SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER STAKEHOLDER ADVISORY COMMITTEE (SAC)
Meeting #12 – Monday, July 23, 2012
10:00am – 3:30pm

Attendance
Members attending*:*
Kelly Brooks, California State Association of Counties; Anne Donnelly, Project Inform; Kristen Golden Testa, The Children's Partnership/100% Campaign; Marilyn Holle, Disability Rights California; Michael Humphrey, Sonoma County IHSS Public Authority; Mitch Katz, MD, Director, LA County Department of Health Services; Lee Kemper, County Medical Services Program; Elizabeth Landsberg, Western Center on Law & Poverty; Marty Lynch, LifeLong Medical Care and California Primary Care Association; Anne McLeod, California Hospital Association; Steve Melody, Anthem Blue Cross; Katie Murphy, Neighborhood Legal Services of Los Angeles County and Health Consumer Alliance; Brenda Premo, Harris Family Center for Disability and Health Policy; Judith Reigel, County Health Executives Association of California; Rusty Selix, California Council of Community Mental Health Agencies; Cathy Senderling, County Welfare Directors Association; Suzie Shupe, California Coverage & Health Initiatives; Herrmann Spetzler, Open Door Community Health Centers; Melissa Stafford Jones, California Association of Public Hospitals and Health Systems;
Richard Thorp, California Medical Association; Anthony Wright, Health Access California; Ellen Wu, California Pan-Ethnic Health Network; Casey Young, AARP California

Members attending on phone:
Stuart Siegel, MD, Children's Specialty Care Coalition

Members not attending: Bill Barcelona, California Association of Physician Groups; Bob Freeman, CenCal Health; James Gomez, California Association of Health Facilities; Sandra Goodwin, California Institute for Mental Health; Ingrid Lamirault, Alameda Alliance for Health;Kim Lewis, National Health Law Program; Sara Nichols, Service Employees International Union; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Center; Marvin Southard, LA County Department of Mental Health

DHCS Staff: Toby Douglas, Director, DHCS; Jane Ogle, DHCS; Len Finocchio, DHCS; Luis Rico, DHCS; Brian Hansen, DHCS; Jalynne Callori, DHCS; Alice Mak, DCHS; Desiree Backman, DHCS; Margaret Tatar, DHCS; Rene Mollow, DHCS, Bob Dimand, DHCS; Vanessa Baird, DHCS

Guests: Michelle Lilienfeld, National Health Law Program; Deborah Bachrach, Manatt Health Solutions; Jonah Froehlich, Manatt Health Solutions; Stephen Maulhardt, CAAPE

23 members of the public attended the meeting.

The meeting was called to order at 10:00 am.

Welcome, Purpose of Stakeholder Advisory Committee, Introduction of Members and Review Today's Agenda; Impact of Supreme Court Decision on ACA in California
Toby Douglas, Director, DHCS

Toby Douglas welcomed everyone and thanked Blue Shield of California Foundation for their support of the Stakeholder Advisory Committee (SAC). He reminded everyone that the SAC has expanded its purpose related to the 1115 Bridge to Reform waiver to include implementation of health care reform in California. Today's agenda reflects this.

Douglas let everyone know he is pleased for California with the outcome of the Supreme Court decision. There is lots of additional activity to accomplish before 2014 but, with the decision, there is a clear path ahead for California to move forward. This is not the case for all states where colleagues are facing questions about whether and how they will move forward.

Douglas reviewed agenda and mentioned that there are a few items mentioned in the pre-agenda planning call with SAC members that we will not talk about today. Rural expansion of managed care will have a separate stakeholder meeting and process. In addition, the SAC will not touch on the transition of Healthy Families to Medi-Cal or the Navigator Program. There is work going on related to these issues and there are separate venues for discussion.

The next SAC meeting is November 19, 2012 and at that meeting we will discuss dates for 2013. There will be public comment at the end of the meeting.

SAC members and DHCS staff introduced themselves, including SAC members attending by phone.

CHCF-DHCS Beneficiary Study Highlights
Toby Douglas, Director and Len Finocchio, Associate Director, DHCS and SAC Member Comments
Toby Douglas introduced Len Finocchio for an overview of the survey study results. The full study results are available at http://www.chcf.org/publications/2012/05/medical-crossroads-what-enrollees-say. Slides from this presentation are available at: http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Douglas opened the discussion by asking SAC members to comment on what the survey study results mean related to access, branding of Medi-Cal and other issues.

Richard Thorp, CMA: It is important to get data such as this about enrollees. What I get out of the information is that 40% of the enrollees have difficulty with specialty care access and 30% can't get primary care. It also tells me that the sicker you are, the more

trouble you have getting care and that is who needs care and access most. My concern is whether the study is robust enough in terms of numbers. It is incredibly difficult to get folks from my rural clinic into a specialist due to reimbursement.

Marty Lynch, Lifelong Medical Care: Did the research try to break out those who are very low income, such as General Assistance or homeless, because that is who we are worried about for successful enrollment under the expansion in 2014.
Finocchio: I don't think they asked about income in the survey. The survey does indicate to us that there will have to be special outreach for difficult populations.

Steve Melody, *Anthem Blue Cross*: Did the survey distinguish between traditional Medi-Cal and managed care Medi-Cal? It would be beneficial to distinguish the data.
Finocchio: Yes, there is separate information in the full report on the CHCF web site related to managed care enrollees. Managed care enrollees reported similar or better access.

Anne Donnelly, Project Inform: I would like to see more of a break down between urban and rural access as well as qualitative data for travel to specialists. Also, I would want to know whether those with HIV can achieve both access to care and access to treatment.

Casey Young, AARP: Are the numbers broken down for the enrollees who actually did receive care vs. those enrolled in the program?
Finocchio: Yes, there is information on this on CHCF web site about those who have received care in the last year.

