

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

October 29, 2019

MEETING SUMMARY

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

Members Attending by Phone: Jessica Rubenstein, CA Medical Association.

Members Not Attending: Bill Barcelona, America's Physician Groups; Michael Humphrey, Sonoma County IHSS Public Authority; Brenda Premo, Western University of Health Sciences.

DHCS Attending: Richard Figueroa, Mari Cantwell, Sarah Brooks, Jacey Cooper, Rene Mollow, Karen Mark, Brenda Grealish, Lindy Harrington, Norman Williams, Morgan Clair.

Public in Attendance: 128 members of the public attended in person and 393 participated by phone.

Welcome, Introductions and Opening Comments

Mari Cantwell, Chief Deputy Director of Health Care Programs, DHCS

Mari Cantwell opened the meeting and introduced Acting Director Richard Figueroa. He welcomed SAC members and offered introductory comments on DHCS' new initiative, California Advancing and Innovating Medi-Cal (CalAIM). CalAIM advances key priorities of the Newsom administration including specific prescriptions for individualized needs of

multiple populations such as, older Californians, justice-involved, homeless, vulnerable children, high complexity/high cost care users and those with behavioral health needs. It sets a foundation for more efficient health care by incorporating initiatives to fight the state's homeless crisis, support justice system reform, and builds a platform for vastly more integrated systems of care. This initiative is essential for the exploration of single payer principles through the revised Healthy California for All Commission. He offered appreciation to previous DHCS Director, Jennifer Kent, and DHCS staff for thousands of hours traveling the state to listen and gather input, thinking, and writing to result in this proposal.

Mari Cantwell introduced state staff and new roles including, Kelly Pfeifer, Marlies Perez, Janelle Ito-Orille and Brenda Graeish. She also welcomed new SAC members, MJ Diaz, from SEIU California and Stephanie Sonnenshine from the Central California Alliance for Health. She thanked Marty Lynch, who is retiring soon, and Brenda Premo for their service to SAC.

Follow-Up Items from Previous Meetings

Norman Williams, DHCS

The follow-up items from the July SAC meeting are available in the updated in the document posted:

https://www.dhcs.ca.gov/services/Documents/052319_SAC_Followups.pdf.

Comprehensive Quality Strategy Report

Karen Mark, M.D., DHCS

<https://www.dhcs.ca.gov/services/Documents/CQSTimeline.pdf>

Karen Mark reviewed the timeline for the quality strategy as a follow up to a previous presentation to SAC. There will be a draft posted for stakeholder feedback in November 2019 with a 30-day public comment and 35-day tribal review process. An email notice will go out to SAC members as well as other DHCS stakeholders upon posting and we look forward to review of those comments. We will incorporate suggestions and have a final Quality Strategy posted in early 2020.

CalAIM – Advancing and Innovating Medi-Cal: Concept Paper - 1115 and 1915b Waivers for 2020

Mari Cantwell and Jacey Cooper, DHCS

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

CalAIM builds on many previous efforts, including our experience over the history of the Medi-Cal program, especially since the shift to managed care as well as the Affordable Care Act, previous waivers and listening tours. We heard from many people across the state, speaking to the problems and the solutions for Medi-Cal. DHCS staff took the input and looked across the delivery systems to identify what can be proposed within the confines of budget and feasibility.

The multiple systems, complexity and fragmentation are problematic. Sometimes there are up to six systems that beneficiaries have to access to meet their needs. There is a focus on particular populations who are driving costs and whose needs may not be met through the program, such as homeless, those with behavioral health needs, children with complex conditions, justice involved population and aging populations.

This is an initial step and we want to work with SAC and other workgroups to refine the proposal, timelines, programs, etc. We will be working with legislature and our partners in counties to understand what funding is available. There is a deep need for improvements in the information technology infrastructure at the state and in local systems to be successful, including capturing granular data and social determinants of health (SDOH), and be able to share data broadly across multiple systems within Medi-Cal and beyond to other systems such as social services.

