DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
May 20, 2015
9:30am – 3:00pm

MEETING SUMMARY

Attendance

Members Attending In Person:
Bill Barcellona, CA Association of Physician Groups; Kelly Brooks Lindsey, CA State Association of Counties; Michelle Cabrera, Service Employees International Union; Sarah DeGuia, CPEHN; Anne Donnelly, Project Inform; Lishaun Francis, CA Medical Association; Marilyn Holle, Disability Rights CA; 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; Chris Perrone, California HealthCare Foundation; Judith Reigel, County Health Executives Association of California; Cathy Senderling, County Welfare Directors Association; Stuart Siegel, Children's Specialty Care Coalition; Rusty Selix, CA Council of Community Mental Health Agencies; 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:
Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center.

Members Not Attending:
Bob Freeman, CenCal Health; Bradley Gilbert, IEHP; Michael Humphrey, Sonoma County IHSS Public Authority; Brenda Premo, Harris Family Center for Disability and Health Policy; Cori Racela, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance; Jim Gomez, CA Association of Health Facilities; Mitch Katz, MD, LA County Department of Health Services; Marvin Southard, LA County Department of Mental Health; Herrmann Spetzler, Open Door Health Centers.

Others Attending: DHCS staff: Jennifer Kent, Mari Cantwell, Anastasia Dodson, Claudia Crist, Danielle Stumpf, Hannah Katch, Rene Mollow, Marlies Perez and Katie Ravel, Covered Calfornia

Public in Attendance: 31 members of the public attended.

Welcome, Purpose of Today's Meeting, Review Purpose of Stakeholder Advisory Committee and Introductions
Jennifer Kent, DHCS Director

Ms. Kent thanked Blue Shield of California Foundation and California HealthCare Foundation for their support to convene the stakeholder meetings. She introduced new SAC member, Molin Molicay, Tribal and Indian Health Services.

Follow-Up Issues from Previous Meetings and Key Updates
Anastasia Dodson, DHCS
Slides for the presentation are available:
http://www.dhcs.ca.gov/Pages/May20MeetingMaterials.aspx

Anastasia Dodson pointed out the matrix in the meeting materials that identifies follow up responses to items from the last SAC meeting. There were no questions about the matrix.

Governor's 2015-16 Budget
Jennifer Kent, DHCS

Ms. Kent referenced the Governor's revised budget released last week and noted the good news that 12.2 million Medi-Cal beneficiaries have health insurance through Medi-Cal. This has significant fiscal implications. Much of the $6.7B increased revenue identified since the budget release in January will go to education ($5.5B) and the rainy day fund (1.2B). The Medi-Cal budget is $94-95B. This includes funding for coverage due to the President's immigration order, a reduction in the projected amount set aside for high cost drugs based on utilization and rate increases for health plans (average 1.6% increase) and for mental health and substance use disorders benefits. There are also smaller items for MSSP and accepting the health homes funding.

Questions and Comments

Marty Lynch, Lifelong Medical Care and California Primary Care Association: Is the managed care rate increase additional, on top of the increases that were planned and talked about earlier in the year?

Mari Cantwell, DHCS: There was a placeholder in the budget in January. This rate is lower than that placeholder and is the actual rate increase for 2015-16. Other discussions were related to rate increases for 2014-15.

Elizabeth Landsberg, Western Center on Law and Poverty: The California Endowment funded enrollment assisters for Medi-Cal enrollments that flowed through Covered CA. My understanding is that since the payments through Covered CA are going away, the Medi-Cal funding will no longer be available?

Mari Cantwell, DHCS: Yes, we do not have the infrastructure to continue payments as it was set up previously. The remaining funding as of June will be transitioned into the county grants.

Elizabeth Landsberg, Western Center on Law and Poverty: We want to ensure that people continue to receive actual enrollment assistance. Will you look at adding a requirement that this money go to actual enrollment with target enrollment numbers? Much of the money in grants was for outreach.

Rene Mollow, DHCS: We have not designated the money for specific activities. Part of the allocated funding in county grants, about 50%,were required to go to CBOs.

Elizabeth Landsberg, Western Center on Law and Poverty: This money was originally designated for enrollment. We encourage consideration that this go to application assisters. In addition to CBOs, brokers have been receiving this assistance and that will also go away if enrollment payments are discontinued.

Steve Melody, Anthem Blue Cross/WellPoint: Does the 1.6% rate increase to plans include the optional expansion rate reduction?

Mari Cantwell, DHCS: It does not factor in the optional expansion rates which continue to go down.

Anthony Wright, Health Access California: In support of the comments by Elizabeth, we also appreciate a focus on CBO application assisters. On the drug budget item, how does it show up? Is this on top of the increase to managed care plans we just discussed?

Mari Cantwell, DHCS: Most of the Hepatitis C cost is in managed care – only a small portion is in Fee for Service (FFS). In total, there is about $228M in the budget. Our costs have doubled based on actual experience since the January budget was released. This is not included in the 1.6% rate increase because it is paid on actual experience with the plans.

Jennifer Kent, DHCS: The managed care plans are submitting a separate document monthly that delineates specific costs for patients with Hepatitis C therapies. They receive a monthly payment rate developed by Mercer that is not in the capitated rates. For as long as that patient receives therapy, they receive the extra payment.

Anthony Wright, Health Access California: The Governor talked about size of the Medi-Cal budget. He mentioned it is going up to $23-24B but the document says $19B General Fund – it is $95B total. Why is there a discrepancy?

Mari Cantwell, DHCS: I am not certain, however, there is some Medi-Cal General Fund in other departments such as Department of Social Services and Department of Developmental Services and that may account for the difference.

Anthony Wright, Health Access California: Thank you for the allocation designation for immigrants under the President's executive order. I can't identify the exact budget number for this and how it was arrived at?

Mari Cantwell, DHCS: There is more detail in the policy change document and that should answer the question. I can make sure we provide that detail and the assumptions.

Lishaun Francis, CA Medical Association: During press conference, Michael Cohen mentioned they were not inclined to increase rates to providers unless there are clear increases in Medi-Cal access. What does he mean when he refers to access? How are you defining access?