Anthony Wright, Health Access California: I appreciate the survey. There is a national discussion about the value of Medicaid coverage and so this is the right time to signify the importance of the program. At the same time, the access data is concerning, especially with the expansion of managed care for seniors and persons with disabilities and the shift of children from Healthy Families to Medi-Cal. There will be new access issues with these changes. The findings call for attention to the managed care standards, network adequacy, timely access and other standards. In addition, the comparison between access in Medi-Cal and private plans will be important going forward. The Medi-Cal expansion will include many who had commercial coverage previously and never imagined being on Medi-Cal. This is a challenge and an opportunity before 2014.

Elizabeth Landsberg, Western Center on Law and Poverty: I applaud the Department. It is great to hear the actual views from beneficiaries in their voices. I agree with concerns about access and I understand there are limitations to the survey. Still, it is good to hear the program is working. There are almost 8 million people on program now and there will be 10 million on the program. We need to do better but it is good to hear that the program is meeting lots of needs.

Hermann Spetzler, Open Door Community Health Centers: Were there any geographic overlays on the data?

Finocchio: No, we have asked them to go back and drill down to do at least urban/rural.
Spetzler: California Health Interview Study (CHIS) is a good model and does a great job. They are the gold standard for language issues, cell phone response and other issues. I wonder if it makes sense to partner with CHIS. I also want to encourage you to consider doing geo mapping. It is easy to do mapping with zip codes that is anonymous. This might allow us to understand and improve on access issues with Tele-technology.
Finocchio: We are a supporter of CHIS and we are talking to CHIS in a health reform context.

Katie Murphy, Neighborhood Legal Services LA County: It is important to drill down demographically. Who you are makes everything about the issues highlighted different and the issues change depending on your coverage and needs. We need to drill down on the specialty care issues because there are all kinds of reasons why access is a problem, such as, your plan doesn't accept the specialist or the wait time for an appointment is long. We have been helping pilot the LA online "your benefits now" system. We found people can do it but often need assistance. For example, the income questions are very detailed and people need help with these questions. We need to consider how the questions ask for information and try to make things easier to understand if you are applying alone. We have to take into account the health literacy and online information that people have. They may answer but incorrectly. We need to make assistance available when applying online.
Finocchio: There is some information in the cross tabs on why specialty care was hard to find. Online enrollment is envisioned to include assistance while online.

Kristen Golden Testa, The Children's Partnership/100% Campaign: I agree that we need the regional break down in addition to rural/urban to see the problem areas. Going forward, it is worth looking separately at the kids who are new to Medi-Cal. We are concerned about access, primarily on the provider capacity, for all who are in the program and coming into the program. Also, we encourage that you consider a provider audit. Finally, I agree with the need to look separately at those reporting fair/poor health because although there may not be large numbers of children in poor health, these are the people who need care and where access is a concern. Do you have a timeline for another survey?
Finocchio: In about two years.

Lee Kemper, CMSP: I want to follow up on when to gather more data. The practical reality is that this data is probably mostly about urban enrollees. As we proceed to expand managed care into rural areas, we should do a similar survey in those areas before the end of the year to understand the depth of the problem in rural areas.

Brenda Premo, Harris Family Center for Disability and Health Policy; The basic findings are very good. We see that 90% like Medi-Cal and 10% like it less. Separately, we know that 7% of enrollees have the highest cost and needs. I am thinking that the 7% are in the 10% group that reported dissatisfaction. We see the dissatisfaction in the disability population with both access to specialists and traveling to get to the care. It looks like the people we want to help through managed care may not benefit in the way we want.

Suzie Shupe, *California Health & Coverage Initiatives*: I commend the Department for gathering actual beneficiary information. This data looks similar to what we see with kids across the state. Where there are problems, they are serious. We need to look more deeply at the access data and especially in the rural areas where we are expanding managed care. In the case of those asked about difficulty accessing specialty care, did the survey ask all enrollees or only those who needed specialty care? I noted 25% could not access specialty care for children and if this was all enrollees, then we need to realize that it would be much higher if we asked only those who were trying to access specialty care.
Finnocchio: Yes, all were asked. We do want to follow up with questions about those people report problems getting specialty care to gather additional information.

Marilyn Holle, Disability Rights California: I want to know more about rural services and specifically about transportation. Some clients in the Central Valley report they have to go two or three counties away to get specialty care.

Anne Donnelly, Project Inform: We need to think about how we ask about primary care/specialty care. Many people don't know the specifics of what their need might represent, they just know they need a physician.

Stu Siegel, *Children's Hospital LA*: It would be useful to also determine more about children with serious chronic conditions. There are probably not sufficient numbers in the sample to determine this without a special sample or method. I also want to echo comments on telemedicine as this is an area we should pay more attention to.

Douglas: Many thanks to CHCF for funding this study and we also greatly appreciate your feedback here today.

Essential Medicaid Benchmark Benefits Options and Design Elements: Presentation of Options and Discussion
DHCS, Deborah Bachrach, Manatt Health Solutions, Advocates' Perspectives and SAC Members

Toby Douglas introduced the next session. The state is delighted to have Manatt Health Solutions working with us and here today. We are joined by both Deborah Bachrach and Jonah Froehlich from Manatt Health Solutions. After the Manatt presentations, we will have a response from Michelle Lilienfeld, National Health Law Program and a presentation on mental health parity by SAC member Rusty Selix, California Council of Community Mental Health Agencies and Stephen Maulhardt, CAAPE.

Bachrach presented a Medicaid benchmark framework through slides.
Slides from this presentation are available at:
http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Douglas: He asked SAC members for questions and feedback on this presentation.

Brenda Premo, Harris Family Center for Disability and Health Policy: I feel like I have had a mini master's course through that presentation. It was very well done. The questions you pose are very good, especially the issue of Long Term Care. We need to encourage people to think about this before they need it. I look forward to learning more about how we can balance all the issues for the diverse population of California.