CalAIM has three primary goals:

- Identify and manage member risk and need through Whole Person Care (WPC) approaches and addressing SDOH;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

There are 22 discrete proposals bundled into CalAIM to meet the goals. They are interrelated and mutually rely on each other for success. The DHCS team emphasized that these remain initial proposals both for vetting within the stakeholder process as well as funding available through the budgetary and legislative processes.

Jacey Cooper reviewed seven proposals related to the first goal:

- Population Health Management: This is a new requirement for Managed Care Organizations (MCOs) to submit an annual population health management plan based on data driven risk stratification, predictive analytics, and standardized assessment processes. The plan will include sections on wellness and prevention, managing members with emerging risks, case management, in lieu of services, coordination between plans and external partners, transitional services and skilled nursing facility coordination. We want to see data drive decisions and greater alignment to NCQA population health requirements.
- Enhanced Care Management: This is new statewide benefit that is different from what is provided today. This is not only case management, but is whole person, in the community and identifies clinical and nonclinical needs, similar to what is currently done in WPC and Health Home pilots. Those programs will transition into this benefit. There is a list of required populations to be addressed, such as high cost, institutionalized or at risk of institutionalization, those transitioning from incarceration and children with complex needs. There is infrastructure in some places for WPC for post-incarceration, but this will have a longer timeline to 2023 to allow for additional

capacity. The MCO will be the entity to transition existing WPC services and contract with a community network to offer the enhanced care management. In rural or other areas, plans may need to play a direct role in this benefit. Due to concerns about duplication, DHCS will not pay Targeted Case Management to counties for those enrolled in managed care. MCOs will submit a transition plan in 2020 outlining how they will implement this benefit.

- **Mandatory Medi-Cal Application & Behavioral Health Coordination:** It will be mandated for all counties to implement a pre-release Medi-Cal application process for jail and juvenile facilities to include a warm hand-off from incarceration to community behavioral health services. We are also considering approaches for populations transitioning from the state prison system.
- **In Lieu of Services and Incentives:** DHCS is proposing a robust set of statewide in lieu services based on previous pilots. MCO will integrate in lieu services into the population management plan. DHCS will evaluate in lieu of services after five years and assess whether to continue by building them into the Medi-Cal program.

There are 13 in lieu of services included:

- Housing Transition/Navigation Services
 - Housing Deposits
 - Housing Tenancy and Sustaining Services
 - Short-Term Post-Hospitalization Housing
 - Recuperative Care (Medical Respite)
 - Respite
 - Day Habilitation Programs
 - Nursing Facility Transition/Diversion to Assisted Living Facilities
 - Nursing Facility Transition to a Home
 - Personal Care (beyond In-Home Supportive Services) and Homemaker Services
 - Environmental Accessibility Adaptations (Home Modifications)
 - Meals/Medically Tailored Meals
 - Sobering Centers
- **Incentive Payments:** Incentive payments are being proposed to build statewide infrastructure for in lieu of services and enhanced care management. The purpose of incentive payments is to drive change down to the provider level, including clinics, public hospitals and counties.
 - **Mental Health IMD Waiver (SMI/SED):** CMS released an opportunity for states to receive federal matching funds for certain specialty mental health services. DHCS wants to hold a stakeholder process to assess this opportunity. There is a detailed FAQ that outlines criteria for a significant set of services required to be in place prior to submitting the IMD waiver.
 - **Full Integration Plans:** This would mean a single entity would be responsible for oral, physical and/or behavioral health. This is a complex policy change and DHCS will

gather stakeholder input on the requirements for the entity, administration across delivery systems, provider network, quality and reporting, and financial considerations. DHCS assumes the selected plans would not go live until 2024 to allow time for this exploration and development.

- Long-Term Plan for Foster Care: DHCS does not have a proposal on this and wants to convene a workgroup to discuss all the needs of foster youth. There are other states that have made large-scale changes that we should consider for California.

