

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

February 11, 2015

9:30am – 3:00pm

MEETING SUMMARY

Attendance

Members Attending In Person:

Bill Barcelona, CA Association of Physician Groups; Kelly Brooks Lindsey, CA State Association of Counties; Michelle Cabrera, Service Employees International Union; Anne Donnelly, Project Inform; Lishaun Francis, CA Medical Association; Bob Freeman, CenCal Health; Bradley Gilbert, IEHP; Marilyn Holle, Disability Rights CA; Michael Humphrey, Sonoma County IHSS Public Authority; Amber Kemp, California Hospital Association; Elizabeth Landsberg, Western Center on Law and Poverty; Kim Lewis, National Health Law Program; Marty Lynch, Lifelong Medical Care and California Primary Care Association; Steve Melody, Anthem Blue Cross/WellPoint; Erica Murray, CA Association of Public Hospitals and Health Systems;. Sandra Naylor Goodwin, CA Institute for Behavioral Health; Gary Passmore, CA Congress of Seniors; Brenda Premo, Harris Family Center for Disability and Health Policy; Cori Racela, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance; Judith Reigel, County Health Executives Association of California; Cary Sanders, CPEHN; Rusty Selix, CA Council of Community Mental Health Agencies; Cathy Senderling, County Welfare Directors Association; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center; Suzie Shupe, CA Coverage & Health Initiatives; Marvin Southard, LA County Department of Mental Health; Kristen Golden Testa, The Children's Partnership/100% Campaign; Richard Thomason, Blue Shield of California Foundation; Anthony Wright, Health Access California.

Members Attending By Phone: Chris Perrone, California HealthCare Foundation.

Members Not Attending:

Jim Gomez, CA Association of Health Facilities; Mitch Katz, MD, LA County Department of Health Services; Stuart Siegel, Children's Specialty Care Coalition; Herrmann Spetzler, Open Door Health Centers;

Others Attending: DHCS staff: Jennifer Kent, Mari Cantwell, Sarah Brooks, Anastasia Dodson, Karen Baylor, Claudia Crist, Danielle Stumpf, Hannah Katch, Wendy Soe, Brian Hansen, Alice Mak; Laura Hogan, Pacific Health Consulting Group.

Public in Attendance: 40 members of the public attended.

Welcome, Purpose of Today's Meeting, Review Purpose of Stakeholder Advisory Committee and Introductions

Mari Cantwell, DHCS

Ms. Cantwell thanked the foundations, Blue Shield of California Foundation and California HealthCare Foundation for their support and introduced new SAC members, Brad Gilbert from Inland Empire Health Plan, Cori Racela from Neighborhood Legal Services-Los Angeles and

Health Consumer Alliance and Sara DeGuia from California Pan Ethnic Health Network who will join at the next meeting. She also introduced Claudia Crist as the new Deputy Director for Long Term Care. A crew will be filming today but the cameras are focused on Jennifer Kent only and will not involve the SAC or the audience. Ms. Cantwell spoke about the great loss of Peter Harbage due to long illness and noted that all will miss his passion and work on health care.

**Introduction of Jennifer Kent, DHCS Director
Mari Cantwell, DHCS and Jennifer Kent, DHCS**

Jennifer Kent was introduced as the new Director of DHCS. Jennifer made opening remarks, noting this is the greatest job and the hardest job. It is a pleasure to be following great leaders previously with DHCS. I am looking forward to working with stakeholders and am mindful of the many stakeholder engagement processes that are currently ongoing. There has been lots of work and ongoing improvements to the process. We have overhauled the website and routinely post materials ahead of stakeholder meetings. I want to work with you all to not only improve the process of engagement but also offer feedback about how stakeholder input impacts the content and outcome of policy. I look forward to working with you and appreciate your support and candor.

**Follow-Up Issues from Previous Meetings and Key Updates
Anastasia Dodson, DHCS**

Slides for the presentation are available:

<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

Anastasia Dodson mentioned there is a matrix in the meeting materials that identifies follow up response from the last SAC meeting. There were no questions about the matrix.

**Governor's 2015-16 Budget
Mari Cantwell, DHCS**

Slides for the presentation are available:

<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

Ms. Cantwell referenced the Governor's proposed budget and noted that the budget demonstrates the administration's ongoing commitment to managed care. Related to the Coordinated Care Initiative (CCI), there is discussion in the budget about fiscal sustainability of CCI given the statutory requirements to make it cost effective. The administration is very committed to the CCI and integrated services. We continue to improve the program to make it cost effective and want to improve the retention and enrollment. Currently, 90% of those enrolled in Cal MediConnect do stay in the program but many are opting out before enrollment. DHCS is looking at those who opt out to understand why and to identify the concerns behind the opt-out. The Department wants to work with providers and enrollees to educate them about the program and why coordinated care will improve their care. There are no specific targets for enrollment to meet the cost effectiveness target.

**President Obama Executive Order on Immigration and Impact on Medi-Cal Program
Mari Cantwell, DHCS**

There is no new information since the release of the budget. The current eligibility process does allow people into Medi-Cal regardless of immigration status and there is no change pending right now. DHCS is assessing what the potential impact would be of the President's order and how many people might come into the program.

Steve Melody, Anthem Blue Cross/WellPoint: What is the timing for additional guidance or decisions?

Cantwell, DHCS: There are no specific pending decisions. We are trying to understand the magnitude of the program. PRUCOL process allows them to be in any aid code for eligibility. There is a flag used on the claiming side. We're just trying to understand the magnitude of the population that might be eligible and entering the program.

Cathy Senderling, County Welfare Directors Association: We have also been looking at this issue because of questions from counties. We want to work with DHCS on the underlying DACA issues. We are happy to be a resource.

Cori Racela, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: You issued a memo on DACA issues and we appreciate that. Additional clarity is needed from DHCS because we see people consistently being turned away from applying at all if they're in a DACA immigration status.

Anthony Wright, Health Access California: We appreciate there is no proposal to change eligibility. Clarity is helpful to communicate to those affected and the general public about the fact that there are no changes. There has been work to estimate the population and the broader undocumented population, to find savings and offset costs. If there is a way to have informal conversations about this with the department, that would be appreciated.

Marilyn Holle, Disability Rights CA: There are also difficulties for those transitioning from foster care that are DACA.

**1115 Waiver Renewal Expert Stakeholder Process:
Outcomes, Integration of Concepts, Timeline and Next Steps in Preparing Waiver Proposal**

Mari Cantwell and Wendy Soe, DHCS

Slides for the presentation are available:

<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

Mari Cantwell, DHCS provided introductory comments outlining the workgroups and thanking all the participants for their input. Today's presentation will review the waiver content and the timeline.

The waiver renewal is based on the success of the 2010 waiver. The waiver renewal is just as critical to the successful implementation of the ACA as the current waiver. How will behavioral health and physical health be integrated plus the support services around people to improve their lives and health as well as make the program more sustainable? Now there are 12 million people in Medi-Cal and we have to think carefully about how we deliver and finance care.