Lee Kemper, CMSP: What is the policy rationale for establishing the benchmark? It seems that the implications flow in myriad directions based on what the incentives might be.
Bachrach: There have been lots of questions about this. I think it was the sense that Congress wanted Medicaid to look like commercial plans, not as rich as standard Medicaid. Later, the benchmark benefits were linked to Essential Health Benefits and were quickly ramped up above Medicaid standard. How we used it then and how we use it going forward may be different. Congress may have thought it was about narrowing benefits but this is not what is happening. .

Katie Murphy, Neighborhood Legal Services of LA County: California diversity seems difficult in this context. For example, parents not being thought of as benchmark, they are thought of as standard Medi-Cal.
Douglas: Yes, the presentation was a national purview, however, there will be a small group that are newly eligible parents in California that we need to consider.
Bachrach: This needs more conversation. Some adults covered today are not "newly eligible".
Douglas: Yes, there is a tension here because we want as many defined as newly eligible as possible.

Elizabeth Landsberg, Western Center on Law and Poverty: It is very helpful to hear that other states are using standard benefits as the benchmark. I am concerned about having several benchmarks or having a difference between standard and benchmark packages. In terms of adding benefits and the concern about cost, we need to remember that if people aren't using a benefit, there is no cost. So we should consider this as we set rates. Also, there is interplay between benefit package and cost of determining eligibility. We add complication in eligibility determination if we have multiple benefit packages as well as increased administrative costs for plans and others with different benefit packages. We can't make an assumption that it is cheaper to have more than one benefit plan.
Bachrach: If you align benchmark to standard, then you have to go the other way also, and that may require new benefits in standard as well, because of parity or other EHB. In terms of Long Term Care, it may be interesting to look at Connecticut.

Anthony Wright, Health Access California: Will making the benefit package the same actually streamline? Are there other obstacles even if you standardize benefits?
Bachrach: if same benefit package offered, then income determination is simpler. There would be a floor and that will be simplified. However, since you can't access Long Term

Care unless you need it clinically, there is still that complication. In short, yes, it is simpler. Although we still need to know who is newly eligible and who is disabled to figure out FMAP, this would not be at the consumer level.
Douglas: We do have the Low Income Health Program to look at for an example and it is similar to a benchmark program. What does this experience tell us?
Bachrach: Yes, New York has a slimmed down package and it has worked well.

Anthony Wright, Health Access California: Removing other issues, is there any prohibition for the state including dental in the interest of maximizing match?
Bachrach: No, not a prohibition. You have to weigh the many issues of simplicity, transparency, fiscal and medical need.

Melissa Stafford Jones, California Association of Public Hospitals and Health Systems: My question is to the Department. Given all of this, are there principles, goals, policy directions being used to guide planning and decisions?
Douglas: There are multiple tensions. We will go through the process thinking through those multiple goals of simplification for state and consumer, creating equity across programs and income levels, fiscal constraints and streamlining. These can be competing goals. Until we get guidance from CMS, there is much we don't know.
Finocchio: We hope to work more with Manatt Health Solutions and with Mercer to do the math. Once CMS guidance comes out, we will look at numbers with modeling. What are the costs if we use standard vs benchmark with various benefits in or out? How is it changed when we weave in the Behavioral Health? The foundations supporting this have not approved this yet but we are hopeful to do this going forward so we can continue to work with Manatt and Mercer.

Hermann Spetzler, Open Door Community Health Center: We are talking about how these issues impact consumers and the state. We need to consider providers as well. No matter how good the system is for families and for the state, we need to bring along the providers.

Casey Young, AARP: I am not clear about EHB reference plan?
Bachrach: You must have a Medi-Cal benchmark plan for new eligibles. There are four ways to establish the benchmark. You can tie this to three different types of plans or use "secretary approved". If you pick a "secretary approved" plan and it doesn't have all ten EHB, then you must go find an EHB reference plan that defines the missing benefit and add it in.

Anne Donnelly, Project Inform: In New York, the slimmed down package for HIV has worked but there is a robust wrap around service available. It would be important to know about other programs people are receiving to understand how it works in our context. Thanks for the presentation. If a person is newly eligible, will they get the enhanced FMAP in the standard benefit package?
Bachrach: Yes, if they are a newly eligible individual and receive the standard benefit, we are fairly certain you will get enhanced FMAP.

Richard Thorp, *CMA*: It is important to the providers for this to be administratively simplified. We are currently overwhelmed. I think it would help increase enrollment of providers in the Medi-Cal program if it was easier. Payment is an issue but so is the complexity. We are facing a provider shortage with the expansion of coverage. Since the payer mix in California is very poor, we find that good talent goes to another part of country. If there is away, we should do this in single benefit package.

Steve Melody, Anthem Blue Cross: What is the timeframe for the final guidance from CMS?
Bachrach: I think that the Mental Health Parity guidance is about ready. It will come out relatively soon.

Marty Lynch, Lifelong Medical Care: How would state decide on waiver services that are an open question? Is it fiscal?
Bachrach: First, it is a legal issue of whether section eight adults can get the services. If CMS concludes that it is legal; then it becomes a policy question for discussion.

Marilyn Holle, Disability Rights California: Couldn't most waiver services be incorporated into rehabilitative option given how open the language is in this area?
Bachrach: That is a really good question. This may be how CMS is going to answer this issue.