Jennifer Kent, DHCS: Where we have landed on increases in rates that Michael was speaking about is that we do not support paying for rate increases to the same providers to see the same patients. They are looking to target rate increases to be tied to incentives to see additional Medi-Cal patients, improve access in certain areas, new providers joining the program or other improvements in utilization.

Anne Donnelly, Project Inform: We have a number of questions about the Governor's budget related to the high cost drug proposal. The amount in the budget was decreased from $300M to $228M – what are the assumptions that go into the numbers. Is it managed care and FFS both?

Mari Cantwell, DHCS: The January budget is a place holder assumption. Over the past several months, departments have developed better estimates to improve the projection. The $228M is the total of each department's estimate. This includes Medi-Cal managed care and FFS, although most of the budget is for managed care.

Anne Donnelly, Project Inform: What is the timeline for reengaging consumer stakeholder work groups announced by Secretary Dooley? We understood we would be able to review draft guidelines prior to work groups.

Mari Cantwell, DHCS: Yes, draft guidelines will be out this week and we are looking for input. I am not certain about the timeline for workgroups because they are organized from health agency. We can follow up to get that information.

Anne Donnelly, Project Inform: We have had difficulty getting numbers of who is being treated through Medi-Cal managed care. It seems that for 2014, only 1,700 patients were being treated for Hepatitis C in Medi-Cal managed care and that is an extremely low number. We estimate close to 200,000 with Hepatitis C in Medi-Cal managed care. The number treated seems out of whack.

Mari Cantwell, DHCS: I can get information about the number of what has been paid in the budget year. We are budgeting for 3,000-4,000.

Marilyn Holle, Disability Rights CA: There have been a number of studies showing that when provider rates are at or comparable to Medicare reasonable rates, access improves to be comparable to private health plan access levels. There is information about what is the right mix to trigger access improvement.

Jennifer Kent, DHCS: We have reviewed some of those studies. In general, a broad lifting of rates up to Medicare would be $6.5B General Fund cost. There is much to be weighed between increasing to Medicare and other needs.

Chris Perrone, California HealthCare Foundation: In follow up to comments by Lishaun and Marilyn. There is disparity among health plans in their financial performance and therefore, their ability to invest in infrastructure, such as programs, new providers and clinics. Better performing plans with surpluses are more able to invest and others are not. Given the Governor's interest in infrastructure such as high speed rail and water bonds, how does DHCS think about investment in infrastructure vs services? Do you think about rounding out or adjusting in areas where plans are not doing well financially?

Jennifer Kent, DHCS: It is situation specific. The most important goal is that health plans meet the terms of their contracts. We lay out specifics about what health plans need to accomplish and levels to perform to and we measure them off of that. To the extent plans can negotiate favorable rates and use funds more efficiently, that is a positive. Not all plans have the ability to accomplish that in different markets. To the extent the plans use surplus to invest in infrastructure locally, this is good as long as this does not undermine the underlying basics such as patient access and other basics. The waiver includes rate incentives to encourage that

investment; however, our view is that beyond meeting contract requirements, it is nice to do but not required.

Mari Cantwell, DHCS: From a federal Medicaid perspective, we can't spend Medicaid on infrastructure. That is why the waiver is structured as incentives for those investments. One concern from CMS is that we may *medicaidize* situations that they can't pay for. Plans can't report those costs so that is part of why we want to change that. We still have to work within the confines of Medicaid rules.

Gary Passmore, CA Congress of Seniors: Is it fair to say that an administration objective is to expand access and that you also watch areas where we are losing access in order to prevent that.

Mari Cantwell, DHCS: Yes.

Jennifer Kent, DHCS: There are two aspects related to rates: general rate increases and opportunities for discretion based on authority under AB97. We don't' have broad latitude to increase rates – it is limited. Through AB97, when organizations bring us data to indicate that access is a problem, we review and have the authority via AB97, in a limited way to change rates for a geography. It is not a proactive tool.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center: Does the rate process hold true for psychiatry? It seems to be a problem that is not yet addressed.

Jennifer Kent, DHCS: Psychiatrists are not enrolled as a separate category from other physicians. Plans are responsible for maintaining provider networks, including psychiatry and they are paid according to negotiated rates. In addition, we don't have ability within the FFS environment to isolate them as a provider or service.

Steve Melody, Anthem Blue Cross/WellPoint: From a network perspective, we are challenged to contract with sufficient psychiatrists. We have submitted that data to Mercer through the established process.

Jennifer Kent, DHCS: Great

Kim Lewis, National Health Law Program: We have submitted a number of concerns and problems related to denials from plans for Hepatitis C treatments. This has been a major concern among advocates and we see people changing plans just to get the drugs. When will the changes in medical necessity criteria around coverage be released?

Mari Cantwell, DHCS: We call it coverage policy and it will be changed this week.

Michelle Cabrera, Service Employees International Union: On the issue of folks appealing inadequate access through AB97, are those requests centrally located and available for review? Given the importance of this, it would be good to know, Who is coming to you; What is the frequency; What is the request; How long is it taking to hear back?

Jennifer Kent, DHCS: The requests come in through Mari Cantwell or myself and we work with Pilar Williams and staff who work on FFS and capitated rates. We communicate the decision out to that provider or class of providers. We are putting together a process and don't have anything

publicly to share yet but we want to be able to share out information. There are many requests and they are quite diverse. It is often difficult to get data on the underlying facts related to the requests. There are few analytics to apply to many requests.

Kristen Golden Testa, The Children's Partnership/100% Campaign: The CHIP "bump" budget estimates changed from last fall to May revise. Can you speak to the change?

Mari Cantwell, DHCS: Medi-Cal is on a cash basis and there is a lag in claiming. The annual budget number is a full year estimate of about $650M. It changed solely based on cash vs accrual. Nothing changed in the calculation assumptions.

Kristen Golden Testa, The Children's Partnership/100% Campaign: On the dental audit, it was disappointing there was no response to the dental access issues and provider participation. I know you are working on the outcome recommendations and quality measures but is there anything to report on access?

