

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

**July 22, 2015
9:30am – 3:00pm**

MEETING SUMMARY

Attendance

Members Attending In Person:

Bill Barcellona, CA Association of Physician Groups; Kelly Brooks Lindsey, CA State Association of Counties; Bob Freeman, CenCal Health; Sarah DeGuia, CPEHN; Lishaun Francis, CA Medical Association; Bradley Gilbert, IEHP; Marilyn Holle, Disability Rights CA; Michael Humphrey, Sonoma County IHSS Public Authority; Marty Lynch, Lifelong Medical Care and California Primary Care Association; Sandra Naylor Goodwin, CA Institute for Behavioral Health; Gary Passmore, CA Congress of Seniors; Brenda Premo, Harris Family Center for Disability and Health Policy; Judith Reigel, County Health Executives Association of California; Stuart Siegel, Children's Specialty Care Coalition; Rusty Selix, CA Council of Community Mental Health Agencies; Cathy Senderling, County Welfare Directors Association; Richard Thomason, Blue Shield of California Foundation; Anthony Wright, Health Access California.

Members Attending By Phone: Anne Donnelly, Project Inform; Amber Kemp, California Hospital Association; Kim Lewis, National Health Law Program; Herrmann Spetzler, Open Door Health Centers; Chris Perrone, California HealthCare Foundation.

Members Not Attending:

Michelle Cabrera, Service Employees International Union; Elizabeth Landsberg, Western Center on Law and Poverty; Steve Melody, Anthem Blue Cross/WellPoint; Erica Murray, CA Association of Public Hospitals and Health Systems; Mitch Katz, MD, LA County Department of Health Services; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Center; Marvin Southard, LA County Department of Mental Health; Kristen Golden Testa, The Children's Partnership/100% Campaign.

DHCS Attending: Jennifer Kent, Mari Cantwell, Hannah Katch, Rene Mollow, Sarah Brooks, Marlies Perez, Nathan Nau and Adam Weintraub.

Public in Attendance: 30 members of the public attended.

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

Ms. Kent thanked Blue Shield of California Foundation and California HealthCare Foundation for their support to convene the stakeholder meetings. She announced a promotion for Sarah Brooks as the newest Deputy Director at DHCS. While taking on new duties, Ms. Brooks will continue to work on managed care metrics and dashboard from her previous responsibilities.

**Follow-Up Issues from Previous Meetings and Key Updates
Adam Weintraub, DHCS**

http://www.dhcs.ca.gov/Documents/SAC%20Meeting%20Materials/SAC_Follow_Up_Item_s-5.20.pdf

Adam Weintraub presented details of follow up based on the matrix in the meeting materials. Links to documents related to follow up are included in the document. There were no questions about the matrix.

Update on SUDS Waiver

Marlies Perez, DHCS

Marlies Perez reported that the SUDS waiver is not approved yet. CMS has completed its review and submitted to its federal partners to finalize. The waiver is intact as submitted with no substantive changes. We are meeting with Bay Area partners on implementation. The American Society of Addiction Medicine (ASAM) criteria for placement are being piloted and ready for release.

Questions and Comments

Rusty Selix, CA Council of Community Mental Health Agencies: Given the delay in approval, will you shorten the time between implementation in the initial counties and the next phase?

Marlies Perez, DHCS: We are working with phase one counties even though the waiver is not yet approved. There is some delay in implementation of phase one but we are working to shorten the implementation delays. One way to support next steps is that we are providing FAQs, building in lessons-learned information to the conference in October and sharing information in real time for stakeholders.

ACA 2703 Health Homes

Hannah Katch, DHCS

We continue to develop the 2703 Health Homes state plan amendment (SPA) and the overall program. There is a webinar tomorrow to address frequently asked questions and any confusion about the state proposal. The webinar will not focus on new information or changes. We are working with technical experts on potential changes to the proposal and expect to release a third concept paper that reflects changes at about the same time we submit the SPA.

Questions and Comments

Kelly Brooks Lindsey, CA State Association of Counties: Will you submit the concept paper in August?

Hannah Katch, DHCS: Yes

Bradley Gilbert, IEHP: There are still concerns from plans about some specifics in the concept, such as the community-based entities, staffing, 24-7 availability and the role of plan, and wrap-around services. These concerns were voiced in concept paper 1.0 and I still see those in concept paper 2.0. What are the steps to work through those issues?

Hannah Katch, DHCS: As part of ongoing conversations with health plan partners, we continue to work on these issues. We want to make the program work in rural or other areas without capacity. We intend to be flexible to ensure this works. You proposed a good model for this and we want to continue to have conversations about that.

1115 Waiver Renewal Application: Medi-Cal 2020

Status of Waiver Renewal Proposal, CMS Discussions and Timeline for Next Steps

Mari Cantwell, DHCS

We have had good discussions during weekly calls with CMS on the 1115 Waiver application. We are working our way through the proposal and answering questions so CMS can discuss issues with other federal partners. We have a series of confirmed meetings and subjects calendared over the next two months.

