnelly, Project Inform); Kim Lewis, National Health Law Program; Chris Perrone, California HealthCare Foundation; Bill Walker, MD, Contra Costa Health Services.

Members Not Attending: Kirsten Barlow, County Behavioral Health Directors Association of California; Richard Chinnock, MD, Children's Specialty Care Coalition; Bob Freeman, CenCal Health; Sarah de Guia, CA Pan-Ethnic Health Network; Gary Passmore, CA Congress of Seniors; Kristen Golden Testa, The Children's Partnership/100% Campaign; Farrah McDaid Ting, California State Association of Counties; Michael Humphrey, Sonoma County IHSS Public Authority; Anthony Wright, Health Access California.

DHCS Attending: Jennifer Kent, Sarah Brooks, Jacey Cooper, Adam Weintraub, Alani Jackson, Brenda Grealish, Morgan Knoch.

Guests: Jayanth Kumar, DDS, CDPH; Mark Ghaly, MD, LA County; Robert Oldham, MD, Placer County.

Public in Attendance: 58 members of the public attended.

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

Director Kent recognized the large public audience attending and welcomed Anne McLeod back to the SAC. A representative from Project Inform, Emalie Huriaux, will replace Anne Donnelly over the next several months. Director Kent thanked Blue Shield of California Foundation and California HealthCare Foundation for their support to convene the stakeholder meetings.

Marty Omoto, California Disability Senior Community Action Network (CDCAN) and California Person Centered Advocacy Partnership was invited to make some opening remarks to the SAC. He let the SAC know that people in the audience today are part of the planning team for the Person-Centered Partnership, including consumers, advocates, and family members here to meet with the Developmental Services Task Force and Secretary Dooley. They wanted to let the SAC know how important the waiver is for the disability community. Families may not know all the opportunities available to them. We want to ensure that all the disability community understands and supports the remarkable opportunities in the waiver, like the Whole Person Care Pilots and Dental Transformation Initiative.

Follow-Up Issues from Previous Meetings and Updates
Jennifer Kent and Adam Weintraub, DHCS:
Presentation slides: http://www.dhcs.ca.gov/services/Documents/102416_Followups.pdf

- State Budget Proposal
- Impact of ACA Changes on California
- Estate Recovery Changes
- Enrollment and Renewals

Director Kent asked members for any questions from the follow-up list circulated after the last SAC meeting.

Kent: The budget process and subcommittee hearings are beginning. The Department received a request to provide information on potential federal changes and the impact on California. DHCS is staying up to date with information but is not speculating about potential federal changes and will wait to follow federal statutory changes or proposals under serious consideration. We are remaining focused on existing work and advancing priorities in the waiver.

The Governor's January budget is a sobering reminder of our reliance on volatile revenue sources. Corporate, sales and other tax revenue are lower than expected and some expenditures in the health budget are higher than expected. This doesn't allow for new initiatives. It is mostly a baseline budget. There are no cuts but some delays due to workload and new resources required. We will talk about budget-related Coordinated Care Initiative (CCI) changes in detail later today.

Thank you to our partners who are in Washington, DC and sharing information about various proposals. Until there are any statutory or regulatory proposals, we won't be commenting but we are offering information and data to advocates about decreasing rates of uninsured, Medi-Cal expansion and other background information. On Estate Recovery, there are State Plan Amendment (SPA) changes to drop state recovery provisions down to federally required minimums. We are working with advocates on FAQ language and continuing to implement per the legislation last year.

On enrollment/renewal data, the AB 1296 changes are posted. There are no particular changes to report. We are continuing to work on refining data with counties.
Questions and Comments

Marty Lynch, LifeLong Medical Care and California Primary Care Association: The Department of Finance (DOF) shows higher revenue in the second half of the year. Do you expect to revise based on that information?

Jennifer Kent, DHCS: We really don't know. This year, we have some indicators of revenue trending down. There are certain economic indicators that are alarm bells and we are watching that, hence the conservative budget..

Linda Nguy, Western Center on Law and Poverty: We happy to see the draft SPA language and pleased that the implementation of estate-recovery legislation is moving along.

Cathy Senderling, County Welfare Directors Association: Front-line county workers get questions on this topic. Could we send information and clarification to county workers, perhaps through an All County Letter, so county staff and plans can accurately answer questions about the estate recovery changes?

Jennifer Kent, DHCS: That is a good idea.