Questions and Comments

Maya Altman, Health Plan of San Mateo: I am excited about the enhanced case management and in lieu of services. I also participate in the Master Plan on Aging. The Long Term Services and Supports (LTSS) touches multiple parts of the state and although we have made progress aligning, I think CalAIM and Master Plan need to articulate a vision.

Mari Cantwell, DHCS: Yes, I agree.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: I agree we need integration of LTSS and CalAIM. On enhanced care management, is this a new rate cell to health plans to fund the service?

Mari Cantwell, DHCS: We will build it into the capitation rates.

Michelle Gibbons, County Health Executives Association of CA: On the target population for enhanced care management, there is a set of mandatory populations and then a process to consult partners to identify additional populations?

Jacey Cooper, DHCS: Yes, the populations listed are required and because needs are different locally, there is the opportunity to engage partners and propose additional populations.

Michelle Gibbons, County Health Executives Association of CA: Is CCS listed as a population in enhanced case management for non-Whole Child Model MCOs?

Jacey Cooper, DHCS: This is an option for Whole Child counties to partner to provide additional case management for complex needs.

Erica Murray, CA Association of Public Hospitals and Health Systems: I appreciate sustaining and building on the successful WPC program that has just started and is showing impressive results. The MCO plans will be the lynchpin for the success in this proposal. It's important for plans to be held accountable for the success of the program going forward and for partnerships with counties to continue.

Michelle Cabrera, County Behavioral Health Directors Association: It seems there is overlap between the Population Management and NCQA workgroups?

Jacey Cooper, DHCS: Population Health includes items that go beyond NCQA requirements. We do want to align population health with NCQA.

Chris Perrone, California HealthCare Foundation: On incentive payments, there are specific populations, like medically complex, and then there is a mention of broader quality measures?

Mari Cantwell, DHCS: Given the broad infrastructure required, we will first focus on infrastructure metrics for in lieu of services and enhanced case management. This doesn't preclude other things, but we want to ensure plans partner with others in the community. Once the infrastructure is there, we expect to move to a metric-based quality approach. For example, we want to look at shared savings.

Anne McLeod, California Hospital Association: Are incentive payments statewide; is there upfront funding?

Mari Cantwell, DHCS: Yes, the payments are statewide through plans to providers. We are exploring ways we can potentially go 5% over actuarial payments as part of regular capitation.

Anne McLeod, California Hospital Association: What is the DHCS infrastructure to monitor the significant responsibility moving to plans?

Mari Cantwell, DHCS: We are looking at the ways to streamline what we already do on oversight and monitoring, as well as build capacity to ensure that things like enhanced care management are happening.

Kim Lewis, National Health Law Program: Are you replacing the Staying Healthy Assessment (SHA) tool? Is it left to the plans to identify what they will use?

Sarah Brooks, DHCS: This is a big piece of the discussion for the Population Health Management workgroup. Yes, the SHA will go away. We want standard elements, but will discuss more about whether there is a standard tool.

Linda Nguy, Western Center on Law and Poverty: In relation to target populations for case management, it seems to focus on high utilizers. Is there attention to others who will benefit from case management, such as those with chronic health conditions? Also, the document refers to "chronically homeless." Will you focus on those who are homeless, but perhaps not chronically?

Jacey Cooper, DHCS: Enhanced care management would include those who are homeless, chronically homeless or at risk of homelessness. However, there are different eligibility criteria for some of the housing in lieu of services.

Mari Cantwell, DHCS: The detailed proposal for in lieu of services lays out eligibility.

Linda Nguy, Western Center on Law and Poverty: Is this a single rate, stratified rate?

Mari Cantwell, DHCS: We haven't determined how rates will flow and generally don't dictate how plans make payments.

Linda Nguy, Western Center on Law and Poverty: The enhanced payments for Health Homes ends later than the transition to this new benefit. Are we leaving money on the table?