We have discussed global payment for the uninsured. We are currently discussing managed care incentives, the rationale for this proposal and how the financial incentives work at the plan, county and provider level. Next, we will discuss the accountability measures and metrics for the five-year outcomes of the waiver that we will commit to as a state. In August, we will discuss financing issues. We have been concerned about CMS discussions of re-basing away from the Fee for Service (FFS) calculations on the “without waiver side” for California. This could mean we have no savings/budget neutrality to implement program changes. CMS continues to say they want to re-base, but that it is not their intention to zero out savings. CMS is working on a national policy on budget neutrality although we are not aware of any discussions about this with other states. Many states have similar shared savings programs based on FFS.

Also in August, we will be discussing federal/state shared savings. CMS isn’t sure about the authority around shared savings and have their legal team reviewing. These discussions will include designated public and non-designated hospital transformation and the Whole Person Care and Housing pilots.

It seems we have satisfactorily answered their questions and they are interested in the concepts. Their primary question is, why do this through a waiver, why do you need more money? We have indicated we want to get to a place, like Medicare, where payment is based on value and we need a transition to get there. We need the ability to test what will work in California and we can’t do that in a situation that has significant risk for the delivery system because projects would likely fail and it would destabilize the health system.

In summary, CMS is engaged and committed to finishing within the timeline. It is certainly possible to reach conclusion within the 100 days remaining. Each question includes follow up in writing and additional details on an ongoing basis. Until we have a better sense of financing, we are not prepared to reconvene any stakeholder groups but hope that in August, we can hold a webinar to update everyone about our status.

Questions and Comments

Gary Passmore, CA Congress of Seniors: What is the process if you end up at loggerheads with CMS on financing? This is so fundamental.

Jennifer Kent, DHCS: Usually we work through the technical and clarifying details first. There may be issues where we have differences and there is a negotiation about how those snags are resolved. Normally, these final issues are elevated for resolution.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: Once we are through the feedback sessions, is there an opportunity for stakeholder input?

Mari Cantwell, DHCS: We hope to hold an update webinar in August.

Anthony Wright, Health Access California: On the global payments for safety net, was there receptivity both to maintaining the safety net care pool financing and to flexibility to transform the safety net as we are envisioning?

Mari Cantwell, DHCS: It seemed that is the case but there is no commitment at this stage. CMS is saying there will also be a new national policy on uncompensated care pools based on what was in the Florida waiver. What we know is that it cannot include all uninsured; it should focus on the uninsured in charity care programs. It is unclear but seems to be developed based on a system of nonprofit hospitals that Florida utilizes. There is a fundamental difference in California because we have a county system and a public system. They were receptive and understood our proposal. We shared there are significant uncompensated costs in public hospitals. It is unclear how the new policy would actually impact or align to California.

Anthony Wright, Health Access California: What is their process for rolling out these two new national policies and for stakeholder input? There are no documents on the CMS website?

Mari Cantwell, DHCS: No, it is unclear. This new low-income policy roll out was not discussed. It is not public and we have no documents to review or share. Similarly with the budget neutrality policy, there does not seem to be a public process.

Anthony Wright, Health Access California: Are they intent that the new national policies go into effect prior to California's waiver? Is there a possibility we will be under existing policy?

Mari Cantwell, DHCS: That has been part of the delay so far. It seems they want the new policies to be part of how California's waiver is approved but we have a need to move forward in order to finalize California's waiver for implementation.

Bradley Gilbert, IEHP: If we are entering the managed care transformation last stages, we stand ready as individuals to offer input, supporting information and comment.

Mari Cantwell, DHCS: Thank you

Chris Perrone, California HealthCare Foundation: On the accountability measures, is that an area where you will bring others into a conversation?

Mari Cantwell, DHCS: it is a conversation scheduled for August so we have no specific questions or issues yet from CMS. We are going into the discussion based on workgroup information. That will be discussed in the webinar assuming we have more information.

Gary Passmore, CA Congress of Seniors: Since this will occur close to deadline, how will you work with legislative approval?

Mari Cantwell, DHCS: We are working with legislative staff and since the timelines are still unclear, we will have to see how this plays out as to timing.

Jennifer Kent, DHCS: In the last waiver, it was part of the budget primarily because the budget approval was delayed to October that year. In the current situation, we don't have enough detail to develop a legislative framework. To the extent possible, we will have as much detail as possible and we will follow up with legislation in a subsequent session in January.

CMS Managed Care Regulations and Impact In California
Mari Cantwell and Sarah Brooks, DHCS
Kim Lewis, NHeLP (SAC member; beneficiary perspective)
Health Plan Representatives (SAC members)

Background materials for this discussion:

http://www.dhcs.ca.gov/Documents/SAC%20Meeting%20Materials/2015_06_Vol_38_Health_Advocate.pdf

Mari Cantwell updated the group on policy specifics related to managed care regulations. DHCS will submit comments. Many issues in the regulations are things we are doing or on the path to doing and we are ahead of the curve. We are supportive of much of what the regulations are doing on protections and other topics. There are new requirements and policy changes that are a one-size approach across all states. One of our major comments is that states need flexibility to work with CMS and with health plans to accomplish consistency across populations and throughout the state – not just across Medicaid plans. In addition, the normal timeline of 60 days for compliance is unrealistic and we are asking for a multi-year implementation. It is likely to be final by mid-2016.