Jennifer Kent, DHCS: We have been working with Delta and hope there will be administrative changes we can make, separate from rates. We have requested they look at the commercial network and deem providers who request to be part of Medi-Cal. They could more easily become Medi-Cal providers. That would help with the issue we hear about providers not wanting to apply separately to Medi-Cal. Another topic is allowing dentists to remove prior authorizations and submission of x-rays on some procedures and services that were put in place because of widespread inappropriate billing at the time. That was a particular point in time and removing them may improve provider participation.

Kristen Golden Testa, The Children's Partnership/100% Campaign: On the provider rate recommendations in the audit?

Jennifer Kent, DHCS: It was acknowledged how California rates compare to other states; however, there was no specific rate recommendation. We would need to look at the numbers similar to the discussion we just had. Many states with higher rates (Illinois, Texas) do not have higher utilization, so finance asks us to justify why increases in rates would help with access with data.

Anne Donnelly, Project Inform: On the AIDS waiver rate, the rate is under minimum wage and there are discrepancies between other waiver provider rates with AIDS providers. We understood it would be addressed yet it was not addressed in the budget.

Jennifer Kent, DHCS: I don't have an answer today. There is a request to meet with us.

Update on Medi-Cal and Covered California Enrollment
Rene Mollow, DHCS and Katie Ravel, Covered California
Slides for the presentation are available:
http://www.dhcs.ca.gov/Pages/May20MeetingMaterials.aspx

Ms. Mollow reviewed the enrollment data presented on slides for open enrollment, renewal data for 2014, transitions from Covered CA to Medi-Cal, transitions from Medi-Cal to Covered CA, Hospital Presumptive Eligibility (PE), and expansion of full scope Medi-Cal coverage for pregnant women enrollment. CMS has approved the state plan amendment for hospital PE with some minor adjustments due to date-specific eligibility system changes. She also offered an

update on the reports provided to the courts regarding a case on renewals for Medi-Cal beneficiaries.

Questions and Comments

Anthony Wright, Health Access California: Is the annual number for hospital PE 6-12 times the monthly number?

Rene Mollow, DHCS: These are point in time numbers and we can't say what the annual number would be because it is a rolling number. It is not 12 times the monthly amount. We are working to be able to provide different data on PE going forward.

Anthony Wright, Health Access California: What is the number of hospitals enrolled? Do we know why there are not more hospitals enrolled?

Rene Mollow, DHCS: There are 279 hospitals enrolled in PE out of around 400 total. Many are in the process of becoming enrolled in the program, including completing the training.

Gary Passmore, CA Congress of Seniors: On the issue of renewals in Medi-Cal managed care, how disruptive is the renewal process to care planning, coordination and disrupting a course of treatment? We want to manage people not just provide episodic care. Do you see this as an issue?

Jennifer Kent, DHCS: As more individuals are enrolled in Medi-Cal managed care, the plans want to work closely with counties and DHCS as the renewal date approaches to proactively reach out to beneficiaries to alert them about the renewal paperwork and make sure there is more emphasis on keeping coverage. This has been a key factor in CCI as plans complete the health risk assessment and other care planning. We and the plans want people to keep continuous coverage.

Cathy Senderling, County Welfare Directors Association: That is right. We are working much more closely together with the plans and DHCS than previously on renewal systems. The first opportunity was working with the pre-ACA eligible enrollees to collect tax information. We continue to improve the systems of how renewal works and to collaborate more closely.

Steve Melody, Anthem Blue Cross/WellPoint: Yes, this issue has broad implications. The overall churn of Medi-Cal members is extremely disruptive to care management and costly in administrative process. When someone loses coverage, they may change plans and there are expensive administrative processes that are duplicative to complete a new enrollment and reestablish care coordination. Plans want to incentivize members to stay and maintain coverage so improving this process is very important.

Rene Mollow, DHCS: We have been working between managed care operations and Medi-Cal eligibility divisions to have eligibility staff participate in calls with the plans and become more proactive. We do want to look at and further encourage local communications because that is more effective. We, at the state, can offer tools and guidance.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: The health centers are the providers for approximately 65% of Medi-Cal members. For the most part, health centers got federal funding to help with enrollment activities and have enrollment staff to work on these issues. Health centers are interested in working with plans and counties to get

information about renewals on their members and work with them to complete the packet. We are willing partners to help with this in FFS or managed care.

Anne Donnelly, Project Inform: One other place it is important to look as we think about the issues of churn is in the private plan enrollment. This is as much in CoveredCA as in Medi-Cal managed care. In San Francisco, we see situations where they get a reference number but can't get care without the group number and ID number. There are significant delays.

Jennifer Kent, DHCS: We need to take this back.

Kim Lewis, National Health Law Program: Will you have specific data on renewal gaps in coverage? Actual numbers and break-downs? At the county level? By month? We are interested in those who are eligible and lose coverage; those who have a gap vs those who move to Covered CA without a gap.

Rene Mollow, DHCS: We get data from county partners on renewals. There are renewals that remain incomplete based on workload at the counties. As we get the specifics, we will figure out how to display that kind of breakout data. Remember that 2014 was very different than 2015, there was "noise" in terms of renewals because of the specific work with the doubling up of renewals. We do want to better understand the data and identify any additional work to be done on systems. We need to figure out how to display the data so it is meaningful.

Sarah DeGuia, CPEHN: We would like to see the data by language to ensure we track renewals

Elizabeth Landsberg, Western Center on Law and Poverty: Can you give us an update on translation of renewal forms and when the forms will be in use?

Rene Mollow, DHCS: I will have to look into the specifics of the release.

Ms. Ravel reported on Covered CA open enrollment data for 2014 and 2015 to date, including race/ethnicity, gender and age break down data; higher levels of African Americans and Latinos and young enrollees. Call center improvements and staff enhancements paid off in better response times. She reported on enrollment compared to forecasts which showed lower enrollment total but higher retention.

