DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
October 19, 2017
10:00am – 3:00pm

MEETING SUMMARY

Attendance

Members Attending: Bill Barcellona, CAPG; Michelle Cabrera, SEIU; Lisa Davies, Chapa-De Indian Health Program; Marilyn Holle, Disability Rights CA; Sherreta Lane, District Hospital Leadership Forum; Kim Lewis, National Health Law Program; Marty Lynch, LifeLong Medical Care and California Primary Care Association; Farrah McDaid Ting, California State Association of Counties; Steve Melody, Anthem Blue Cross; Linda Nguy, Western Center on Law and Poverty; Gary Passmore, CA Congress of Seniors; Cathy Senderling, County Welfare Directors Association; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers; Herrmann Spetzler, Open Door Community Health Centers; Kristen Golden Testa, The Children's Partnership/100% Campaign; Richard Thomason, Blue Shield of California Foundation; Bill Walker, MD, Contra Costa Health Services.

Members Attending by Phone: Anne Donnelly, Project Inform; Bradley Gilbert, MD, Inland Empire Health Plan; Brenda Premo, Harris Family Center for Disability & Health Policy; Chris Perrone, California HealthCare Foundation.

Members Not Attending: Kirsten Barlow, County Behavioral Health Directors Association of California; Richard Chinnock, MD, Children's Specialty Care Coalition; Sarah de Guia, CA Pan-Ethnic Health Network; Bob Freeman, CenCal Health; Michelle Gibbons, County Health Executives Association of CA; Carrie Gordon, CA Dental Association; Michael Humphrey, Sonoma County IHSS Public Authority; Anne McLeod, California Hospital Association; Erica Murray, CA Association of Public Hospitals and Health Systems; Rusty Selix, CA Council of Community Behavioral Health Agencies; Anthony Wright, Health Access California.

DHCS Attending: Jennifer Kent, Sarah Brooks, Alani Jackson, Jacey Cooper, Karen Baylor, Lindy Harrington, Marlies Perez, Javier Portela, Norman Williams, Morgan Clair.

Guests: Giovanna Giuliani, California Health Care Safety Net Institute and Sarah Hesketh, California Association of Public Hospitals and Health Systems, Rhyan Miller, Riverside University Health System

Public in Attendance: 28 members of the public attended.

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

Director Kent welcomed everyone. She acknowledged Sandra Naylor Goodwin's retirement and noted two vacancies on the SAC.

Follow-Up Issues from Previous Meeting and Updates
Norman Williams, DHCS:

Norman Williams reviewed the follow up list from the July SAC meeting. All items were followed up.

Updates from the DHCS Director
Jennifer Kent, DHCS Director

- State and Federal Developments
- Full Restoration of Adult Dental Benefit
- Enrollment
- Prop. 56 Payments
- Deferred Action for Childhood Arrivals (DACA) FAQs

Director Kent offered federal updates, including the significant uncertainty and concern related to Children's Health Insurance Program (CHIP) reauthorization and the federal Medicaid budget. While it is difficult to assess what the program redesign might look like under each Congressional proposal, the fiscal impact worsened with the Graham-Cassidy legislation. It takes some time for DHCS to respond to questions and scenarios, however, we are well positioned compared to others in this climate because of Mari Cantwell's knowledge. She is a fantastic resource for these analyses.

The delayed CHIP reauthorization could have significant fiscal impact, however most children will have ongoing coverage under Maintenance of Effort (MOE). There are about 32,000 children and pregnant women not covered under the MOE. No decisions have been made about continuation of coverage for these groups not included in the MOE. We will run out funding in late December and are working to assess the costs and how we could bridge any fiscal gap.

Questions and Comments

Gary Passmore, CA Congress of Seniors: Is there any alternative to CHIP reauthorization? Is it yes/no on reauthorization?

Jennifer Kent, DHCS: There is no alternative. For states where CHIP is a stand-alone program, this is even more acute, but California includes CHIP has incorporated its Medi-Cal program.

Kim Lewis, National Health Law Program: There are three states who got reallocated unspent funds in CHIP. Can California benefit from this?

Jennifer Kent, DHCS: California already did get reallocated funds. The Centers for Medicare & Medicaid Services (CMS) has been talking to states for several months and that is what will carry us through December.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Health Center reauthorization is also under debate and this means that two-thirds of health center funding is at risk. This could greatly impact our ability to work with those not enrolled in Medi-Cal.

