DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
July 10, 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; Anne Donnelly, San Francisco AIDS Foundation; Michelle Gibbons, County Health Executives Association of CA; Brad Gilbert, MD, Inland Empire Health Plan; Kristen Golden Testa, The Children's Partnership/100% Campaign; 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; Anne McLeod, California Hospital Association; Farrah McDaid Ting, California State Association of Counties; Chris Perrone, California HealthCare Foundation; Kiran Savage-Sangwan, CA Pan-Ethnic Health Network; Linda Nguy, Western Center on Law and Poverty; Jessica Rubenstein, CA Medical Association; Cathy Senderling, County Welfare Directors Association; Jonathan Sherin, LA Department of Mental Health; Bill Walker, MD, Contra Costa Health Services; Anthony Wright, Health Access CA.

Members Attending by Phone: Richard Chinnock, MD, Children's Specialty Care Coalition; Lisa Davies, Chapa-De Indian Health Program; Carrie Gordon, CA Dental Association; Erica Murray, CA Association of Public Hospitals and Health Systems.

Members Not Attending: Bill Barcelona, America's Physician Groups; Michael Humphrey, Sonoma County IHSS Public Authority; Gary Passmore, CA Congress of Seniors; Brenda Premo, Western University of Health Sciences; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers; Stephanie Welch, Department of Corrections and Rehabilitation.

DHCS Attending: Jennifer Kent, Brenda Grealish, Lindy Harrington, Nathan Nau, Michelle Retke, Norman Williams, Morgan Clair, Mari Cantwell (phone)

Public in Attendance: 49 members of the public attended in person and 91 participated by phone.

Welcome, Introductions and Opening Comments
Jennifer Kent, DHCS

Director Kent welcomed SAC members. She offered thanks and appreciation to Brad Gilbert, who is retiring, for his service in multiple positions in counties and managed care and for being a true partner to the state in designing and implementing solutions. Director Kent congratulated Kiran Savage-Sangwan on her appointment as Executive Director of

CPEHN. She thanked Anthem-Blue Cross for sponsoring the lunch for SAC members and reminded the group that going forward meetings will be shorter and will not include lunch.

She reviewed the new structure of SAC and BH-SAC. DHCS accomplished an internal reorganization on behavioral health and this led to a need to elevate behavioral health issues and weave physical health and behavioral health policy together in the next waiver. There are overlapping memberships and the groups will meet on the same day, alternating morning and afternoon. Members are encouraged to attend both meetings.

Follow-Up Items from Previous Meetings
Norman Williams, DHCS

Mr. Williams reviewed the follow up items from the May SAC meeting contained in the document posted.
https://www.dhcs.ca.gov/services/Documents/052319_SAC_Followups.pdf.

Questions and Comments:

Marty Lynch, LifeLong Medical Care and California Primary Care Association: When will we see the list on Prop. 56 loan repayment?

Norman Williams, DHCS: We recently checked in with them and it will be posted very soon.

Anne Donnelly, San Francisco AIDS Foundation: What is the timeline on plan level data on HIV suppression data?

Jennifer Kent, DHCS: We will follow up on that.

Updates on Key Policy Issues
Jennifer Kent, DHCS

- Fiscal Year 2019-20 Budget Approved and Signed
- Governor's Pharmacy Executive Order, 340B Update and Stakeholder Input
- 1115 Waiver and 1915b Waiver Processes
- Performance Outcomes System Early and Periodic Screening, Diagnostic, and Treatment (EPSDT Psychosocial Services Chart

We are pleased to be in a position to discuss new spending. On eligibility, the budget included coverage expansion to young adults without documentation status up to age 26 that will be effective January 2020. Similar to the Senate Bill (SB) 75 expansion implementation, we will work with counties on notices and will move anyone currently in limited scope into full scope aid codes fairly seamlessly. There was a change in the disabled income level up to 138%. Also, those with pregnancy-related coverage and a mental health diagnosis will continue to receive full scope eligibility for one year. On benefits, there will be a restoration of optional benefits in January 2020 for optical, audiology, speech, podiatry and incontinence creams and washes. Screening and brief

intervention coverage will be implemented for the tool to cover all substances. There was a supplemental payment approved for Multipurpose Senior Services Program (MSSP); asthma mitigation $15 million; medical interpreter pilot $5 million; Long-Term Services and Supports (LTSS) actuarial study $1 million; hospital-based pediatric providers $2 million; changes to group home extension; $100 million for housing in current Whole Person Care (WPC) counties and $20 million for readiness for counties not yet operating WPC; $25 million for provider training for trauma and developmental screening; and, $20 million for behavioral health (BH) providers to be placed in emergency room settings.