Slides for the presentation are available:
http://www.dhcs.ca.gov/Pages/May20MeetingMaterials.aspx

Questions and Comments

Anne Donnelly, Project Inform: What do you make of those who are subsidized increasingly choosing the bronze plan, which may be a bad plan choice for those who are subsidized?

Katie Ravel, Covered California: It may be the right choice for some because they gain coverage with very little cost per month to them. We don't see this as a good or bad decision but we want it to be an informed choice.

Anne Donnelly, Project Inform: We are concerned because we hear that people don't understand the choice and don't realize it until they can't pay for prescriptions.

Katie Ravel, Covered California: We are looking at the decision tools that people need at the point they make that decision and analytic tools so we can see if people have what they need to make a good decision and understand whether it turned out to be a good decision for them.

Cathy Senderling, County Welfare Directors Association: Are the 74,000 special enrollment period data, did they all select a plan?

Katie Ravel, Covered California: They all selected a plan but they have not yet effectuated payment. There could be some drop-off from this number.

Anthony Wright, Health Access California: Are the MAGI Medi-Cal numbers listed new enrollees?

Rene Mollow, DHCS: Yes.

Elizabeth Landsberg, Western Center on Law and Poverty: Do you have a timeline for release of ABX data?

Rene Mollow, DHCS: Soon, we are working to get it finalized.

1115 Waiver Renewal Concept and Application: Status of Waiver Renewal Proposal, CMS Discussions and Timeline for Next Steps
Mari Cantwell, DHCS
Slides for the presentation are available:
http://www.dhcs.ca.gov/Pages/May20MeetingMaterials.aspx

Mari Cantwell, DHCS provided a brief update on the waiver submission and comment timeline. There is no specific feedback from CMS yet and we hope to receive it this week. CMS has committed to regular meetings that will start soon. Secretary Dooley and Ms. Cantwell met with CMS soon after the submission and walked them through the proposal. They are generally supportive and offered some high level feedback on a few issues. These issues were expected and have been discussed at previous SAC meetings. CMS shares the understanding that some of the proposed benefits do impact health and reduce costs but they have concerns about whether Medicaid can pay for those services, such as housing. California is very different than the states that received letters of concern from CMS about safety net care pools. She reviewed a proposed timeline for next steps to share the feedback and finalize the waiver prior to November.

Questions and Comments

Gary Passmore, CA Congress of Seniors: We had hoped to have initial feedback prior to now. What is the thought about convening this group to provide information?

Mari Cantwell, DHCS: We intend to have some type of stakeholder engagement, however we don't know how comprehensive the comments from CMS will be and whether it will be useful to have a webinar or some type of meeting.

Gary Passmore, CA Congress of Seniors: If you are getting substantive programmatic feedback, we would like for that to be shared even if you don't have the final financial information.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: Can you share more about concerns on budget neutrality from CMS?

Mari Cantwell, DHCS: There are concerns about whether the budget neutrality base should be calculated on FFS or not. Our current base is FFS given the fact that Medi-Cal managed care exists with authority in the waiver, we think this is the right base. Absent the waiver, we could be in FFS. They have raised whether this is an appropriate base because we have had managed care for so long. Every other state has FFS as the base and many are much larger than California. Those states are not being asked to re-base. Our perspective is that we should have ongoing apples to apples and not fundamentally restructure the financing.

Erica Murray, CA Association of Public Hospitals and Health Systems: This is a critical issue. If there is a re-base, we will not be able to do everything proposed. I think the stakeholder input is critical; however, having a conversation about what we might do with funds without knowing the savings numbers is discussion in a vacuum. If we don't know the financing, we could be having a discussion that is not possible. It is our hope that we avoid expectations that may not be possible.

Jennifer Kent, DHCS: We will likely do a webinar as soon as we have feedback. The legislature will be interested in hearings as well as stakeholders.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Our previous budget neutrality calculation included FFS as the base?

Mari Cantwell, DHCS: Yes, we are proposing to continue as we have in the past. They raised the issue but have not requested that we re-base budget neutrality.

Marilyn Holle, Disability Rights CA: What is your overall sense of this? Is this back to a previous era of negative relationships with CMS? Are we being treated differently because we are so big?

Mari Cantwell, DHCS: I think what is driving the question is wanting to follow the federal regulations; understanding the justification. I believe they want to have a successful waiver and have it in place in November. The GAO released a report that raised concerns about the clarity of how CMS makes decisions in waivers.

Elizabeth Landsberg, Western Center on Law and Poverty: The legislative session includes two bills that we look forward to engaging in and the session ends September 15th.

Kim Lewis, National Health Law Program: Will there be an opportunity in the process to engage in terms and conditions?

Mari Cantwell, DHCS: I have no idea. It is difficult to say.

Elizabeth Landsberg, Western Center on Law and Poverty: Last time we did have the opportunity to engage in the terms and conditions and we do care about the details.

Jennifer Kent, DHCS: They trickle in and can drag past November, so it is difficult. As open and transparent as we can be once we have information to share – we are committed to doing that.

Sarah DeGuia, CPEHN: Did CMS have a response to our proposal to reinvest the shared savings?

Mari Cantwell, DHCS: They did not have specific feedback although there was an interest in understanding how it would work and whether it was allowed.

Anthony Wright, Health Access California: Can you offer the case for shared savings and how it connects with the program changes we seek in the waiver?

Mari Cantwell, DHCS: Our perspective is that California has saved the federal government billions of dollars in the way we have operated the Medi-Cal program. The transformation we are proposing in this waiver will continue to save money for the federal government. Just as we have looked at how to incentivize and participate in shared savings with health plans, there should be a way for the state to participate in the shared savings from the federal level. California is the single largest provider and payer of health care. Let us share in savings so that it can continue to drive system reform.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Is the shared savings dollar amount from the individual program proposals included?

Mari Cantwell, DHCS: The shared savings is not specific to the proposals, but to how we operate the program and what the plans have achieved overall. The proposals are what keep the trend lines lower than they would be. There are not specific dollar amounts of savings tied to specific proposals.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center: Is there any indication of timing related to 5 years?