Director Kent spoke to the Sonoma/Napa fire disaster and the state's response. DHCS is finalizing a submission for federal flexibility under a Public Health Emergency 1135 waiver. Information is being submitted today in the waiver, such as eligibility redetermination, provider enrollment attestations, displaced persons; facility capacity. This is a significant disruption. The Sonoma State Developmental Center was evacuated twice and residents are now in Dixon. In addition, a clinic was destroyed in the fire.

Herrmann Spetzler, Open Door Community Health Centers: There are ramifications beyond the immediate fire as well. For example, PG&E can't hook up our new health center even though we are 100 miles from the fire, because they are doing fire response. Can we create a standard letter that acknowledges delays or other problems emanating from the fire?

Jennifer Kent, DHCS: Yes, we have included documentation and audit issues, as well as placeholder language to cover other items we discover in the future.

Contra Costa has a reciprocal aid agreement with Sonoma and has offered help.

Bill Walker, MD, Contra Costa Health Services: Contra Costa took Skilled Nursing Facility patients and we are working to help with Developmental Center patients.

Alani Jackson, DHCS**,** spoke to the restoration of the adult dental benefits, effective January 1, 2018. There is an outreach and access plan detailed by population and county.

Questions and Comments

Herrmann Spetzler, Open Door Community Health Centers: This is an important step forward, but it is important to note that it does not create any more access where the workforce doesn't exist. It will take time to build up the capacity to treat adults. There are many waiting for access. Dentistry is complex and once capacity is lost, it takes time to restart. Rural areas have been greatly impacted by discontinuing adult dental benefits. Letting people know there is a benefit does not make care available.

Alani Jackson, DHCS: We have had success with the Dental Transformation Initiative (DTI) in expanding access for children by getting dentists not previously participating or at very low levels to serve new and more children. We also hope teledentistry will help expand access. We understand that in some areas Medi-Cal access is extremely limited.

Linda Nguy, Western Center on Law and Poverty: We are happy to hear the State Plan Amendment (SPA) for adult dental benefits is being worked on. Do you have a timeline for the codes? Can you talk about outreach? Will there be a provider bulletin?

Alani Jackson, DHCS: There is not a new list of codes for adult restoration benefits – previously optional codes will now become active. We anticipate submitting the SPA in November. As soon as we have firm information, we will send a provider bulletin and we will send mailers to offices. There will be additional outreach through the dental workgroup.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: We welcome the restoration of benefits. This doesn't deal with the capacity and workforce issues even in non-rural areas. It will be important going forward to do what we can to address workforce issues.

Linda Nguy, Western Center on Law and Poverty: If there is an opportunity for stakeholder comment on the Jackson v. Rank mailings (JVR), we would be pleased to.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Is there any counter effort to offer outreach that will keep enrollment high in the face of continued news that Obamacare is threatened?

Jennifer Kent, DHCS: Medi-Cal doesn't have open enrollment or a media budget as Covered California does. Anecdotally, the numbers are trending the way we would expect. The expansion population has slowed/decreased due to a better economy. We do have banners on the Covered CA website to announce Medi-Cal availability yearlong.

Cathy Senderling, County Welfare Directors Association: Covered California has taken steps to mitigate the cost reductions from the federal government. On Medi-Cal, local staff understand how to communicate a confusing situation. We used to do lots of outstationing that we no longer have funding to do. We do continue to see strong application numbers in Medi-Cal.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Can you say more about training available for how to use the open data portal? There is additional SB75 data available through the portal that would be helpful.

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

Director Kent offered an update that the SPAs for Prop. 56 were filed in September. We received approval for HIV providers. We are now working on supplemental payments in fee-for-service (FFS) and payments to the plans that will be passed on to providers. Payments will be made at the beginning of 2018 and are retroactive to July 2017. The dental benefits required a methodology that relied on some assumptions given there is no utilization to rely on as it pertains to some adult benefits. We would also like to remind everyone that these are an annualsupplemental payment that may not remain the same in future years, in terms of providers, amounts or both.

Questions and Comments

Steve Melody, Anthem Blue Cross: What is the timeline for the All Plan Letter (APL)? We anticipate questions from providers and need specific guidance to offer them. We agree about tempering expectations given this is likely a one-year bump.

Lindy Harrington, DHCS: Because of the managed care rule, we have additional requirements for approval on directed payments and we currently are waiting for CMS response. We have the APL ready to go and hope to have CMS approval within 30-60 days.