There are two major components to the waiver: Strategies and Financing.

Strategies

- Delivery System Transformation & Alignment Incentive Programs
- Payment and Delivery System Alignment for Public Safety Net Systems for the Remaining Uninsured

Financing

- Federal/State Partnership on Shared Savings
- Budget Neutrality
- Continued Federal Funding Support

California has saved the federal government billions of dollars and our premise for shared savings is that we need a reinvestment of some of these savings to organize a system of care that is effective and sustainable. While establishing the budget neutrality “room” is important, the federal government is not required to share these savings.

Current waiver accomplishments – California has cut the uninsured rate by 50% with 29% included in Medi-Cal. California led the nation in the creation of DSRIP and many other states have now followed that lead to improve the safety net systems.

The new Waiver’s vision and goals seek to continue to build capacity – not just medical care but also behavioral health and other support services – to improve care and to work through partnerships with counties, plans, providers and others. California is committed to develop and achieve specific metrics.

Questions and Comments on Overall Waiver

Marvin Southard, LA County Department of Mental Health: An important thing to focus on is the area of collaborative partnerships to look beyond health and mental health partnerships but also remember to partner on the community component to address social determinates of health outcomes. I think we are all committed to this but it could be highlighted.

Gary Passmore, Congress of CA Seniors: When you mention we need to demonstrate specific things, does that need to be in the waiver application or over 5 years?

Cantwell, DHCS: We will need to have a sense of what we will accomplish over the five years prior to submission and have some broad target metrics.

Marilyn Holle, Disability Rights CA: Is there any recognition at CMS of the savings in Medicare? It is troubling to me that Medicare shifts costs to Medi-Cal.

Cantwell, DHCS: That has not been recognized or included in the current waiver. We are having success in the Coordinated Care Initiative discussion to demonstrate how this conversation could happen. We do receive a proportionate share of the overall savings. The discussions have been challenging.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: You mention community services that back up mental health. Are you thinking about pushing CMS beyond the comfort zone on issues like supportive housing – joining other states that are also pushing these issues?

Cantwell, DHCS: We are seeking more flexibility to fund those services. CMS does not disagree philosophically. They are looking at the constraints of Medicaid.

Michelle Cabrera, Service Employees International Union: The theme of health equity comes up later in the presentation. I would like to see this called out explicitly in the goals – especially in

the 5-year targets. We can improve quality and drive to the triple aim and not improve disparities or make them worse. We can't assume that equity is baked into triple aim.

Cantwell, DHCS: I appreciate that and we can look at how to bring that in.

Cary Sanders, CPEHN: I wonder if we can address this in the 2020 Vision to explicitly call out health equity.

Anne Donnelly, Project Inform: In the HIV strategy, reducing disparities is a key goal. In the partnership with public health, there have been advances. Will CMS score savings from population health as well as individual health? Also, how is Medi-Cal going to deliver high cost drugs and treatment? It is not sustainable to be focused on cost containment.

Bill Barcelona, CA Association of Physician Groups: What is the overall figure for the savings you want to capture through the strategies?

Cantwell, DHCS: We are still figuring out the long term cost and savings and how to measure that. However, we are asking for agreement on upfront investment because we believe over the 5 years, it will impact the cost drivers.

Elizabeth Landsberg, Western Center on Law and Poverty: I want to echo the health equity discussion given the diversity in California. It needs to be called out explicitly and we want to focus on the health disparities and our communities of color in CA.

Chris Perrone, California HealthCare Foundation: The workgroups provided input on goals and metrics. SAC members also may want to have input on metrics. Do you have a process for input on metrics or straw proposals?

Cantwell, DHCS: Detailed metrics will not be in the initial application. We will continue to simultaneously get input here in the state and from CMS to develop them during Waiver negotiations. We don't have a specific process.

Amber Kemp, California Hospital Association: With regard to the goals listed, we would note that an integral part of sustainability is ensuring access by ensuring adequate reimbursement to providers. With regards to the achievements of the current waiver, we applaud DHCS for investing in public hospitals but encourage the state to think more broadly about the safety net.

Kim Lewis, National Health Law Program: Will the metrics be required by CMS to approve the waiver?

Cantwell, DHCS: Over the next 6 months prior to approval, we will need to develop these.

Kent, DHCS: In the 2010 waiver, we got basic agreement on the waiver first, heard from CMS about general metrics and then we developed the specific metrics in the terms and conditions. It's an iterative process but CMS will not want to put money into a waiver unless we've articulated some goals.

Cathy Senderling, County Welfare Directors Association: In some places, you mention county – in other places region. Can you talk about the distinction between county and region?

Cantwell, DHCS: Yes, we are leaving our flexibility open. In some cases, it may be county-specific, but other times counties group together and partner with other groups.

Marvin Southard, LA County Department of Mental Health: Would that flexibility apply to sub-areas of a county?

Cantwell, DHCS: We could look at populations but sub-county geography could be difficult.

Ms. Cantwell then reviewed the three core strategies.

Core Strategy 1: \$15 - \$20 billion Federal investment in the Waiver's comprehensive approach to delivery system alignment and innovation

Core Strategy 2: Advance quality improvement and improved outcomes through expanded Delivery System Transformation & Alignment Incentive Programs

Core Strategy 3: Transform California's public safety net for the remaining uninsured by unifying DSH and Safety Net Care Pool funding streams into a county-specific global payment system

Ms. Cantwell offered specifics related to core strategy one, federal state shared savings. This is fundamental to implementing the other aspects of the waiver. We are asking for \$15-20B of federal investment overall. The current waiver is about \$10B in federal funding over 5 years so this is a larger investment. Given the ability to demonstrate savings through the waiver, the state is requesting retaining a portion of the savings for additional services. There is an estimated \$2B savings per year reinvestment in addition to other savings. This concept is not a cap to entitlement programs – to the extent we accomplish savings, we can spend it but this would not impact our ability to finance core services in the managed care program.

Questions and Comments on Federal State Shared Savings

Amber Kemp, California Hospital Association: Has the state had additional discussion with CMS on this initiative?

Cantwell, DHCS: Very minimal. CMS shows interest and they understand the request but need to explore more about how it will work within federal rules.

Ms. Cantwell continued with a presentation of strategies. Core Strategy 2 is delivery system transformation and alignment. This includes all the necessary services for beneficiaries to lead a healthy and successful life. Health equity, health care and delivery, better integration of services and impacting total cost of care are all objectives of this strategy.

