

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

September 11, 2014

9:30am – 3:00pm

MEETING SUMMARY

Attendance

Members Attending:

Bill Barcelona, CA Assoc of Physician Groups; Bob Freeman, CenCal Health; Amber Kemp, California Hospital Association; Elizabeth Landsberg, Western Center on Law and Poverty; Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance; Anthony Wright, Health Access California; Richard Thomason, Blue Shield of California Foundation; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center; Erica Murray, CA Association of Public Hospitals and Health Systems; Lishaun Francis, CMA; Gary Passmore, CA Congress of Seniors; Herrmann Spetzler, Open Door Health Centers; Judith Reigel, County Health Executives Association of California; Kim Lewis, National Health Law Program; Stuart Siegel, Children's Specialty Care Coalition; Marvin Southard, LA County Department of Mental Health; Marilyn Holle, Disability Rights CA; Michael Humphrey, Sonoma County IHSS Public Authority; Suzie Shupe, CA Coverage & Health Initiatives; Marty Lynch, Lifelong Medical Care and California Primary Care Association; Kelly Brooks Lindsey, CA State Association of Counties; Michelle Cabrera, Service Employees International Union; Brenda Premo, Harris Family Center for Disability and Health Policy; Steve Melody, Anthem Blue Cross/ WellPoint; Kristen Golden Testa, The Children's Partnership/100% Campaign;

Members Attending by Phone:

Chris Perrone, California HealthCare Foundation

Members Not Attending:

Sandra Naylor Goodwin, CA Institute for Mental Health; Cary Sanders, CPEHN; Lee Kemper, County Medical Services Program; Anne Donnelly, Project Inform; Rusty Selix, CA Council of Community Mental Health Agencies; Mitch Katz, MD, LA County Department of Health Services; Cathy Senderling, County Welfare Directors Association; Jim Gomez, CA Association of Health Facilities; Teresa Favuzzi, CA Foundation for Independent Living Centers

Others Attending: DHCS staff: Toby Douglas, Mari Cantwell, Anastasia Dodson, Rene Mollow, Sarah Brooks, Nathan Nau, Marlies Perez, Bruce Lim, Audits and Investigations. Nancy Feng, Department of Managed Health Care

Guests: Paul Phinney, Immediate Past President of the CMA and Acting Chair of the Advisory Panel for Medi-Cal Families Amy Turnipseed Partnership Health Plan of

California, Greg Buchert, MD, California Health and Wellness, Richard Chambers, Molina HealthCare

Public in Attendance: 63 members of the public attended.

Welcome, Purpose of Today's Meeting and Introduction of Members

Toby Douglas, Director, DHCS

Douglas welcomed everyone. Thank you to the California HealthCare Foundation and Blue Shield of California Foundation for their support of the stakeholder process.

Brief overview of the meeting agenda:

- Network adequacy
- Upcoming 1115 waiver renewal
- Coordinated care initiative update
- Update on ACA & eligibility enrollment

Douglas: I hope you received and will respond to the stakeholder assessment survey requesting information about the process. We appreciate your input. SAC will continue to meet through the end of this waiver, October 31, 2015. New members will not be added to replace anyone who has left the group or for new issues; it is not anticipated that SAC will continue as an oversight body for the new 1115 waiver renewal.

Paul Phinney: Acting Chair of the Advisory Panel for Medi-Cal Families. I am looking forward to being part of the process of reorganization of member groups. I encourage everyone to fill out the survey. Please contact Anastasia Dodson if you would like Paul's contact information to be in touch with comments or questions.

Douglas presented the following updates:

RURAL MANAGED CARE EXPANSION

- As of June 30th approximately 420,000 individuals were enrolled across the 28 rural counties.
- On September 1, 2013, Medi-Cal Managed Care expanded into eight northern rural California counties, including; Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou and Trinity under the County Organized Health System model of managed care.
- On November 1, 2013, the remaining 20 Fee-For-Service counties, including; Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne and Yuba were transitioned to managed care.

SPDs

- In August, DHCS submitted a waiver to transition SPDs into Medi-Cal managed care in 19 non-COHS counties effective December 1, 2014.
- There are approximately 24,277 SPD's in these 19 counties.

- **CBAS**

- DHCS submitted an amendment to the CBAS BTR waiver to extend CBAS for another five years, with an effective date of September 1, 2014. CMS has extended the current CBAS BTR Waiver end date until October 31, 2014 to complete its review of the proposed amendment.
- Enrollment data reflects that the CBAS participation remains a little under 30,000 statewide.
- As of June 30, 2014, CDA, the state Department that certifies and provides oversight of CBAS Centers, had 245 CBAS Center providers open and operating in California.
- Additionally, the CBAS benefit will transition to the managed care plans in four rural counties before the end of 2014: Shasta, Humboldt, Butte, and Imperial. These counties are the only new managed care counties that have CBAS Centers.

Pregnant Women Waiver

- As of September 3, 2014, DHCS submitted an amendment to CMS requesting full scope Medi-Cal coverage for qualified low income pregnant women, with incomes up to and including 138% FPL with an effective date of whenever federal approval is obtained.
- Currently full-scope Medi-Cal is available for women with incomes up to 60% FPL, a SPA was submitted to increase income limits up to 109% FPL and the waiver amendment increases up to 138% FPL. This will also require enrollment into a managed care plan in counties where one is available.
- Pregnant women with incomes above 138 – 213% FPL who enroll in both Medi-Cal and a QHP through the Exchange will be eligible for the pregnancy wrap, which is where Medi-Cal will pay for premium and out-of-pocket costs.
- Pregnant women will be able to access Medi-Cal services to the extent services are not covered in the Exchange QHP.
- Current efforts include coordinating between Medi-Cal and the Exchanges, expanding the network of providers, reviewing the impact on CPSP provider networks and developing a payment mechanism for paying premiums and out of pocket expenditures for beneficiaries.