On DACA, Director Kent reported that DHCS issued a document detailing messaging about how undocumented can continue to receive care under Medi-Cal.

Questions and Comments

Kim Lewis, National Health Law Program: Thank you for the resources. It helps with the fear consumers are experiencing.

Cathy Senderling, County Welfare Directors Association: It is very helpful to have this confirmation that it is "business as usual". I have had questions from workers and the materials help clarify our process.

Managed Care Final Rule Implementation
Lindy Harrington, Alani Jackson, Karen Baylor and Sarah Brooks, DHCS
Presentation Slides:
http://www.dhcs.ca.gov/services/Documents/FinalRuleImplementation_SAC.pdf

Sarah Brooks provided an update on implementation and planning under the Managed Care Final Rule (Final Rule). This was the first overhaul of managed care rules for Medi-Cal since 2002. CMS looked to align Medi-Cal to other rules, increase consumer protections and transparency. It began July 2016 but there is a long roll-out of the provisions. The Governor signed two bills related to implementation on the rules and there is additional information there. The approach we have taken included an analysis of the various methods and places we communicate requirements such as APLs. In 2017, DHCS worked on beneficiary experience, quality of care, program integrity and financing areas under the rules. We have consulted with stakeholders and we have issued eight APLs as guidance. We submitted our contract to CMS in April and are working through the questions. We are also working through the policies and procedures submitted by health plans to ensure they comply with the new rules. We have appreciated the help and comments on various notices to make them clear for beneficiaries.

On Directed Payments, Lindy Harrington spoke to the pass-through payments. Payments flowing to private and public hospitals through managed care were deemed to be unacceptable pass-through payments. CMS does allow value-based purchasing models, delivery system reform or performance improvement initiatives or fee schedules/uniform increases.

The goal is to maintain and improve quality and access to care, and improve encounter data reporting. We have proposed five directed payments; three are based on hospital directed payments and two are related to Prop 56 (physician and dental) that were submitted in June. DHCS is working with CMS to reduce the risk of the methodology in these programs. We will create a proxy per-member-per-month rate (PMPM) at the start of the program and then calculate an actual PMPM at the end of the year based on actual utilization from encounter information. For public hospitals, there will be a pooled amount and payments will be made based on quality. For private hospitals, there will be a pooled amount with payments made on actual utilization from encounter data. For physician payments, there are 13 codes with risk-based rate add-ons developed based on anticipated utilization of the 13 procedures. There are not pooled amounts in this category given that this is new. We submitted to CMS and hope to have final approval within 30-60 days. We have determined that the prime health plan is responsible to make the payments, not the delegated plan. This is all based on encounter information, so it is important this is submitted to the prime plan or payments cannot be made. Dental directed payments mirror the physician payments and timeline.

Alani Jackson reported on the Dental Managed Care Plan implementation. Many provisions mirror hospital and physician proposals and follow similar categories of activity (beneficiary experience, quality of care, program integrity and financing). DHCS issued six APLs (May 2016) to outline their implementation and submitted contract amendments to CMS in April 2017. This is currently pending approval.

Karen Baylor reported on County Mental Health Plans and Drug Medi-Cal Organized Delivery System (DMC-ODS) implementation. This also follows the same activities reviewed for the previous sections. DHCS has provided extensive training and technical assistance. The process includes:

- Crosswalk identifying impact of Final Rule
- Draft Mental Health Plan (MHP) contract and comparison crosswalk
- Established DHCS/CBHDA Final Rule workgroup
- Provided extensive training and technical assistance
- County Information Notices (in progress)

DHCS submitted the contract amendment to CMS in June and is working through comments. This has been a good exercise for county mental health plans to bring them up to the same practices as the physical health managed care plans. For example, credentialing will be in alignment with how managed care health plans operate.

Under DMC-ODS waiver implementation, there are seven counties currently providing DMC-ODS services (Contra Costa, Marin, Los Angeles, Riverside, San Francisco, San Mateo and Santa Clara). There are five counties that are close to beginning services (Napa, San Luis Obispo, Santa Cruz, Sonoma and San Bernardino). The DMC-ODS requirements will only apply to those counties opting into the waiver. There are some similarities to the requirements for the MHPs, although many of these activities have never been implemented in the substance use disorder (SUD) area. For example, this is the first time the SUD system will utilize an External Quality Review Organization (EQRO).

Sarah Brooks reviewed the upcoming activities for 2018 and 2019, such as a quality strategy and rating system.