DSRIP 2.0 builds on existing DSRIP. It will include designated and non-designated public hospitals to accomplish improvements across five domains:

- **Delivery System Transformation** – focused on redesigning ambulatory care, improving care transitions, and the integration of behavioral health and primary care
- **Care Coordination for High Risk/High Utilizing Populations** – focused on care management, health homes, and palliative care
- **Resource Utilization Efficiency** – focused on appropriate use of antibiotics, high cost imaging and pharmaceuticals
- **Prevention** – focused on core areas such as cardiac health, cancer, and perinatal care
- **Patient Safety** – focused on improving performance on metrics related to potentially preventable events and reducing inappropriate surgical procedures

Regional Incentives to coordinate care across the spectrum to improve quality and value within the delivery system. The incentives would require plans and counties to work together to achieve metrics. This would include shared savings and flexibility to test alternate ways to set rates for health plans to improve overall quality of health care. There are specific elements of the rates that we are looking toward to implement a similar strategy to the federal state shared savings strategy that recognizes plans should share in savings generated to the program for investing in care delivery strategies that promote efficiencies and positive health outcomes.

Questions and Comments

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center. Going back to DSRIP 2.0, I am wondering what happened to the comprehensive input and feedback provided because I don't see any change here from the original proposal.

Soe, DHCS: We are still wading through the input and this does not reflect all of the changes we are making to the domains and projects based on recent stakeholder input.

Kent, DHCS: My perspective is that waivers are stories we want to tell CMS. Part of our story is that our last waiver provided the first step to accomplish coverage for millions of new people. The story in this waiver is that we want to align systems and improve care for those who obtained coverage. We have so many challenges with the population in Medi-Cal. How can we link services in a way that forces siloed programs to do things differently? That is the story we want to tell with this waiver. What you reference is an important part of what we want to address. We are not looking to see your input drop off.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center. The more we reiterate it, the better.

Cantwell, DHCS: DSRIP is only one of the six strategies under delivery system transformation. As we talk through other strategies you will see more of the ideas that you're referencing.

Bradley Gilbert, IEHP: I was on the plan/provider workgroup and was very pleased with the ideas. For example, many beneficiaries are homeless. When they are admitted to the hospital, many times they could be safely transitioned to community but we can't because they are homeless. We are looking to develop short-term recuperative care housing. Under current rates, I could not claim those costs and, if I went ahead and did the right thing, I would be penalized over time for reducing cost. From the plan perspective, this is a much better way to think about care and not create a negative incentive.

Steve Melody, Anthem Blue Cross/WellPoint. It appropriately aligns the incentives between the states and the managed care plans to drive efficiency.

Erica Murray, CA Association of Public Hospitals and Health Systems: How does the drug Medi-Cal systems delivery waiver fit in with the second strategy? Where are the localities that participate in the shared savings and flexibility?

Cantwell, DHCS: It will be easier to integrate in counties that are already investing in coordinated care. It doesn't foreclose the ability to do this in counties that are not there yet.

Cori Racela, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: How much is DHCS involved with plans as they work with IPAs? The objective is to have coordinated care. It seems very fragmented in LA County because of the IPAs. Consumers call and say they can't see the right specialist because the provider is not contracted to the IPA. They are a contracted provider with the health plan but not with the IPA. It is difficult to navigate this substructure. It is nebulous who has the responsibility.

Brooks, DHCS: This is on our radar. We are looking at communication to beneficiaries, stakeholders and advocates about delegated models to help them understand this issue. It fits in the waiver and beyond. We would like to follow up with you.

Marvin Southard, LA County Department of Mental Health: In the final version of the waiver, I hope the overall story is that we are looking for behavioral health to play a robust role. Second, in LA we are looking at including forensic populations to divert them to enroll in primary care and behavioral health as part of release or in lieu of incarceration. I think that is useful to include in the story.

Brenda Premo, Harris Family Center for Disability and Health Policy: California is one of the leading states in some access issues. We created the first tool for physical access. We are a leader and deserve credit for the progress. We are now in the situation with this waiver of having demonstration projects for disability populations. But those were created with a children/family approach, with some differences, but not planning them as a disability-only product. Now we need to create a plan that is not an afterthought. How do we create incentives that do not punish providers but help them get the exam tables they need or refer to accessible testing facilities, etc. There is great variability. I have certain access issues by being disabled – others are different. Some plans are thinking this through – others are trying to do care coordination the way we always did it for healthy families. We need to offer ideas to hospitals, plans, and providers to show them how to do care correctly. It can't be an afterthought if we want to generate savings. How will we look at the waiver and provide the incentives to plans to create the innovation and alternatives to provide access for all of the disability populations? We now have specific programs for these populations and we are being looked at across the country. We need the right incentives for the disability elements of the product and ensure we have the right product in place.

Cantwell, DHCS: This goes to one of the fundamental issues. How do we give plans and contracted providers the flexibility to do what they need? Your examples are excellent for how this would work. It would give the plans and providers the knowledge and the flexibility to retain savings and fund the changes to the way we're delivering care.

Kent, DHCS: This goes to the equity comments as well. Everyone needs to be included and we need to look across the population to achieve health equity.

Brenda Premo, Harris Family Center for Disability and Health Policy: In LA, one thing I learned in Duals is that 100% of the folks included have disability and many have diverse cultural issues. First we look at disability, then we look at cultural issues. We can't separate these. We can't say you get care based on being in a wheelchair absent the issues related to culture and language.

Kent, DHCS: That is helpful and as we refine the concepts, we will weave this in.

Michelle Cabrera, Service Employees International Union: In terms of shared savings, there is a lot that is exciting. Our story includes the fact that we have newly enrolled people in Medi-Cal

managed care. How do we make that truly work? We are starting with low per member per month (PMPM), so there is not much give there. When you say you are looking for value and efficiency, it causes concern for me because we are starting at such a low rate. That doesn't mean there are not efficiencies to be gained but let's remember that plans have a role/function and providers have role/function. We need to include community and beneficiaries to get improved cultural and linguistic competence. We have to connect the piece of the waiver to financial elements and think through how to change things. We need to be cautious given California does not have lots of excess spending to cut.

Cantwell, DHCS: We are looking for \$15 - 20B of federal investment. How do we get to a place that changes how we finance health plan reimbursement so they're reinvesting in these things that we know increase quality care. It isn't about reducing day one. It will take long-term investment.

Kim Lewis, National Health Law Program: One of the things in behavioral health for children, I want to put a fine point on integration vs coordination that are both used in different places. Kids in foster care and others that are particularly complex, it can be difficult to do care coordination but there are specific models that provide coordination of social supports, coordination across systems. We need to be sure we are not disincentivizing those models that work. Let's keep the models that work and expand them.

Anne Donnelly, Project Inform: As a placeholder for a later conversation, I am wondering about the Ryan White care system. It's small relative to Medi-Cal but important in HIV care. There are supplements for areas that are not included in traditional Medi-Cal. We are tripping over the payer of last resort rules to adhere correctly. Is there a place for a pilot?