Questions and Comments

Kristen Golden Testa, The Children's Partnership/100% Campaign: On the $15 million asthma in-home assessments, what is the mechanism? Is it matched?

Jennifer Kent, DHCS: No, it is not matched. Given it is a one-time allocation with a short lead time, we decided not to seek federal approval for the match. If this is continued in subsequent budgets, we can work on the items that are eligible for match.

Linda Nguy, Western Center on Law and Poverty: We are pleased about the new expansions. On coverage for young adults, is there a push to move sooner than January 2020?

Cathy Senderling, County Welfare Directors Association: With the changes and testing required to Cal-HEERS and SAWS, there is no ability to speed it up.

Anthony Wright, Health Access CA: What is the timing for the senior penalty? (increased income eligibility for seniors and persons with disabilities up to138%)

Jennifer Kent, DHCS: We will get back to you with the timing.

Anthony Wright, Health Access CA: It's good to use the lessons from SB 75 in the young adult expansion. Are there system differences given the adult age of this group? There is also a different environment today and we are concerned about people signing up and getting the care they need. How many are in new aid code?

Jennifer Kent, DHCS: We are estimating 80-90,000 will be eligible. We will share the language in the draft notices to review the messaging.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: On the provider trauma training allocation, what are the mechanisms to be used?

Jennifer Kent, DHCS: We are working closely with the Surgeon General on ideas about the training and we are working on curriculum development. Given there is no ready training or mechanism, we are working with external entities to develop best practices, prepare a curriculum and deploy the training. It is currently focused on provider training and professional education, less on community.

Maya Altman, Health Plan of San Mateo: Can you say more about the actuarial study for LTSS?

Jennifer Kent, DHCS: There is a collaborative group with a growing concern about individuals who are above eligibility levels for Medi-Cal, yet unable to afford LTSS. How might we construct a way for these individuals to contribute toward coverage? This is not intended to be an extension of existing Medi-Cal covered services.

Kim Lewis, National Health Law Program: Do you have details about how the trauma training and screening will roll out?

Jennifer Kent, DHCS: The Surgeon General has convened an expert panel and is working with them. DHCS will help with the roll out and draw federal funding to the extent possible.

Brad Gilbert, MD, Inland Empire Health Plan: I'm participating on that group. It has been a free flowing discussion about training physicians and staff. The thoughts include requiring training as part of required continuing medical education (CME) or using trade associations to deliver training: About 15 years ago, all physicians were required to take end-of-life training and I would like to see a similar process here. It creates an obligation and that would require legislation.

Jennifer Kent, DHCS: There is great interest and we will share out information as we know more.

Updates on Key Policy Issues (continued)
Governor's Pharmacy Executive Order, 340B Update and Stakeholder Input

Director Kent reported on the Pharmacy Executive Order. DHCS is holding a series of meetings on the carve-out to start on July 17. They will walk through implementation timeframe activities; details on the fiscal savings estimates; information on options to address concerns from plans about managing patient care.

Questions and Comments

Maya Altman, Health Plan of San Mateo: Is this a public invitation or a group?

Jennifer Kent, DHCS: The trailer bill listed an advisory meeting. We decided to open it up publicly for input and feedback. We will offer updates throughout implementation.

Anne McLeod, California Hospital Association: It's important to have a transparent process. One suggestion is that given the safety net hospitals will be hard hit, we would welcome the opportunity for a subgroup to work with you on that.

Anthony Wright, Health Access CA: Will the internal reports mentioned by the Executive Order be released publicly?

Jennifer Kent, DHCS: DHCS has submitted recommendations to the Governor. It is up to Governor's Officer to determine what, if any, of the recommendations become public.