Questions and Comments

Kim Lewis, National Health Law Program: In terms of contract amendments and timing of July 2017, is there retroactive timing here?

Sarah Brooks, DHCS: We don't expect significant change and expect the contracts are in compliance. As we move forward with CMS to finalize contracts, we will update the APLs. We will need to update contracts for 2018.

Kim Lewis, National Health Law Program: Karen, what is the timing for the Grievances and Appeals? Are you reviewing policies and procedures from plans?

Karen Baylor, DHCS: I can't give you a date certain, but it will be finished soon. Yes, we are reviewing policies.

Bill Walker, Contra Costa Health Services: Can you review the major CMS approval timelines? There is some concern that we are implementing without any certainty.

Lindy Harrington, DHCS: We are discussing managed care health plan contract amendments with CMS now; Dental contract approvals are in the works; hospital quality improvement payments are pending. CMS is focusing on Prop. 56 first. We anticipate this within 60-90 days.

Marilyn Holle, Disability Rights CA: When can we see the new boiler plate language for managed care plans and mental health plans?

Sarah Brooks, DHCS: For managed care health plans, we will post very soon.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: Are the documents already posted for ODS?

Jennifer Kent, DHCS: They will be posted upon CMS approval and the ADA compliance review. For each delivery system, they will be posted.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: I am interested in network adequacy issues for Mental Health and ODS. Does it mirror what health plans do today? Today, they credential primarily licensed practitioners and I think there is a problem there. The Mental Health and Substance Use providers are more varied and rely on bachelor's level. Will credentialing follow all the various workforce?

Jennifer Kent, DHCS: We can look. I think it has to do with the health plans and mental health plans' process for credentialing to ensure a standardized way to build a network.

Kristen Golden Testa, The Children's Partnership/100% Campaign: On the initial health assessments, are there guidelines for plans to follow?

Sarah Brooks, DHCS: There is language in contracts about health assessments and what the requirements and categories should be. We also have older APLs that reference these requirements from the previous state health assessment (SHA).

Kristen Golden Testa, The Children's Partnership/100% Campaign: On the hospital quality improvement program, where are the measures you mentioned?

Lindy Harrington, DHCS: They are not yet posted, pending CMS approval. We will notify you when it goes up and where it is on the website.

Cathy Senderling, County Welfare Directors Association: On mental health plan notice templates, for foster kids, who gets the notices? Is it a caregiver, parent, multiple people?

Karen Baylor, DHCS: Yes, we have had discussions on this and I will follow up.

Richard Thomason, Blue Shield of California Foundation: How do directed payments for public hospitals relate to the waiver programs? Are they overlapping?

Lindy Harrington, DHCS: The work under the quality improvement program is informed by the waiver. For example, we had to ensure there was no overlap in the quality measures – that hospitals are not paid for the same thing twice. We also looked at what level of funding was provided under the previous payments programs for transition of Seniors and Persons with Disabilities, and the Medi-Cal Expansion population, and changed to allocate this funding across all populations. There is no linkage going forward to those specific populations.

Lisa Davies, Chapa-De Indian Health Program: Under network adequacy, are there any incentives for plans to beef up networks? Are there any penalties if they don't?

Sarah Brooks, DHCS: The contracts require network adequacy for all beneficiaries and we have robust monitoring system for network adequacy. We recently created an automated provider file that allows more robust monitoring and GIS mapping.

Steve Melody, Anthem Blue Cross: The oversight and compliance on network adequacy and readiness has been going on for some time via the California Department of Managed Health Care (DMHC). This is becoming more stringent for good reasons, but we are not starting at the initial stages.

Update on PRIME and GPP
Giovanna Giuliani, CAPH/SNI and Sherreta Lane, District Hospital Leadership Forum

Slides available: http://www.dhcs.ca.gov/services/Documents/PRIME_DHLF.pdf and http://www.dhcs.ca.gov/services/Documents/PRIME_GPP_update.pdf

Sherreta Lane offered background on district hospitals, their locations and size. They are public entities with elected boards of directors and therefore able to participate with certified public expenditures (CPE)/ intergovernmental transfer agreements (IGTs). All but one of the 37 district hospitals are participating in the Public Hospital Redesign & Incentives in Medi-Cal Program (PRIME) with at least one project. Eleven hospitals are doing multiple projects. These hospitals did not participate in the previous Delivery System Reform Incentive Payments (DSRIP), so some readiness was built into the plan to address IT, staffing, training, etc. There are 110 projects among 37 hospitals/systems. The Projects were chosen to meet communities' needs/gaps in services and include primary and specialty care, behavioral health, preventive programs, and post-acute transitions (the most popular project).