Marty Lynch, Lifelong Medical Care and California Primary Care Association: The talk about siloes and trying to improve our efforts reminds me about this example. A 50 year-old schizophrenic who thought they were being denied care because of the distinction between mild/moderate and severe mental health. Will the waiver help us get past the mild-mod and severe mental illness silo?

Cantwell, DHCS: Yes, in that the goal is that whatever system mentioned we want to integrate and coordinate. No, in the sense of changing the structure of the county mental health plans. We want seamlessness across the spectrum.

Ms. Cantwell continued with presentation of additional regional incentives, pay for performance for provider organizations. Standardized core elements include quality measures, health equity, and flexibility for plans to choose to meet the needs of specific populations. This aligns with State and Managed Care Quality Strategy, triple aim and the waiver metrics.

Ms. Cantwell reviewed fee for service (FFS) quality incentives for Maternity Care and Dental. Most of Medi-Cal is in managed care, however, maternity services have a higher level in FFS. This incentive will address improvements through reducing early, elective cesarean delivery and promote efficient maternal care. Dental care is primarily FFS and the waiver will include some strategies such as increased provider participation in the program through targeted financial incentives.

Questions and Comments

Marvin Southard, LA County Department of Mental Health: In the current waiver, there are many counties that worked on this. It might be useful to include stories of successful models.

Cantwell, DHCS: We would love more case studies.

Marilyn Holle, Disability Rights CA: In moving to managed care, we often lose the benefits of the clinic approach. There are facilities with full service so the consumer does not have to go to multiple places. These integrated facilities for Genetically Handicapped Persons Program or other complex clients are being lost. The integrated approach saves hospitalization and keeps people in the workforce. In addition, the Hill Burton regulations have not been updated to reflect managed care. Access to outpatient care needs to be added.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: We have done a lot of co-location and integration work over the past few years. There are issues that need to be changed that are not part of a waiver. For example, clinics want to go into other facilities to offer primary care at mental health facilities but rules prohibit us. It is important to align those other areas of DHCS.

Michelle Cabrera, Service Employees International Union: In pay for performance for provider organizations, I was confused because the language is about plans. Also, I would like to see health equity listed up there as an incentive.

Cantwell, DHCS: Funding will flow through the plans to the provider.

Sandra Naylor Goodwin, CA Institute for Behavioral Health: When we say behavioral health, we mean both mental health and substance use disorders. The problem is that there are many parts of the state without robust systems for SUDS. Could you allow part of the state to start with mental health and add SUDS as they develop capacity?

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Questions and Comments

Amber Kemp, California Hospital Association: While we share the state's goals to improve maternity care, we are concerned about the design of the maternity incentive. While we look forward to working with the state on improving the care provided to mothers and babies, the concept of placing the incentive on reduced cesarean deliveries is concerning to us.

Suzie Shupe, CA Coverage and Health Initiatives: On the dental incentives, can you talk more about ways to increase provider participation? This is an important aspect of the waiver. One area for attention is sedated dentistry – there is a serious lack of hospital access to dentistry for these services. This has a significant negative impact on overall health.

Cantwell, DHCS: We are looking at the details here.

Marilyn Holle, Disability Rights CA: Looking at dental, we should look at Medicare model for how sedation dentistry is handled. Also, we are concerned about the importance of ensuring access for cranio-facial abnormalities. When you look at incentives, keep this population in mind.

Lishaun Francis, CA Medical Association: At plan/provider workgroups, there were specifics provided that are not reflected here.

Soe, DHCS: We are still evaluating and developing options, looking at input and evidence.

Michelle Cabrera, Service Employees International Union: In plan/provider workgroup, there was discussion of early elective C-section in FFS Medi-Cal. Were you able to bring forward specific information on this? African American mothers are three times more likely to die in childbirth. Disparities have been increasing for Latinas as well from 2000 – 2010.

Brooks, DHCS: We are still looking to identify the data and will look at stratifications based on your comments.

Ms. Cantwell then reviewed Workforce Development as a way to expand and transform primary care. How do we attract more workers who are from the community and may be outside the traditional provider type? Some of the arrangements include peer providers, Telehealth and other nontraditional elements.

- **Financial Incentives to Increase Provider Participation:** Incentive payments for newly participating providers or providers expanding the number of Medi-Cal beneficiaries served
- **Pilots for voluntary workforce training programs:** Likely administered through managed care plans for targeted high-need populations (potentially peer providers, IHSS workers, CHWs).
- **Expand use of telehealth:** Incentivizes plans and providers to leverage telehealth strategies to address geographic needs for specialty access
- **Expand residency slots/programs:** Funding for programs at teaching health centers or for new programs in geographic areas and/or specialties of need
- **Cross-training and use of multi-disciplinary care teams:** Incentivizes integrated model for better coordinated physical health, behavioral health, and long term care for high need populations
- **Potential for palliative care training**
- **Include non-licensed, frontline workforce**

Questions and Comments

Amber Kemp, California Hospital Association: Can you clarify if current hospital GME providers will be included in the expanded funding for residencies?

Dodson, DHCS: We haven't gotten to that level of specificity but it was discussed in the workgroup.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: Remembering Brad Gilbert's comments at a previous meeting about recruiting providers. Health centers are facing cuts in residency funding and we may be looking at the waiver for continuing some of these programs. For that to happen plans must be engaged to work on provider recruitment and those costs must be allowable for the plans. Is that what we are talking about here?

Cantwell, DHCS: We are trying to figure out how to get the upfront investments to plans to do those types of strategies. How do we use the information we get to change the rate setting for plans going forward?

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center: The workforce issue touches everything but my comments are about substance use services. We have a broken system. There are folks who want to work in the field and are pursuing other licensure and want expertise in SUDS. When the regulations passed that we must use certified counselors, the bill required they be registered as SU counselors when they are pursuing a higher level of licensure. The provider community opposed this at the time and now really needs to be addressed. The second issue is that the overall process of certification must be fixed. There were 10 certifying agencies – now there are 3. The number of those applying for certification is growing; the need for services is growing but we can't get the workforce certified through the system.

Cary Sanders, CPEHN: I want to say I appreciate seeing community health workers in the proposal. I hope that you consult with groups that work specifically in chronic disease areas. There is interest in this from federal government.

Gary Passmore, CA Congress of Seniors: Speaking to pilots for a voluntary program as a tentative approach and I hope this is not a tentative commitment. Are you working on the definition for a high need population? Are you going to propose incentives for providers who are/become trained or keep up to date with their skill set? Is there experience at managed care organizations (MCO) for overseeing training? What is the rationale this being called out in the waiver? Do you have examples of MCOs doing training?

Dodson, DHCS: I think you are looking at IHSS with your questions? We had a meeting this week with IHSS authorities and consumers. What is the intersection with MCOs and the potential IHSS provider training waiver? It is important to keep plans connected to IHSS provider training, MCO however we recognize it is a sensitive issue and folks have questions. We are looking at creating specifics to the definition. We don't have details tied up and we want more input prior to doing that.