Anne Donnelly, San Francisco AIDS Foundation: Are you considering a subgroup for public hospitals?

Jennifer Kent, DHCS: We are happy to meet with the 340B entities and already have met with them extensively. A public process does not preclude other meetings.

Anne Donnelly, San Francisco AIDS Foundation: Are there any changes to the drugs already carved-out?

Jennifer Kent, DHCS: No. They are fee-for-service (FFS) already.

Michelle Cabrera, County Behavioral Health Directors Association: Will you address the issue of the six-prescription limit on FFS drugs? This impacts individuals with multiple prescriptions.

Jennifer Kent, DHCS: Yes, that issue is on the list to talk about.

Brad Gilbert, MD, Inland Empire Health Plan: In terms of the mechanics, such as the formulary and what drugs require authorization, will that be part of the meetings?

Jennifer Kent, DHCS: There is not a formulary, Medicaid rules require us to cover all FDA approved medications.

Updates on Key Policy Issues (continued)
1115 Waiver and 1915b Waiver Processes

Director Kent reported on the Waiver Process. There is an internal process to think through the possibilities and implications to develop a cohesive set of options. DHCS will work with Agency and the Governor's Office before releasing publicly. She expects this will be covered in the fall 2019 SAC meeting. We have already spoken to the Centers for Medicare & Medicaid Services (CMS) about timelines because the 1915b Specialty Mental Health Services waiver expires in June 2020 and the Medi-Cal 1115 waiver expires in December 2020. We will request a six-month extension for the 1915b waiver to align with the 1115 timing for a single waiver renewal. There are many programs to talk through: the Dental Transformation Initiative (DTI), WPC, and, the whole Medi-Cal Managed Care Program are all in the current 1115 waiver. This is the opportunity to think long term. There are new things to contemplate such as the waiver for Institution for Mental Disease (IMD) provisions. The bar is high for this on federal requirements and we know there is interest in discussing this. The SUDS/ODS waiver is important to us and we want to continue that important program.

Questions and Comments

Kristen Golden Testa, The Children's Partnership/100% Campaign: Will the Care Coordination Initiative discussions all be combined into this waiver discussion? What will be discussed this fall?

Jennifer Kent, DHCS: DHCS (Jacey Cooper) held meetings across the state and heard many ideas and suggestions to consider. We have included what we heard on ways to improve care coordination in our waiver renewal thinking. In the fall, you will see an overall conceptual proposal. There will be a small 1115 proposal (Global Payment Program, Organized Delivery System claiming for residential treatment) and programs in other authorities as well. We are looking to this as a foundational change in the Medi-Cal program.

Erica Murray, CA Association of Public Hospitals and Health Systems: The stakes are high for public systems' transformation efforts and funding. We are looking for how to build on the good work and take it even farther in the current context of quality improvements. There are billions of dollars annually on the line. As a result of self-financing in systems where the revenue does not meet costs, there is an inherent structural deficit that is growing.

Barsam Kasravi, Anthem Blue Cross: Is there a thought about combining the Health Homes Program and WPC for the future waiver?

Jennifer Kent, DHCS: Yes.

Farrah McDaid Ting, California State Association of Counties: It's great to see the Governor's commitment to WPC and the ODS waiver continuation. We want to work with DHCS on applying for an IMD waiver. And, we are concerned about the future of the public hospitals.

Michelle Cabrera, County Behavioral Health Directors Association: We are thrilled with the success on WPC. I have questions about DHCS comments on WPC-like opportunities through managed care plans. On the IMD, we need to look at the continuum of care outside of IMD. Have you had initial conversations with CMS?

Jennifer Kent, DHCS: There is an FAQ on the CMS website. States need to show what currently exists as part of the mental health delivery system, states have to describe how they will build additional capacity, there is a funding maintenance of effort, the IMD average length of stay has to be less than 30 days, and states must report to CMS quarterly. It is a high bar and I would encourage everyone to read it. No state has applied for the waiver opportunity yet. On WPC, the existing waiver authority will end and we will use different authorities and funding mechanisms, such as directed payments as recently released in the federal managed care rule.