Examples of PRIME projects include Million Hearts, integration of behavioral health and primary care, ambulatory care redesign, and chronic non-malignant pain management. Funding through IGTs will draw down $100M federal funds. There was a funding floor put in place to ensure sufficient infrastructure to participate. The service capacities are directed to Medi-Cal but will benefit the entire community.

Some of the challenges relate to the diversity of the hospitals. Those with Rural Health Clinics can provide the full continuum of care. Others provide only acute, inpatient care and must build new strategy to address primary care and community partnerships. There are ongoing infrastructure challenges, such as IT systems that are not integrated; licensing; staff recruitment; and ensuring the minimum number of patients. Many successes already are resulting from the investments to change the systems, become less reactive, and hire staff dedicated to population health. She reported that the hospitals are enthusiastic about the program.
Specific successes include:

- Increased the number of primary care clinicians within RHC sites (ambulatory care redesign)
- Start-up of farmers' markets at hospitals and cooking programs in coordination with schools (obesity prevention/healthier foods initiative)
- Providing behavioral health services and screening primary care patients to allow for early intervention

Giovanna Giuliani shared early learnings from 12 designated hospitals and five UC hospitals participating in PRIME and the Global Payment Program (GPP). The pay-for-performance program is worth up to $3.26B in federal funds over five years and is the successor to California's DSRIP. The focus is on primary and preventive care and requires year-over-year performance improvement targets. She reviewed the structure of PRIME and provided specific examples of member progress under each of the six required projects listed below:

1. Integration of Physical and Behavioral Health
2. Ambulatory Care Redesign: Primary Care
3. Ambulatory Care Redesign: Specialty Care
4. Improved Perinatal Care
5. Care Transitions: Integration of Post-Acute Care
6. Complex Care Management for High Risk Medical Populations

Emerging themes:

- Investing in IT and data analytics: new infrastructure, such as Electronic Health Record (EHR) enhancements, eConsult platforms, development of dashboards, and customized registries to more effectively care for patients.
    - Kern implemented a new software system that administers patient screenings and surveys electronically.
    - Ventura created health maintenance tools and reminders in their EHR to flag for providers when screenings are needed.
- Strengthening and standardizing performance improvement: quality improvement principles and methods, such as Lean Management or Model for Improvement, to identify areas for metric/project improvement and to test changes.
    - Riverside's Ambulatory Care Redesign team implemented PDSAs (Plan-Do-Study-Act) at10 of the 13 primary care clinics on Screening, Brief Interventions, and Referral to Treatment (SBIRT), tobacco cessation counseling, diabetes control, hypertension control, race, ethnicity, and language (REAL) data completeness, and patient experience
- Developing the workforce: engaging employees in change, training staff, and changing staffing models.
    - Alameda Health System enhanced team-based care by training medical assistants to order labs and hiring additional clinic nurses and pharmacists.
- Implementing new processes and workflows: some are tech-enabled, to enhance patient care.
    - San Francisco developed a standard set of REAL categories, created an intake form (now translated into the 15 threshold languages), trained staff and implemented new workflows to collect data.
- Improving coordination and partnerships: coordinating internally and enhancing external partnerships to improve performance and patient care.
    - Many systems are improving coordination between primary and specialty care through the use of e-consult.
    - LA County partnered with the local health information exchange, LANES, to upload complete specialty visit notes in real-time so that they are readily available to partners.
- Enhancing patient engagement: includes outreach and in-reach, new campaigns and non-traditional services (such as telemedicine and phone visits).
    - Santa Clara Valley Medical Center developed a care transitions program with a team of registered nurses who initiate interactions with patients while they are hospitalized and facilitate their transition into ambulatory care.

She also provided information on optional projects (three are required) and quantitative data on hospitals that met or exceeded measures in the first year. Overall, hospitals are meeting 87% of metrics (from over 100 different metrics).

PRIME also includes an alternative payment methodology element intended to tie value to payment. There are individual hospital requirements, such as completing at least one health plan contract that is Alternative Payment Methodology (APM). There are also aggregate requirements for all patients that 50% of all beneficiaries in the system will be under APM by 2018. Primary care capitation is the most common form of APM although some are at full capitation. Also, members are exploring bundled payments and shared savings/shared risk or other episode of care payments. All systems are on pace to reach this target.