CCI – Duals Demonstration Project Update
Sarah Brooks, DHCS
Presentation slides: http://www.dhcs.ca.gov/services/Documents/CCI_Update_SAC.pdf

Sarah Brooks provided an update on the Coordinated Care Initiative, which was included in the January budget. When created, the CCI contained a provision requiring the DOF to determine each January if the CCI program is cost-effective, and if not, discontinue the program the following year. The DOF estimates that CCI will not be cost effective, thereby triggering the process that ceases all statutory provisions related to CCI as of January 1, 2018. Until then, DHCS is taking this opportunity to restructure parts of the program to make it cost effective.

CCI core components will continue; Ms. Brooks also mentioned some changes proposed under the Budget:

- In-Home Support Services (IHSS) funding
- Multipurpose Senior Services Program (MSSP) transition
- Universal Assessment Tool (UAT)

IHSS funding will be removed from the health plan rates, although all benefits and services will continue. Another change is that the MSSP transition, previously set to become the full responsibility of health plans this year, will be delayed to at least January 2020. The UAT will not be implemented moving forward although she acknowledged the good work of SCAN Foundation, DSS and CDA among others in developing the tool.

As of December 1, there were 113,601 people enrolled in Cal MediConnect (CMC) and this continues to increase. Streamlined enrollment allows Cal MediConnect health plans to submit enrollment to DHCS on behalf of Managed Long-Term Services and Supports (MLTSS) members. This began the week of August 22, 2016 and is accelerating enrollment. We are able to enroll 85% of those sent from plans to the state. The other 15% are not eligible. The process includes a follow-up call from the state to confirm they want to be enrolled. DCHS is not seeing any problems with the referrals received.

DHCS is working with stakeholders on an updated health risk assessment (HRA). Plans are required to do an HRA under guidance from DHCS; however, each plan develops a specific HRA. A workgroup formed to identify best practice HRA tools to standardize the HRA across plans. There are 10 questions that will be required for Service Delivery Plan (SDP), MLTSS and CCI enrollees.

An MLTSS resource guide mailing began in November. About half of the beneficiaries in the initial mailing made a health plan choice and about half defaulted to a plan. Beneficiaries are still choosing or being assigned (default) a plan. As of the end of December, we have seen approximately 15,000 defaults to Medi-Cal plans and 11,300 choices. Of these choices, 2,700 have been to join a CMC plan.

Ms. Brooks reviewed CCI best practice meetings and the topics discussed there. There is a CalDuals workgroup to update the website to be more beneficiary friendly in March.

Questions and Comments

Steve Melody, Anthem Blue Cross: From the health plan perspective, there is more work to do relative to MLTSS and CMC. Do you see MLTSS going beyond the current seven CCI counties?

Sarah Brooks, DHCS: We want to monitor these seven counties and see how the implementation goes. We could consider that in the future.

Jennifer Kent, DHCS: We are committed to seeing the demonstration through a full five years and would not add counties before that timeline. Most likely, we would discuss expansion in 2020 with the ending of the current waiver.

Bradley Gilbert, MD, Inland Empire Health Plan: I appreciate the streamlined enrollment. We are continuing to grow slowly but surely. Are there thoughts on other changes to enrollment? Have we done the extension with the Centers for Medicare & Medicaid Services (CMS)?

Sarah Brooks, DHCS: We want to look at this voluntary enrollment strategy and what happens with it before we move on any other options. We have seen beneficiaries choosing through the mailings. Yes, we have discussed with CMS. It would be part of amending the three-way contract and will happen during this year.

Rusty Selix, CA Council of Community Behavioral Health Agencies: Does IHSS going back to counties impact the mental health share of realignment growth? Will this cause mental health to lose some of the realignment growth that it is now getting? I have seen analysis that implied it would have that impact.

Jennifer Kent, DHCS: With the Governor's budget proposal on CCI, three things happened. 1) statewide collective bargaining was ended; 2) the IHSS pass-through to health plans ends and IHSS goes back to the counties; 3) the maintenance of effort with counties was ended. Realignment is not under DHCS purview but we are aware there are concerns and counties are meeting with DOF and others to assess the impact. There are concerns about how changes in the IHSS program, e.g. minimum wage, overtime, sick leave, will impact counties and DOF is in discussion with them about that.

Rusty Selix, CA Council of Community Behavioral Health Agencies: In summary, it's a work in progress and we are not sure at this point.

Jennifer Kent, DHCS: Yes.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Are we doing MLTSS only in the seven counties? Will the HRA work go beyond the seven counties with SPDs?