Mari Cantwell, DHCS: Yes, there are counties who will not finish the eight quarters, but we are choosing this path because the way Health Homes is designed is not hitting the intended target.

Gary Passmore, CA Congress of Seniors: Are you proposing a uniform assessment?

Mari Cantwell, DHCS: There are layers. What are the initial assessments that everyone needs? Where do we drill down for specific needs and populations? How do we ensure that there is consistency statewide?

Gary Passmore, CA Congress of Seniors: How does enhanced care management differ from Multipurpose Senior Services Program (MSSP)?

Sarah Brooks, DHCS: There are some similarities and we will not duplicate. We need to do a crosswalk to study that more.

Gary Passmore, CA Congress of Seniors: Looking at the lack of infrastructure for rural, do you have time/distance for rural areas? Including transportation?

Mari Cantwell, DHCS: In both federal and state law, we have robust time and distance standards.

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: Is the Population Health Management Plan replacing the Group Needs Assessment? Do in lieu services have to adhere to the target population list or can we specify culturally specific services that could benefit?

Mari Cantwell, DHCS: Yes, we listed the ones we think would benefit, but we want input on populations. We want to keep to about the same length so there is enough data to know if we should move it into a statewide benefit.

Kristen Golden Testa, The Children's Partnership/100% Campaign: I would request DHCS consider a specific group on financing options. It warrants a discussion.

Mari Cantwell, DHCS: Yes, it's a fair question and we can figure out how to incorporate that into either existing workgroups or discuss it here. It is awkward without knowing the budget available.

Anne Donnelly, San Francisco AIDS Foundation: I want to urge public health representation on all workgroups. Other states do more to integrate public health, physical health and behavioral health. In New York, new HIV rates have decreased by 30% where it has increased in California.

Mari Cantwell, DHCS: All of our sister departments are invited and will be able to participate.

Carrie Gordon, CA Dental Association: It's evident this builds on previous work and it makes sense. I hope that the workgroups address accountability and metrics in depth.

MJ Diaz, SEIU: Is there a plan to work with DSS on the transition to statewide LTSS and IHSS?

Mari Cantwell, DHCS: We have engaged DSS and will continue that, especially on IHSS. We have no proposal to change IHSS, but want to ensure we wrap around services to support people who may be waiting to get into the program and we want to make sure we streamline.

Barsam Kasravi, Anthem Blue Cross: On accountability for plans, we have HEDIS measures set and other dashboards. Is the thought to tie those to CalAIM?

Mari Cantwell, DHCS: Given what CMS is requiring, those will need to continue. We are looking to change medical audits to see how we can capture more of what is needed as well as track the more innovative metrics.

Mari Cantwell reviewed proposals to move Medi-Cal to a consistent and seamless system.

- **Standardize the Managed Care Benefit:** This proposal will bring consistent benefits across all counties statewide, with the exception of CCS, which is not proposed to change. This includes the Pharmacy RX carve-out to fee for service and MSSP. This proposal will carve in long-term care, where it is not yet done via the Coordinated Care Initiative and organ transplants to be paid at current fee-for-service rates.
- **Standardize Managed Care Enrollment:** This will make enrollment consistent across all counties. The foster care population will continue to have voluntary enrollment. This will begin in 2021 for non-dual eligible and in 2023 for dual eligible Medicare/Medi-Cal. There is a detailed chart that outlines the timing and specifics for each population and zip code proposed. There are some mandatory fee-for-service populations, like restricted scope of service and share of cost.