Kim Lewis, National Health Law Program: We are submitting comments and have a legal position about the legality of waiving IMD. We are separately concerned about using the IMD to build out what is missing in the system. I wouldn't want us to jump to IMD thinking it would solve the problems.

Anthony Wright, Health Access CA: Can you ask for extensions on both waivers?

Jennifer Kent, DHCS: That is more problematic. There are pieces of funding that expire even before December 2020 and it may not be helpful to extend.

Anthony Wright, Health Access CA: Is there any thinking about looking for items that will achieve savings as a way of financing other programs?

Jennifer Kent, DHCS: No, not necessarily. We don't to identify programs for possible savings calculations if we are only seeking waiver authority for pass-through programs.

Mari Cantwell, DHCS: There is risk to including certain items and no real opportunity to identify savings. We haven't identified things we want to do that can't be done in other authorities. Our approach is to think about what we want to accomplish, not to focus on savings.

Updates on Key Policy Issues (continued)
Performance Outcomes System EPSDT Psychosocial Services Chart.
https://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx and
https://www.dhcs.ca.gov/services/MH/Documents/20190501_EPSDT_Psychosocial_Utilization_youth.pdf

Director Kent reported on utilization data for youth and adults in specialty mental health and mild-to-moderate service systems. Reviewing April 2019 All EPSDT Psychosocial Services chart (link #2), data show significant increases on the mild-to-moderate managed care services as well as individuals continuing to utilize services from specialty mental health systems and individuals using both systems.

Questions and Comments

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: Can you explain the utilization displayed in the chart?

Jennifer Kent, DHCS: The chart shows that a total of 10,000 youth utilized services in April: 1,070 used exclusively managed care, about 10%, and 31% (3,160) used exclusively Short Doyle specialty mental health services. It displays the various systems that were utilized. The adult population shows slightly different data but similarly breaks out utilization in the different systems.

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: The utilization on the managed care seems very low compared to the need. We would expect to see 20% of the population to need mild-to-moderate services. We are interested in details of who is getting served in managed care.

Jennifer Kent, DHCS: We have looked historically, and since the implementation of the managed care services, there have been increases in utilization quarter over quarter. It can take 4-5 years to reach full maturity.

Brad Gilbert, MD, Inland Empire Health Plan: It is a combination of building the network and increasing services over time as the network increases and, yes, it is still underutilized.

Maya Altman, Health Plan of San Mateo: We have seen increases over the past two years because of the maturity of the network and getting the word out. I agree there is a large unmet need.

Barsam Kasravi, Anthem Blue Cross: There is still a learning curve for providers to make sure they know this is a benefit.

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: Thanks, this is a promising opportunity, we are interested in continuing to see it grow over time.

Prop. 56 Comprehensive Review
Lindy Harrington, DHCS

Lindy Harrington reviewed continuing and new Prop. 56 payments. The state plan amendment and directed payment proposals have been submitted to CMS for approval. DHCS is continuing physician and dental payments for supplemental payments from prior years, including the HIV waiver increase, Family Planning, Access, Care, and Treatment (Family PACT) program, free-standing pediatric subacute, home health and pediatric day health care, pregnancy termination – all at the same rates as prior years.

There are also proposed new supplemental payments in Medi-Cal. New payments for family planning, separate from the payments mentioned in Family PACT, will use separate codes to avoid confusion with the previous supplemental payments through Family PACT. Trauma screening codes are being added with a payment of $29 per screening to begin January 2020. There are also $59 payments for developmental screenings. In managed care, DHCS created metrics for value based payments (VBPs) that will flow through managed care plans to physicians meeting those metrics. There is a payment for non-emergency medical transportation that is still in development and a payment for Community-Based Adult Services in FFS and managed care.

The loan repayment program was increased by $120 million, including $100 million for physicians and $20 million for dentists. The list of recipients includes 247 physicians in 39 counties in 40 different specialties across practice settings. There are 40 psychiatrists, 70

pediatricians, 13 surgeons and 48 family medicine physicians. We awarded $58.6 million to physicians who were reporting a total debt load of $73 million. We also made dental awards of $10.5 million to 40 dentists in 20 counties across multiple practice settings. There were 31 general and five pediatric dentists, and four with unknown specialty.