SUDS Waiver

- The Department of Health Care Services (DHCS) is seeking an 1115 Demonstration Waiver for the Substance Use Disorder Drug Medi-Cal (DMC) Program. The overall purpose of the Waiver is to create a model that will provide an Organized Delivery System of Substance Use Disorder (SUD) services. This Waiver will be an amendment to California's existing section 1115 Bridge to Reform Waiver.
- In mid-July, DHCS publicly released draft Standard Terms and Conditions (STCs). A meeting was held on July 30, 2014, to receive input from stakeholders.
- The final STCs are expected to be submitted in the next month.

Elizabeth Landsberg, Western Center on Law and Poverty: I want to let everyone know that the wrap for pregnant women will include newly qualified immigrants. Will the pregnant women waiver be implemented Jan 1?

Douglas: More likely we will not make the January 1 date. We are moving as quickly as possible to make the enrollment changes.

Marvin Southard, LA County Department of Mental Health: What is the timeline for the SUDS waiver implementation?

Douglas: We have a draft with everyone's comments and we are working with counties to work out implementation details and financing at the state and county levels. We are moving as quickly as possible but don't have a date.

Judith Reigel, County Health Executives Association of California: Will the SUDS be integrated into the 1115 waiver?

Douglas: We see this as an amendment to the current waiver, unless CMS says for some reason that they want a separate waiver.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center: Will there be a final draft of the SUDS language, and do you have a final date for submission?

Douglas: It is not final yet. Even after submission, there will still be time for changes from CMS and other stakeholders.

Access and Network Adequacy

Sarah Brooks & Nathan Nau, Program Monitoring and Medi-Cal Policy, DHCS; Nancy Feng, Department of Managed Health Care

- Overview of Network Review Components
- Network Adequacy Standards
- Plan Monitoring & Evaluation
- Work in Progress & Future Endeavors

Health Plan Representatives:

- Bob Freeman, CenCal – SAC member
- Steve Melody, Anthem Blue Cross – SAC member
- Amy Turnipseed, Partnership HealthPlan of California
- Greg Buchert, MD, California Health and Wellness
- Richard Chambers, Molina HealthCare (on phone)

Presentation slides available at:

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

Stuart Siegel, Children's Specialty Care Coalition: Can you give us more information about measurement criteria for whether care is being coordinated adequately? Do you have a way to understand whether the person caring for a patient has the experience required for the patient?

Lim: We coordinate our efforts with DMHC so we don't duplicate. They perform the survey; we perform the Medi-Cal audit. At the entrance and exit interviews, we encourage additional information. I can get back to you on the details related to your question.

Brooks: We do review documents that include provider adequacy and coordination of care. Perhaps the health plans with us today will comment.

Steve Melody, Anthem Blue Cross/Wellpoint: This is a very extensive audit; up to a weeklong session. The post-audit debrief provides an opportunity for plans to ask questions and come up with an action plan to address deficiencies. Generally, the audit does look at whether we have the adequate specialist network and the right complement of specialists. More recently, they are looking at SPD population to ensure we have the right complement of providers to satisfy those needs.

Marilyn Holle, Disability Rights CA: We see clients going to the incorrect specialist because they haven't had done adequate pre-screening. Is there anything in the audit that addresses this problem?

Brooks: We will go back and respond to your question once we've had a chance to review all audit questions.

Gary Passmore, CA Congress of Seniors: The Department submitted All Plan Letters with specific details on timeline and specific care coordination requirements. Is this the basis of the audit? You are adding many older people in managed care – do you have requirements for plans to have gerontologists in network?

Brooks: Yes, we reference All Plan Letters or policy letters in contracts to include them as requirements for the audit. All medically necessary services are referenced and required in the health plan. DMHC works with health plans on readiness assessments to ensure adequate specialists within their networks.

Nau: Each section of the audit has verification process to pull samples to ensure that all requirements are in compliance.

Brooks: Can someone from the health plans speak to how you ensure network adequacy, particularly for specialists that may be more difficult to recruit?

Bob Freeman, CenCal Health: We recruit as deep and broad a provider network as we possibly can. In the unusual case where we don't have a local contract available, we pay for out of area care. We are constantly recruiting for those specialists with less availability.

Steve Melody, Anthem Blue Cross/Wellpoint: We also have a clinical team to help patients navigate where services can be accessed. Where we know our network has deficiencies, we have established out of area resources – we routinely refer into SF Bay area for specialties so we're not confined by geography.

Marvin Southard, LA County Department of Mental Health: Do the requirements apply to carved-out portions of the Medicaid program?

Brooks: These standards apply to Knox Keene and non-Knox Keene (COHS) Medi-Cal Managed Care plans. They are specific to managed care plans and not to specialty mental health plans.

Marilyn Holle, Disability Rights CA: Except for EPSDT, which would be required.

Brooks: Yes, there are no limitations in EPSDT services – all medically necessary services must be provided.

Marvin Southard, LA County Department of Mental Health: Would SUDS services under EPSDT be required to meet these timely access standards?

Brooks: I will follow up on this after the meeting.

Gary Passmore, CA Congress of Seniors: Do you look at language access, physical access of providers, particular equipment – what do you mean by access?