Sarah Brooks, DHCS: For MLTSS, there will be no expansion beyond the seven counties. For the HRA, the questions will be required in all counties for the SPD population.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Is it correct that in other counties, the plans are responsible for Adult Day Health Care (ADHC)/Community-Based Adult Services (CBAS) but not for other pieces of CCI?

Sarah Brooks, DHCS: Yes, all other plans are responsible for CBAS and in addition some plans have responsibility for skilled nursing. Regardless, we believe it is important to identify any need for MLTSS, so plans will be responsible to assess needs even if the service is out of plan's responsibility.

Stephanie Lee, Neighborhood Legal Services of Los Angeles County: Thank you for continuing the CCI core elements. In addition to the HRA workgroup recommendations on the 10 questions, is there thought about a second aspect of work that would identify best practices for meeting the needs identified through the assessment?

Sarah Brooks, DHCS: We could have another workgroup meeting to talk about best practices with HRA. There is also an opportunity to talk about this in our best practice meetings with health plans. Certainly, the referral process is in place between the plans and services, but if we can identify best practices, we will share them.

Marilyn Holle, Disability Rights CA: We have a concern about the intersection between IHSS and health plans related to sick leave, covering absences, etc. There should be clarification about responsibilities for plans to fill-in for those severely disabled with complex health interventions. It is quite difficult to find someone to step in. This flows from mandatory provisions under 1902.

Jennifer Kent, DHCS: The practical implications of the IHSS change is primarily the flow of money. The counties retained responsibility for authorizing hours and the Public Authority maintains the emergency registry. If there is conversation we need to have about plan responsibility for home health, we can do that but home health is different.

Marilyn Holle, Disability Rights CA: For those individuals with complex health needs, it is not different. Particularly with higher needs for fill-in work, there should be more understanding for health plans to fill in home health.

Jennifer Kent, DHCS: We can look at contracts and discuss.

Dental Transformation Initiative (DTI)
Alani Jackson, DHCS, Jayanth Kumar, DDS, MPH, CDPH and Carrie Gordon, CDA, SAC Member
Presentation slides: http://www.dhcs.ca.gov/services/Documents/DTI_MDSD.pdf and http://www.dhcs.ca.gov/services/Documents/Dental_SOHP.pdf

Carrie Gordon provided an overview of Denti-Cal, oral health and the DTI. Dentistry is changing rapidly from solo practices to integrated practices. Trends in the field were recently covered in a full issue of Health Affairs. Dental disease is most common disease in children and we are understanding more about the impact on overall health. DHCS is offering leadership to bring this forward with more attention. There was a Little Hoover Commission report and CDA recommendations in 2011. The first priority of those reports was state leadership based on a review of other states indicating that state leadership is a best practice. After talking to Dr. Kumar about the success of initiatives in New York, he subsequently joined us in California. Under his tenure in New York, dental disease rates decreased. California moved forward to establish the Office of Oral Health in CDPH, in partnership with DHCS. The tobacco tax is earmarked for oral health and we have the DTI with $750M federal funds in the Medi-Cal 2020 waiver to test incentives, understand what works and replicate what works. CDA is pleased to play a role as we identify what works and communicate to providers to increase participation. This is about overall health by preventing health consequences of inflammation and other impacts on health from untreated oral disease.

Alani Jackson provided an overview of Medi-Cal Dental Program. It includes:

- Medi-Cal Dental Program Overview
- Performance Measures and Benchmarks
- Managed Care Regulations
- Advisory Groups
- DTI

Medi-Cal dental services are delivered through a fee-for-service delivery system, the Dental Managed Care delivery system, and the safety net clinics system paid on an encounter basis where all services provided at one visit are billed one set rate. She reviewed performance measures available on dental care for FFS and Managed Care (DMC), and where reports can be viewed.

Ms. Jackson also spoke to how the federal Managed Care Rules impact dental managed care, such as network adequacy for pediatric dentists, provider screening and enrollment requirements, quality rating system, expand quality efforts of the External Quality Review Organization (EQRO) and other changes. She reviewed the Medi-Cal Dental Advisory Committee (MCDAC) in Sacramento and the Los Angeles Stakeholder meetings and their purpose in advising DHCS. She then turned to a presentation of the DTI. There are four domains in the incentive:

Domain 1: Increase Preventive Services Utilization for Children: This incentive is statewide. About 2,500 service office locations received $20M in incentive payments based on increased utilization in 2016.