On specific provisions, there are a few that have the potential to interrupt our system and rise to a level of critical importance for change.

- **Directed Provider and Incentive Payments:** CMS states that existing policy does not allow us to direct health plans about payments they are making. CMS acknowledges this may be already happening but they want to end this practice. In California, this could impact hospital fees and IGTs used to mirror FFS into managed care where there are supplemental payment programs that support core providers would not be allowed. This could impact funds of \$2B in managed care that goes back to providers. This would destabilize our safety net delivery system.
- **Actuarial Rates:** Instead of the common practice of certifying to a rate range for actuarials, CMS is seeking that actuaries certify to a specific rate, not a range. This impacts our ability to pay the upper bound of the rate range in certain situations.
- **Provider Enrollment:** CMS wants a single way to enroll providers so in California, all provider enrollment would need to go through the FFS side. There are many physicians that participate only through managed care. They would be required to go through FFS provider enrollment even if they do not participate in FFS. This would also impact MSSP, IHSS providers and other programs. CMS states this will ensure program integrity but we believe this is not the best way. We can't have a uniform process for all – in particular LTSS providers and others need a specific process. Our stance is that this will reduce the number of providers. Our plans have responsibility for ensuring providers are appropriate and this is duplicative. Our request is that states maintain ability to delegate responsibility as long as we continue to do some database match to identify suspended providers and other issues such as that.
- **Quality Monitoring Data:** We currently monitor quality through encounter data. The new policy states they will withhold FFP if a state does not submit complete, accurate encounter data. We don't know what that means. We are proposing they should work with the state to ensure accurate, timely data and should specify what will happen with FFP. The withhold should only happen after multiple problems.

Questions and Comments

Judith Reigel, County Health Executives Association of California: Is the rate range what we use for public health service contracts with plans?

Mari Cantwell, DHCS: Yes, lots of entities put up IGT for EMS and other services

Anthony Wright, Health Access California: What is the CMS rationale for the change in rate ranges? What are they saying on the other issue?

Mari Cantwell, DHCS: There is wide variation across the country. Some states decide to pay different rates without notifying CMS. California puts any change into the contract documents that CMS reviews. CMS may be signaling they don't like not having information and part of this may be CMS not liking alternative sources of payment. On the first issue, they feel it takes away from capitation being risk-based if the state directs the payment. Our response is that there are reasons that certain providers should receive different payments.

Gary Passmore, CA Congress of Seniors: In the example of SNF, we have written in statute a range of rates. Would that be gone? Are there models from other states this is based on?

Mari Cantwell, DHCS: We are not clear about their intention but I think no. Their perspective is that the negotiation is between plans and providers. There are no models we know of.

Kim Lewis, National Health Law Program: What is the overlap between plan requirements for Medi-Cal managed care and FFS requirements?

Sarah Brooks, DHCS: The plans are required to meet the same standards as in FFS. There are differences in how it is structured depending on the types of providers, such as IHSS. We have systems in place to do monthly checks against federal databases for verification. There are different components that are facilitated at the plan level vs state level.

Kim Lewis, National Health Law Program: Would you want to propose language to indicate we are meeting the requirements through the plans?

Mari Cantwell, DHCS: Yes, that is what we are asking.

Bradley Gilbert, IEHP: The level of credentialing at the plan is much more extensive than enrollment in FFS Medi-Cal, including peer review, malpractice, etc. If the issue is program integrity, then it is adequate. There is no question that we will lose providers with the FFS enrollment system. It does not seem to add value and it runs the risk of reducing access.

Jennifer Kent, DHCS: We are a paper-based enrollment. To the extent a plan wants enrollment of a specific physician quickly to create access for a difficult case, they would have to come through DHCS.

Kelly Brooks Lindsey, CA State Association of Counties: I assume this impacts county mental health plans and plans under Drug Medi-Cal waiver?

Mari Cantwell, DHCS: Yes, it applies to anything that is a managed care entity. There are audit requirements that exceed the time limits for what county mental health plans currently maintain. We are trying to reflect how these regulations will impact the different managed care entities.

Bill Barcellona, CA Association of Physician Groups: Our experience in capitated groups is that we are needing to expand providers rapidly to serve the volume of new enrollees and wouldn't be able to do that with a paper system. We will be commenting on the regulations.

Jennifer Kent, DHCS: When we think of 400K IHSS providers alone, you can see why this is a problem

Lishaun Francis, CA Medical Association: We agree and will also be commenting.

Michael Humphrey, Sonoma County IHSS Public Authority: There are basic requirements and background checks for IHSS right now. Anything else will be onerous. What is the timeline for comments and perhaps our state association could comment?

Mari Cantwell, DHCS: Comments are due Monday, July 27th. We agree that hospitals and IHSS providers should not be treated the same - they are very different types of providers. CMS is looking to finalize the regulations by early 2016. They have not indicated what level of flexibility is likely in conversations with Medicaid Directors. There is concern across all states.