Mari Cantwell, DHCS: That has not come up as an issue and it is assumed it will be 5 years.

Cathy Senderling, County Welfare Directors Association: On the question of re-basing, I wonder if the story includes the fact we are still in the process of moving people into managed care. It is not finished – we are still in the process of making managed care work. Now is not the time to move away from the prior conversation.

Public Comment Specific to the Waiver
No public comment

CCS RSAB Workgroup Update
Anastasia Dodson, DHCS and Hannah Katch, DHCS
Slides for the presentation are available:
http://www.dhcs.ca.gov/Pages/May20MeetingMaterials.aspx

Ms. Dodson reported on the CCS redesign process including goals, overview of the technical workgroups, 2014 stakeholder survey data and the CCS Alternatives that are being discussed. The alternative models include:

- Bay Area Stakeholder Models, including county regional collaboratives
- Hospital ACO Model
- LA County Targeted Case Management
- Children's Hospital LA Medical Home

- Rady Children's Hospital Pilot
- COHS Carve-In (HPSM and Partnership)
- Kaiser Permanente.

Hannah Katch offered an update on the CCS pilots in Health Plan of San Mateo and Rady Children's Hospital San Diego.

Questions and Comments

Stuart Siegel, Children's Specialty Care Coalition: What are your take-aways from the survey?

Anastasia Dodson, DHCS: Certainly, whole child care is a need and a goal. Some models are working to achieve this although it is hard to know if there is one ideal model that can work statewide.

Stuart Siegel, Children's Specialty Care Coalition: Looking at the data, the whole child care issue is prominent. I am struck that many other issues that might be expected to be bad are not showing in the survey as being a problem. On many topics, there is no major objection. Is that a message that comes from the data?

Anastasia Dodson, DHCS: This is only one survey we have done. Other surveys, such as the Title V survey, have pointed to Durable Medical Equipment, speed of provider credentialing in some parts of the state and other issues that don't show up here. This is not the last and only information on what might be improved. The Title V survey was published yesterday and includes some other issues.

Jennifer Kent, DHCS: Some people said things are working; then in another question they also said it isn't working. Depending on who we ask, the answers are variable. The surveys help us generally, but it is not useful to get too wedded to individual results.

Gary Passmore, CA Congress of Seniors: My observation is that CCS is intended to acknowledge high acuity children who need special attention and care. They are a carve-out from managed care. It is clear that these needs are also true of people at the older end of age spectrum and people with disability across the age spectrum. I am curious about the rationale from DHCS about why those with very similar needs have been treated very differently - children vs seniors.

Jennifer Kent, DHCS: The CCS population is high cost and there are other high cost populations that have been included in managed care. CCS began in 1927 and part of this is a historical legacy program. In some cases, children are relying on others and can't speak for themselves and we have a network developed that is very specific to their needs. When you look at changing CCS, it is undoing years of history, facilities and service systems around the population. There is complicated, multi-layered financing, including state-county relationships. We are mindful that we are moving other populations into organized delivery systems and we believe this improves our ability to be accountable. We can measure, report and monitor organized delivery systems and cannot in FFS. This is a conversation about how we do a better job with what we have.

Marilyn Holle, Disability Rights CA: We are dealing with lots of low incidence conditions. This created a quality and specialized system of services for these low incidence conditions that has

set the standard of care. The system protects kids by creating these standards and that is part of the purpose of Title V. CCS has preserved quality and access for every child with disability.

Stuart Siegel, Children's Specialty Care Coalition: The CCS population is cared for in large centers. There is no system of private providers within CCS. The standards are critical; the center-based care ensures quality. We saw negative situations when SPD populations were disrupted from care they received through centers as they moved into managed care.

Gary Passmore, CA Congress of Seniors: The other alternative is to create the same model for people at the other age continuum or severely disabled adults. I am not attacking CCS. I think there is a population of high acuity, special needs, older people that would benefit from a CCS-like system.

Marilyn Holle, Disability Rights CA: There is a system in MSSP that is similar for individuals 65 and older.

Kim Lewis, National Health Law Program: In the second goal on the coordination for this population look like? I am not clear about the overlap of specialty mental health and CCS populations? What would this look?

Anastasia Dodson, DHCS: That is why it is on the list for improvements. Some of the items here will take years to identify a model, build partnerships and transition populations.

Kristen Golden Testa, The Children's Partnership/100% Campaign: What is the difference between the pilots?

Hannah Katch, DHCS: Health Plan of San Mateo is a carve-in. Rady is a hospital and will begin in Fall 2015. They both have full financial risk, unlike other CCS providers.

Claudia Crist, DHCS: One difference to note is that the Rady proposal limits the conditions covered. The details are being finalized.

Stuart Siegel, Children's Specialty Care Coalition: The pilots are moving but will not be done by the sunset date of the carve-out at the end of this year. We are not ready for a new program.

Anastasia Dodson, DHCS: There are two upcoming stakeholder meetings to discuss concepts to address the sunset of the carve-out. This is a sensitive issue. It is unlikely we will have the detail of a new model in statute. We are aiming for a framework, not a detailed statute. The conversation will continue in June and beyond. We want to find consensus on the major building blocks.

Chris Perrone, California HealthCare Foundation: In terms of this process with the re-design stakeholder group, does that stop in June? Given your comments about the potential for regional approaches, can you reflect on lessons from the two pilots? Does the long ramp-up for these pilots indicate this may be a decade long process?

Anastasia Dodson, DHCS: We are looking at a calendar for 2015 for the stakeholder group to meet. What needs to happen is a mix of items that will take an ongoing process for implementing building blocks and other items that can change now. Quality measures, publishing better data are items that can be changed now. Even if we knew what model to implement, it would still take years to phase that in across the state.

Jennifer Kent, DHCS: It is somewhere between 1 and 10 years. Anything we do will take time. There are readiness standards, guidance, rates and lots of other pieces to phase-in. We need to continue a process with a focus on timelines for improvements.

Sandra Naylor Goodwin, CA Institute for Behavioral Health: There is a high rate of serious mental health and substance use concerns in the population.