Kent, DHCS: On training, are you meaning providers broadly? MCOs credential many providers. Some have promotores now. We are differentiating between contracted providers and non-licensed community providers.

Bill Barcelona, CA Association of Physician Groups: I do think it is appropriate that the plan act as the payer to bring people on to the coordinated care teams. I think this will work well.

Bradley Gilbert, IEHP: There are some settings where the plan wouldn't be the primary entity involved in training. We have a successful health navigator program. On physicians, getting providers new to Medi-Cal doesn't really expand access because they already have full practice. It's not good to take providers from another community. Residency programs are a

good option but they need to be in the right places. Some of the FQHC programs have been successful. I would want to see targeted training incentives targeted to geography and setting.

Michael Humphrey, Sonoma County IHSS Public Authority: My comments are about the pilot proposal on IHSS workers. I know this has created controversy and appreciate your willingness to meet with us. Part of the issue is that consumers were not involved in the dialogue about how training for IHSS providers should happen. One of the cornerstones of IHSS is that it came from the independent living movement – a social model program. One of the founders, Ed Roberts, when he went to college was put in dormitory hospital and was treated as if he was a patient. I don't want to be a patient unless I need to be. Moving to a collaborative model in CCI, there is concern that it means moving to a more medical model. The proposal refers to "patients" and is clinical, and that is not the term we use. It is important to have consumers at the table. The IHSS public authorities are the entities designated to provide training. As we move forward there is a need for IHSS workers to get better quality training. Do we need more support, more funding to enhance what we are doing? Yes. We are meeting with health plans and clinics to improve training. We need to be cautious with this proposal and involve public authorities and consumers. We are advised by a majority consumer IHSS advisory committee.

Dodson, DHCS: Thank you for this. It was my oversight that consumers were not at the table earlier in the process and we are committed to involvement and discussion as we move forward.

Lishaun Francis, CA Medical Association: I would like a better understanding of the overall process and how you will choose the final ideas to be submitted. This is a laundry list of good proposals. How will DHCS choose?

Marilyn Holle, Disability Rights CA: I underscore Michael's comments. The social contract and the social character is missing in the proposal. The mandatory nurse supervision was removed from personal care assistant. Families need training in how to help the IHSS recipient. It would be helpful to have some training such as how to move consumers but the real character has to be social, with consumers calling the shots.

Richard Thomason, Blue Shield of California Foundation: I want to highlight a report released as part of a series that talks about a survey of consumer satisfaction with their care. The survey results indicate lots of interest in team care, health navigators. And they don't get this now. We see an opportunity to improve access to care in this area.

Mari Cantwell, DHCS offered remarks on the strategy: Access to Housing and Supportive Services. This is targeted to high-risk individuals to offer services and will allow plans the flexibility to provide non-Medicaid services that allow someone to stay at home, offer respite care, form partnerships and pilot programs that bring together resources locally to ensure housing and access to services.

Questions and Comments

Marty Lynch, Lifelong Medical Care and California Primary Care Association: Having run frequent user programs, we have learned that many of the folks using the emergency room are homeless. We need to create a relationship and housing before we can get them to primary care and mental health services. To offer services is a tremendous step and I applaud inclusion of this in the waiver,

Marvin Southard, LA County Department of Mental Health: I agree. This has strong opportunities. To the storytelling, we have permanent housing stories that show the reduction in costs when you employ these strategies.

Mari Cantwell, DHCS offered details about the final strategy element: Regional Integrated Whole Person Care Pilot proposal. There is a thread throughout all the proposals in the waiver that is captured here. It requires including the broad spectrum of workers and partners. Having money at the table will help bring everyone together. The entities involved in the spectrum of services share the same end goal but it is hard to realize collaboration and investment without the funding. When we focus on the whole person, we would be able to demonstrate what it would mean for that person and their quality of life as well as the cost savings in their care. This idea is in development and has been recently added. This will have an evaluation component.

Questions and Comments

Marvin Southard, LA County Department of Mental Health: Would it make sense to have a pilot that focuses on a forensic population or some other subgroup?

Cantwell, DHCS: Yes, this could be one target population.

Gary Passmore, CA Congress of Seniors: There are plans in CCI that have had experience doing this, like San Mateo. We want to replicate that around the state not recreate it.

Gary Sanders, CPEHN: We support this concept as potential for new pilots. There are opportunities for us to look beyond the chronic condition clinical care and offer upstream strategies to help individuals take control of their health.

Kristen Golden Testa, The Children's Partnership/100% Campaign: We are excited to see this. Given that it is new, will there be a budget? Will it be based on savings?

Cantwell, DHCS: it will be included in the federal-state savings, \$2B per demonstration year savings element. We're still working on the funding details.

Kelly Brooks Lindsey, CA State Association of Counties: We are very excited to see this and the investment in collaboration in housing and social services.

Amber Kemp, California Hospital Association: Can you clarify if all counties will be eligible to participate?

Cantwell, DHCS: We are open to any area that is interested. It will require the commitment and participation of the county, plan and providers.

Richard Thomason, Blue Shield of California Foundation: We too applaud the inclusion of this. As you think about the story of the waiver, encourage you to frame the whole waiver with the person at the center, whole person care.

Anthony Wright, Health Access California: We are excited as well. This is the real frontier. Post or pre incarceration population is an area where we have work already underway and we can build on that. Corrections are not included in the diagram and would be a good addition. Pilot suggests small.

Michelle Cabrera, Service Employees International Union: I have questions around the non-licensed frontline worker discussion – we are very supportive of that. Going back to sustainability, we need to think through who employs them, who trains them. We have good plans that do this but are they the exception? I just want to make sure that the workers being recruited have a place to live, and that training is happening and capacity is being built in appropriate ways.

Suzie Shupe, CA Coverage and Health Initiatives: Another circle missing is community-based organizations. Many of the populations you're targeting receive services in community-based services through contracts with counties or other funding. Finally, regional collaboration is difficult and requires planning money.

Brenda Premo, Harris Family Center for Disability and Health Policy: I worry that clinical folks will get together and not include community services. We need state housing authorities, nonprofits and other partners who are important to the funding picture. It should be more than an idea, but a requirement for housing, transportation – to support health through a truly integrated system. This is a priority for the Olmstead Committee and I invite you to become part of that to create systems in home and community.

Katch, DHCS: Such an important point. We have been discussing that point in the housing workgroup. Where is the nexus of these organizations to support the relationships to connect services for consumers?

Marilyn Holle, Disability Rights CA: On housing, if you are on SSI and go into a nursing facility for short term, you can maintain SSI as if you're in the community. If you are a share of cost person and go into long-term care, even for a short period, the benefit for housing will not cover the costs. We need to be sure people don't lose their housing when they have a short-term stay in a nursing facility.

Anne Donnelly, Project Inform: This model offers opportunity for addressing infectious epidemics of Hep C and HIV through the ramp-up of pre-exposure prophylaxis.