Feng: We do look for language assistance to ensure that providers are meeting the accessibility requirement. We also look at timely access, as well as geographic accessibility.

Brenda Premo, Harris Family Center for Disability and Health Policy: Do you assess whether providers have particular equipment to serve special populations, particularly people with disabilities? You have a website to allow people to file a complaint if they find they can't be served due to accessibility issues.

Feng: I will have to get back to you with specifics.

Nau: We do have an addition specific to SPD populations to cover physical access. It's required for credentialing and re-credentialing of providers.

Kim Lewis, National Health Law Program: There are problematic policy and procedure issues related to children's special needs. How do you split up the review?

Brooks: We coordinate with DMHC to identify filing checklists for our health plans. Plans are required to submit their policies and procedures to both DMHC and DHCS. To your point, we recognize the need to review policies and procedures that may be outdated. For example, we are looking specifically at speech therapy based on issues you have raised.

Douglas: We are trying to be clearer with health plans and to follow up to clarify school and health plan response.

Greg Buchert, California Health and Wellness: As a plan, there is an ongoing dialogue with DMHC and DHCS related to All Plan Letters and other issues as they arise. We don't wait for an audit to have the dialogue – it is informally done on an ongoing basis.

Feng: To clarify our roles – DMHC covers Knox Keene. If there is something more restrictive in Medi-Cal, DHCS covers that.

Kim Lewis, National Health Law Program: Related to that, if you find a problem that's raised with you, do you know the Medi-Cal standards and are you able to refer that problem to DHCS?

Feng: We share the standards so we can flag it and refer to DHCS.

Brooks: We meet regularly to share information proactively to make sure we're all on the same page in terms of requirements and problems with compliance we may be seeing.

Anthony Wright, Health Access CA: On timely access to care, how do you verify compliance?

Feng: Every health plan does an annual timely access report to DMHC. We are trying to improve the reporting because the methodology of timely access not detailed and consistent. Currently, we allow plans to report their performance by surveying a sample of their providers, assuming it is representative of the entire county. We are working with plans to get better information that is more consistent across plans. There are two ways we monitor timely access standards – the annual report and the audit every three years.

Brooks: We are working on a tool to be implemented that asks for specific information related to wait time for next and subsequent appointments.

Steve Melody, Anthem Blue Cross/Wellpoint: In addition, grievance and appeals are also monitored for a retrospective look at access.

Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: You spoke to the coordination and filing of IMR's. It is very fuzzy where the enforcement activities are. What do you do with the problems that emerge?

Brooks: I will answer later in the presentation.

Gary Passmore, CA Congress of Seniors: What is the link to the joint audits, coordination and action plans?

Brooks: We will send out the link to DHCS web site.

Douglas: This is streamlined in response to requests.

Gary Passmore, CA Congress of Seniors: Can you comment on the review of Cal Optima? I thought that was a federal audit. Will you have voice in a CMS decision to allow Cal Optima to proceed into the CCI?

Brooks: We conducted a review of areas identified in the federal audit.

Douglas: We are following up on this. There were many gaps and we will go back out to see if these are corrected. Any decision to proceed to participation in CCI will be joint with CMS.

Kim Lewis, National Health Law Program: Given that CMS found problems that you didn't find, have you looked at your process to identify why they were missed?

Douglas: Delegation is being used more and more to comply, but delegation needs accountability. We are providing more guidance to plans for risk and delegation. We are looking at health plans' direct role in delegation, their oversight and monitoring of the subcontracting agencies.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center: This is a follow up to Marv's earlier comment on MH. I understand

that specialty MH is a carve-out but mild to moderate is covered in managed care and are significantly ignored. How do you apply those set of standards to mild to moderate mental health services? It is pretty impossible to get services because psychiatrists won't work for the rates.

Brooks: We conducted readiness review, and I believe DMHC is still conducting some component of that readiness review. When we look at MH, it is considered a specialty service. Perhaps the health plans can comment on building this network.

Bob Freeman, CenCal Health: We are paying much, much more for psychiatry to get providers than the allowed rates. We are doing a pretty good job but it will get better as we go along.

Steve Melody, Anthem Blue Cross/Wellpoint: We have previous relationships with providers through commercial work, and that created a rate expectation that we have to meet.

Greg Buchert, California Health and Wellness: We have embedded behavioral health case management specialists inside the plan and we work in coordination with county mental health agencies to manage the hand-offs between mild/moderate and severe MH.

Marvin Southard, LA County Department of Mental Health: An unfinished issue in this benefit is establishing the boundary of mild/moderate and serious. Even the counties are not in agreement about this. Over the next 6 months, we need to finalize this. I think we need to design the system so patients get what they need.

Bob Freeman, CenCal Health: We have monthly calls between plan and county MH to discuss this handoff issue so it is not on the patient.

Brooks: This is a very important issue. We are holding meetings to work out this issue of level of impairment. We will come out with guidance about what to do if there is a dispute about who should be providing care.

Douglas: We will come back to a future SAC with a report out on this topic.

Michelle Cabrera, Service Employees International Union: We all need to hear the follow up information from this meeting.

Herrmann Spetzler, Open Door Health Centers: We are talking about this from an urban point of view. Rural and frontier are worrying about primary care access in very basic ways. Everything we are discussing works when there is an economy of scale. I am seeing rural collapsing. Just the introduction of EMR has put small, private MD out of business. We are happy with the managed care plan, works well with our county but I am concerned that the conversation never considers rural issues. The issue you are discussing about MH is a core issue for all care in rural areas. We may need to bend rules to make it work. Having managed care is not creating more doctors.