Domain 2: Caries Risk Assessment and Disease Management: Introduces a caries prevention model in 11 participating counties. CDA provides training to providers who opt into the incentive.

Domain 3: Increase Continuity of Care: Incentive payments will be available for providers in 17 pilot counties starting in 2017. Dental managed care is not part of this pilot.

Domain 4: Local Dental Pilot Programs (LDPPs): There are 15 projects approved to participate.

Questions and Comments

Michelle Cabrera, SEIU: Are there improvement targets tied to the performance measures?

Alani Jackson, DHCS: This is primarily data reporting, but there are benchmarks identified that we hope to reach as part of performance improvement. We have an ability to earn $10M based on meeting benchmarks in Domain 1.

Michelle Cabrera, SEIU: Are there early indications of what is working to improve access and quality?

Alani Jackson, DHCS: We don't have full encounter information for year one, but it is looking promising that access to prevention is increasing. We are focused on outreach to providers and beneficiaries to inform them that they have benefits. Stakeholder meetings indicate some beneficiaries don't realize they have benefits.

Michelle Cabrera, SEIU: Who does that outreach?

Alani Jackson, DHCS: Delta Dental for FFS and Liberty for DMC.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Does DHCS have data on how much dental service is in each of the three types of delivery system?

Alani Jackson, DHCS: On the website, we have utilization for FFS and DMC. The safety net clinic system information is in a different system within DHCS.

Jennifer Kent, DHCS: We hope this changes so that we can capture that utilization. We are hopeful the DTI will provide some data.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: On the performance standards, are they related to SPD and other adult populations in addition to kids?

Alani Jackson, DHCS: There is no performance data on adults and the DTI only includes kids.

Dr. Kumar described the collaboration between California Department of Public Health (CDPH) and DHCS to implement the State Oral Health Plan. He described the ten essential public health services and how oral health is aligned to this program. He reviewed tooth decay data in children and reported that California has a high rate of dental disease in children. Benchmarks for improvement are established for kindergarten and third grade through a series of strategies such as prevention education (starting in prenatal care), increasing visits and addressing social determinants of health.

Questions and Comments

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Although I noted the performance benchmark for kids, your comments make me assume this plan is across the life span? Will data surveillance be across all ages? How long until we see some data?

Jayanth Kumar, CDPH: Yes, there are indicators for all ages as part of the surveillance system. We are working on a baseline report and then expect to report the data every five years.

Rusty Selix, CA Council of Community Behavioral Health Agencies: We see data that more than 50% of mental health or substance abuse disorders consumers are smokers. We lack best practices with this population. Could there be work to develop best practices with mental health and substance use disorder providers or pilots that may be introduced to improve cessation for this population?

Jayanth Kumar, CDPH: In New York, Medicaid reimburses dental providers for tobacco cessation and we are discussing how to expand these strategies.

Michelle Gibbons, County Health Executives Association of CA: Can you describe who is on the advisory committee?

Jayanth Kumar, CDPH: There are 50 members. It is a broad representation from local health departments, advocates, professional associations and other stakeholders.

Michelle Cabrera, SEIU: Given need to educate women prenatally about need for oral health care for their children, this requires working with health plans. Can you speak to any efforts?

Jayanth Kumar, CDPH: The pilot in Sonoma County includes health plans. We are working with them generally and specifically in Sonoma.

Alani Jackson, DHCS: We also do targeted outreach to zero-3 and we have noticed good improvement in access.

Jennifer Kent, DHCS: There was a bill last year that required all managed care organizations (MCO) to have a dental coordination role so although they don't provide dental, the MCO will help with referral and coordination.

Carrie Gordon, CA Dental Association: The CDA Foundation worked on perinatal guidelines that include best practices to inform policy decisions. There was a bill ten years ago that required a pre-K oral health screening. With renewed interest in surveillance, there is a new bill that will bolster kindergarten surveillance.

Brenda Premo, Harris Family Center for Disability & Health Policy: Western University has a dental college with a huge clinical service. There is an opportunity to influence faculty and students while they are training. If we could inform the curriculum with information from state, it will improve future practice. Secondly, there are many factors that impede access to dental care for the SPD population. We need to acknowledge this. Providers need training to ensure that children with special needs have access to oral health care. Access for everyone means addressing the unique needs of populations as well.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: To add to the comment Rusty Selix made, we need to educate dentists in the program about prescription abuse. People who have not had dental care for many years require serious procedures and there are a range of medications that can be used. Some medications are better for our population than others.