Mari Cantwell reviewed Core Strategy 3 on public safety net payment reform to move away from volume, cost based reimbursement to flexible funding. Public hospital systems would instead be paid a global budget for services provided to the uninsured based on their meeting an established service threshold. We will establish targets for each system for the level of traditional services to be provided as well as t services not traditionally reimbursed like e-consult. The design promotes the high-value of non-traditionally reimbursed services while still funding essential traditional services, reduce unnecessary emergency room visits/hospital stays and the costs associated with them. There will be an evaluation and accountability structure to identify the outcomes. A final workgroup meeting on March 3rd will refine this.

Questions and Comments

Marvin Southard, LA County Department of Mental Health: The issue will be the details so there are no unintended consequences to defund certain things in favor of others.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: Is there guidance from public hospitals to offer best practices for reimbursement?

Cantwell, DHCS: There are close relationships to help with this transfer of experience.

Erica Murray, CA Association of Public Hospitals and Health Systems: We are also looking to existing DSRIP for its success and experience. We hope to apply models we have begun to employ.

Ms. Cantwell offered thanks to consultants and foundations for supporting workgroup effort. The process for refining and gaining CMS approval was presented. DHCS has started weekly/bi-weekly discussions with CMS and leadership check-in discussions occurring with submission by the end of March. There will be an initial waiver proposal offered for public comment with a very brief comment period. We do expect the waiver to change between submission and approval because this is a very iterative process. There will be webinars and other opportunity for input from stakeholders.

Kent, DHCS: We will also work with the legislature and are mindful of the timing challenge related to the legislative session timing.

Kim Lewis, National Health Law Program: I'm glad you mentioned the feedback process because I'm hoping that there will be opportunities for stakeholders to offer feedback on the iterative versions of the waiver as you continue in negotiations with CMS.

Cantwell, DHCS: The workgroup process has led to a lot of different ideas and concepts. Hopefully from what you've seen here, as we finalize the application, we've tried to focus on the ideas that are most consistent with our overall vision for the waiver. We have to focus on the Department's priorities for what we want to see change in the system five years from now.

Eligibility Transitions and Enrollment Update Anastasia Dodson and Mari Cantwell, DHCS

Presentation slides: http://www.dhcs.ca.gov/Documents/EE_SAC_Presentation_Updates.pdf

Ms. Cantwell provided an update on Medi-Cal enrollment. There has been an increase in Medi-Cal enrollment during the Covered CA open enrollment period even though Medi-Cal is available all year. More than 80% of the determinations are being accomplished in real time.

Questions and Comments

Cori Racela, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: I know that the online application has no real way to recognize a duplicate application. So is that 83% in new applications after the duplicates have been accounted for, or does that happen at the county level?

Mak, DHCS: CAL-HEERS does a well-timed check for eligibility upon application and they are determined conditionally eligible pending additional information. The 83% includes eligible and the number of conditionally eligible who have received an aid code. We check for duplicates after applications have been submitted.

Redetermination Process and Renewals Mari Cantwell, DHCS

Slides for the presentation are available:

<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

We are continuing to do research on 2014 renewals. We know that return rates were lower than what we saw in 2013. Our team and the counties and health plans have been doing additional outreach to help increase the return rate. We're planning on putting together a more detailed report to be released in March on the return rate. One of the challenges we had was related to the non-MAGI population and we had a significant dis-continuance in that population.

In terms of 2015, the MAGI renewal process with ex-parte reviews has begun. It's still early to get data on how the process is going. We hear anecdotally that electronic verification for MAGI households is going fairly smoothly for those households that are not mixed status. It is more difficult for the more complex cases. We are looking at having dashboard data that will include this information.

Questions and Comments

Cori Racela, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: I've been unable to get a full answer on how many counties have finished the 2014 renewal process. We're hearing from some counties that they haven't started at all, or are planning to start in January 2015. Do you know anything about that?

Cantwell, DHCS: All the counties sent out renewal notices, but you're correct that each county has its own process and timing for issuing discontinuance.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: My understanding is the majority of Medi-Cal recipients get their health care in FQHC's, and I know FQHCs are interested in helping patients through the renewal process. Do we know if there is a systematic way that counties are getting renewal information out there to providers and patients?

Cantwell, DHCS: Given all the changes in the process, we did focus on working with the health plans in order to reach out to their members. We're open to continuing to figure out the best way to distribute that information. It's a great idea to think about partnering with the community health centers.

Cary Sanders, CPEHN: On the renewal report coming out in March, we would be very much interested in seeing more detailed data, particularly by language of folks who have fallen off. We know that not everyone was able to receive a renewal notice in their primary language.

Elizabeth Landsberg, Western Center on Law and Poverty: We are hearing that in some counties, up to 50% of their renewals are being done with the ex-parte verification process.

Kim Lewis, National Health Law Program: In talking with CMS last week, they're also very interested in the whole ex-parte re-determination process and are looking to give states more guidance and clarity on how to do verification without sending out any forms for more individuals.

Covered California Transitions to Medi-Cal Plans

Mari Cantwell, DHCS

Slides for the presentation are available:

<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

Mari Cantwell, DHCS presented on transitions from Covered CA to Medi-Cal. We are working to identify the individuals and ensure there is no gap in coverage. There is a process for continuity of care by matching them to same MMC plan they had in Covered CA to the extent possible. This process will remain in place. About 100,000 individuals were transitioned from Covered CA to Medi-Cal during January and only 6,000 in February so this is slowing. There are some individuals who look eligible for Medi-Cal but do not have final approval. Covered CA is moving forward to terminate their coverage and they will receive temporary aid codes in Medi-Cal.

Questions and Comments

Cori Racela, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: We see issues through the health consumer hotline with individuals who did not report a change or are not eligible for Medi-Cal but getting them back into Covered CA has been difficult. There are gaps in coverage. We hope DHCS advocates with Covered CA to maintain coverage.

Cantwell, DHCS: We are working with Covered CA to resolve this.

Elizabeth Landsberg, Western Center on Law and Poverty: When moving from plan to plan, does the Department assume the same network? I am not clear that DHCS has the authority to move people into managed care without choice. Also, we are concerned about the timing and language in the notices.

Cantwell, DHCS: No. The option was to have them go into fee for service and there was concern that would be more disruptive.

Kim Lewis, National Health Law Program: What efforts are you taking to talk to plans to help individuals with the transition and explain their options?

Cantwell, DHCS: We are making sure that plans got the information on which of their members were coming up for renewal so they could help with that process. On the Covered CA to Medi-Cal transition, I'm not sure what the plans have been able to do.

Brooks, DHCS: There was an issue on timing of notices and we have reached out to beneficiaries to notify them about continuity of care.

Steve Melody, Anthem Blue Cross/WellPoint: We reached out to help inform beneficiaries of their options and consider continuity of care. Also, those beneficiaries going into temporary aid codes, they are going into fee for service Medi-Cal and not managed care. Is that correct?