Anastasia Dodson, DHCS: This is something to put on the list to address inside the model.

Jennifer Kent, DHCS: Mental health components are not well addressed within CCS. It is focused on medical conditions and the specialized care system around that condition. For MH/SUD, it goes out of CCS and is handled under EPSDT. No one has a great handle on this.

Stuart Siegel, Children's Specialty Care Coalition: Children's Hospital started a psycho-social program for children with cancer but the reimbursement was too low for sustainability. We should look at this issue because this ends up costing more in the end when services are not available.

ACA Section 2703/AB 361 Health Homes Update
Hannah Katch, DHCS

Ms. Katch provided a brief update on the health homes concept being proposed and reported that more than 200 pages of comments were received related to the concept. DHCS is continuing to reach out to stakeholders for discussion. Slides are available at: http://www.dhcs.ca.gov/Pages/May20MeetingMaterials.aspx

Questions and Comments

Amber Kemp, California Hospital Association: Can you comment on the inclusion of CCS?

Hannah Katch, DHCS: There are federal requirements about how the program must operate and one rule is that anyone in a particular geography must be eligible. We cannot limit the populations. Anyone who does not want to accept the health homes benefit is not required to do so. This will not impact any other coverage. There is concern about health homes care coordination and other programs that include care coordination. However, we don't have the authority to change the beneficiary coverage.

Stuart Siegel, Children's Specialty Care Coalition: The health homes proposal has the money flow through managed care plans. How would that work for CCS given the previous discussion that we are not there yet? Could that money be used to help with the redesign effort?

Hannah Katch, DHCS: For all programs including CCS, only individuals enrolled in managed care will have access to health home services. If a CCS child is in FFS for primary care, they are not eligible for the health home program. On the second question, health homes is a 90-10 match for clinical services and 50-50 for other items. We have not considered using this for redesign given how separate the program is, but if you have suggestions, we are happy to hear them.

Stuart Siegel, Children's Specialty Care Coalition: It seems the purpose of the two programs, the whole child concept in CCS and the health home concept are so similar.

Hannah Katch, DHCS: The concepts are similar but the majority of the enrollees in the health home program will be adults. There is a very different timeline as well. We will submit to CMS in August with implementation for the first counties January 2016, so it is on an expedited timeline.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: Could you speak to the tiering of rates for populations? Can you speak about the non-CCI counties, both what the criteria for readiness and who might approach you? Do you have more information on the criteria for readiness?

Hannah Katch, DHCS: We envision there will be tiering based on acuity. There will be eligibility criteria for the program and then within that eligibility, different services will be offered based on the acuity of the individual. There will be tiering of rates based on acuity. For a patient with intensive needs, there may be very intensive services available to coordinate their care. The authorizing legislation outlines that there should be a special focus on individuals experiencing homelessness. For individuals who may have not had access to this level of service or may be homeless could receive intensive services while other individuals, or later on in the program, individuals may have less intensive services.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: When will rates and tiering be available?

Hannah Katch, DHCS: This is TBD. We are working to develop rates but don't have any information yet. We will have more information on acuity levels in advance of the SPA submission in August. We are committed to stakeholder review prior to the SPA submission.

Hannah Katch, DHCS: Initially, we thought the first round of eligibility might just be CCI counties given they may have more infrastructure for this. We heard feedback that other counties that may have readiness and want to be considered. We are open to talking to other counties about their readiness and consider them. We don't have additional information developed on readiness beyond the concept paper.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: Is it the county or health plan that would approach you?

Hannah Katch, DHCS: Either, in order for the health to implement the program, all health plans in the county must participate. That is a federal requirement.

Kim Lewis, National Health Law Program: In terms of children, can you talk more about how you will decide on eligibility?

Hannah Katch, DHCS: We can't decide based on age. We proposed a list of conditions that would determine eligibility in the concept paper and we are continuing to refine that. We want to focus on the top 3% of utilizers whose utilization can be more appropriate with care coordination. The top 1% may not benefit from case management because they have a clear need for that level of care. Based on our data and other states, there are 2-3% that are accessing care in ways that is not appropriate and their health outcomes could improve with care coordination.

Kim Lewis, National Health Law Program: If you are considering diagnoses for specialty mental health, EPSDT coverage is required. There are other programs that do this same set of services

although it may be different rates, such as intensive care coordination team approach through wrap around. There is a whole robust level of service coordination that may be more than what a health plan would do. It is a pretty elaborate model – have you thought about how you are already paying for services to this population and how to integrate or avoid duplicating the model for children in that arena?

Hannah Katch, DHCS: Absolutely, there is lots of care coordination in the program already – through Katie A, CCS, health plans, CCI, the waiver. Health home services are probably 10% of that and the other programs already in place are 90%. Health homes is different in that it is care coordination at the point of care. It is provider or clinic based.

Kim Lewis, National Health Law Program: And is the home considered a point of care?

Hannah Katch, DHCS: We have not contemplated it in the home, no.

Rusty Selix, CA Council of Community Mental Health Agencies: For people with serious mental illnesses, the concept paper lays out that the health home would not be with primary care, it would be at the behavioral health provider. I have two assumptions I want to ask about. The money would flow to a physical health plan and they decide whether to pay directly to a provider or through the county to the provider? Is this a plan by plan choice or will there be some uniformity in this?

Hannah Katch, DHCS. This is still to be decided. We would like to continue to discuss this with you. The money will go first to the managed care plan but we want to ensure there is a 'no wrong door' approach. We want to be sure there is an option contemplated for those who want to have primary care at mental health provider and have that available.

Rusty Selix, CA Council of Community Mental Health Agencies: Those that may need it most may not have a primary care provider and the services would need to be brought to the mental health provider. Through Prop 63, counties have funded similar services. My assumption is that if those services are already reimbursable under rehabilitation option, which includes some care coordination, health homes would cover what is not covered by the rehab option? Or can there be overlap to bill at the 90% match for items currently billed under 50% federal share.