Gary Passmore, CA Congress of Seniors: Is your ask that states need flexibility?

Mari Cantwell, DHCS: We are saying we want to maintain the flexibility we currently have. There should be the ability to delegate as appropriate.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: We agree these are good concerns for the comments. Can you provide a summary so we can include some of these points in our comment language?

Herrmann Spetzler, Open Door Health Centers: I support what we are asking of CMS. I have experienced these problems. All of the issues you report are familiar for those of us who contract with the state. Will the state allow the same flexibility to providers as you request from CMS?

Jennifer Kent, DHCS: You are saying that the state should take the same point of view with contracting providers that it is asking of the federal government? Your comment is noted.

Kim Lewis, National Health Law Program Beneficiary Perspective

The NHeLP perspective is from representing beneficiaries and means we have a different point of view. We are concerned with too much flexibility and have seen problems across the states. During the Bush regulations in 2002, we saw loose requirements and protections for beneficiaries. We support the regulations across the board for the benefits they bring for beneficiaries. We have 150 pages of comments that I am happy to share with others. We are calling for more clarity, specificity and monitoring of states. Some highlights include:

- The appeal/grievance procedure: The changes will improve appeals as we have long recommended and will require that while the appeal proceeds, the action is halted. This improves protections for those who are getting ongoing care so they don't lose benefits.
- State monitoring: We support CMS doing more to monitor compliance. California is a poster child for the problem of monitoring quality as the recent state auditor report indicates we are not doing a good job.
- Other items: More transparency of formulas, network adequacy and direct testing of provider networks. LTSS standards are critical and we support the change.

We welcome the direction CMS is taking.

Stuart Siegel, Children's Specialty Care Coalition: Can you offer more information on the impact to provider arrangements?

Mari Cantwell, DHCS: Particularly, the arrangement with the hospital provider fee and funding mechanisms with counties and public hospitals would be at risk with these requirements. The long term care provider fee will not be impacted.

Stuart Siegel, Children's Specialty Care Coalition: This point should be made strongly because if the children's hospitals are impacted, it will undermine the entire children's safety net.

**Bradley Gilbert, IEHP
Health Plan Perspective**

A few comments:

- We support the rate range comments made here.
- They talk about transparency and we have worked with DHCS to make the rate process better.
- We also don't support the 14-day change that was not mentioned. This is already short and would increase defaults.
- The grievance appeal alignment with Medicare is a good thing but 72 hours is too short for urgent appeals.
- On network adequacy, the rigid time-and-distance requirements will not work in rural areas, where there are few people and few providers.
- Printed provider directories are outdated immediately and doing this monthly is onerous and wasteful. We support 30-day updates online; weekly updates online is too often.
- We are ok with standardized metrics but not supportive of their directing quality payments.

In summary, we are in line with most of the state comments.

**Bob Freeman, CenCal
Health Plan Perspective**

We agree with the state's comments. If you look at the totality, they propose to take money out of the system, then make it more difficult to recruit and maintain providers. The plans have to turn this into a working process so the multi-year request is important. One additional section is the program integrity section related to fraud. It isn't clear if we must suspend a provider even if the claim is a mistake. This may alienate providers and will add to the difficulty of retaining providers. The monitoring needs to be localized – we were dinged for no providers on the Channel Islands, but there are no people there.

Gary Passmore, CA Congress of Seniors: There is a collaborative of LTSS organizations. We held two meetings on this subject. California's Knox-Keene laws don't cover LTSS. All of our comments are focused on LTSS to strengthen the proposal in regard to LTSS.

Mari Cantwell, DHCS: A few last comments. On the medical loss ratios, we think it should be consistent across the contract; it doesn't make sense to measure by rate. On the 14-day timeline, we are not in agreement with the comments. With transitions between Covered CA, and Medi-Cal, we want to ensure they can stay in an organized delivery system. We do have comments on this issue but this was not one of our top issues.

Kim Lewis, National Health Law Program: Do you support the current time lines?

Mari Cantwell, DHCS: Our comment is that when there is a particular circumstance, such as transition from Covered CA to Medi-Cal, the proposed requirement could disrupt, rather than enhance the choice process.

Jennifer Kent, DHCS: We have the option for beneficiaries to change plans every month and this would mean they are out of Medi-Cal managed care longer than 14 days.

Jennifer Kent, DHCS: We will share our letter broadly through stakeholder groups and welcome receiving copies of your letters.

Update on State Auditor Report on DHCS and Health Plans Monitoring and Oversight
Sarah Brooks, DHCS and Nathan Nau, DHCS
Health Plan Representatives and Advocates

Slides are available for this presentation:

http://www.dhcs.ca.gov/Documents/SAC%20Meeting%20Materials/SAC_Mtg_State_Audit_Report_July_2015.pdf

Ms. Brooks and Mr. Nau updated the group on a state auditor's report and findings, DHCS response and activity on monitoring and oversight. This includes network adequacy, provider directories, plan audits and other monitoring topics. They also reported on activity and systems to address the findings, many of which are already in progress. While DHCS agreed with many findings, it is important to note the auditors did not study all monitoring activities.