Douglas: Let's have comments and then open it up to additional questions.

Steve Melody, Anthem Blue Cross/Wellpoint: To Herrmann's point, we do have to satisfy the network adequacy standards by identifying viable alternatives if there are no primary care or specialist providers in the patient's geographical area.

Amy Turnipseed, Partnership HealthPlan of California: We do need to figure out other ways to serve rural areas, including telemedicine, e-consult, etc.

Douglas: That was a requirement of expansion into rural areas.

Greg Buchert, California Health and Wellness: In addition, Telehealth is not just physician-to-physician. It is also trading information such as x-rays and other services.

Richard Chambers, Molina HealthCare: Good issues raised during this discussion. Want to emphasize that plans spend lots of time working on these issues of access. We have struggled with some of these issues for a long time and are working to address shortcomings.

Other Questions

Marty Lynch, Lifelong Medi-Cal Center and California Primary Care Association: Access comments suggest that the department could work with providers to make it easier to report when there are difficulties of access. I want to support the overlap of PCP shortage and the specialist issue. We push issues to specialists when there aren't enough primary care providers. I would put care coordination here as well – there is room for investment here. If a plan doesn't meet these standards, what do you do?

Brooks: DHCS requires a corrective action plan. If a plan did not come into compliance, the department can seek sanctions or penalties.

Feng: We have a similar process. We seek corrective action, and if the plan does not comply, there are fines or we can freeze enrollment.

Marty Lynch, Lifelong Medical Center and California Primary Care Association: Has this happened in relation to network adequacy?

Brooks: From the DHCS perspective, we have not issued any fines in relation to network adequacy.

Feng: There was one fine on MH several years ago for commercial. No fines recently on Medi-Cal.

Michelle Cabrera, Service Employees International Union: What is asked of beneficiaries in assessment surveys on care coordination and network adequacy?

Brooks: We conduct CAPS survey that includes info on access. We will survey separately Healthy Families. We can send out the survey questions. For rural expansion, we have a survey both before and follow up to enrollment in managed care.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center: I am aware of two large plans that are allowing interns to serve mild/moderate MH because there are not enough providers and this will help with access in these plans. None of this addresses psychiatry network adequacy.

Brooks: We did add interns to SPA with appropriate supervision. I would like to follow up with you on the psychiatry issue.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Do you look at children separately for each monitoring issue, for example, reviewing the network adequacy for pediatricians for the number of children?

Feng: We do make sure that pediatricians are included in the range of PCP, but we don't have an enrollee break-down of adults vs. children. But this is something that we could look at in the future.

Kristen Golden Testa, The Children's Partnership/100% Campaign: How long is the monitoring for transition populations?

Brooks: The timeframe varies, but generally for several years.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Where is EPSDT in the monitoring, considering some are in managed care and some are not?

Brooks: We look at plans for managed care enrollment. We will be issuing a new all plan letter on EPSDT. Need to follow up with specific monitoring information.

Bill Barcelona, CA Association of Physician Groups: Cap G groups want to integrate health homes that serve both BH and physical health. We have groups working on health homes and have some lessons to share. We need to have dialogue with the department.

Douglas: We have an agency wide discussion of health homes as part of CalSIM. There will be a process going forward on all payers related to health homes. More to come.

Marvin Southard, LA County Department of Mental Health: In LA, we are working with health plans and the PCPs and FQHC's, to develop health neighborhoods. This would support care coordination and community outreach readiness for the health home.

Douglas: It is good to hear you are all thinking about this because readiness will be important.

Marilyn Holle, Disability Rights CA: What happens to CCS clients when they turn 21? Also those with genetic handicaps? What happens related to outcomes when they move to the adult population without coordination? I'm seeing a lack of any kind of meaningful transition for people with cystic fibrosis, sickle cell, etc.

Brooks: We can follow up with you. We work closely with CCS on this. There are oversight abilities that the Department can put into place.

Bob Freeman, CenCal Health: We are responsible for payment of CCS, but we don't work directly with this transition issue.

Douglas: We will follow up to get more information on this.

Elizabeth Landsberg, Western Center on Law and Poverty: It's great to have DMHC here and the coordination between the departments is great to see. Can you talk specifically about the difference in reviews for non-Knox Keene plans? We have a

concern that you are looking globally at commercial plans and not looking at Medi-Cal population network separately.

Brooks: We look at same things DMHC does when we monitor non-Knox Keene. There is a bill on the governor's desk that will impact the oversight responsibilities of DMHC.

Feng: On audit, we do look separately for Medi-Cal. On the survey side, we haven't caught up and improved that process.

Douglas: On the COHS, we do want to discuss in the next year about what does it mean not to have Knox Keene for some plans. We don't have a position at this point, but we want to have a discussion with all stakeholders.

Marilyn Holle, Disability Rights CA: The older OBRA legislation did require Knox Keene but it got overlooked in CA.

Elizabeth Landsberg, Western Center on Law and Poverty: You gave provisional authorization for CA Health and Wellness and Blue Cross. I understand there's some alternative standards, but is your process finished?

Feng: CA Health and Wellness has an open file to show their ongoing efforts to contract and improve. Blue Cross has been approved to move forward with expansion. For expansions, there is a threshold of 10% before a material modification is required.

Gary Passmore, CA Congress of Seniors: Thank you for the level of detail in this presentation. We are concerned about state's capacity to handle the expansion of covered lives in managed care. How many staff have been added?