- Transition to Statewide MLTSS: This means that Cal MediConnect will end, and the Coordinated Care Initiative will transition into managed care through the integration of long-term care. All managed care plans will operate Dual Eligible Special Needs Plan (DSNP) to accomplish better integration of Medi-Cal and Medicare.
- Annual Medi-Cal Health Plan Open Enrollment: Similar to other health insurance practices, the Medi-Cal open enrollment process would allow enrollees to change their Medi-Cal managed care plan only during a specified open enrollment period, effective 2022. We have talked about this over a long period of time and the proposal lays out the reasons and advantages for this. Alongside this is a very consumer friendly process to change plans, in consideration of the many concerns raised over time by stakeholders.
- NCQA Accreditation of Medi-Cal Managed Care Plans: DHCS proposes to require NCQA accreditation by 2025 for plans and contracted (delegated) providers and is considering required NCQA accreditation for LTSS. DHCS would use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain State and federal Medicaid requirements. This frees up state capacity for other oversight.
- Regional Rates for Medi-Cal Managed Care: This is an important pathway toward simplification of the rate-setting process by streamlining the many rates currently requiring separate calculations. The proposed simplification will afford DHCS the flexibility to continue to pursue strategies that support advancements and innovations. This will be implemented in a phased approach to be complete by 2023 and starting in places where regional rates are easiest to accomplish. This is not regional service networks.
- Behavioral Health Proposals
 - Payment Reform: Currently services are financed as Certified Public Expenditures, a cost-based system, that is an intensive cost settlement process that takes years and is complex for counties. The first step would be to shift away from the cost-based Certified Public Expenditure-based methodologies to other rate-based/value-based structures that instead utilize intergovernmental transfers to fund the county non-federal share. The shift will: 1) Establish rates for reimbursement that are not limited to cost and instead focus on the quality and value of services; 2) Create opportunities for improved coordination of care by simplifying options for contracts and payments between Medi-Cal managed care plans and counties, without limiting financial benefits for the county; and 3) Reduce State and county administrative burdens and allow counties to close their accounting records closer to the end of a fiscal year by eliminating the lengthy and labor-intensive cost-reconciliation process.
 - Revisions to Medical Necessity:
 - Separate the concept of eligibility for receiving specialty mental health or substance use disorder services from the county and medical necessity for behavioral health services.

- Allow counties to be paid for services to meet a beneficiary's mental health and substance use disorder needs prior to the mental health or substance use disorder provider determining whether the beneficiary has a covered diagnosis.
 - Identify or develop a new statewide, standardized level of care assessment tool (one for 21 and under and one; one for over 21) to determine the need for services and which delivery system is most appropriate to cover and provide treatment.
 - Revise the existing intervention criteria to clarify that specialty mental health services are reimbursable when they are medically necessary.
 - Administrative Integration Statewide: Today, the State has separate contracts for specialty mental health and substance use disorders with counties. We will move to a single managed care contract with counties.
 - Regional Contracting: DHCS recognizes that some counties have resource limitations and wants to work with counties on regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries, through options such as Joint Powers Authority.
 - SUD Managed Care Renewal (DMC-ODS): The DMC-ODS waiver is proposed to be renewed and become statewide based on its positive impact. It remains new and there are lessons that have led to an initial set of changes as well as changes suggested from CMS, such as the 90-day length of stay. California was the first state with this waiver and there are other states with lessons to inform this renewal.
- Future of Dental Transformation Initiative Reforms: There are new statewide dental benefits proposed based on pilots in the previous waiver, such as the caries risk assessment bundle and silver diamine fluoride. Also, the proposal includes performance incentives for preventive services and continuity of care.
- Enhancing County Oversight and Monitoring: DHCS wants to work with county partners to improve performance metrics in order to avoid future federal audit findings. Specifically, there are issues related to timeliness of application processing and annual eligibility renewal processing and discrepancies resulting from data systems. DHCS intends to provide enhanced monitoring and oversight of all 58 counties to promote continuous and optimal care for children. There will be a phased approach for the increased oversight.
- Improving Beneficiary Contact and Demographic Information: Accurate beneficiary information is critical for ongoing program enrollment and care management and this has been a challenge. DHCS will convene a workgroup to determine the best way to ensure that reported data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

A cross-walk and timeline for programs in the Medi-Call 2020 waiver and CalAIM is available.