Questions and Comments

Sara DeGuia, CPEHN: Will there be one number to call for the ombudsman or are there language specific numbers as well? How will people identify their language needs and be served?

Sarah Brooks, DHCS: Right now there will be one call number. We would like to meet with you about this to build this out in a responsive manner.

Brenda Premo, Harris Family Center for Disability and Health Policy: Does the system have capacity for relay service function to serve the deaf? You have beautifully mechanized the system. Most deaf use a sign language relay system or caption system. There would have to be a way to let them know what number to call.

Sarah Brooks, DHCS: I completely agree and would like to pull you into a small workgroup to advise us so we can ensure we address all the issues.

Gary Passmore, CA Congress of Seniors: You have described new data you will have through the ombudsman program. Is it appropriate to share the data with us?

Sarah Brooks, DHCS: Yes, we will share the information quarterly.

Anthony Wright, Health Access California: On the ombudsman program, our understanding is that this is a staffing issue in addition to a technological upgrade issue. How will this enhance monitoring information?

Jennifer Kent, DHCS: It is both. We have nine new positions for the ombudsman office in addition to the technology systems. The audit highlighted this but we were pursuing better

systems already. We have the same expectation for all customer service resources where consumers get help.

Sarah Brooks, DHCS: We are also strengthening the training for ombudsman staff. We need to ensure language or other special needs assistance. We need to develop FAQs to improve ombudsman and health care options staff ability to answer questions. This will help us report and classify needs with more specificity so we can analyze the data in a much better way. We will have geographic, demographic and health plan specifics.

Nathan Nau, DHCS: We will build a database that includes multiple inputs that we can review monthly or quarterly.

Bradley Gilbert, IEHP: We run call centers as well and we could be helpful about how we manage our call centers, specify data and analyze data. Please use our expertise on this.

Jennifer Kent, DHCS: Thank you. We are in touch with Maximus and county call centers as well.

Sara DeGuia, CPEHN: There is recent data on Spanish speaking Medi-Cal beneficiaries who were turned away at vastly higher rates than other beneficiaries. We want to be sure that there is understanding of the legal requirements for language.

Sarah Brooks, DHCS: I have a copy of the CHCF report. We are reviewing closely

Stuart Siegel, Children's Specialty Care Coalition: Staffing is really important, in addition to the technology, to allow for reasonable response times. What is the interaction between the DMHC and Medi-Cal Managed Care Committee, I am curious to know if this came up? Have they provided input?

Sarah Brooks, DHCS: The Medi-Cal Managed Care Committee meets quarterly. We have provided reports to the group and received input and we will be providing the data reports to them ongoing.

Kim Lewis, National Health Law Program: We bring problems to you on a regular basis as we find them. Will these additional efforts also be on the monitoring websites? Will there be an overall/meta-analysis that brings together all the data to offer the big picture?

Nathan Nau, DHCS: Yes, there will be links to monitoring information and the database we are building will attempt to bring that big picture analysis.

Sarah Brooks, DHCS: There will be links to a consolidated monitor plan that includes all monitoring efforts, including ad hoc items like secret shopper exercises. We have been developing a monitoring plan for some time to present a consolidated view of HEDIS and other data.

Jennifer Kent, DHCS: The dashboard element has required two years to develop into a system. We continue to refine things so it is useable. These are complicated efforts.

Anthony Wright, Health Access California: How do these data compare with other advocate units in sister agencies, such as the Office of the Patient Advocate (OPA)? Does DHCS have goals for consumer standards for wait time etc.? Are you collecting data from Maximus and aggregating that into these data?

Sarah Brooks, DHCS: Yes, we work with other agencies and national groups to see how we compare. We are not yet pulling data from HCO/Maximus but are looking at that. OPA is now mandated to collect information about complaints across departments. We are working on definitions and consistent reporting to make sure the data reflect the right information.

Anthony Wright, Health Access California: A final comment. The goals and standards are essential and of interest to us. It is not enough to have staffing and technology if the standard is to leave people on hold for 30 minutes.

Update on ABx 1 1 Report and Timeline for Implementation of Budget Language to Cover Undocumented Children

Rene Mollow, DHCS

Slides for this presentation are available: <http://www.dhcs.ca.gov/Documents/SACABX1-1070715.pdf>

Ms. Mollow provided a report on ABx 1-1 data that covers the period of October – December 2014. She highlighted key data on enrollment through CALHEERS, 2014 Medi-Cal renewals and new systems to provide full scope coverage for non-citizen children. Reporting was delayed for this period and is on track for the future. She clarified that renewals not yet processed remain in coverage. For non-citizen children, the system will begin May 2016. Outreach will be important but 122,000 of the 140,000 to 170,000 total eligible children are known to us through episodic care.

Questions and Comments

Gary Passmore, CA Congress of Seniors: Do you have a rough estimate of how many children might be eligible for LTSS?

Jennifer Kent, DHCS: We don't know but it is very small.

Marilyn Holle, Disability Rights CA: You would expect savings from ER care for the children. Is there a way to capture the savings into the program? It is my understanding that San Mateo discovered the cost of ER care and full coverage to be almost the same.