Alani Jackson, DHCS: To follow up on Marty's question about data for adults, there is data in a "over 21" category on the FFS.

Herrmann Spetzler, Open Door Health Centers: In rural areas, access to dental care is a challenge and some consumers may be sent 3-4 hours away. We don't have any participation from the private sector. Is there anything in this proposal to get the private sector involved? There is a part of the reimbursement system, the complexity and rates that cause private providers to opt out of participation. I am supportive of this program and suggest we need to harness all providers in the state.

Jennifer Kent, DHCS: The local pilots are encouraged to focus on new applications to help bolster access and access to specialty services through approaches like tele-dentistry. There are some specialists that are extremely difficult to work on, such as endo-dentistry.

Alani Jackson, DHCS: We monitor access for both FFS and managed care and that informed the development of the DTI. The 15 pilots include some rural counties and there is a focus on dental homes. In remote areas, we are relying on dental homes and allied professionals.

Jayanth Kumar, CDPH: I would add that this is a national problem in dentistry.

Michelle Cabrera, SEIU: Does CPCA track which FQHCs provide dental services? It seems we could get some estimates of services provided.

Alani Jackson, DHCS: There are 460 clinics providing dental services, out of about 1300 total.

Jennifer Kent, DHCS: We are paying for encounters. The issue is that there no actual service data. The claim is not specific to services – it is only an encounter.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: The individual clinics do have detailed level information. I will follow up with CPCA.

Carrie Gordon, CA Dental Association: On the question regarding private dentist participation, we know there is no easy fix. We advocate for increases in rates. Another strategy is for dentists to contract with FQHCs. Also, DHCS is streamlining the application process. However, rates remain a significant problem.

Managed Care Rule Update: Network Adequacy
Sarah Brooks, DHCS
Presentation slides: http://www.dhcs.ca.gov/services/Documents/NetworkAdequacy_SAC.pdf

Ms. Brooks provided background and updates on the managed care rules and network adequacy. Last year, the federal government issued a complete overhaul of managed care rules effective July 2018. Network adequacy is a major topic. The document addresses time and distance regulations and this presentation speaks to the executive summary. There is state flexibility to set rules – the federal rules require states to set standards but flexibility as to the specifics. Specifically, the regulations cover managed care plans and also county mental health plans, Drug Medi-Cal plans, dental managed care, and long term services and supports (LTSS). She reviewed the various provider types under time and distance, timely access, transparency and reporting requirements, and annual certification of the network. Federal rules set forward specific elements mandated to be included as well as additional factors to be considered. The proposed standards are based on a review of all the mandated and additional elements in the federal rules.

Ms. Brooks reviewed the proposed standards for primary and specialty care time and distance as well as timely access. These are similar to many current DHCS and DMHC Knox-Keene regulations but those are not in place across the board today. Specific standards for rural/small counties, medium counties, and large counties for 15 different critical specialty care providers were developed. Psychiatrists are included – facility-based physicians such as anesthesiologists are excluded. She reviewed the specific standards for OB/Gyn, hospitals, pharmacy, mental health (non-physician), substance use disorder services, pediatric dental, and LTSS providers. LTSS services cover the situations where a beneficiary is traveling to the service – not situations such as IHSS, where the provider goes to the beneficiary. There are access standards for non-physician mental health providers and opioid programs. DHCS welcomes comments through February 28th to be submitted to the website.

Questions and Comments

Lisa Davies, Chapa-De Indian Health Program: Will plans be able to use telemedicine to meet the time/distance standards?

Sarah Brooks, DHCS: I will speak to telemedicine under exceptions. If a beneficiary is outside the time and distance, they can use telemedicine. We do want to ensure in-person access as well.

Linda Nguy, Western Center on Law and Poverty: Related to the grouping of county types, we would prefer to see a statewide approach with some exceptions. How did you come up with the standards?

Sarah Brooks, DHCS: Comments are welcome through this month. On standards, we look at geo-mapping for how many Medi-Cal beneficiaries are enrolled, population density and other factors.

Cathy Senderling, County Welfare Directors Association: Is there a gray area between primary care OB/Gyn and specialty Ob/Gyn?

Sarah Brooks, DHCS: It is case specific. We want to be sure plans have enough OB/Gyns in network to meet primary care and specialty standards.