Cantwell, DHCS: No, they're going into the express lane eight codes, which are managed care aid codes.

Anne Donnelly, Project Inform: We are seeing some who went into Covered CA mid-year because of a change of income and somehow Cal-HEERS got the old income data and they can't get back into Covered CA.

Update on Full Scope Benefit for Pregnant Women under 138% FPL and Pregnancy Only Women to 215% FPL

Slides for the presentation are available:

<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

Mari Cantwell let the group know we are still waiting on CMS approval for the state plan and waiver amendments. Based on what we've heard from CMS, we're assuming that when they do approve the pregnancy state plan amendment they will indicate our pregnancy-only coverage will be considered minimal coverage, so the Pregnancy Wrap program will not go into effect.

Questions and Comments

Cori Racela, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: Isn't pregnancy a basis for exemption from being enrolled in managed care?

Brooks, DHCS: Beneficiaries can request to enroll in managed care, but they wouldn't be mandatorily required to do so.

Cantwell, DHCS: For the full scope expansion, they will be enrolled in managed care but they can request to be dis-enrolled. It will be a different aid code now and the default for that will be managed care.

Elizabeth Landsberg, Western Center on Law and Poverty: This is different because they are being transitioned and could be 8 months pregnant. We have an official letter in about this issue and we think that women mid-pregnancy should not be transitioned for those reasons. We are excited to see them get full scope Medi-Cal.

Bradley Gilbert, IEHP: We have individuals who become managed care in 2nd/3rd trimester. We have to honor existing care relationships and almost all obstetricians are part of plans. Occasionally there is a medical exemption but we have not seen an issue with this.

Hospital PE

Mari Cantwell, DHCS

Slides for the presentation are available:

<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

This is also still pending approval with CMS. We have worked to improve our list of hospital PE providers on the DHCS website, so hopefully you all will find this as a helpful resource.

Questions and Comments

Kim Lewis, National Health Law Program: For those eligible in Cal-HEERS system for Covered CA, they are excluded from hospital PE even if they never got coverage. The policy is inconsistent with federal law and policy. People are not getting PE who are fully eligible.

Cantwell, DHCS: Please send me an email about that.

Amber Kemp, California Hospital Association: I want to thank Alice Mak and her team for great work on this.

Mak, DHCS: On the issue Kim raised, our legal team is doing research on this issue and we hope to respond to the concern soon.

Written Update on AB 1296
Anastasia Dodson, DHCS

Ms. Dodson let the group know that there is a written update on AB1296 in the materials for the meeting. A meeting is set for tomorrow, so this is brief. There are more things needed and desired than we have capacity to accomplish. There is a list of CR's requested that have not been accomplished for discussion tomorrow.

Questions and Comments

Kristen Golden Testa, The Children's Partnership/100% Campaign: California Health Care Foundation presented information on applicant experience with the online application. Are they releasing information on this?

Chris Perrone, California HealthCare Foundation: We are working with Covered CA and will be releasing this later this month.

Elizabeth Landsberg, Western Center on Law and Poverty: Is the ABX-11 report coming out (eligibility enrollment report)?

Cantwell, DHCS: It is set to come out within 2 weeks. The time period is 12 months from October 1, 2013 – September 30, 2014. It will not include renewals.

Coordinated Care Initiative
Claudia Crist, DHCS

Slides for the presentation are available:

<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

Claudia Crist DHCS, provided an update on enrollment, opt out data and health assessment dashboard information. There was a large increase in a January due to the DSNP. Health plans offered assistance with this transition and it was very smooth. There is an average of 40% participating, 48% opting out and 12% dis-enrolling. The highest opt-out is in LA and lowest in San Mateo. We had a provider summit in LA recently with over 400 attending and hope this will help us identify and address the issues with opt out. We are working with CMS to move towards a more voluntary enrollment process. The health risk assessment dashboard indicates that 78% were completed within the required 90 days.

Questions and Comments

Cori Racela, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: What are the reasons for the high opt-out rate in LA and in general? When will you have more analysis?

Crist, DHCS: The IHSS population has higher opt-out rates and we are starting to look at why this is happening. We are looking also at zip codes, language, specific provider groups? It will take another month to get through all the layers of data. We will share the information when we think the data is clearer and we welcome input from you.

Bradley Gilbert, IEHP: Remember with CBAS transition, we had lots of physicians saying they didn't want patient participation in managed care. There are MDs who are fee for service who want to stay there. I don't think we should spend time there because we won't make progress.

We need to look at the enrollment process – we are highly regulated by CMS and I don't think it is useful to go through HCO for this population. It is a black box as to why we hear positive feedback from clients, pass them off to HCO and they never enroll. If you look at better enrollment process instead of MDs outside the managed care system, it would be more useful.

Crist, DHCS: Yes, we need to look at the experience of the beneficiaries and see if it works the way it looks on paper. One of the discussions with CMS is about the level of outreach plans can do for those enrolled in the plan already.

Bradley Gilbert, IEHP: CMS put this guidance out. San Mateo's high participation rates is likely because they do enrollment.

Marilyn Holle, Disability Rights CA: Medicare affiliation with Cedar Sinai is an issue in LA. People don't want to lose this facility as an option and they are not affiliated with any plan.

Lishaun Francis, CA Medical Association: I am thinking about how we can educate providers about the program. They don't understand the program. I still get questions about what the benefits of Cal-MediConnect mean for the patient. I don't think the number of fee for service physicians could drive this opt out rate.

Katch, DHCS: We would love to partner with you to get that message out.

Anne Donnelly, Project Inform: I don't think HIV is driving these opt out rates, but there were early missteps that may cause confusion in the field.

Crist, DHCS: This is really helpful so that we can target the outreach to be more useful.

Cori Racela, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: Do you have a pure number for completion of the HRA that includes all beneficiaries? How many attempts do you use to contact them?

Brooks, DHCS: It is important to take out beneficiaries that chose not to participate because we are looking for a picture of completion by health plan for those who want the HRA. We are working with plans to define the unable to locate beneficiaries.

Cori Racela, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: Sometimes the unwillingness to participate is a language barrier or misunderstanding about the process.

Crist, DHCS: Yes, we know this is new to them. Plans are working to understand this so they can complete the HRA and coordinated care.

Brooks, DHCS: Plans do have requirements to mail things in threshold language, reach out a certain number of times, etc.

Bradley Gilbert, IEHP: Our real number of completed HRA is 40% even though we are listed at 100%. Our DSNP completion was in high 50%. The data is not as good on Cal MediConnect as it is on the DSNP side. It is useful for us to do the HRA.

Bill Barcelona, CA Association of Physician Groups: Once patient touches primary care doctor's office, the physician could do the assessment. As we move forward, we can do more of these.

Cori Racela, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: Are you tracking how many of the high risk individuals got their notice within the first 45 days?