Takeaways:

- There are significant increases in prevention screenings that will result in early detection
- Infrastructure investments are significant
- Data is essential and challenging
- Looking ahead, it is important to recognize how difficult it is to continue to accelerate the trajectory of improvement, add new change efforts, and accomplish spread and scale.

She offered background on the GPP. GPP streamlines the previous Disproportionate Share Hospital (DSH) and Safety Net Care Pool into a global budget. To draw down the entire budget, a hospital must earn points through services – with decreasing points for ED visits and increasing points for primary care over time. Similar to PRIME, early themes include strengthening IT infrastructure for tracking and reporting. GPP is also strengthening ambulatory care networks and this has benefit for all low-income patients.

- Strengthening data infrastructure through new tracking and reporting
- Strengthening local coverage programs
- Expanding and strengthening ambulatory care
- Increasing provision of nontraditional services

She also offered early data on GPP, showing baseline and Year 1 and 2 (interim results). The trend lines indicate lower inpatient utilization and higher outpatient care trending in the right direction compared to baseline.

GPP Takeaways:

- Data capture and reporting is a work in progress: IT systems, data sharing, insurance status, coding, workflows
- Expansion of outpatient care is taking place

Questions and Comments

Marilyn Holle, Disability Rights CA: Is the list of non-traditional services cataloged?

Giovanna Giuliani, CAPH/SNI: Yes, it is on the SNI website with all the details.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: The projects in PRIME and GPP are also being worked on with community health centers. Are there best practices to show the way these are working together?

Giovanna Giuliani, CAPH/SNI: There is lots of collaboration through CP3 Pilot for Learning and Action Exchange and the Center for Care Innovation. I also think we need to work on this much more.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Are there any of the public systems taking full risk? Are they delegated?

Giovanna Giuliani, CAPH/SNI: Yes, LA and SF are full risk and delegated.

Bill Walker, MD, Contra Costa Health Services: We are beginning to talk about health, not coverage, and it's reflected in senior staff meetings that I conduct. They are working across departments and collaborating in new ways.

Herrmann Spetzler, Open Door Community Health Centers: How would someone know about this? Would the foundations be interested in helping spread the positive message here?

Jennifer Kent, DHCS: The best news is that those using services in our public and district hospitals will see the result without reviewing the presentation. There has been lots of work over the last two waivers that is not necessarily publicly known but leads to very important changes in care delivery.

Mental Health Parity Compliance Rule
Jacey Cooper and Karen Baylor, DHCS
Slides available: http://www.dhcs.ca.gov/services/Documents/MentalHealthParity.pdf

Jacey Cooper provided background on the mental health parity rule specific to Medicaid. Parity requirements span Inpatient, Outpatient, Prescription Drugs, and Emergency Care benefits. The analysis of parity required review of CMS guidance and looking across many state documents such as the Medicaid State Plan, Waiver programs, State and Federal statutes and regulations, DHCS contracts, APLs, County Information Notices, Medi-Cal Provider Manual, Drug Medi-Cal Billing Manual and the Specialty Mental Health Services Billing Manual. Several multidisciplinary workgroups have been conducting this work. She then reviewed the findings and compliance action available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/ParityComplianceSummary_clean_rev%209.28.2017.pdf and
http://www.dhcs.ca.gov/formsandpubs/Documents/Parity_Compliance_Plan_9.29.2017.pdf

Questions and Comments

Farrah McDaid Ting, California State Association of Counties: Can you talk about the fiscal impact of implementing the changes due to parity? Are you working on both county mental health plans as well as others?

Jennifer Kent, DHCS: We are working on a fiscal estimate and will it will be released in the 2018-19 budget and in time for the next SAC meeting. It will be a similar methodology for county mental health plans.

Kim Lewis, National Health Law Program: I am happy to see the comprehensiveness of the compliance plan by looking across the system. There are so many carve-outs, different elements of the system. You talked about prior authorization, do you have a list of the services that will require prior authorization?

Karen Baylor, DHCS: We are having discussions about that and will include it in the materials we send out. We have been talking with behavioral health folks as well as CMS. For example, some things are clear, like 'no prior authorization for crisis services.'

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Community health centers have been working for many years on being able to be reimbursed for mental health services and physical health on same day.

Jacey Cooper, DHCS: The current same-day rule is in compliance with parity. We are not making changes to the Federally Qualified Health Centers (FQHC) methodology.

