

**CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
1115 WAIVER RENEWAL
EXPERT STAKEHOLDER WORKGROUP on DSRIP 2.0
MEETING SUMMARY**

**Wednesday, November 13, 2014
10:00am – 3:00pm
Sacramento Convention Center**

Members present: Molly Brassil, County Behavioral Health Directors Association of California; Michelle Cabrera, SEIU; Sarah DeGuia, California Pan-Ethnic Health Network; Catherine Douglas, Private Essential Access Community Hospitals; Richard Figueroa, The California Endowment; Jon Freedman, LA Care; Judi Hillman, Health Access; Manel Kappagoda, ChangeLab Solutions; Barsam Kasravi, Anthem Blue Cross; Ken Kizer, UC Davis; Sherreta Lane, District Hospital Leadership Forum; David Lown, Safety Net Institute; Anne McLeod, California Hospital Association; Erica Murray, California Association of Public Hospitals and Health Systems; Kelly Pfeiffer, California Health Care Foundation; Al Senella, Tarzana Treatment Centers; Bill Walker, Contra Costa County Health Services.

Members on the phone: Christina Ghaly, Los Angeles County Department of Health Services; Angela Gilliard, University of California Office of the President; Bill Henning, Inland Empire Health Plan

Members Not Attending: Susan Ehrlich, San Mateo Medical Center; Leslie Mikkelsen, Prevention Institute; Richard Rawson, UCLA

Others Attending: Neal Kohatsu, DHCS; Erica Murray, DHCS; Sarah Brooks, DHCS; Pilar Williams, DHCS; Betty Lai, DHCS; Wendy Soe, DHCS; Tricia McGinnis, Center for Healthcare Strategies; Peter Harbage, Harbage Consulting; Don Kingdon, Harbage Consulting; Lisa Chan-Sawin, Harbage Consulting; Bobbie Wunsch, Pacific Health Consulting Group

15 Members of the public attended the meeting.

Meeting Summary

Presentation Slides are available at:

http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Renewal_Workgroup_DSRIP.aspx

Following introductions of Workgroup Members, Neal Kohatsu of DHCS provided an overview of DHCS Quality Strategy and 1115 Medicaid Waivers, including budget neutrality, as the overarching context. He reviewed the 2015 1115 Waiver Renewal

goals and objectives, timeline and the eight renewal concepts. Dr. Kohatsu also reviewed the relationship of the renewal to the Cal SIM effort and the purpose of the DSRIP 2.0 workgroup. The current waiver expires October 2015.

Erica Murray, CAPH provided lessons learned from the DSRIP 1.0 (Delivery System Reform Incentive Project). DSRIP is a 5-year demonstration project to create enhanced health care systems (infrastructure, outpatient, inpatient, primary and specialty care). Ms. Murray reviewed the history of the DSRIP, financing and structure of the plans and reviewed examples of what public hospitals are doing. Dr. Walker presented an example in Contra Costa County. DSRIP accomplished many successes, especially inside individual systems, and offers us important lessons for developing DSRIP 2.0.

Looking forward, Dr. Kohatsu presented a list of proposed concepts for DSRIP 2.0:

- Coordination leading to integration
- Depth required for CMS review process
- Prevention
- Complex patients
- Overuse
- Care transitions
- Efficiency
- Patient safety
- Alignment with other initiatives
- Patient/family, community engagement
- Cross-system and center-specific projects
- Technology (e.g., EHR)
- Potential for tiered involvement of District Hospitals

Questions/Comments from Members:

Molly Brassil, County Behavioral Health Directors Association of California: Are the incentives linked to the expected savings under the Waiver?

Erica Murray, California Association of Public Hospitals and Health Systems: The short answer is No. Savings are derived from two characteristics. 1) An estimate of the projected spend in an absence of a waiver. The difference between that and what would be the savings from the waiver. 2) Most of the savings in the 2010 waiver stem from the shift of seniors and persons with disability into managed care. If those savings fail to materialize, the state may have to pay the federal government back for those funds. A vulnerability right now is that DSRIP could get cut from a budget neutrality circumstance if the savings are not realized. We did not tackle cost savings in the current DSRIP – the focus was on system improvement and the other two aims of quality and experience. We are now considering what cost savings we could include into DSRIP 2.0.