Hannah Katch, DHCS: I don't have a definitive answer and it will depend on the specifics. To the extent that services are really the same, we need to prevent duplication. There may be a limited set of circumstances where that does exist.

Rusty Selix, CA Council of Community Mental Health Agencies: I don't think the issue is duplication of payment for services, the question is whether it could be billed under the 90% federal share or would it have to be billed at 50%? Is this only for services not covered under 50% federal share.

Mari Cantwell, DHCS: Health homes can be for services already available under the 50% federal share.

Jennifer Kent, DHCS: That is one of the reasons we identified the CCI counties as most ready. Part of the CCI requirement is that they need to renew their MOU with county mental health agencies. Some of the work is already done on these relationships.

Gary Passmore, CA Congress of Seniors: Some comments on health homes. I would hope we do not look at health home as a supplantation to the 50-50 federal share. When you are doing county selection, think about pairing CCI and non-CCI that is similar. Then run them as two initiatives trying to reach the same goal of care coordination through different models where you can test the approaches – to learn about the impact on things such as provider participation.

Erica Murray, CA Association of Public Hospitals and Health Systems: My comment is that county and public hospitals see an opportunity and benefit to align the health home project with whole person care pilots in the waiver. Health homes are a central hub of a larger effort on integrated care. We are interested in a range of perspectives from stakeholders on the health home proposal. Is there a way to see the comments received and understand the range of input?

Jennifer Kent, DHCS: They are public documents and I don't know why not. We will make sure that happens.

Stuart Siegel, Children's Specialty Care Coalition: What kinds of activities will be funded? How is this voluntary?

Hannah Katch, DHCS: it is completely voluntary for the beneficiary. We determine the conditions and the beneficiary chooses to participate or not. The services are intensive care coordination. It is a community health worker working with the patient to access health care and social services.

Jennifer Kent, DHCS: The federal requirements are clear that this must pay for care coordination not health care services.

CCI/CMC Update
Claudia Crist, DHCS
Slides for the presentation are available:
http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Ms. Crist provided an update on enrollment, enrollment process improvements, Cal MediConnect, the Multipurpose Senior Services Program (MSPP) transition, opt-out data and disenrollment data. Disenrollment data is higher than DHCS would like and is creeping up slightly. There will be additional analysis to understand this trend. She presented details related to the In Home Supportive Services (IHSS) opt out data. The top three subpopulations opting out in each county by ethnicity, language and age was reported. Gender data indicated no differences between male and female. Ms. Crist reported on solutions in place to solve issues related to enrollment assistance and care coordination. The MSSP transition will be 12/17 or earlier if readiness criteria are met.

Questions and Comments

Elizabeth Landsberg, Western Center on Law and Poverty: What is Amerasian?

Claudia Crist, DHCS: I am not certain and will follow up.

Claudia Crist, DHCS: For the SAC members, are there surprises in the data?

Sarah DeGuia, CPEHN: This data raises questions about whether everyone is getting complete information. Is this voluntary or involuntary disenrollment? I have questions about what information they are receiving and whether it is in all the languages.

Gary Passmore, CA Congress of Seniors: I would focus on the provider community for these ethnicities and identify what is going on in the relationship with the providers. In CCI, physicians receive Medicare rates so it must be other issues, comfort levels or other issues. The data also suggest ways to improve the numbers over time. If they were spread throughout all groups, it would be more difficult to target the approach.

Jennifer Kent, DHCS: It may relate to managed care and requirements to provide encounter data back to plans compared to FFS Medicare. In some cases, this is a generational difference as to who is practicing in a managed care environment or not. The fact that the data are concentrated in a few sub-populations means we can identify ways to address this.

Marilyn Holle, Disability Rights CA: Also, look at the hospital relationships. In LA, Cedars-Sinai has high levels of certain ethnicities. No one wants to change where they provide care or change admission practices. I think that is a large disconnect and a bigger barrier than reporting.

Michelle Cabrera, Service Employees International Union: There is a middle space. If you feel that there are only a few providers who offer services in your language, your fear level is higher and the alternatives are fewer. The solution comes by way of the provider relationship but the problem may be cultural and language access. Taking both of those into consideration is important.

Claudia Crist, DHCS: We have heard anecdotally these same issues. This helps us refine, to drill down and focus on identifying the specifics.

Anthony Wright, Health Access California: It is hard to read the data without seeing how it relates to the overall picture. Should we assume that Spanish and English are not included because they are at much lower levels? Another helpful item is the geographic information at the neighborhood level. How much have you looked at that data?

Claudia Crist, DHCS: Yes, we did run it by ZIP code and it depends on the county. There are some ZIP code hot pockets. I want to take some time to display that in a way that is helpful

Mari Cantwell, DHCS: To Marilyn's point, in LA, the highest opt out is the ZIP code around Cedar Sinai.

Marilyn Holle, Disability Rights CA: I find the information about IHSS vs non-IHSS very interesting. The folks in IHSS have high needs and likely have the longest relationships with providers and may be most resistant to changing those relationships.

Gary Passmore, CA Congress of Seniors: This means there are caregiver relationships in this process as well, including many family members.

Jennifer Kent, DHCS: At a recent meeting, some Olmstead committee members who are beneficiaries reported that they did opt out. Their comment was they don't want to be the experiment when I have worked hard to establish care. We have a network and it may not be

perfect but I don't want to try something new until we hear from our friends that it is better, that you can show me it will be better.

Anne Donnelly, Project Inform: On ethnicity, what does the opt-out rate look like below the top 3 that have language issues? Is there benefit to looking at where the opt-out rates are better rather than only where there is a problem?

Claudia Crist, DHCS: Absolutely. There are a few groups in the middle 40-50% range and then it drops off significantly.

Mari Cantwell, DHCS: We will release additional detail as soon as we can organize its presentation and all the data, not just the top ones.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: We heard previously about small private providers not understanding that the base payment rate would look like Medicare rates vs Medicaid rates. Do we have any information to indicate we have succeeded in educating those providers?