Questions and Comments

Brad Gilbert, MD, Inland Empire Health Plan: The family planning increases are very large and will positively change practices. It will be important to follow utilization, including IUD insertions, because it will make a difference. There will be challenges implementing the value payments and we need to track this annually to identify the improvements and how to achieve impact.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Can you say more about the process and applications for loan repayment?

Lindy Harrington, DHCS: DHCS contracted with Physicians for a Healthy California (PHC) and established an advisory group to review the application and criteria for scoring. They reviewed the ranking of scores to determine the final recommendations that were balanced across specialties and geography. There were 1300 applications total, including 900 physicians and 350 dentists. Some applicants were ineligible. The total amount was limited to $300 million, but the total combined debt reported by the applicants was $500 million in total debt.

Michelle Cabrera, County Behavioral Health Directors Association: To what degree will DHCS overlay known regional and practice shortages in the general health system in this process? Will there be coordination across the gaps and Prop. 56?

Lindy Harrington, DHCS: Absolutely, this is the first of five cohorts. DHCS will continue to refine the process. We will hold webinars for applicants not awarded to improve success.

Jennifer Kent, DHCS: There were some remote counties where we didn't get enough applications. We want to work with local medical societies to get the word out.

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: Can you offer a break down on language capacity in the awards?

Lindy Harrington, DHCS: We are still working through the statistics and it will be available soon.

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: Can you say more about VBP for BH?

Lindy Harrington, DHCS: We see this as a grant-type program focused on delivery system change. The specifics of the Behavioral Health proposal is out for public review and comment.

Barsam Kasravi, Anthem Blue Cross: I met recently with legislators from rural areas and they all cite physician shortage as a major need. Are there ways to focus the program?

Lindy Harrington, DHCS: The applicant had to be enrolled in Medi-Cal but many applicants were at low levels of participation in the Medi-Cal program. We do not have a relocation element included for physicians.

Barsam Kasravi, Anthem Blue Cross: We could help facilitate that and will follow up.

Kristen Golden Testa, The Children's Partnership/100% Campaign: On the draft BH VBP, is that matched?

Jennifer Kent, DHCS: Yes, it is going through managed care and is matched. It is intended to be similar in structure to the PRIME program by implementing screenings for all patients and changing the way the office operates.

Kristen Golden Testa, The Children's Partnership/100% Campaign: I don't recall the rationale for excluding clinics if we are trying to encourage the same changes?

Jennifer Kent, DHCS: They are already paid for costs that are calculated in a prospective payment system rate, so they are only eligible for trauma and developmental screening payments.

Chris Perrone, California HealthCare Foundation: The last estimates of physician need in Medi-Cal are for 3,000 more PCPs and specialists, so we still have a long way to go. What are your thoughts about whether the supplemental payments will also drive more participation in Medi-Cal? Will you monitor how participation changes over time?

Jennifer Kent, DHCS: We would look to the plans although the payments have changed every year so it will be difficult to know what makes a difference.

Lindy Harrington, DHCS: We do intend to do that analysis. We have seen more dentists participate in the program. It is easier in the dental program because it is primarily FFS.

Brad Gilbert, MD, Inland Empire Health Plan: We had one example of a high-end specialist and were able to contract based on leveraging the supplemental payments. On the VBP BH, realistically it will be the plans or counties who do the applications for smaller practices and for employed physicians. The dollar flow may need to be different if they are employed.

Jennifer Kent, DHCS: We need to talk that through. We have concerns about that.

Linda Nguy, Western Center on Law and Poverty: Related to loan repayment, were any relocation grants awarded?

Lindy Harrington, DHCS: Nine applications were submitted. No relocation grants were awarded.

Linda Nguy, Western Center on Law and Poverty: Would DHCS be open reconsidering the criteria to a lower the award amount to expand the number of people who receive awards.

Jennifer Kent, DHCS: No. We saw high amounts of debt reported - $300,000 is the average. I am not in favor of a change at this time.