Bradley Gilbert, MD, Inland Empire Health Plan: OB/Gyns have right to be designated as a primary care physician (PCP). Some choose this but others act only as specialist. I would assume only PCP OB/GYN must meet that rule.

Steve Melody, Anthem Blue Cross: In addition, the beneficiary has the option to choose an OB/Gyn as their PCP and that would prompt the designation to meet primary care standards.

Stephanie Lee, Neighborhood Legal Services of Los Angeles County: Some people need drugs from specialty pharmacies. Does this apply to specialty pharmacies? In addition, hospitals may be tertiary or not; may have certain specialties or not.

Sarah Brooks, DHCS: Excellent comments we can take back. These are for all hospitals and pharmacies. There are also mail order pharmacies that are included in meeting standards.

Jennifer Kent, DHCS: This is setting the floor for adequacy in the network. If there are patients with a specific need, a tertiary care hospital or a compounded drug, the plan is still responsible for arranging that care.

Stephanie Lee, Neighborhood Legal Services of Los Angeles County: Yes, however, there are issues for beneficiaries in remote areas even in LA.

Sarah Brooks, DHCS: We don't want to have lots of alternative access standards. We want to set baseline standards. We know we will need to offer alternative standards in some cases.

Bradley Gilbert, MD, Inland Empire Health Plan: As an example, there are only some hospitals that offer neurosurgery. It wouldn't make sense to set time and distance standards for this, however we have to get the patient to the right place for the service regardless of where it is located.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Are there any standards for time and distance on CBAS?

Sarah Brooks, DHCS: There is a requirement that they can serve beneficiaries within one hour of their facility. I am not certain if there is a time standard for assessments and program entry.

Sherreta Lane, District Hospital Leadership Forum: Is there a list of the alternative access standards?

Sarah Brooks, DHCS: If a health plan has exhausted all options to meet a standard, we can approve an alternative standard. There is not a list of these but there are criteria developed for what can be approved. There are only five approved alternative access standards.

Steve Melody, Anthem Blue Cross: Do these regulations align with active DMHC standards?

Sarah Brooks, DHCS: Yes, we have aligned to DMHC Knox-Keene where they exist.

Chris Perrone, California HealthCare Foundation: Can you elaborate on the five approved alternative access standards? Are they given for a county, certain members, a service, a geographic area?

Sarah Brooks, DHCS: It is by ZIP code. If a health plan says they can't meet a standard in a general area. There are five plans with ZIP codes approved. They are generally in rural areas.

Bradley Gilbert, MD, Inland Empire Health Plan: In many places where there are no doctors, there are often not many people – very few people. We have two ZIP codes which have an access exception to the next closest ZIP code because there are no providers. We have a contract with the closest hospital but it is beyond the time and distance standard.

Richard Thomason, Blue Shield of California Foundation: We worked on a project with LA County to do electronic referrals to speed up access to specialty care. Will the standards allow for this methodology to be used?

Sarah Brooks, DHCS: Yes, we encourage e-consult. Telemedicine and mail order pharmacy are other examples. The standards are to ensure there is access with these methods as additional options.

Linda Nguy, Western Center on Law and Poverty: DMHC has timely access monitoring, how closely are you working with them on monitoring? Can you comment on the recent report that there are many data errors?

Sarah Brooks, DHCS: We share information. We have implemented a new data collection system (274 file) that allows submission of more detailed information than previously. We will have information on delegation; it will give us reports on time and access. We are also working with ERQO who will do surveys and collect information on timely access. We can add any items that appear to be trouble spots.

Michelle Cabrera, SEIU: Can we engage with DHCS to support development of provider infrastructure where there is need? Areas where there may be anticipated population growth and few providers?

Sarah Brooks, DHCS: We are open to working on that. I know the Office of Statewide Health Planning and Development does work in this area. The plans do work as well.

Carrie Gordon, CA Dental Association: Compared to other areas, the dental area is only a brief reference that is fairly generic.

Sarah Brooks, DHCS: We welcome input about additional information.

Chris Perrone, California HealthCare Foundation: What is the interaction between access and distance? If the requirement is 15 days for an appointment, can I meet the requirement by sending a patient from Humboldt to Sacramento? Are there instances where they can meet the timely access but not the distance?

Sarah Brooks, DHCS: The standard is within the plan area, so yes, that could occur.

Bradley Gilbert, MD, Inland Empire Health Plan: For an example, there is no pediatric urologist in the high desert. My responsibility is to arrange care within the 15-day timeline but it may be farther than 30 miles away.