Douglas: We are evolving as an organization. This has been a 36 month process. We have restructured staffing in A&I with more staff on managed care vs FFS; added staff under Sarah; also DMHC has expanded. There is always more we can do. We need to focus on being effective with oversight – it is not all about more staff. There is focus on quality and monitoring. It is both how we are structured and how many staff.

Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: How much of this information will be on the web site so we can continue the robust level of this conversation? What are you willing to do to open up what is investigated – not to lead to corrective action but to offer information from ombudsman programs and other programs that will give you additional data points to contribute to oversight?

Douglas: I think that is great feedback and that is exactly what we want to discuss. We are talking to DMHC about which of their meetings we could participate in.

Brooks: We also have Medi-Cal Managed Care Division Advisory Group quarterly meeting. Encourage everyone to attend those meetings.

Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: I am suggesting more than conversation but allowing more input on specific problems we are gathering information about.

Lim: Every audit has a risk assessment prior to the engagement so we can focus on the most important areas.

Stuart Siegel, Children's Specialty Care Coalition: Great info on process. We have information to offer on the content of the audits. We have raised the GHPP issues many times. We have good examples of coordination of care issues overall. All specialists are not the same; all hematologists not able to care for sickle cell – it requires the right content, the right question in the audit. I think that needs to be done. In addition, can you tell me what has happened with GHPP? Is it being handled on case-by-case basis?
Douglas: We will get back to you on that. You want information on continuity of care for GHPP transitioned into managed care. We are working with UC to ensure they partner with plans. I think we need more information on this topic from you.

Marilyn Holle, Disability Rights CA: Access to hospital outpatient clinics is a mandatory service for GHPP and this is the vehicle through which GHPP receive clinical oversight.

Kim Lewis, National Health Law Program: I echo my thanks for this discussion. I hope this adds to transparency to offer more public information about how managed care performs that will lead to greater confidence with managed care. As I understand it, the audit process for specialty MH is a separate process through DHCS? How will kids be handled by those two systems effectively? We are hearing concern about where they will end up – foster kids and other vulnerable populations? We want consistency across health plans, counties need to have same answer to consumers. There have been letters on this but there is more to do on this roll out.

Brooks: Any specialty MH is separate, but mild/moderate is covered.

Douglas: We do need to talk more about this as we go forward.

Marvin Southard, LA County Department of Mental Health: The medical necessity threshold for EPSDT has been lower until this point and the responsibility of the county.

Lishaun Francis, CMA: I want to suggest this as a standing agenda item considering everyone's interest in this topic. I am interested in timely access verification study and report, as well as the network adequacy monitoring. I want to encourage the department to rethink how you collect grievances. We need centralized information, and more ability to get information directly to the department.

Brooks: Appreciate the comments. I agree that we need to identify how we can gather that information from stakeholders. In the interim, I encourage you to follow up directly with me with any information you may have so the department can follow up.

Anthony Wright, Health Access CA: I agree it would be good to know where you are in the process of timely access verification surveys becoming public, and if there is a chance for stakeholders to participate. On the ratio of PCP to consumers, how do you monitor whether a PCP is signed up with multiple plans? Is there any desire to revisit the standard ratio for PCP to consumers?

Brooks: We will post timely access information on the website. It will be implemented in upcoming audits.

Feng: We are discussing whether the current PCP to consumer ratio is the correct ratio, and even if the current measure is sufficient, as it does not cover PPO's.

Richard Thomason, Blue Shield of California Foundation: BSCF made a number of grants to advance BH integration with FQHC partners. I want to emphasize that we are hearing a significant amount of confusion about the transitions between the new managed care benefit and specialty mental health, and I encourage the department to continue its efforts to clarify who should get treated where.

Douglas: Thank you and we will continue to work on this.

Steve Melody, Anthem Blue Cross/Wellpoint: I appreciate the balance in this conversation, and the partnerships that make this conversation possible. I echo that we need to find creative solutions to provider shortage issues.

Douglas: We definitely need to be looking at other ways to improve access, including payment reform and other approaches.

Bob Freeman, CenCal Health: We have all grown hugely and we are not creating huge numbers of new doctors. We want to be sure that perfect is not the enemy of good.

Brenda Premo, Harris Family Center for Disability and Health Policy: My comment on the renewal of 1115 waiver. I commend departments on listening and there has been a lot of progress. The plans have done a wonderful job with kids and families. The problem is readiness for SPD and Duals, a population that is 100% people with disabilities and needs with very diverse disabilities and different issues than kids and families. The state has taken huge new populations of limitations and disability. We need to look more holistically at the needs of people. We need to rethink the way we serve people with diverse disabilities and needs. I want this committee to look at things differently. Two examples: Network adequacy needs to include physical access so the machinery and whether that equipment is accessible. The state is starting to look at this now but it is late. How do we look at developmental disabilities who need guidance to navigate the system? For the renewal of 1115 waiver, this is the discussion we need to have. How can we refocus our questions of access for persons with disabilities?

Douglas: Thank you for that challenge and it gets to our need to have venues for those conversations. Thank you to all who shared here today. Thank you to partnership with DMHC.

Coordinated Care Initiative Status Report

Mari Cantwell, DHCS

Presentation slides available at:

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

Gary Passmore, CA Congress of Seniors: Can you provide break out of who is opting out demographically?

Cantwell: Yes, we will look into it and get back to you.

Herrmann Spetzler, Open Door Health Centers: What happens when the request for continuity of care is denied – is the provider at risk?

Cantwell: This shouldn't be a problem if it is submitted within the time limits and it is a service that is covered. For situations that are prospective, the provider has to agree to follow the program and plan rules.

Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: We are concerned about the huge group expected to come through in January and I encourage you to stagger this. The policy on D-SNP is causing confusion and needs more communication – we see marketing abuse. Also enrollment problems are happening with those trying to opt-out in addition to large numbers of people with general confusion. The process you outline sounds good although I am concerned about DME – this is a huge access problem that needs to be looked at.

Cantwell: More than half of population is required to be transitioned in January – the D-SNP population and the low-income subsidy. However, many are D-SNP and they are staying with the same plan.

Cantwell: There were some issues with opt-outs although we believe we resolved most of them. If you are still seeing systematic problems with this, please get in touch. Let's connect in the future about DME clarity.

Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: There are whole batches of opt-outs who were assisted, but they did not make it through. We are able to help them one by one but want to look at why these are not getting through the system.

Marilyn Holle, Disability Rights CA: We have seen this as well. I just want a clarification. When you get the continuity of care referral that includes the lab work, CT scan if necessary, etc., so that it's all done in one place?

Cantwell: I will follow up with you.

Marty Lynch, Lifelong Medical Center and California Primary Care Association: How do you see the 2703 health home interacting with this CCI effort?

Douglas: It does connect. Many components of health home are requirements of CalMedi Connect, and we will be building off that.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center: Are the opt-out numbers on track with expectations? Do you have information on the reasons why?

Cantwell: The numbers are very close to our estimates and are on track. The numbers may change in the future, as individuals begin to opt out who were enrolled. Of those who are eligible to opt out (got 90 day notice about enrollment), there are 39% of opt-outs. We will follow up to offer a clearer way to present this. We don't have the reasons for opt out.

Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: Can you include people with language problems in the break out of data? We are hearing about problems for those with language needs.

Lishaun Francis, CMA: When will the physician toolkit be ready?

Cantwell: We are updating it with this policy and I don't have exact date yet – very soon.

Public comment on Network Adequacy or Coordinated Care Initiative

Diane Van Maren: I just wanted to make one comment on network adequacy. Recall that we did legislative language on EPSDT regarding performance contracting and measures for mental health.

Douglas: We have the performance outcome system and will add special issues related to EPSDT in January.

1115 Waiver Process: 2014-2015

Mari Cantwell, DHCS

- Purpose of an 1115 Waiver Renewal
- Results of current 1115 Waiver including status report on CCS pilots
- Components of 1115 Waiver Planning Process, Stakeholder Engagement and Timeline
- Role of Foundations
- Key Concepts from 1115 Concept Paper; Feedback on Additional Topics from July 25 Webinar and from SAC

Presentation slides available at:

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

Anthony Wright, Health Access CA: This is a broad list. How do you distinguish what is in the waiver in terms of the list of successes as opposed to everything else? Some items are only being implemented now?

Cantwell: The waiver is an essential element even if every success on the list is not solely because of the waiver. Other than the LIHP, items can be included in the next waiver. We will likely include them in the next waiver.

Lishaun Francis, CMA: What does CMS mean by budget neutrality?

Cantwell: At a high level, it means that the program can't cost more than it would have without the waiver. There is an art to the details of budget neutrality.

Gary Passmore, CA Congress of Seniors: How does the CMS recent communication about the managed care provider fee impact budget neutrality?

Cantwell: The issue of the MCO tax is important to work through. It could mean we would have fewer resources. There is a two-year window – by the end of 2016.

Elizabeth Landsberg, Western Center on Law and Poverty: More on why these managed care related issues are in waiver? What did we waive on some of these?

Cantwell: We gain budget neutrality through inclusion of issues.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Does that mean that all the populations in the waiver are subject to budget neutrality?

Cantwell: If the actual costs in the 1115 renewal for the waiver approach budget neutrality, we would have to cut back on the new programs proposed in the waiver.

Elizabeth Landsberg, Western Center on Law and Poverty: How do you come up with the PMPM cap?

Cantwell: We use the FFS rate. We are not capitating the program.

Anthony Wright, Health Access CA: Will there be an agreement that x dollars will be in safety net pool? You also want a mechanism for increasing the amounts for DSRIP and other programs if you are below the cap. Is that correct?

Cantwell: Generally, if the program trends at 5%, we would have a higher trend line if we didn't have managed care and the cost would trend higher – say 10%. With all the programs inside the waiver, if we came in at 7%, we can retain the difference between 10% and 7%.

Anthony Wright, Health Access CA: Is there a document from CMS that outlines the goals? I am surprised that access and coverage are not goals from CMS.

Douglas: For overall Medi-Cal, yes, access is a goal. For the 1115 waiver specifically, it will be about payment and delivery that we can't do in a SPA.

Elizabeth Landsberg, Western Center on Law and Poverty: Is the concept of capturing the federal savings a standard assumption?

Cantwell: No, we are blazing the trail on that.

Michelle Cabrera, Service Employees International Union: Is the Medi-Cal expansion included in the budget neutrality?

Cantwell: It was not included in the current waiver – it was a SPA. The argument was that it was new and without experience we couldn't claim to know how to calculate savings. We will seek to include them.

Kristen Golden Testa, The Children's Partnership/100% Campaign: You will include low-income children population?

Douglas: They are included in the waiver but are not included in budget neutrality because they are title 21.

Marty Lynch, Lifelong Medical Center and California Primary Care Association: If savings are achieved, what happens?

Douglas: That is part of the discussion and there would have to be a priority list.

Gary Passmore, CA Congress of Seniors: Are you planning to expand managed care to the rest of the population not currently included (e.g. duals in additional counties)?