Presentation of advocate response from Michelle Lilienfeld, National Health Law Program. Slides from this presentation are available at:
http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Presentation by Rusty Selix, California Council of Community Mental Health Agencies

We currently have Mental Health Parity in Medi-Cal. Therefore, there is no required change in the mental health benefit. However, we don't have Substance Abuse Parity and this is a significant issue for providers. Most people with substance abuse have underlying mental illness. The impact will come from enrollment of people who are disabled but their disability involves underlying mental illness. As the eligibility expands, we will see high enrollment of individuals with co-occurring disorders. This population can eventually qualify for disability for underlying issues however there is no incentive to do this after 2014, given the higher FMAP for new eligibles. This is the population in the public health mental health system and many are involved in criminal justice system. They are currently uninsured with mental health and substance abuse problems. They will be eligible for coverage in 2014. This will also represent an opportunity for mental health providers to be paid for the substance abuse services.

It is very important to include all the services in the rehabilitative option in the benefit package. When you look at commercial plans, there are many fewer individuals in the commercial system using these benefits. Commercial plans do not tend to contract with same provider system that is in Medi-Cal and many of the private network providers can

only handle mild cases. They have services for inpatient and less complex cases but nothing in between.

The key to meeting needs going forward is that we need to move to a system where primary care can identify Mental Health/Substance Abuse (MH/SA) needs and refer to co-located services for the MH/SA.

I am very concerned about capacity issues. The needs study supposed to come out in October is critical. We will have shortages of MFCC/LCSW. California is competing nationally and we are at a disadvantage for expanding providers because of strict non-reciprocity rules in our licensing. In addition, we have work do to in licensing those who have "lived experience" or family members who can provide some services.

The way to do integration correctly is to do bi-directional integration with county systems into the medical provider networks. This will have to be mandated. Plenty of models that show savings on inpatient physical health costs - CMSP is a good example.

Steve Maulhardt, Legislative Chair, Board of California Association of Alcohol and Drug Program Executives (CAAPE) was on the phone and made the following comments. He raised three points:

1. Reorganization of Alcohol and Drug is now on hold for a year pending a stakeholder process.
2. CAAPE has taken a formal position on essential health benefit bills to oppose unless amended. CAAPE wants to see assurance that parity benefits of case management, prevention, wellness and recovery will be clearly defined to include all standards of care. We have language to suggest for the amendments.
3. CAAPE issued a letter to Director Douglas related to the 1915(b) waiver but not in time to be distributed today. The letter includes recommendations to take the opportunity of the waiver to include parity in spite of exemption since the services save money. Since CMS has the intention to include parity, it should be included now.

Brian Hansen, *DHCS*: Related to the behavioral health needs assessment mentioned by Rusty Selix, we are waiting for guidance from CMS. We need time to digest the guidance on Benchmark benefits and Medicaid parity, which CMS has not yet provided, then plan and forecast numbers before we can incorporate this into the Plan to provide behavioral health benefits to the expansion population, which is required as part of the 1115 Waiver. We are looking for a delay of 4-6 months from the current due date of October 1, 2012.
Douglas: We will email the CAAPE papers to SAC members. In California, we have carved out MH/SA services from Medi-Cal managed care. Currently only managed care plans have a parity requirement and California has a carve out of mental health in Medi-Cal Managed Care. In addition to the general issues discussed, we will have to also see these implications of from both a state and a county fiscal lens, given realignment.
Vanessa Baird, DHCS: In response to the issue raised, there is a letter from CMS to Medicaid Directors from 1998 that notes, if a Medicaid managed care plan does not

include mental health benefits, then parity requirements don't apply. Following the 2008 amendment to include substance abuse, an SCHIP letter came out that referenced Medicaid and said the same thing. Parity laws don't apply to fee-for-service. They do apply to Medicaid unless the Medicaid managed care does not include mental health – as is the case in California. I am mentioning this for clarity on compliance issues. This does not mean that it is not a good idea to look at benefits and improve the program, but only to say we are in compliance via these letters.

Kelly Brooks, California State Association of Counties: I want to agree that parity is very complex due to the county-state financing as Director Douglas mentioned. The funds provided to counties were based on the program as it existed in 2011-12. The state is moving to more managed care environment. The delivery system is changing in many ways and we need to rethink this, particularly in the context of the benchmark benefits.

Rusty Selix, California Council of Community Mental Health Agencies : This is a comment about the dilemma for providers in 2014. Since substance abuse was taken away as a disability, It takes one year for co-occuring disorders to quality for Medi-Cal. After 2014, the population will already have Medi-Cal. If we work to qualify individuals for a disability and SSI, this will mean that the state will only get 50% FMAP. This is thorny for providers and DHCS. Has this come up in other states?

Kelly Brooks, California State Association of Counties: I am not sure I agree about the county incentives here. Many in this population are on General Assistance and it may not be correct that the state-county perspective is really different.
Douglas: This sounds like a separate discussion.

Mitch Katz, LA County Department of Health Services: We may not be able to maximize all parts of the equation and that is the importance of a group like this. As a provider, I want benefits to be uniform. But the opportunity for substance abuse treatment is great and this may be a case where a difference should be considered. If there is a way to help them and have the federal government pay for services, that would be great even though it would mean different benefit package. Another way to look at this is that, in a managed care environment, there is flexibility to offer anything that is preventing cost and helpful. Methadone services would fit this situation – it would be a smart thing to offer this service to avoid inpatient costs. Generally, my point is that it may be useful to have the advice of this group for items like this where we may not be able to get all incentives aligned.
Douglas: A breakout group in the afternoon is to help us get this type of input.

Finocchio: On next steps, we have held one informal discussion already to discuss what the policy issues are on the benchmark benefit. This is the beginning of the formal discussion. We hope to engage Manatt and Mercer as well as internal staff in discussions through the fall and come back to this group in November with ideas.

Elizabeth Landsberg, Western Center Law and Poverty: So the Department doesn't have to decide this in the current year?

Douglas: No final decision, but we are leaning toward waiting on this issue.

Douglas: Thanks to all presenters and constructive input for the group. We will break for lunch and reconvene at 1:00pm.

Members moved to round robin small group discussions at 1:00pm.