Whole Person Care Update
Sarah Brooks and Jacey Cooper, DHCS
Mark Ghaly, MD, Los Angeles County and
Rob Oldham, MD, Placer County
Presentation slides: http://www.dhcs.ca.gov/services/Documents/DHCS_WPC_Ppt.pdf and http://www.dhcs.ca.gov/services/Documents/LACounty_WPC.pdf and http://www.dhcs.ca.gov/services/Documents/PlacerCounty_WPC.pdf

Ms. Brooks offered a program overview on Whole Person Care (WPC) including the overall goal of improving care across the health, mental health and social services continuum. The pilot is five years, $300M annually. There are examples in the pilots of bundled payments and other innovative payment mechanisms as well as FFS. There are metrics required in the pilots. Jacey Cooper provided specific information about the WPC round one applications. Target populations were broad including high utilizers, individuals with mental health, homeless, recently released from incarceration. She reviewed care coordination, data and information sharing and service innovation strategies included in the applications. There is great excitement in learning from the

pilots over time. She also explained the Round Two opportunity to participate in WPC, due March 1st. A county, city or tribe can apply.

Dr. Mark Ghaly presented on the WPC initiative in Los Angeles. He thanked state staff and the California Association of Public Hospitals and Health Systems (CAPH) for assistance in developing the program. He focused on implementation as well as a program overview. The program is funded with $900m ($450m federal funding) over 5 years and includes five target populations and 11 projects with 50,000 annual enrollees. The initiative is 58% homelessness focused, 32% justice involved-reentry, 6% serious mental illness, 3% substance use, 1% medical high risk. The themes for the initiative are to: create an integrated delivery system; offer care coordination & care management; address social needs; and create jobs for individuals with shared lived experience. Dr. Ghaly outlined implementation challenges and the many innovations across systems that are allowing the WPC to move on its timeline. For example, county job descriptions and job application process are significantly different for WPC. The re-entry program will hire those with lived experience as community health workers and this required new practices.

Dr. Oldham reported on the Placer County WPC initiative. The Placer County pilot builds on local priorities and collaboration with stakeholders. For example, there is a large and long-term homeless population, crowding of emergency department and a need to build capacity of local providers to improve timely primary care access. The pilot was developed with broad representation and involvement of organizations and stakeholders. The mission is to improve individual lives and simultaneously change the system of care for the future. Approximately 150 residents will be served at any one time with a total of 450 unique individuals over the course of the pilot.

Questions and Comments

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Great information. Is there guidance to the counties on contracting out for services vs. providing services directly?

Sarah Brooks, DHCS: That is at the discretion of the county and depends on the infrastructure.

Richard Thomason, Blue Shield of California Foundation: Can we find information on the web site about individual pilots and underlying details within the various buckets presented here?

Sarah Brooks, DHCS: The applications are on the WPC website and we will report out a summary soon.

Brenda Premo, Harris Family Center for Disability & Health Policy: A problem we encounter is the opposite of homelessness. In rural areas, some are almost imprisoned in their home because of lack of physical access. In many cases, small modifications could be made to improve access. Is the housing pool able to help improve access by making changes in the home environment?

Mark Ghaly, MD, LA County: I don't see that as part of the flexible fund although supporting physical access is part of the navigation pool. Staff should be working to identify how to actually achieve the care and services that are needed.

Rob Oldham, MD, Placer County: We didn't envision that in our application, but it is an excellent point. Care coordination is about community treatment, getting outside the four walls to meet members where they are. We want a culture of doing whatever it takes.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Does the care coordination/care management services you describe overlap with what health plans do with their care management teams?

Rob Oldham, MD, Placer County: It will be very different. Most of the health plan care coordination is by telephone.

Sarah Brooks, DHCS: Pilots can't cover services that Medi-Cal already covers. They will provide different types of services and need to be in regular contact to coordinate information and services.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: In the real world, the two entities need to be working very closely together to improve care.

Jennifer Kent, DHCS: Health plan care coordination is often focused on physical health needs. These pilots focus much more on the social service supports. The linkage and bi-directional information flow will be important to develop.

Sarah Brooks, DHCS: One of the exciting things in the pilots is the flexible housing pool we might want to hear more about.

Rob Oldham, MD, Placer County: We learned that neither our mental health nor managed care plans could tell us about homelessness. The flexible housing pool is a unique opportunity here.