Rene Mollow, DHCS: ER care is the way that we know many of the kids although we have not specified any savings. It was not a factor in expanding coverage.

Anthony Wright, Health Access California: On the transition from limited to full scope, the budget was estimated on 30 day timing. Is there a timetable for the steps to get the system up and running? We are interested in reviewing the steps and system changes related to the timeline.

Rene Mollow, DHCS: We are working on the timelines but I don't have them for today. We need to be thoughtful and determine the right timing.

Richard Thomason, Blue Shield of California Foundation: BSCF and all the foundations are excited about this new coverage. We and other foundations offer our assistance in this transition.

Anthony Wright, Health Access California: Does the 122,000 include all kids in county programs or Kaiser?

Jennifer Kent, DHCS: The number is for kids with an aid code through MEDS. The main venue for ongoing discussion will be the Immigrant Work Group.

Bradley Gilbert, IEHP: Our healthy kids program is small, 800-900 total, but we can cross walk the individuals. I would like to discuss the recent injunction.

Rene Mollow, DHCS: There has been litigation against DHCS about renewals. We recently received a preliminary injunction from the court that ordered DHCS not to issue any denial or discontinuances for anyone who does not have a NOA that is specific. Also, the NOA should have information on 90 day cure period and that services be restored if they provide information within the 90 day period. We have notice snippets language that is inserted to tell a beneficiary as to why an action is being taken on their case. The snippet language will say we don't have the information we need and because it is not specific to what information is needed, the judge says we cannot issue notices. The automation for CALHEERS for notices is scheduled in the future so we are working out what we can offer as policy guidance to county partners to minimize manual work-arounds.

Bradley Gilbert, IEHP: I know it is not simple to develop the specific language. Our county let us know they will not be sending notices of denial of eligibility. This is significant as to volume of membership.

Cathy Senderling, County Welfare Directors Association: There are many layers to the notices. This relates to those notices where we need more information, it does not apply to everything. We are still assessing and working with DHCS to minimize the work load and manual work-arounds. There may need to be a quick reaction that will change over time.

Jennifer Kent, DHCS: We have been waiting for months to implement new elements within CalHEERS so this is problematic on the functionality of the release.

Kim Lewis, National Health Law Program: We are not surprised by the judge's decision because this legal issue was raised months ago. Are you holding people in the application period?

Rene Mollow, DHCS: There are instances where we can't issue denial or discontinuance. We are looking at all ways to best comply with the order and issue appropriate notices. We can't approve them if we don't have all the information.

Kim Lewis, National Health Law Program: Are you considering issuing Rivera backlog notices? Do you know the average monthly numbers?

Rene Mollow, DHCS: We do not know the numbers. We are working to get the numbers. There will be some notices that can go out. In terms of issuance language, we are looking at everything.

High Cost Utilizers Data

Jim Watkins, DHCS

Slides for this presentation are available:

http://www.dhcs.ca.gov/Documents/SAC%20Meeting%20Materials/RASD_HCU_June_Pres.pdf

Jennifer Kent introduced the report by noting that SAC members hear many reports on how DHCS is working on quality for managed care populations. There are also three million FFS Medi-Cal beneficiaries and DHCS wants to ensure high quality care and ongoing improvements

for FFS populations as well as managed care beneficiaries. The data combine vital records and other data sets for both FFS and managed care beneficiaries to understand chronic conditions, utilization and more. Mr. Watkins provided a report on data related to high cost populations based on five years of multiple data sets.

Questions and Comments

Marilyn Holle, Disability Rights CA: Where is long term care?

Jim Watkins, DHCS: The Dual eligible population is not in the data set but those who reside in long term care and are Medi-Cal are throughout the cost payment distribution.

Kelly Brooks Lindsey, CA State Association of Counties: You mentioned that 40% of beneficiaries do not use their coverage at all. Do you know if they are having difficulty finding providers? Are there other difficulties?

Jim Watkins, DHCS: The 40% is high but we traditionally see 20% in coverage who do not use their coverage. The new sub-population were in FFS

Stuart Siegel, Children's Specialty Care Coalition: Some working in the field are trying to reduce costs through a focus on high cost populations such as Camden, New Jersey. How might we use these data to understand hot spots, sub populations or ED utilization?

Jim Watkins, DHCS: Yes, we are doing some of that through the health home initiative and the waiver. We are working on a paper for publication on several aspects of the data. ED use may or may not be the indicator of high cost.

Brenda Premo, Harris Family Center for Disability and Health Policy: I love the report. This shows cost. Are there data comparing interventions, such as transportation, and how that impacts cost? For example, in a small study at the pharmacy at Western, of those who self-identify as low literacy, the pharmacist gave them talking bottles and the compliance went up by 25%.

Jim Watkins, DHCS: We just finished a paper on ambulatory care sensitive conditions comparing Medi-Cal and commercial populations. We have to look carefully at the data to understand what they mean. We can't always control for all variables. For example, we have a very high rate of ED visits of ambulatory care – what did this mean? It turns out it is primarily in dual eligible beneficiaries and we don't manage them. Just making a comparison is not helpful.