Round Robin Small Group Discussions*: Six round table update discussions were facilitated by DHCS staff on the topics listed with each SAC member able to rotate among four of the six sessions of their choice for 20 minutes each.*

- Policy Intersections between DHCS and Health Benefit Exchange: AB 1296 Eligibility and Enrollment Systems - Len Finocchio and Rene Mollow, DHCS
- Dual Eligibles Demonstration Project including Duals in Waiver Programs – Jane Ogle, DHCS
- LIHP Transition Plan and HIV Transition – Jalynne Callori and Alice Mak, DHCS
- CCS Pilots – Luis Rico, DHCS
- SPD Transition: Status of MERS and Continuity of Care – Margaret Tatar, DHCS
- DHCS Quality Strategy – Desiree Backman, DHCS

Materials from the round robin discussions are available at:
http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Policy Intersections between DHCS and Health Benefit Exchange: AB 1296 Eligibility and Enrollment Systems
Len Finocchio and Rene Mollow, DHCS

Issues for discussion:

1. Update on AB1296 stakeholder process

- The AB 1296 planning group, consisting of CHHSA and DHCS, in collaboration with the California Health Benefit Exchange (HBEX), legislative staff, Western Center on Law & Poverty, the California Welfare Directors Association, and Department of Finance, organized the AB1296 and Eligibility Expansion Stakeholder Meetings to consult key stakeholders on policy and other issues central to eligibility, enrollment and retention in subsidized health coverage programs. These activities were intended to assist the state in implementing provisions of the Patient Protection and Affordable Care Act in California.

  Five stakeholder workgroup meetings were convened between April and June. As outlined in the statute, these meetings focused on the following topics:
  - Eligibility (April 9)
  - Data Collection and Confidentiality (May 3)
  - Health Plan Selection (May 10)
  - Presumptive Eligibility and Deemed Infants (June 11)
  - Application Forms and Renewal (June 29)

Organizations invited to participate in the workgroups had either previously expressed their willingness to share their expertise or had been identified by the planning group as important to participate in some or all of the stakeholder meetings. There were about 40-50 attendees at each meeting. Stakeholders included advocates, labor, counties, legislative staff, and other state partners (i.e. MRMIB, DOF).

2. Pregnant women at the eligibility margin: premiums, cost-sharing and benefits

- This issue discussed here is the scenario wherein a women covered by premium tax credits in the California Health Benefits Exchange (Exchange) below 200% becomes pregnant. Advocates have raised the issue the she would likely have better benefits, and no premiums and reduced cost-sharing, in Medi-Cal. The related policy question was raised about whether: 1) to transfer the woman to Medi-Cal or 2) have Medi-Cal pay a “wrap-around” that would cover premiums, reduce any cost-sharing and add any benefits not currently coverage by her Exchange plan. Also, it is unclear what role Access for Infants and Mothers will play as it covers pregnant women up to 300% FPL (though only if uninsured). These questions will be address by DHCS and the Exchange in work they are doing with the consulting firm Manatt Health Solutions.

3. Pre-enrollment of populations in existing categorical programs

- This breakout group also discussed the possibility of pre-enrolling potentially eligible persons-- currently receiving services from a DHCS categorical program – into Medi-Cal or the Exchange. These programs include Family PACT (FPACT), the Breast and Cervical Cancer Treatment Program (BCCTP), Every Woman Counts (EWC), Access for Infants & Mothers (AIM), Genetically Handicapped Persons Program (GHPP), and Med-Cal five-year bar immigrants. There are over 2 million persons served by these programs though not all would be eligible for Medi-Cal or the Exchange. DHCS is considering how to assess these programs for Medi-Cal eligible and enroll them as of January 2014. The objectives of such an assessment would include:
    - Prioritize programs based on current beneficiaries who will be eligible for Medi-Cal or the Exchange in 2014;
    - Develop a framework for transitions, including such criteria as feasibility, coverage continuity, administrative simplification, program feature protection and fiscal impact; and
    - Develop an operational plan for those programs selected for transition.

4. Health plan contracting: alignment for coverage and care continuity

- The ACA and the California Health Benefit Exchange will expand coverage for Californians by nearly 4 million. Many families with have “mixed” eligibility status wherein the parents will have premium tax credits in the Exchange and their children will have Medicaid/CHIP coverage. This will present challenges for families to have

the same plan and provider network. Moreover, as incomes change and therefore eligibility, enrollees may move from Exchange coverage to Medi-Cal or visa versa. To remedy these challenges, the Exchange and Medi-Cal would contract with the same health plans so that mixed families or "churning" persons can maintain their plan and providers. Furthermore, by contracting with the same plans, the Exchange and Medi-Cal can align their purchasing power.

5. Medically Needy population

- The groups discussed the need for further federal guidance on how this population would be addressed:
  - Their eligibility for Medi-Cal or the Exchange
  - Benchmark benefits and the inclusion/exclusion of long-term care services for the Medi-Cal expansion population
  - Their "exempt" status for benchmark benefits

Dual Eligibles Demonstration Project including Duals in Waiver Programs
Jane Ogle, DHCS

Presentation Summary:
Jane Ogle provided an update on the status of the Duals Demonstration since the last SAC meeting. The Governor signed the Coordinated Care Initiative (CCI) expanding the demonstration project to eight California counties. These counties are Alameda, Santa Clara, San Mateo, Los Angeles, Orange County, San Diego, San Bernardino and Riverside. The State is establishing a passive enrollment process for dual eligble beneficiaries in these eight counties.

Populations exempt from passive enrollment include beneficiaries:
1) with a prior diagnosis of end-stage renal disease;
2) with other health coverage that provides the same or partial benefits as the Medi-Cal program or federal medical care program;
3) with health coverage under a contractual or legal entitlement such as a private group or indemnification insurance program;
4) who are enrolled in a HCBS waiver;
5) who receive services through a regional center or state developmental center;
6) who reside in an area not serviced by a health plan; or
7) who reside in a Veteran's Home.