Mark Ghaly, MD, LA County: The care management is a living document. Patients arrive in many settings and we want a care coordination document that is shared so that the information builds over time.

Bradley Gilbert, MD, Inland Empire Health Plan: I agree. It is additive, not duplicative. We take into account social determinants of health, but our ability to know what has been tried and how to leverage each other's advantages will be improved.

Marilyn Holle, Disability Rights CA: The Social Security Administration has flagged homeless individuals by flagging consumers with P.O. Box addresses.

Chris Perrone, California HealthCare Foundation: This is an exciting effort. What plans are underway to share lessons? What do you see as the long term, post-pilot implications? How does this work get sustained? Will the state begin to allow these services as part of the cap rate?

Sarah Brooks, DHCS: On sharing best practices, we will have collaboratives for learning that include in-person gatherings. We hold bi-weekly calls with pilots that also share innovations and implementation challenges. In terms of post-pilot, we want to see this sustained. The funding will not necessarily continue. However, what is happening includes building relationships, data infrastructure and other capacities that will remain.

Erica Murray, CA Association of Public Hospitals and Health Systems: Just as the Delivery System Reform Incentive Payments (DSRIP) served as a foundation for this waiver, it is our premise that WPC could serve as the foundation for the future. What would WPC 2.0 look like? How can we build on it in multiple ways? What conditions are needed to sustain?

Michelle Gibbons, County Health Executives Association of CA: To underscore these comments, there is a new level of coordination and collaboration happening that will set the stage for work in the future.

Erica Murray, CA Association of Public Hospitals and Health Systems: My question is for all of us. If you could have additional support in implementation, what do you need?

Rob Oldham, MD, Placer County: Eventually, we need to be on similar data systems,to scale up on a regional or state level.

Mark Ghaly, MD, LA County: We talk a lot about the difference between what we are doing in the pilot vs Targeted Case Management (TCM). People run away from TCM because of the difficulty in managing it and that is a missed opportunity. We need to see how we can use TCM going forward in new ways.

Specialty Mental Health Waiver: Performance Dashboard
Brenda Grealish, DHCS
The dashboard can be reviewed at:
http://www.dhcs.ca.gov/services/MH/Pages/SMHS_Performance_Dashboard.aspx

Brenda Grealish presented on the new mental health dashboard. It is a requirement included in the Special Terms and Conditions (STCs) in the 1915(b) Medi-Cal Specialty Mental Health waiver lasting until 2020. She walked through the various elements of information on the website. For example, each county's quality improvement plan is linked on the DHCS website. A parallel effort on the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) utilization data exists on children's outcomes and the MH dashboard is modeled on the children's dashboard. There are reports on the EQRO website related to behavioral health quality. DHCS does on-site reviews and chart reviews to ensure county Mental Health plans and corrections are compliant. The performance dashboard includes utilization, demographics and specialty mental health services.

Questions and Comments
Linda Nguy, Western Center on Law and Poverty: When do you expect information on timeliness, language and quality to be available? Does that include wait time for providers?

Brenda Grealish, DHCS: We will work on this over the next year. Counties are changing their data systems and we are responding to build the systems at the state level. We will cobble together what we have in the meantime to report out what we have. Yes, it includes several measures on wait time for appointments.

Chris Perrone, California HealthCare Foundation: Can you pick out a finding or two to report to us?

Brenda Grealish, DHCS: The expansion population provided lessons as the number of beneficiaries grew rapidly and created an artifact that made it look like penetration was lower. The denominator grew before the numerator increased. We are learning about data quality as

well. On the kids side, there is a report and measures catalog to document the methodology over time and track how we do things. We are using match data with social services to report on child welfare beneficiaries. We have learned a lot from that process.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: One interesting thing is the mild-to-moderate and severe mental health services providers. What are we learning about coordinating those levels of care?

Brenda Grealish, DHCS: We are looking at how to report on this to clarify roles and responsibilities. On the kids system, the legislation required we look at movement between managed care and mental health specialty systems. We see growth on the managed care side.

Linda Nguy, Western Center on Law and Poverty: How are stakeholders involved in the performance dashboard?

Brenda Grealish, DHCS: Two ways: we contract with California Institute for Behavioral Health to operate a stakeholder group, and on performance outcomes, we have an expert task force to advise us. Stakeholders have offered a lot of expertise and guidance.

Public Comment
There was no public comment.

Next Steps and Next Meetings 2017
Jennifer Kent, DHCS

May 17, 2017
July 19, 2017
October 19, 2017