Jacey Cooper summarized the overall priorities for CalAIM. CalAIM includes a Health for All priority of both preventive services and identifying risk and needs to deliver services beneficiaries need including SDOH. CalAIM also includes enhanced case management and in lieu services to better serve high utilizers. Behavioral health initiatives represent a fundamental shift in the way services will be delivered. Finally, CalAIM proposes initiatives for vulnerable children through enhanced care; addresses homelessness and housing through in lieu services; justice involved individuals through the pre-release application and better coordination and aging population needs through aligning with the Master Plan for Aging, and expanded infrastructure for home and community based services. There are initiatives throughout the proposal to streamline administrative complexity, integrate systems and coordinate services.

There will be stakeholder engagement from November 2019 – February 2020 through five workgroups to discuss CalAIM and the renewal of the 1115 and 1915b waiver(s). The public can attend workgroups and make public comment or listen in on the phone. DHCS will work with the Administration, Legislature and our other partners on these proposals and recognizes the need to discuss the prioritization within the state budget process because implementation will ultimately depend on whether funding is available.

Director Figueroa thanked staff for the hard work and thorough detail in the proposal.

Questions and Comments

Gary Passmore, CA Congress of Seniors: A comment: you are pursuing a LTSS system for 2026 and that is halfway through the baby boomer age group.

Paul Curtis, CA Council of Community Behavioral Health Agencies: In my first year, we did a yearlong process on payment reform and it showed that there is a lot of work and resources required. Will there be training and technical assistance? We just did a training on how to contract with managed care entities and many providers were new to this. My observation is that this effort will require quite a bit of assistance.

Jacey Cooper, DHCS: Yes, we recognize this is complex and will require training and TA. We will work with county associations and partners.

Paul Curtis, CA Council of Community Behavioral Health Agencies: On payment incentives, I urge this get all the way down to providers.

Mari Cantwell, DHCS: We are thinking through how to monitor that. We know that county plans need resources for certain changes; however, we want to drive change at the provider level.

Paul Curtis, CA Council of Community Behavioral Health Agencies: On medical necessity, I have spoken often about administrative burden in California so I'm glad to see you this tackle that. Workforce development ties into this and there are needs for fundamental changes in the workforce at multiple levels.

Carrie Gordon, CA Dental Association: Can you give us a sense of what will come back to this group? What are the milestones for the next two years?

Jacey Cooper, DHCS: The proposal includes a high-level timeline. We will work on a schedule of topics to bring back to this group and how to inform the group about what ultimately goes to CMS.

Kim Lewis, National Health Law Program: On medical necessity, statewide consistency on tools is a good concept, but it isn't clean with EPSDT as to what system the services are in. On pre-release, the focus on county systems is critical. We currently terminate people when they are in jail for more than a year and it is not a federal requirement. Will CCS stay the same or be carved in?

Mari Cantwell, DHCS: It will stay the same. We want to see how the whole child model works.

Anthony Wright, Health Access CA: What is the rationale for fee-for-service and managed care mandates? It isn't clear that this is simpler. For this and other items that are not specific to a workgroup, where will that discussion happen?

Mari Cantwell, DHCS: This is primarily about consistency across the state.

Jacey Cooper, DHCS: We will bring items to this advisory group and to other existing work groups.

Anthony Wright, Health Access CA: How does this the proposal fit with the broader topic of funder streams and budget? What are your thoughts about financing for the overall approach?

Mari Cantwell, DHCS: This is a critical part of the future process. There is a legislative process. What funding is currently used, and can it continue? What is the state budget?

Anthony Wright, Health Access CA: For the non-high need family in Medi-Cal, what changes are available through this proposal? What wellness proposals exist for them?

Mari Cantwell, DHCS: There are preventive services for children that were introduced earlier this year; the population health management approach is for broad health needs; and, we believe that standardization is a benefit for all.