Ms. Ogle provided insights into the Department leaders' recent trip to Washington D.C., where they met with staff from the Centers for Medicare and Medicaid Services and members of the California Congressional Delegation. California continues to pursue a six-month stable enrollment period for those enrolled in the demonstration. CMS has expressed concerns with the stable enrollment period because other Medicare beneficiaries will be able to opt out or switch health plans every month.

Ms. Ogle also discussed the size of the demonstration population. CMS continues to state that the demonstration population will be no more than two million beneficiaries nationwide. The 850,000 enrollment target previously stated for California was inflated, Ms. Ogle said. Once you subtract the populations excluded and those exempted from passive enrollment, the number of dual eligible beneficiaries projected to participate in the demonstration will be closer to 500,000, she said.

Questions and Comments from SAC members:

Q: Where will the savings come from and how will it be shared?
A: CMS is worried that since the savings will initially be on the Medicare side, sharing those savings with the State will deplete the Medicare trust fund. However, DHCS leaders believe California should share the Medicare savings because the state is doing a substantial amount of work to implement the demonstration.

Q: How will the State learn from the ADHCS/CBAS transition to ensure the enrollment and transition process for dual eligibles is smoother?
A: The State has learned a lot from the ADHC transition. DHCS continues to work with CMS on a coordinated appeals and grievances process that will easier for consumers to navigate.

Q: What is the status of Behavioral Health coordination in the duals demonstration?
A: Behavioral health coordination issues are being worked out in cooperation with the stakeholder workgroup process. The State understands that there is a robust county mental health system. The State is working with its plan and county partners to address care coordination and funding mechanisms. The State is looking at how the plans can work with the counties to develop incentives for behavioral health coordination.

Q: Participants requested an enrollment timeline and clear articulation of what populations will be enrolled and when.
A: The State is pursuing a staggered enrollment period with beneficiaries being enrolled in Medi-Cal managed care for their LTSS wrap around services (IHSS, CBAS, MSSP and nursing facility needs), and a few months later enrolled in the same plan for their Medicare benefits. The goal with this process is that the health plans will receive Medicare data on their enrolled beneficiaries before serving them to ensure continuity of care. Enrollment will be staggered by birth month.

Q: How will the state engage and inform providers?
A: DHCS continues to work on provider outreach and engagement. The State recognizes the medical providers were not well informed of the Seniors and Persons with Disabilities (SPDs) transition and this caused confusion. The State is working on reaching out to Medicare providers and explaining the demonstration. The Demonstration health plans are encouraged to reach out to these physicians and expand their networks.

Small Group Discussion Notes
LIHP Transition Plan and HIV Transition
Jalynne Callori and Alice Mak, DHCS

1. What is the CMS timeline for approval for the Low Income Health Program (LIHP) initial transition plan?
    - DHCS will submit initial transition plan to CMS by August 1, 2012
    - No specific time line for CMS approval is specified in the STCs
    - DHCS will have continuing conversations with CMS during the plan review process and information can change as result of issues raised by CMS and later during the stakeholder process
    - DHCS is working on a separate operational plan outlining the activities and timelines
    - There is no “drop dead” date for the operational plan as the dates will be based on what needs to be done
    - Will DHCS post all comments received on the initial draft transition plan on the LIHP webpage?
        - DHCS will consider this

2. What will the stakeholder process look like?
    - DHCS will develop a plan for stakeholder engagement within three to four weeks after submission of plan to CMS
    - DHCS envisions different workgroups based on recommendations received to date and the workgroups may be in broad subject categories, such as consent, eligibility and enrollment, and outreach
    - May take the form of standing meetings, focus groups, or online review process for written materials such as notifications– advocates at the meeting generally approve so long as there are opportunities for comment.

3. What does the transition timeframe look like for the counties?
    - Not all the counties have implemented their LIHPs. The process may be different for counties with active LIHPs vs. those who have not yet implemented LIHP

4. Medi-Cal Managed Care plan (MMCP) assignment and selection:
    - The current process in the plan is to default the population into a MMCP that has their current LIHP medical home (if it is in the network) without having to do anything
    - The enrollee would be able to change plans/providers after January 1, 2014
      (Note: This was changed in the initial plan submitted on August 1, 2012. Enrollees will be able to choose plans/providers during pre-enrollment prior to January 1, 2014)
    - DHCS will start looking at LIHP and Medi-Cal provider network overlap in first quarter of 2013
    - Los Angeles Neighborhood Legal Services suggested enrollees be given a choice if their current provider is in 2 different plans
    - Western Center on Law and Poverty (WCLP) strongly recommends enrollees be given the option of choosing their MMCP and medical home and be defaulted into their current LIHP medical home (if it is in the Medi-Cal network) only if they do not chose and wanted to know the rationale behind this decision
    - WCLP also noted all Medi-Cal enrollees are given a choice of medical homes, why not in the LIHP transition
    - DHCS believes the "opt out" approach to MMCP assignment is to ensure continuity of care and is a top priority for DHCS (WCLP does not see how giving the enrollee choice will affect continuity of care)
    - DHCS notes that enrollees still have a choice to select another plan, just not until after they have been pre-enrolled
    - DHCS also believes there may be "technical" issues with giving enrollees the choice up front because technically, they are not in Medi-Cal until they are enrolled into a plan
    - CAPH supports the "opt out" approach suggested by DHCS because:
        - Enrollee is already connected to the provider
        - If enrollee is currently in a LIHP medical home, they may say, "I chose my medical home, why are you asking me again?"