Cantwell: Families and SPD's are mandatory in all 58 counties. As an overall goal, we believe coordinated care makes sense but we are at the beginning of a 3 year demonstration project and it is too early to predict whether this would be discussed.

Marilyn Holle, Disability Rights CA: Can you bank savings since the first 1115 waiver being renewed? Has there been any flexibility in being able to capture MediCare savings?

Cantwell: No, we capture those and don't anticipate any change.

Amber Kemp, California Hospital Association: What is the backup plan if CMS does not approve this concept? Is there any plan to allocate general fund dollars?

Cantwell: There are no general funds.

Douglas: We have put forward a concept and we have proposed work groups to be sure we have all creative concepts included in the discussion.

Gary Passmore, CA Congress of Seniors: Is it true CA is unusual in not having state funds behind its waiver proposals?

Cantwell: NY's new waiver has no state funds.

Douglas: Most states are doing waivers because they want to do things not allowed by a SPA.

Erica Murray, CA Association of Public Hospitals and Health Systems: The payment delivery reform is a really important idea to use federal funds in more creative and effective ways to provide care for those populations who will remain uninsured through more outpatient, primary care. California is leading the way here.

Anthony Wright, Health Access CA: We agree the waiver needs to support the safety net to survive and thrive. We also want the remaining uninsured to be included with access in a coordinated way. It would be useful to have even modest state funds so that federal dollars could be leveraged. Maybe there are opportunities to support the safety net in addition to coordinated care for the remaining uninsured.

Marty Lynch, Lifelong Medical Center and California Primary Care Association: CPCA is supportive of moving ahead with the payment reform for FQHC's and want to reiterate we are not moving away from the requirements related to PPS.

Brenda Premo, Harris Family Center for Disability and Health Policy: In rural areas, most care is provided by clinics. We should explore how we help create real medical homes for all populations, including the unique needs of the disabled. We can have savings and high quality.

Marty Lynch, Lifelong Medical Center and California Primary Care Association: More and more, health centers are serving the SPD populations everywhere.

Suzie Shupe, CA Coverage & Health Initiatives: Can you give us an idea of how patients would utilize services under the FQHC changes?

Cantwell: We want to move away from limitations that clinics can only be paid for a face-to-face visit, once per day. Sometimes this has caused increased costs and less access. We seek the flexibility from these rules.

Suzie Shupe, CA Coverage & Health Initiatives: I do hear lots of stories about children returning to a clinic multiple times to fix dental caries in what could be done in a single visit because the reimbursement inhibits that.

Richard Thomason, Blue Shield of California Foundation: BSCF is very supportive of this change. We see many examples of ways to take care of health needs with texting, Telehealth and other ways that do not require a face to face visit and could be scaled if payment rules did not get in the way.

Amber Kemp, California Hospital Association: We encourage that any savings in the CCS pilot be reinvested in the program not included in the pool.

Elizabeth Landsberg, Western Center on Law and Poverty: Appreciate CA pushing the envelope of Medicaid funded shelter. The concept paper is not clear if this is intended to be emergency only or longer term housing as well. How does the health home legislation intersect with this?

Cantwell: Yes, this is also part of Cal-SIM. We will have to be careful we don't duplicate federal resources.

Douglas: Our proposal is to test overall care to reduce overall costs; you need the continuum to include housing, coordination, and better aligned payment.

Brenda Premo, Harris Family Center for Disability and Health Policy: We should be looking at HUD here to coordinate with other systems to create a seamless system for consumers. We should build those relationships as part of this effort.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Does this concept include staying in your own home where housing barriers such as pest control or air quality would mean you have to move?

Cantwell: We are open to exploring that as well.

Kelly Brooks Lindsey, CA State Association of Counties: We are supportive as well of the shelter concept and are having conversations about how this fits with county conversations of whole person care. This links with homelessness, jail, drug overdose and other county-based issues. We want to be active and are already having conversations about integrating creatively. We should think about how this fits with other drug Medi-Cal treatment program waivers.

Marilyn Holle, Disability Rights CA: There are nursing facility residents who will never get out because they can't live on \$600/month. Is there a way to bring them back into community and gain savings?

Michael Humphrey, Sonoma County IHSS Public Authority: Olmstead Advisory Committee would be interested in more conversation about how housing can facilitate moving individuals out of SNF into community. Also, can we think about how DME will be included? Often people with disabilities spend time in bed because of inadequate medical equipment. Access to special rehab centers would help with this. There is very

little collaboration between plans and FQHC's and the specialized rehab centers. Finally disability navigators inside the plans are needed for service coordination for complex needs – case managers don't always have the right information.

Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: Housing really must include supportive services. I am not clear about the conversation: we are invited to discuss the concepts that exist or can we also talk about other good ideas under these umbrellas?

Cantwell: These really are just concepts and the work groups will be an opportunity to discuss more fully how they should work.

Michelle Cabrera, Service Employees International Union: For us to do all envisioned here will require front line worker transformation and we look forward to engaging in this conversation about work force.

Michael Humphrey, Sonoma County IHSS Public Authority: I would ask that you coordinate meetings with the Olmstead Advisory Committee.

Douglas: Yes, and if you have members to suggest for the work group, let us know.

Kristen Golden Testa, The Children's Partnership/100% Campaign: I want to raise a concern that you need to include the overall budget and list included in consideration of budget neutrality.

Gary Passmore, CA Congress of Seniors: Can you post the ideas you receive on the waiver?

Cantwell: Yes, I will work to see how to do this.