Erica Murray, CA Association of Public Hospitals and Health Systems: I want to acknowledge the breadth and thought to these improvements. Over the years, there has

been intent, but this actually moves to action. However, we are grappling with a lot in this beyond the end of an 1115 Waiver. This is a time of extreme uncertainty for public hospitals and this is fundamentally changing the structure of financing for supplemental payments. The leaders in public health are having to imagine various scenarios. We are committed to significant system transformation and continuing robust pay for performance. It's important for the group to realize that the degree of self-financing itself contributes to our inability to meet costs. We are not just looking at the need to replace the waiver, we are going to have to beyond that to achieve stability for public systems.

Farrah McDaid Ting, California State Association of Counties: We are excited to get to work on this. As flagged by Erica, we have concerns about how CMS will react and have questions about where the match is for Whole Person Care. We are really happy about Global Payment Program extension and jail inmate proposals.

Anne McLeod, California Hospital Association: There are many rate increases to the MCOs for enhancements in the proposal. Do you anticipate erosion of any specific payments, like IGTs?

Mari Cantwell, DHCS: No, we appreciate the advocacy on directed payments with CMS and we don't expect difficulty with agreements on existing payments.

Anne McLeod, California Hospital Association: On the NCQA measures for delegated entities, what about farther down the line in the delegated levels?

Mari Cantwell, DHCS: There are many questions around NCQA and that is why we have a separate workgroup. What are the requirements? How do we continue those for delegated entities? How many levels of delegation or what other pathways for oversight?

Anne McLeod, California Hospital Association: In the crosswalk, the GPP will continue in a waiver, is there budget neutrality?

Mari Cantwell, DHCS: It is a pass through because it is just DSH.

Maya Altman, Health Plan of San Mateo: What is your thinking on aligning mandatory duals enrollment with long-term care. I am concerned about confusion of not doing LTSS at the same time.

Mari Cantwell, DHCS: The challenge is needing to tie Cal MediConnect and everything together. We have heard concerns about how quickly we moved duals into mandatory managed care, and we want to be thoughtful about this.

Linda Nguy, Western Center on Law and Poverty: On the pre-release, we recommend this be used as an opportunity to choose a plan. We have concerns on open annual enrollment. In terms of mandatory enrollment, we have concerns when plans have not demonstrated they have adequate networks, especially specialists. In every transition, we have seen beneficiaries go without needed services.

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: On the behavioral health no wrong door approach, is there a reason this can't apply to adults?

Mari Cantwell, DHCS: We were focusing on EPSDT obligations and that is the rationale, but we are open to further conversation on this.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: On the DSNPs, do you imagine a process to help plans get up to speed?

Mari Cantwell, DHCS: There are plans with more and less experience and there will be a need for TA. If the timeline is too aggressive for some new to this, we are open to discussion.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: On regional rate setting, is there benefit for plans and beneficiaries? What risk adjustment will you use?

Mari Cantwell, DHCS: I think the primary benefit is that it is critical for us to have capacity to innovate by reducing the state staff time on rates. We have existing rate adjustment methods and will discuss the most effective way to do this.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Are the local DTI pilots expanding?

Mari Cantwell, DHCS: No, the pilots are ending, and we are incorporating their success into the proposal.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Are you planning to invest in different measures for care coordination?

Mari Cantwell, DHCS: Yes, we will add measures as part of incentives.

Kristen Golden Testa, The Children's Partnership/100% Campaign: We are disappointed there is no attention to pediatric whole person models. Really there is no place for those not experiencing complex conditions. Where do they go when they show up in an ACE screening that doesn't fall into complex care? That level of care would be very valuable, and we have ideas on that.

Barsam Kasravi, Anthem Blue Cross: Open enrollment is a positive step. We have seen challenges with members enrolling, so are you also looking at simplifying enrollment? Also, I want to offer anything we can do to help with the beneficiary demographic information improvements.