Brooks, DHCS: We will have that going forward but don't have it today.

Cantwell, DHCS: We chose this particular measure because it is tied to the quality withhold.

Cathy Senderling, County Welfare Directors Association: Looking at the dashboard, it seems like we have to take together the 45 day and 90 day data in order to better understand the "could not be reached" category and identify ways to improve the rate of completion.

Crist, DHCS: The next cut of data will be cleaner and that will be a good time to make these links.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: When do we start to see results on integration and coordination measures? Is that part of the UCSF evaluation – more outcome measures?

Brooks, DHCS: Data will become available later this year with quality metrics. We will focus on quality withhold measures.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: When will we begin to see outcome data? On the finance side, there is the poison pill side of this issue. Where are you in measuring potential savings? What does this mean for statewide roll-out?

Cantwell, DHCS: The break-even analysis is partly the program side as well as other things such as, how much does it cost in managed care vs FFS; the program itself, will we have higher impact to the services and the cost in Cal-MediConnect than in the Duals? Upfront, we knew there would be fewer savings due to care management and HRA but over time the savings will grow because of changes in acute care side and moving people out of institutions/avoiding institutionalization in the first place. We do anticipate that the total picture will produce savings but more importantly, it is the right thing to do. I am optimistic about the potential.

Crist, DHCS: On the care delivery side, we're very excited about the potential of this program.

Kent, DHCS: Like everything else, there is a ramp up to get to success. It is too early to know but we believe we have a compelling story to tell.

**ACA Section 2703/AB 361 Health Homes
Brian Hansen, DHCS**

Slides for the presentation are available:

<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

Brian Hansen offered information about the Health Homes initiative and the timeline for implementation. The elements of the program design topics were described. He also highlighted several other updates: an updated concept paper, exploring how to accomplish activities included in the Cal SIM proposal not awarded, BH/CCS connections and working with plan partners. There will be a stakeholder event in March.

For more information: <http://www.dhcs.ca.gov/provgovpart/pages/healthhomes>

Comments and Questions

Amber Kemp, California Hospital Association: Will you release the concept paper prior to SAMSHA meeting?

Hansen, DHCS: Yes, that is the goal.

Amber Kemp, California Hospital Association: Can you comment on accepting the Cal SIM that was made?

Kent, DHCS: I don't have an update on that.

Richard Thomason, Blue Shield of California Foundation: What is the vision for how this fits with waiver concepts? We provide for TA at the local level and it seems this will play out with the same partners locally. I am hoping that there will be knitting together of the waiver and health homes so we can work with you and grantees to participate in all the opportunities.

Cantwell, DHCS: Yes, we are still working that out but it will have to work together. We don't know yet how the final waiver will look.

Katch, DHCS: In several of the workgroups, we discussed how we can layer the health homes initiative throughout the waiver. Health home initiative won't roll out in all counties simultaneously.

Elizabeth Landsberg, Western Center on Law and Poverty: What is the rationale for targeting the CCI counties?

Hansen, DHCS: The general thinking is that the work in Cal MediConnect and CCI pave the way for Health Homes. There may be other counties that are far along as well. We will be doing readiness discussions over the next few months and we have heard from others about their interest.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: On the concept of targeting, Health Centers have become qualified as PCMH and other initiatives that can provide readiness. I think that frequent user experience is a good marker of readiness. I hope it rolls out statewide eventually.

Hansen, DHCS: There is a lot of information about who benefits from Health Home services. We are doing our only analysis that starts with a broad lens of who might benefit – conditions, acuity and exclusion of some folks where it doesn't make sense. Then we need to estimate costs and savings assumptions.

Kent, DHCS: One of the options for the SPA is that we can separate it by region of the state as well as population. We want to maximize the 90-10 match from the federal government.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: Are you considering tiered rates based on acuity?

Kent, DHCS: I think the answer is yes. A CCS health home would look different, for example.

Marvin Southard, LA County Department of Mental Health: It might be good to look at health neighborhood effort in LA.

Kim Lewis, National Health Law Program: As you look at populations and readiness, please look at models that are working. BH, youth in foster care and others. What can we build on that is already there as an option.

Hansen, DHCS: We are working on a behavioral health concept.

Anne Donnelly, Project Inform: Ryan White has built medical homes for HIV and has data to share. There may be partnership for HRSA and with the state office of AIDS to have some additional funding for medical homes for people with HIV.

Bill Barcelona, CA Association of Physician Groups: We walked through a prototype for one of these. There is a wealth of information on health homes and we would like to see them involved.

Katch, DCHS: We look forward to connecting with them.

SUDS Update

Karen Baylor and Marlies Perez, DHCS

Slides for the presentation are available:

<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

Karen Baylor spoke to efforts on the SUDS. The waiver has been submitted and expect to hear by March 24. A brief indication of interest produced 53 counties saying they have interest in participating. We expect to do this in a regional model with all counties opting in at the same time will minimize beneficiary disruptions.

Comments and Questions

Kelly Brooks Lindsey, CA State Association of Counties: How are you thinking about the 1115 waiver renewal incentive proposal working with this?

Baylor, DHCS: I think that is down the road a bit. County rates will vary.

Behavioral Health Therapy Service

Sarah Brooks and Laurie Weaver, DHCS

Slides for the presentation are available:

<http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>

Sarah Brooks offered information on the Behavioral Health Therapy service. All children must receive screening as early as possible. An interim policy is in place directing health plans to offer services.

Laurie Weaver offered information on beneficiaries receiving service through Regional Centers and we are working on transitioning them to the plans. Beneficiaries are not required to transition at this point. There is a monthly stakeholder meeting; bi-weekly calls with health plans and weekly meetings between DHCS and DDS. The primary providers for behavioral health therapy are not licensed providers. The SPA from CA is the first to be submitted on this benefit.

Comments and Questions

Marilyn Holle, Disability Rights CA: What have been the comments from CMS?

Weaver, DHCS: We haven't had difficulties but there has been interest in spelling out all the details to serve as a model for other states.

Cathy Senderling, County Welfare Directors Association: DDS is currently coordinating these services now even for those who are not clients of the regional center?

Weaver, DHCS: There are two systems: managed care and regional centers.

Cathy Senderling, County Welfare Directors Association: Is there a continuity of care requirement?

Brooks, DHCS: Yes.

Cathy Senderling, County Welfare Directors Association: Will the materials be on the website? County eligibility workers might get questions.

Weaver, DHCS: Everything is posted on the website.

Kim Lewis, National Health Law Program: Where and how services are available would be good to highlight.

Brooks, DHCS: Managed care is building up networks. We are monitoring to be sure there is sufficient capacity.

Weaver, DHCS: There is a mailbox on the web page for questions.

Public Comment

There is no public comment.

Dates for Next SAC Meetings:

- May 20, 2015 (new date)
- July 22, 2015
- October 14, 2015