Jennifer Kent, DHCS: There was a bill signed by the Governor (Senate Bill 323, Mitchell). I think there can be changes if clinics apply for scope of practice change.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: What are some changes specific to prior authorization? For example, the residential benefit prior authorization?

Karen Baylor, DHCS: We have offered some examples such as the change from 14 days to 5 days.

Jacey Cooper, DHCS: In addition, we are specifically outlining how residential services will reach parity.

Jennifer Kent, DHCS: I want to thank Karen and Jacey for this extensive work and accomplishing a very difficult crosswalk analysis.

State Transition Plan for Developmental Centers
Javier Portela, DHCS

Javier Portela offered an overview of the Developmental Center (DC) Closure Plan prepared in response to legislation. Three DCs are being closed: Sonoma, Fairview and Porterville. The DHCS plan describes the managed care transition plan which provides for transition of medical services as individuals move from the DCs to their new community living options. The closures will be complete in 2021. We are working with Regional Centers to coordinate with them about support services and living options. There is transition time included to move in and out of the community and center to normalize the new situation. We are relying on our lessons-learned from other transitions of Medi-Cal populations into managed care. For example, we are working with beneficiaries about where they want to go and staying ahead of enrollment transitions. The Sonoma DC closure is scheduled for the end of 2018 and transitions are in process now. Continuity of Care is not really an option, since the facility is closing so we are focused on Continuity of Services.

Questions and Comments

Marilyn Holle, Disability Rights CA: How will you address the criminal justice aspect at Porterville?

Jennifer Kent, DHCS: Porterville includes other populations beyond those transitioning and the entire center is not closing. What is closing is called the General Treatment Area of Porterville DC.

Bill Walker, MD, Contra Costa Health Services: Can you talk about the early transition occurring because of the Sonoma fire?

Javier Portela, DHCS: Residents have moved for a couple of months to Dixon. Since the transition is being handled in an ongoing way, some may not go back to the Center. The transition is very individualized. For example, we look to see if there is family or a conservator in a particular location.

Innovative Approaches to Substance Use Treatment in Medi-Cal
Marlies Perez, DHCS

Rhyan Miller, Riverside University Health System
Slides available: http://www.dhcs.ca.gov/services/Documents/DMC_ODS_MAT.pdf

Marlies Perez opened the DMC-ODS presentation by sharing that California is now part of a group of states implementing an 1115 Waiver for SUD. . California was the first state to receive approval to implement an 1115 Waiver for SUD.

The core elements of the program are:

- Benefits: Continuum of care modeled after national standard of care
- Accountability: Increased local control and accountability
- Beneficiary Protections: Strong provisions for program integrity and beneficiary protections
- Oversight: Utilization tools to improve care and manage resources
- Quality: Evidence-based practices
- Integration: Coordination with other systems of care

She reviewed the standard benefits available in all counties, regardless of their participation in the DMC-ODS, and the benefits available in pilot counties that have opted in for participation. The deadline for counties to opt-in for participation was September 1, 2017. In total, there are 40 counties that have opted-in, representing and 97% of California's population. Marlies offered specific information on each core element of the program and highlighted information from implementation. For example, Los Angeles began July 2017 and will serve 16,000 youth and 89,000 adults with an EHR for mental health, physical and substance use disorder services to coordinate systems.

California Health Care Foundation (CHCF) and Blue Shield of California Foundation (BSCF) are supporting projects as part of the DMC-ODS implementation. Training in American Society of Addiction Medicine (ASAM) assessment of beneficiaries has been delivered. DHCS contracted with Behavioral Health Concepts to conduct External Quality Review activities for the Waiver. UCLA is conducting an evaluation covering four areas: Access, Quality, Cost and Integration and Coordination of Care.

Marlies also reported on the state's response to the opioid crisis. California was awarded $90M over two years to: 1) serve counties without a narcotic treatment program (NTP); 2) increase the availability and utilization of buprenorphine statewide 3) improve medication assisted treatment (MAT) for California's American Indian and Native Alaskan tribal communities. California is implementing the hub and spoke model similar to that adopted in Vermont. The California model:

- Hubs provide care to the clinically complex buprenorphine patients and manage buprenorphine inductions
- Hubs provide support to the Spokes when they need clinical or programmatic advice
- Spokes provide ongoing care for patients with milder addiction (managing both induction and maintenance) and for stable patients on transfer from a Hub.