Jacey Cooper, DHCS: The annual open enrollment is not tied to eligibility. It is only for the selection of the plan. Eligibility continues throughout the year.

Sherreta Lane, District Hospital Leadership Forum: Will the fee-for-service population in San Benito County be an exception to the mandatory enrollment?

Sarah Brooks, DHCS: That will fall under reprocurement in 2023, so there will be an exception for the first two years. We hope to have two plans in San Benito County following procurement.

Public Comment

Peter Hansel, CalPACE: There was not much mention of PACE in the plan. We assume, then that PACE will continue to operate on a parallel track. There are some places where CalAIM intersects. For example, if there is mandatory enrollment, will PACE be offered? What happens when someone reaches the threshold for qualifying for PACE, is that a qualifying reason for disenrollment? Also, in regional rate setting, is that a construct applying to PACE?

Mari Cantwell, DHCS: The enrollment and qualifying issue is a good point. We have not considered that. We did not assume PACE would be in the regional rate setting. We would consider that, but it is not contemplated now.

Susan McLearen, California Dental Hygienists: Is there a workgroup on workforce?

Mari Cantwell, DHCS: We did hear input about workforce, and we will take it back to consider the right venues to have those discussions.

Rene Mollow, DHCS: We are looking to restructure some dental stakeholder workgroups in the near future and will be working with stakeholders on the CalAIM proposal.

Susan McLearen, California Dental Hygienists: Also, how do the homebound fit into the system?

Jacey Cooper, DHCS: The benefit of in-lieu-of services options is that it will provide wrap around services through home and community based services and allow individuals to stay safely home.

Arif Shaikh, Inland Empire Health Plan: On the mandatory enrollment, does this include the voluntary carved out zip codes? In the Cal MediConnect phase down, it sounded like there an expectation that Cal MediConnect plans will need to have a DSNP in place; will there be a crosswalk to transition beneficiaries?

Mari Cantwell, DHCS: We will no longer have zip code differences; the entire county will be included, and the population will follow the mandatory proposal for managed care or fee-for-service. On the DSNP, there will be a transition plan and we will work with CMS to have a seamless transition.

Claire Ramsey, Justice in Aging: We appreciate the focus on aging throughout the plan. We have concerns given this will impact a huge number of dual eligible older adults that there is very limited representation of aging advocates on the workgroups, especially since the issues cross multiple workgroups. We are concerned there won't be adequate discussion of duals because it doesn't seem there is a natural home for LTSS and dual eligible issues to be discussed. We appreciate the focus on aligning CalAIM and the Master Plan but worry that, given the speed of this work, there may be a wonderful Master Plan that can't be implemented because it is not integrated into CalAIM.

Mari Cantwell, DHCS: We want to work with folks outside the workgroups and tap our relationships to discuss these issues as well as inside the workgroups. The reality is that the workgroups are important to provide input to us and we need your input and expertise. We are interested in hearing from you to change and improve what is in CalAIM.

Hellan Roth Dowden, Teachers for Healthy Kids: We were also hoping for a larger scope for kids. I didn't see any mention of involving the education institutions in this. Particularly for special needs kids in our schools, integrating them into the larger Medi-Cal system has always been a challenge. I hope you will work with California Department of Education and others on this.

Next Steps and Final Comments; Adjourn

Richard Figueroa, DHCS

Mari Cantwell thanked stakeholders for their input and for offering their ideas. We can't always do everything we want to, but we are all here to make this work for beneficiaries and we want the best product possible. We really appreciate the acknowledgement you offered today.

2020 SAC Meeting Dates:

- February 12, 2020 9:30 a.m. – 12:30 p.m.
- May 27, 2020 1:30 p.m. – 4:30 p.m.
- July 16, 2020 9:30 a.m. – 12:30 p.m.
- October 28, 2020 1:30 p.m. – 4:30 p.m.