Linda Nguy, Western Center on Law and Poverty: Do you have a sense of timing on the Prop. 56 analysis of the payments?

Lindy Harrington, DHCS: There have been delays in approvals from CMS so it has been difficult to see the flow of payments. We hope to have approvals more quickly this time and dollars will flow more quickly so we can have better results and analysis.

Brad Gilbert, MD, Inland Empire Health Plan: To Barsam's point, we have had success in getting physicians to move and I see the loan repayment as a complement to that approach.

Jessica Rubenstein, CA Medical Association: Have you submitted to CMS already and do you have information on the VBP?

Lindy Harrington, DHCS: Yes, and the valuations themselves are still being worked on.

Anne McLeod, California Hospital Association: There is an additional program of GME going through PHC. Those first set of awards were granted earlier this year and can complement the DHCS program.

Jonathan Sherin, LA Department of Mental Health: In Los Angeles, we are using workforce investment for loan repayment and it has been important for bringing in and retaining physicians. Is there consideration for looking at the burdens of clinical documentation as part of retaining great providers?

Jennifer Kent, DHCS: It is on the list as part of our waiver renewal process.

Carrie Gordon, CA Dental Association: Thanks for the loan repayment program and the sense of urgency from DHCS to get this moving. We have seen an increase of 1,000 providers in the program since Prop. 56 began. We are hopeful we can do more on relocation.

Barsam Kasravi, Anthem Blue Cross: I think there is a need for training on the Medi-Cal program itself, especially for new physicians. As you think through the trauma screening training perhaps there is a way to include more information about how to be successful in Medi-Cal documentation.

Audit and Budget Resources Update
Nathan Nau and Michelle Retke, DHCS
Slides available:
https://www.dhcs.ca.gov/services/Documents/Preventive%20Services%20and%20Access%20Assessment.pdf

Nathan Nau reviewed DHCS follow up to the children's audit report. As part of that, DHCS is in the process of creating the preventive service utilization report attached to the meeting materials that includes both children and adult metrics. DHCS is currently evaluating metrics for the first year report. There are complex elements being worked out, such as defining metrics technical specifications, how to avoid duplicative reporting and align with existing metrics. For the current report, the focus is on metrics that can be calculated with existing encounter data. In the future, we will modify that. We are focusing on AAP Bright Futures and USPSTF Grade A & B recommendations that we hold plans accountable for. Of the 60 total services, there are 29 services that can't be reported solely based on encounter data and require a chart review. We can look to bring those measures in over future years.

He reviewed the list of metrics being considered for pediatrics and adults that can be analyzed with existing encounter data. Metrics will adjust depending on changes to CMS Core Set or other available metrics. Performance benchmarks will need to be set for some metrics because they do not exist. DHCS will analyze trends and develop a Managed Care Plan level Corrective Action Plan sanction process.

Questions and Comments

Michelle Gibbons, County Health Executives Association of CA: For some measures listed, they are not the top concerns trending in California. For example, gonorrhea is listed although syphilis is increasing. There are other pressing issues, like opioids, not included. Will there be a way to include California specific health concerns that are significant but not included?

Nathan Nau, DHCS: We are looking at that and will evaluate more California-specific measures in conjunction with the federal level. Also, we expect that federal changes may include some of those, like opioids.

Anne Donnelly, San Francisco AIDS Foundation: Recently, HIV prophylaxis got a grade A from USPSTF, but can't be captured in encounter data. How will that be planned for?

Nathan Nau, DHCS: There are secondary ways to capture the data. We can require the plan to capture it or look at administrative data. That will not be in the first iteration.

Linda Nguy, Western Center on Law and Poverty: Where are you in the process of creating the medical record review process?

Nathan Nau, DHCS: DHCS will be doing that. We recently sent out a revised facility site review (FSR) tool for comment that will collect more information from medical records.

Kim Lewis, National Health Law Program: You will collect full data – 100% of all medical records?

Nathan Nau, DHCS: Plans look at all physicians and a sample of medical records for each physician. We will look at plan results of their sample size.

Kristen Golden Testa, The Children's Partnership/100% Campaign: What are the metric technical specifications?