Jennifer Kent, DHCS: The single most expensive individual was \$17M but it was not a condition we can control. The top 1% often may not be individuals who benefit from intervention to reduce cost but the group in the top 5% can often benefit.

Rusty Selix, CA Council of Community Mental Health Agencies: With the focus here on serious mental illness (SMI), we need to dig in to understand the subgroups. The mental health system can't track the physical health care. In the waiver, we focused on those in the mental health system and in primary care. We have missed an important population in the waiver not in care - the revolving door population with incarceration, hospital admission and mental health system will not be addressed through the waiver. We need to ensure they get into a comprehensive program.

Michael Humphrey, Sonoma County IHSS Public Authority: Great presentation. Are there data on those in various waiver programs such as nursing facility, acute care, assisted living?

Jim Watkins, DHCS: They were not looked at but that is an excellent follow up to look into.

Michael Humphrey, Sonoma County IHSS Public Authority: Are you able to look at durable medical equipment and where it was requested but not received and resulted in high costs? A recent story emerged about an individual who didn't get a wheelchair battery for several months and ended up with \$1M in care due to complications of inactivity.

Stuart Siegel, Children's Specialty Care Coalition: This was very interesting data. There are interventions you can learn about in these data by teaming up with both internal and external experts to help identify interventions that might reduce cost. I would like to see more of this on California Children's Services (CCS) care. I want to encourage more of this work.

Jennifer Kent, DHCS: This data set took months to build and it is cool.

Kelly Brooks Lindsey, CA State Association of Counties: Great information. How might this inform policy proposals in the waiver? How might you share the data with counties, providers, plans or others? How are you thinking about data for other purposes such as local data in the housing proposal?

Jennifer Kent, DHCS: The Coordinated Care Initiative (CCI) data informed some proposals. The health homes concept and the whole person pilot were also informed by the data. Sharing the data externally does require some careful attention to privacy and data sharing agreements.

Jim Watkins, DHCS: We did work with the California Health Interview Survey (CHIS). Many of the metrics were developed in commercial populations and we want to develop a better understanding of subpopulations.

Bradley Gilbert, IEHP: I was struck by the diabetes graph with the co-morbidity of alcohol/drug and mental health. We bend the curve with people who are part of the system but I think Rusty and Kelly make good points to draw out the people who are not in the system and are the ones who are very difficult to impact. Use these data to say to CMS that we are paying for people in multiple programs. We have to pick the right conditions and the right people to follow up and intervene and this is how we get there.

Jim Watkins, DHCS: There are multiple ways to look at where the impact is best. There are the highest-cost individuals and there are many in the middle tier that can benefit from interventions.

Marty Lynch, Lifelong Medical Care and California Primary Care Association: How good is the homeless data? Where are we with risk-adjustments per member to the plans? How will this data be used in the 2703 health home target process and tiering the rates?

Jim Watkins, DHCS: We may have 75,000 of a total 134,000 homeless included in the data. We look at over time and can build a group of people where we can see certain characteristics in certain sub-populations – higher mental health, skin infections and drug use. Not all homeless are high cost.

Jennifer Kent, DHCS: We use some of the data through Mercer to identify how rates are determined. We risk-adjust with a plan within a service area looking at relative utilization.

Today's presentation included FFS so it is not apples to apples comparison. Our waiver contemplates changing the rate methodology but we do not anticipate other changes. To the extent the plan can provide services that lower utilization, they aren't penalized.

Anthony Wright, Health Access California: How do you control for the fact that FFS beneficiaries don't all have access to the same services?

Jim Watkins, DHCS: That is exactly the issue we spend time on. In lots of literature, there are rates for conditions but the eligibility creates different benefits. We have adjusted for this.

Gary Passmore, CA Congress of Seniors: These data might look different next year? Do we have the opportunity to take these data over the next five years and modify the waiver based on what we find? Is this only useful for actions much farther out?

Jennifer Kent, DHCS: In the waiver today, we have indicated the high incidence of deliveries in the FFS system and our desire to improve the outcomes there. We know there are costs in different systems – not just FFS Medi-Cal – and the data can drive that discussion. Duals, Foster Care, Mental Health systems are all places where we could work across systems to save costs somewhere across the system.

Sarah Brooks, DHCS: A part of the waiver will have the plan, do, study, act (PDSA) process to think through the data and the interventions to modify structures within the waiver so when we get to 2020, we have a firm grasp.

Rusty Selix, CA Council of Community Mental Health Agencies: One thing we know is that there is huge variation in penetration rates and spending in mental health by county and ethnicity. SB82 so that SMI in crisis would not go to the hospital but immediately into crisis stabilization and directly into mental health system.

Jim Watkins, DHCS: We are looking geographically although we have not specifically looked at mental health across geography.

Jennifer Kent, DHCS: This work was supported by the California HealthCare Foundation.