5. Eligibility, enrollment and redetermination:
    - CPEHN inquired if there might be a "grace period" for the newly eligibles during the transition
    - CalHEERS will be doing the MAGI determination, not the counties
    - DHCS stated the plan would try to minimize the amount of additional information required for eligibility determination and redetermination in 2013 by:

    - Using existing LIHP data to the extent possible
    - Requesting any additional information at time of new enrollment or redetermination in 2013
    - Obtaining consent for data sharing and transfer
    - Working with the counties to obtain income and household composition data
    - Contacting the enrollee only if more data is required
    - Attempting to electronically match data first

6. What is the role of the Exchange in the continuity of care?
    - DHCS will work with the Exchange on transfer of enrollee data
    - The Exchange can leverage electronic data matches to other data sources
    - DHCS is having discussions with the Exchange on many levels

7. Rate setting – What is the benefit going to look like?
    - DHCS will have to factor in what the population will look like and what the benefits package will be

8. What types of data will be required for the transition? These should be identified well in advance of the transition.
    - Data for rate setting and medical home assignment
    - Income and household composition data
    - Will need to obtain Consent from LIHP enrollees for data sharing and transfer

9. How does the transition plan address the mental health component?
    - Medi-Cal carves out mental health services and provides funding to the counties to provide direct services to individuals
    - This is different from LIHP benefits where continuity of care can be an issue because this differs from county to county.
    - How can LIHP enrollees continue to receive needed treatment and services after the transition?
        - DHCS does not have a written document on this topic
        - DHCS should have a meeting with mental health providers and advocates before drafting a plan

Low Income Health Program (LIHP) and LIHP HIV Transition Notes:
Highlights of the presentation:

- CMS recently approved a Section 1115 Demonstration amendment allowing DPH systems with approved 5 years DSRIP plans in a county with a LIHP to now establish Category 5 HIV Transition projects.
- Tailored HIV Transition plans will address infrastructure, program design, and improvement to clinical and operational outcomes.
- Additionally, all plans will included a shared learning component
- The term of the projects are from July 1, 2012 – December 31, 2013
- A total of $110 million in DSRIP Category 5 HIV Transition project payments (total computable) will be available for SFY 2012-2013 and $55 million (total computable) will be available July 1, 2013 through December 31, 2013.
- Projects must align with local needs.
- CMS is currently reviewing the performance measures and project structure. These metrics are aligned with the HRSA HAB measures.
- STC are currently being developed
- CMS must approve each DPH's DSRIP Category 5 Plans. Stakeholder input will be part of the plan process.

Summary of Issues Discussed:

- How does the $110 million and $55 million project payments (total computable) compare with the actual costs of HIV/AIDS care that will be incurred by local LIHPs?
  - Answer: It does not compare dollar for dollar. It is based on the expected ADAP expenditures that will be incurred by the county.
- How do counties become whole for costs associated with care for low-income persons with HIV enrolling in LIHP?
  - Answer: The DRSIP Category 5 does not make counties whole. It is an incentive payment for HIV transition projects.
- How can we use the work of DSRIP Category 5 projects as a model? How do we get "best programs/lessons learned" out to providers?
  - There was enthusiasm for using the Integrated Communications Plan Committee, AIDS education and training centers as well as other establish HIV transition policy and program committees as a place to share best practices.

CCS Pilots
Luis Rico and Bob Dimand, DHCS

Presentation Summary:
Improve delivery of health care for children with CCS conditions through use of organized health care models.

- Make access easier for clients/families;
- Reduces or eliminates administrative barriers for physicians in providing services;
- Permits measured provider performance; and
- Improves health outcomes.

What new approaches in the delivery of care for children with CCS eligible medical conditions can be designed to effectively manage and coordinate all of the child's health care needs?

DHCS Questions to guide further development of these models

1. What components of the current CCS program must be preserved?

- Quality of care – Maintaining CCS standards of care.
- Need to update and maintain CCS Standards to ensure quality standards for the best outcomes, i.e.: verifying providers are Board Certified and have necessary experience.
- Design CCS Standards for new categories of Special Care Centers (SCC).
- CCS Program refers children to the most appropriate service.

2. What requirements are needed to promote effective case management and care coordination?

- Quality of care provisions needs to remain intact for providers (i.e. social worker, nutritionist).
- Payment model – how do you fund the "connections?", such as client moves from inpatient services to outpatient model and still receives the same level of care.
- Difficult to support a home health model of care – difficult to get primary care providers to commit for a year for children with complex health conditions.
- How to fund the TeleHealth Model? *DHCS:* More internal discussion needed.
- What do families think about a medical home in comparison to the professionals? DHCS should survey families, patients, and providers to identify satisfaction with access to care, or measure dissatisfaction by flipping the survey to figure out what is unsatisfactory.

3. **What activities must be undertaken to measure and monitor the performance of organized health care delivery systems, including support of quality improvement activities?**

   - Quality improvement, Customer/Provider satisfaction, timely access, financial performance, dashboard report for rapid intervention
   - Historically, the State had interaction with the families, but what is the role of the State with the new models in providing oversight?
     - The State will audit the program. (There will be a variable oversight because each county does things differently.)
     - Evaluation reports.
     - Encounter data: the State will collect encounter data and will have the ability to review the information.
     - Grievances (How are complaints being used? They can be used to drive change with routine Quality of Care evaluation):
       - First level: health plan.
       - Second level: CCS State Hearings.
     - Dashboard reporting system will provide “real time” feedback on the program.

4. **At the conclusion of a series of workgroup discussions, it was decided that an independent evaluation needed to be included along with the creation of a CCS Demonstration Advisory Committee. Now that this has been completed:**

   What critical performance measures must be included in the evaluation?

   - Communication needs to exist between the “old” care team and the “new” care team.