Nathan Nau, DHCS: Each metric has rules used to calculate it.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Why is it that developmental screenings are not on the list since you do have encounter data?

Nathan Nau, DHCS: It may require a medical record review, or we don't have confidence in the data. There is a look-back period to be confident of the data so it may be a year two metric.

Kristen Golden Testa, The Children's Partnership/100% Campaign: And the same for trauma screens? When will you roll out the results?

Nathan Nau, DHCS: Yes, this will be on the agenda for the next review. The roll out will be next year.

Brad Gilbert, MD, Inland Empire Health Plan: Are you going to use HEDIS type recommendations, continuous eligibility? A medical record could be from a beneficiary in the program for one month.

Nathan Nau, DHCS: We will follow technical specifications where they exist, and it could be from HEDIS or other specifications.

Brad Gilbert, MD, Inland Empire Health Plan: The statewide report was not based on continuous eligibility. It is good that Prop. 56 is focused but they only need one code to get paid. To ensure all of Bright Futures, it will be difficult to ensure all the activities through the medical records. We find many times that information is in the medical record when we don't have encounter data. Looking at the electronic health records or physical records is painful.

Nathan Nau, DHCS: Yes, there is a lot of work to be done on the non-administrative measures.

Barsam Kasravi, Anthem Blue Cross: On the administrative measures, will you ask plans to submit supplemental data, for example labs?

Nathan Nau, DHCS: We are discussing that but haven't made a final decision yet.

Linda Nguy, Western Center on Law and Poverty: Is this only for preventive services or will this be carried forward into the External Accountability Set (EAS) and utilization reports?

Nathan Nau, DHCS: The EAS is now the managed care accountability set that is double the size. This is focused on prevention services and we are doing additional work on utilization.

Nathan Nau reported on the Access Assessment Report required by the waiver. DHCS contracted with the external quality review organization (EQRO), Health Services Advisory Group (HSAG) to conduct the Assessment and formed an Advisory Committee in 2016. CMS approved the Assessment Design in 2017. Nathan reported the results from network capacity, geographic distribution and availability of services utilization. The report will be posted and sent to CMS after incorporating feedback.

Questions and Comments

Linda Nguy, Western Center on Law and Poverty: Related to the time/distance measures, you mentioned that 99% met the standards. Does this mean that alternative access is included in the 1%?

Nathan Nau, DHCS: Four plans has less than 99% of the time and distance standard. I am not certain of the calculation of the 99% so I can't answer the question.

Michelle Cabrera, County Behavioral Health Directors Association: Are you using 1:1200 and 1:2000 for physician ratio?

Nathan Nau, DHCS: Yes.

Michelle Retke offered an update on the outreach campaign required by the audit. Outreach will begin in January 2020. DHCS is working through requirements including a notice and call campaigns the health plans will conduct. There will be stakeholder engagement through the advisory groups once the notices are drafted. There will be an outreach consultant brought on following after January 2020.

Questions and Comments

Kristen Golden Testa, The Children's Partnership/100% Campaign: Is the consultant work also part of the stakeholder engagement process?

Michelle Retke, DHCS: Yes, that work will be developed after January 2020 in phase two.

Public Comment

Susan McLearan, California Dental Hygienists Association: I am happy to see you are including data on utilization of fluoride varnish. Are you collecting data only from medical or also dental offices and clinics?

Nathan Nau, DHCS: That data is from medical providers and community clinics.

Mandy Taylor, California LGBTQ Health and Human Services Network, a program of Health Access: On the Prop. 56 loans, are you already prioritizing providers who offer trans-related care? I would advocate for you to include that. Primary care providers can offer hormone replacement therapy and specialists can offer gender affirming medical procedures. When there is access to trans-care, it increases utilization of preventive care, drastically reduces suicide and encourages positive habits and wellness. There are providers in Sacramento, San Francisco, Los Angeles, but we hear from transgender people, particularly in the Central Valley, San Luis Obispo, Inland Empire and above Chico that they are driving hours to receive care.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: I just came from a Clinical Excellence Conference. Providers at Lifelong are doing a very popular workshop on trans-care for safety net providers. More to do on this important topic.

Next meeting

October 29, 2019