UCLA will conduct an evaluation and a learning collaborative with other states on this effort. Funding specific to the American Indian and Alaskan Native Population will include Project Echo, suicide prevention, Naloxone distribution to first responders, culturally specific MAT programs, needs assessment, education and training and support for MAT access expansion under the Indian Health Program-ODS.

Marlies and Rhyan Miller from Riverside presented information about the significant volume of ASAM and continuum of care training. This includes mentoring scholarships, webinars and training, and assisting with recruitment of waivered prescribers for the Spokes. Rhyan spoke to the significant increase in calls for services and described the system of determining the availability of residential and detox beds now run by the county. A new practice is that every DUI is assessed and may be referred into treatment. This is resulting in decreases in the mandatory referrals for treatment.

Questions and Comments

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: Thank you for the work on this. The increase in access is fantastic and I am confident we will work out the bugs along the way. My greatest worry at this point is about quality and compliance -- so many new people in a system with a high level of requirements. I am concerned we will have very difficult situation when monitoring reviews occur.

Marlies Perez, DHCS: There are mock monitoring requirements happening to help with this and we will adjust technical assistance to respond to needs identified.

Cathy Senderling, County Welfare Directors Association: How are people referred, especially if they are not Medi-Cal eligible? Can they walk in? Can you explain what is driving the change, what is so different in ASAM?

Marlies Perez, DHCS: We are just finishing the contracting and part of this includes a requirement to develop an outreach plan. The grant is “payer of last resort” if someone has other coverage but if not, they can receive services. On your second question, ASAM has an individualized element that tailors for different approaches from lower level needs to higher level needs.

Lisa Davies, Chapa-De Indian Health Program: Fresno is developing MOUs. What will this accomplish?

Marlies Perez, DHCS: They are required; however the MOUs also encourage more coordination of care as well as covering referrals and placement. The California Office of Health Information Integrity (CalOHII) has confidentiality rules and I will send a link as follow up.

Kim Lewis, National Health Law Program: How does the number you reported grow over time?

Marlies Perez, DHCS: The number can’t change. The expanded waiver opportunity is closed.

Kim Lewis, National Health Law Program: When will California be fully implemented?

Marlies Perez, DHCS: It will be a roll-out over time and it is difficult to project the exact time. The bulk of counties will be implemented in 2018 with some outliers. For example, the tribal system will implement in 2019.

Jennifer Kent, DHCS: This is not expected to end with the current waiver. There has been a high level of scrutiny and administrative work on each contract and county and we expect this to continue under future waivers.

Richard Thomason, Blue Shield of California Foundation: Thanks to all the staff and partners. It is great to see this huge lift coming to life.

Anne Donnelly, Project Inform: I would like to talk offline about the intersection of this and the HIV/Hep testing.

Public Comment

California Dental Association: We appreciate the opportunity for comment on Prop. 56. On dental restoration benefits, we are seeking additional clarification on billing.

Health Access LGBT Network: We look forward to seeing the new disparities measures incorporated and the dashboard. In addition, we want to hear more about how new Prop 64 funding may complement or add to existing systems.

SAC in 2018: Future and Direction

Jennifer Kent asked SAC members for feedback about the composition of the advisory committee, agendas and how the SAC meeting should be used going forward. Currently, state staff spend a lot of time talking and providing updates. Is this a good benefit to committee members? Over the time that the SAC has existed, DHCS has also added new workgroups that incorporate deeper work on specific issues and/or are an opportunity for people to offer input based on specific expertise.

- Is SAC useful for you? In what ways?
- Are there particular ways SAC should build its agendas?
- Are there specific topics to include?

We would appreciate hearing from you. We will be pulling together a small group to provide input on these questions and I am happy to hear from you now.

Comments

Kim Lewis, National Health Law Program I am glad you are doing this. It is hard with so many topics to get and give meaningful input. I think we should assess how we can be more effective in both directions.

Jennifer Kent, DHCS: It is also difficult to find common ground for topics across this broad of a group.

Cathy Senderling, County Welfare Directors Association: By way of feedback, I can say that I looked at the agenda today and wasn't sure I would stay all day, but each topic offered something I can use and I have stayed for the entire meeting. Even though we are a varied group, the information is useful. In addition, I appreciate the cross section of members and find it helpful to develop relationships.

Anne Donnelly, Project Inform: It is very helpful to have the broad view and understand where to plug in for more detailed discussion. One suggestion is that we could spend the morning in an overview and the afternoon in a deep dive on a single topic.

Jennifer Kent, DHCS: We look forward to input on topics and on the composition of the membership.