5. **One of the guiding principles at the outset of the 1115 Waiver process for CCS was to “do no harm”. What are the components of performance measurement that must be included to ensure no harm?**

   - Care conforms to existing protocols (actively press group to come to best practices).
   - Lack of underutilization.
   - Team meeting evaluation between the specialist and ancillary (helps establish a baseline.) Did it affect the care of the patient?
   - Continuity of care if possible

6. **What are the important considerations for a successful transition of CCS enrollees into an organized system of care?**

   - Informing materials with adequate notice
   - Coordination with county, contractor, and state.

SPD Transition: Status of Medical Exemption Request (MERS) and Continuity of Care
Margaret Tatar, DHCS

Presentation Summary:
Margaret Tater, Chief of the Medi-Cal Managed Care Division, DHCS, opened the session by providing an update on the SPD transition. The SPD transition concluded in May 2012, with 333,075 SPD beneficiaries transitioning into managed care health plans. DHCS continues to monitor the transition and publish data and analysis in the SPD Dashboard report. Through March 2012, health plans received 11,068 requests for continuity of care. The approval rate was approximately 81% and a total of 8,963 requests were approved. DHCS tracks the denial reasons in the SPD Dashboard report and the most common reason that health plans denied a continuity of care request was the provider would not accept payment. Through April 2012, DHCS received 19,684 MER requests, with approximately 18% being approved, 31% denied, and 50% incomplete. DHCS has learn that it was a common practice for beneficiaries to submit more than one MER, and DHCS is working to add data to the SPD Dashboard to show how many unique SPD beneficiaries submitted a MER. DHCS is working on a process where all MER denials will be automatically considered a continuity of care request. Each health plan will receive a data file with the beneficiary's information shortly after enrollment. The project is already in the testing phase and should become official policy within the next 3-6 weeks.

Comments from SAC members:

- DHCS should monitor for what happens after a beneficiaries 12-month continuity of care request expires. Are health plans approving extensions or are permanent contracts being reached?
- Provider knowledge of the continuity of care provisions did not kick in until after the transition began. Once providers and beneficiaries began requesting continuity of care, there was confusion among the health plans on how to handle the requests. Some health plans did a good job with the requests.
- DHCS should rethink the policy of not sending beneficiaries a notice if their MER is placed in an incomplete status. The beneficiary would help to ensure that the information being requested is sent to DHCS in a timely manner.
- The MER form does not specifically state that notes from the last five provider visits are required to decision a MER.
- Follow-up should be done on why beneficiaries where denied continuity of care requests, especially if the reason for denial was a quality of care concern.
- DHCS should spot-check if notice of denial for services is happening at the IPA level.
- The MER denial notice should be updated to include the circumstances when a beneficiary can remain with Medi-Cal Fee-For-Service when a timely appeal is made.
- DHCS should publish specific guidelines or standards for what will constitute a MER approval or denial.

DHCS Quality Strategy
Desiree Backman, DHCS

- Questions:
  - Is there a State Quality Strategy in the works?—something that represents all programs collectively?
    - Dr. Desiree Backman, Chief Prevention Officer, DHCS explained that the DHCS QS is representative of the State QS
  - What is in it for doctors, how do we make it enticing for them to participate in the QS?
    - We need to work to create an interface between DHCS & CDPH so we can coordinate efforts and achieve preventive care
  - Will there be a website available to stakeholders?
    - It was expressed that a forum would be nice where stakeholders can communicate and collaborate with each other on their efforts
    - Dr. Backman explained that we were in the process of planning a webinar for stakeholders as well as coordinating a Survey Monkey to ensure transparency and stakeholder participation.
- Comments:
  - One area missing in the QS is medical education—providers need to be educated, they need to learn to value "well-care" and prevention. Bring the evidence to them, so they can get behind our movement.
  - We need to continue to bring forward the concept of rapid-cycle quality improvement.
    - This helps build the confidence in members and makes them feel as if they are not the "test group" of a new project.
- Questions:
  - What is the interaction between Let's Get Healthy California (LGHC) and the QS?
    - There is an important connection between the two. LGHC provides a platform to elevate the work of the QS and likewise, the QS helps inform LGHC work efforts.
- Comments:
  - Someone liked that it is called a "strategy" not a "plan"
  - Someone liked the priorities of the QS
    - Suggested that we define what we mean by health disparities
  - Someone liked that families were incorporated when addressing quality of care in the QS
  - To eliminate health disparities, we should consider making it a goal.
    - Address: Race, language, ethnicity, age, disease
  - Suggestion that we incorporated the word "stigma" in the QS
    - The notion that poor health effects a person in many ways and illness creates a stigma

    - Suggestion that at the population level, we address the demographics that are ignored such as foster children—notably the "aged-out" foster children (those ages 18-25).
        - It is important to address health disparities
    - Suggested to look at the Agency for Healthcare Research and Quality (AHRQ) website as a place to refer people, because there are great consumer pieces available.
- Questions:
    - How do we build a robust mental health component?
        - It is important to remember that mental health and behavioral health are important parts of whole-person care.
- Comments:
    - Regarding the micro-level quality issues—there is a failure of due diligence in specialist referrals within the managed care arena. This problem needs to be addressed.
    - On the Fee for Service (FFS) side there must be incentives in order to get the providers to participate in achieving quality goals. We should consider this potential push-back.
- Comments:
    - Patient experience is so important—it should be used as part of the QS
        - Suggested that we look at the Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores of plans and use those scores to shape the QS measures/goals.
    - In order to get engagement in the culture change from provider to patient care we must establish partnerships to collaborate
        - Suggested looking at the California Association of Physician Groups (CAPG) and the California Medical Association (CMA) would be a great bridge. They have good measures and therefore would be great to collaborate with.
    - It is important to look at the outcomes of measures NOT the process.
        - This is the problem with HEDIS measures—there is a lack of integration.

The SAC large group meeting reconvened at 3:00 p.m.

Public Comment
There was no public comment.

Next Meeting and Adjourn
Douglas announced the next meeting on November 19, 2012. He thanked members for all of the valuable feedback.