Gary Passmore, CA Congress of Seniors: My concern is that there is no focus on long term care programs, except for a few counties. There is an LTSS effort underway but it's not part of the waiver. There are specific issues, such as hospital discharge planning, that are an opportunity for savings.

Douglas: Our intention is that these do fit in the concept. It is embedded in this concept.

Gary Passmore, CA Congress of Seniors: Going beyond those, can we break down barriers between community programs like CBAS and long term care to would improve continuity and save money? I think there are other topics not included.

Marty Lynch, Lifelong Medical Center and California Primary Care Association: The CCI relies on health plans to reform the system and that is not their role. I agree there are other ways to improve the system.

Suzie Shupe: Another idea for consideration – the lack of understanding about what it means to have coverage and access to the system is one of the biggest wastes we see. Could we include health literacy in the system?

Erica Murray, CA Association of Public Hospitals and Health Systems: CAPH, with BSCF and others, has worked on a paper called, Opportunities for Whole Person Care, based on opportunities such as the ones being discussed.

Submit comments on the waiver renewal process to: waiverrenewal@dhcs.ca.gov

Eligibility, Enrollment and Benefits Update

Rene Mollow and Anastasia Dodson, DHCS

- Enrollment Numbers
 - Current Caseload
 - Pending Caseload
 - Express Lane
 - Hospital Presumptive Eligibility
- Renewals
 - 2014
 - 2015
 - Pre-populated
- Single Streamlined Application
- CHIP Programs
 - SPAS
 - Mitigation Strategies
- Autism

Michael Humphrey, Sonoma County IHSS Public Authority: What was the backlog previously?

Mollow: It was 900K and now is down to 350K.

Dodson: Many of the applications pending are missing key parts of applications, may be duplicates and may need to be administratively redrawn. We are developing guidance to emphasize and clarify.

Gary Passmore, CA Congress of Seniors: Do the remaining 350K look like the original batch? By the end of the year, will you be able to process applications without a backlog?

Dodson: The remaining do not look like the larger batch. The larger number group was close to completion, and we were able to use a batch process and verify missing elements. These applications are so incomplete or otherwise very difficult. It will be cleared within 8 weeks or so and we won't have this kind of enrollment again but we are trying to learn about application completion for the future.

Marty Lynch, Lifelong Medical Center and California Primary Care Association: Have we resolved how providers should bill while applications are being processed?

Mollow: There is a process in place for billing Fee For Service to the state.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Excited about express lane success. When will this happen again – we would like to work with you to get the word out. There is a national report on uninsured children in ACA enrollment. It helps to see reports on children specifically so we can monitor it.

Mollow: Yes, we will.

Marilyn Holle, Disability Rights CA: Is there a flyer about getting care if you don't have a BIC card?

Mollow: There is no flyer; it is posted on the website and we can make it available to you.

Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: I want to encourage you to reconsider the policy decision to exclude ex parte information.

Mollow: We can take a look. Part of the 2014 process was not having household tax filing information.

Kim Lewis, National Health Law Program: I want to clarify the timeline. People in January and June may have been cut off already.

Mollow: Yes, there could be people who were discontinued based on the guidance we provided. For 2015, the renewal process will change.

Kim Lewis, National Health Law Program: Are you able to collect by county who has been terminated based on the renewal policy?

Dodson: It is part of performance measures and we have not yet started reporting this to CMS.

Mollow: People will have 90 days to respond to pre-populated form.

Katie Murphy, Neighborhood Legal Services-Los Angeles and Health Consumer Alliance: Will this form be translated?

Mollow: Yes

Kristen Golden Testa, The Children's Partnership/100% Campaign: If they do report information, there's a scenario that resets in 2015? How is this different?

Mollow: The difference is that counties are assessing it and it is not going through CalHEERS.

Suzie Shupe: Will you offer webinars to CEC's – we would be happy to partner with you to get the word out.

Mollow: Yes.

Marilyn Holle, Disability Rights CA: What about the SPA for amendments of LEA under ABA?

Mollow: We will look to see if this is needed and we will follow up.

Public Comment

Adam Francis, CA Academy of Family Physicians: We are concerned about supporting PCMH in the waiver. I want to comment on the workforce element of the waiver. We are not opposed to the malpractice proposal but feel the state can be more aggressive and hope you will look at Illinois waiver. There are opportunities to match loan repayment and GME fund within the waiver. I would say there are opportunities for plans to be

involved in this as well such as Kaiser, who dedicates a portion of spending to GME support.

Aaron Starfire, Maxim Healthcare Services: We care for people who use health care every day. Many of them are in FFS, will they be included going forward in managed care?

Douglas: We don't include these options in the concept paper. If managed care is considered to be the way, it can be included, but we will use the stakeholder process to explore this. We don't have *one solution* for CCS.

Nicette Short, CA Dental Association: I echo comments to ensure access and want to point out that it did not include any reference to access to dental care, specialty dental, rural dental. On the 1115 waiver, there is room to include dental care in the waiver.

Gabrielle Lessard, National Immigration Law Center: Want to encourage you to include consumer advocates in safety net payment reform work group conversations.

Elizabeth Landsberg, Western Center on Law and Poverty: Can you comment on dental access over the last 6 months?

Mollow: it is improving.

Cantwell: We did have an issue with call center capacity with Sacramento County Delta and this is resolved.

Douglas: We are monitoring this but it is early. Please get information in to our dental team.

Next Steps and Next Meeting – December 3, 2014

- Next meeting of SAC is on December 3, 2014 at 9:30am
- Look for the announcement of the start of the new 1115 waiver planning process meetings

3:00 Adjourn