CCS RSAB Workgroup Update

Louis Rico, DHCS

Comments from RSAB Members

Slides for this presentation:

http://www.dhcs.ca.gov/Documents/SAC%20Meeting%20Materials/CCS_Whole-Child_Model_for_SAC_20150625.pdf

Mr. Rico provided an update from the CCS Redesign Workgroup and the Whole-Child Model. He discussed plan readiness and other plan requirements, stakeholder engagement and the implementation timeline.

Comments

Stuart Siegel, Children's Specialty Care Coalition: As stakeholders, we are facing a situation where things are moving in accelerated manner. I want to highlight the positives and also the problems given there is little time for modification and so we don't make missteps along the way. Initially, there was an understanding we needed to look at solutions to what could be better in CCS. We want to look at models, including managed care, that that will protect children and

their services. Where we stand now is that we have recommendations to address some of this but the process has gone off track. There is only one pilot and it is not in a representative county and it has not been evaluated. This has made the stakeholders uncomfortable. The whole child model is a positive and it is needed. The addition of CCS provider coverage for those who age-out is a great element. Also, the phased in approach is positive. We understand why the state wants to change the program so it will be easier to manage and perhaps result in cost savings. The big question is whether we are ready to do this and whether this is the only way forward. One concern is the history of the SPD transition. The process was not a smooth one. There will be danger to vulnerable kids if that were to happen here. Second, the state audit is disquieting. It is good to hear you are dealing with it but the issues there are concerning. Third, surveys of parents show satisfaction with CCS program and there is sentiment saying, what is so wrong that we must change it and put in a new system when we are not sure what is best. We don't have data to show us the best way forward. We do have data on cost by county; this is not data that will create comfort that patients will not be at risk. We need analyzed pilot data; we need more evidence about what the problems are in the current system; we need evidence that managed care will result in the high level of coordinated care required. The bottom line is that we understand the goals, but we are too rushed. Stakeholder input is that there is overwhelming concern about whether we are ready to move forward.

Marilyn Holle, Disability Rights CA: I have two concerns. I see current problems in meeting the needs of CCS beneficiaries. There is hostility to the cost related to specialty care centers. One of the virtues of the specialty care centers is one stop. The data on CCS kids who age out and go into managed care is not good and should be analyzed. There are advantages in the whole child approach but we need to preserve the current system for kids with severe disabilities and wait before moving to managed care. How will you incorporate federal Medicaid regulations that decisions should be based on clinical decisions by those with experience in that disability? Whole person is a laudable goal but premature.

Bradley Gilbert, IEHP: It is disheartening to hear (assertions) that Medi-Cal managed care puts a child at risk. Children who age-out with hemophilia go to LA Children's because you are correct that they need that care. I wouldn't think of doing this without pulling together county CCS, local advocates, county hospital, Loma Linda Specialty Hospital to propose a way forward. The key is put safeguards in place because it doesn't make sense to care for these kids in anything other than a coordinated care approach. The state should do its due diligence to be sure everyone locally is on board and if that is the case, I think it can be done with high quality.

Brenda Premo, Harris Family Center for Disability and Health Policy: Health plans are not alike. We need to be careful to look at the individual structure before we know. My concern is not the health plan. I go back to Cal MediConnect and the problems. The process was problematic and we now have high opt-out rates. Thinking about any approach for difficult, high need populations, we need to think about how we go forward. For any complex population, we need to think it through and we need to learn from Cal MediConnect. It needs more time and needs better attention to how the member (and in this case, Mom) will walk through the process to understand how to get care. The initial response they hear will remain with them.

Questions and Comments

Stuart Siegel, Children's Specialty Care Coalition: Can you comment on the legislative element?

Louis Rico, DHCS: DHCS released proposed statutory language to implementing organized system of care, with consumer protections. We welcome comment and input.

Lishaun Francis, CA Medical Association: The major concern seems to be the timeline, not the concept. Is DHCS open to discussing the timeline? Are you willing to discuss the proposal?

Jennifer Kent, DHCS: We are open to discussion. Stakeholders did not comment on the proposal. The input was they didn't want to have a dialogue about language because they didn't like the overall proposal. The HHS Secretary has said we are not going to have a renewal of the carve-out. We are willing to consider other options that are not a renewal of the carve-out.

Stuart Siegel, Children's Specialty Care Coalition: I have heard that the biggest concern is not the model, but the lack of information about the pilot or that managed care can't work. There has not been enough experience to know if this will work.

Bob Freeman, CenCal: We have had risk for CCS and have cared for SPDs for many years. I want to set the record straight. We are community-based, mission driven, nonprofit plans. In Santa Barbara, the county does utilization, we have risk. Everyone goes to CCS-paneled providers and CCS-paneled institutions. What is being proposed is transitioning the utilization.

Stuart Siegel, Children's Specialty Care Coalition: I don't know that any analysis of Santa Barbara has been presented. Hearing about the different approaches has not happened and the process has not been useful.

Bob Freeman, CenCal: I think people should have an open mind and look at what is actually happening in different parts of the state.

Public Comment

There was no public comment.

Next Steps and Next Meetings

Jennifer Kent announced that the SAC is funded through October. We will be inquiring of current members about their willingness to continue in an advisory group for the waiver and suggestions for other groups that should be included. Next meeting is October 14, 2015