Claudia Crist, DHCS: We revised the provider toolkit and received positive response on that. There is continued need for some outreach but we need to target outreach and partner with local entities. Should it be visits to physician offices? Is there opportunity to work with county medical organizations? We do continue to work on outreach and there is a weekly update on the CCI website about outreach.

Elizabeth: On enrollment, you are relying on someone to attest that they have the beneficiary's permission without speaking to the beneficiary or having anything in writing?

Claudia Crist, DHCS: Correct.

Marilyn Holle, Disability Rights CA: Many people do have someone acting on their behalf. I am surprised that the information about who is on record as authorized representative is not already available as a solution for the enrollment mechanism? That would narrow the universe.

Claudia Crist, DHCS: Yes, that was the intent and we do have access to the information but the information is not always in there. So, rather than working on a multi-year technology system, we wanted to create a faster way to accomplish this. The beneficiary is the first source, the system designated authorized representative is the second source and the HCO process is the final alternative but would not replace the other avenues.

Chris Perrone, California HealthCare Foundation: What is the care coordination landscape assessment you spoke about? Is this within Medi-Cal? What is the timeline? Who is conducting this? Will you include what the health plans and IPAs already do? Is it at the state level?

Claudia Crist, DHCS: We are starting internally at what information we have and want to look at other standards that exist to learn from them. It is both internal and external. I don't have a timeline yet but we expect a grid of key issues in care coordination and who has that information. If you have suggestions of areas we should look at, please let us know. Internal staff is working with the Harbage team. It will include both state and local levels.

Cathy Senderling, County Welfare Directors Association: It is great to hear that IHSS is being included in the interdisciplinary planning. We would be happy to help with the beneficiary toolkit about how IHSS is explained and presented.

Gary Passmore, CA Congress of Seniors: A note - a caregiver is not allowed to participate on a care team unless the beneficiary authorizes it.

Jennifer Kent, DHCS: I was in LA and met with IHSS program at the county. Their social workers are being included on the health plan care team and the caregiver joins if permission is given.

Michelle Cabrera, Service Employees International Union: I appreciate how the care coordination is going beyond Cal MediConnect. The health plan medical officer meetings are closed, however I wonder if there is an opportunity for broader stakeholder participation in the process. At what point do we hear what happens and inform that process?

Claudia Crist, DHCS: The meeting is not CCI specific; it covers all care coordination and is an opportunity to compare notes to solve issues. The input can flow both ways and when there is an issue related to care coordination around CCI, we can suggest issues from this group for them to discuss and they may ask us to offer thoughts on a particular issue.

Jennifer Kent, DHCS: Dr. Kohatsu chairs the CMO group and we could ask Dr Kohatsu to report out from the CMO group.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: Could you talk more about the care coordination landscape in terms of whether you will look at how integrated care coordination is with care provision – whether it is right at the provider level, at the IPA, at the health plan? There is information from long term care that there are significant differences whether you get that day to day integration as opposed to a removed approach. It would be helpful to know how this is rolling out via CCI.

Claudia Crist, DHCS: Thank you for the suggestion of including the IPA as a category. I also included the behavioral health topic from previous comments. We will include your input as we consider the issues to include in the survey.

SUDS Waiver Approval and Implementation
Marliese Perez, DHCS
Slides for the presentation are available:
http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Ms. Perez presented an update on the Drug Medi-Cal/Other Drug Services waiver implementation. There will be a phased regional implementation. An effective model for implementation is in place in the Bay Area and other areas may want to replicate this. A Phase V for Tribal Delivery Systems has been added to the plan. She reported on terms and conditions changes from CMS. The waiver advisory group continues to meet and there are county regional meetings. Implementation will include technical assistance from DHCS. There is a special website for this waiver: http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal

Questions and Comments
Gary Passmore, CA Congress of Seniors: Given the timeline, will this be continued in the new waiver?

Marliese Perez, DHCS: This will be an amendment to the existing waiver and it will be carried over.

Jennifer Kent, DHCS: I think this is indicative of how supportive CMS is in the fact that CMS is allowing an amendment this late in the process speaks highly of where we are trying to take the system.

Public Comment

Kym Flores, Senate Office of Research: Can you talk more about the Youth Recovery programs you are developing in the counties and American Society of Addiction Medicine (ASAM) designated residential levels? Are they actually different sites for the different levels? Can a residential program have different levels? What are the services in the different levels?

Marliese Perez, DHCS: The Youth Recovery Services is related to a bulletin put out by CMS about how to provide youth services on a continuum. It is very similar to our proposal but they are asking for us to add a bit more. This is relatively small. In reference to residential criteria, it could be all levels. Level 1 is intensive counseling and could have housing offsite vs Level 3 is 24 hour and has residential and service onsite. DHCS licenses facilities and we will monitor by going out and check via chart audit whether clients receive the services required.

Chris Perrone, California HealthCare Foundation: We are hearing about value based payments from prominent health leaders. In your conversations with CMS or internally, are you planning targets for the level of value based payments?

Mari Cantwell, DHCS: The Medicare system is vastly FFS, so it is very different than California. We consider the whole waiver to be about driving toward value based care. We want to move to shared savings arrangements and incentives that move to more value-base. Linking to the conversation about CCI, this is a huge shift toward value in a program that has been FFS. We are not talking percentages but we do want the system to move toward a value-based orientation through the waiver and incentivize that change.

Sandra Naylor Goodwin, CA Institute for Behavioral Health: When I share with national groups what California is trying to do for substance use disorders, they are surprised and delighted. Other states are watching closely. Some of the services don't exist yet so it will take time to put this together. .

Joel Ervice, Regional Asthma Management and Prevention: Can you talk more about health homes program design work sessions?

Hannah Katch, DHCS: You may be referring to technical workgroups. We are going to be working with stakeholders to identify a number of issues such as readiness criteria.

Jennifer Kent announced that Danielle Stumpf will be moving within DHCS to work with the Substance Use Disorder program and we thank her for all of her good work. Mari Cantwell announced that Pilar Williams is leaving the department and we will be hiring a replacement.

Dates for Next SAC Meetings:

- July 22, 2015
- October 14, 2015.