Jon Freedman, LA Care: We often think of Medicaid as an uncapped entitlement, when in reality there are a variety of limits. The short story is that California developed a supplemental payment practice to the UC's and public hospitals. At times the federal government has tried to get rid of those supplemental payments. The federal government said it was possible to extend and perhaps expand the supplemental payments if specific improvements were included.

Al Senella, Tarzana Treatment Centers: Why did none of the private safety net hospitals choose to participate in the DSRIP?

Erica Murray, California Association of Public Hospitals and Health Systems: It was structured that way historically. The dollars for supplemental payments were financed from and dedicated to the public system.

Al Senella, Tarzana Treatment Centers: But as I am reading this, the private hospitals were eligible to participate.

Wendy Soe, DHCS: Public hospitals fund their share of the DSRIP with IGT's, whereas private entities can't put up IGT's under federal rules. So, historically, private hospitals have not participated in the DSRIP.

Christina Ghaly, Los Angeles County Department of Health Services: It's also important to remember that private hospitals have provider fees.

Catherine Douglas, Private Essential Access Community Hospitals: Private disproportionate share hospitals wanted to participate. This was budget neutral and the state did not want to devote any additional funds. The public hospitals funded this from their own sources and the private DSH did not have that mechanism. The provider fee is not the topic of this discussion. At the federal level, cuts were so egregious that the entire hospital community discussed taxing themselves to draw down more federal funds. Private hospitals do want to participate in 2015.

Barsam Kasravi, Anthem Blue Cross: Are the 217 milestones self-selected by each health system? And were they expected to self-fund until the money was available?

Erica Murray, California Association of Public Hospitals and Health Systems: It depends on the category. In some places there was agreement over milestones, and in others they selected from a menu of projects and set milestones related to that. Yes, they were expected to self-fund.

Barsam Kasravi, Anthem Blue Cross: Some of the projects seem more costly than others. Were the incentive payments aligned with the complexity of the work?

Erica Murray, California Association of Public Hospitals and Health Systems: There was no relationship between the complexity of the work and the actual incentive payments. Although all of the programs took quite a bit of work.

Manel Kappagoda, ChangeLab Solutions: Can you highlight which examples are in Category 3 (population focused improvements)?

Erica Murray, California Association of Public Hospitals and Health Systems: Category 3 is a reporting-only category. There is more of an emphasis in the early years on Categories 1 and 2. That shifts to Categories 3 and 4 in the later years to reflect the shift in focus to patient safety and outcomes.

Angela Gilliard, University of California Office of the President: I want to emphasize that there have been a deep investment from the public hospital systems in several areas to reform the delivery system. I want to emphasize, in terms of volume and depth, for those who are not familiar, how important the DSRIP has been to transforming systems.

Bill Walker, Contra Costa County Health Services: It's important to capture how the DSRIP has affected the culture of our system. These more qualitative changes are some of the most important but also the most difficult to measure.

Judi Hillman, Health Access: If these initiatives are to really be successful (especially ED redirect initiatives) you have to involve other community-based organizations (social services, transportation, etc.). Can you pull any insights or examples of community collaboration from the Counties that you are referring to?

Erica Murray, California Association of Public Hospitals and Health Systems: We are trying to construct a successor DSRIP that would include more integrated systems to provide the services that are needed. In thinking about where public healthcare systems need to be by 2020 – cost effective, competitive, patient-centered care – you can't do that without including social service organizations. There are opportunities to leverage county-based structures and other systems to address whole person care.

Barsam Kasravi, Anthem Blue Cross: Is there a way to quantify these investments – what is the percentage of revenue?

Bill Walker, Contra Costa County Health Services: These incentives are a significant part of the hospital and clinic budget that totals \$500M annually. It also spills over into the health plan revenue. It has impact all over the department.

Christina Ghaly, Los Angeles County Department of Health Services: The allocation of the DSRIP revenue varies between hospitals. Total incentive dollars in LA is about \$220M.

Molly Brassil, County Behavioral Health Directors Association of California: I was struck by the significance of the investment made to build infrastructure. Can you talk about the challenge of the up-front investment to reach the milestones to get the incentives?

Erica Murray, California Association of Public Hospitals and Health Systems: The achievement of the milestones requires culture change of the system, away from safety net mentality and into a mentality that is more patient-centered.

Christina Ghaly, Los Angeles County Department of Health Services: The financial investment varied greatly by project. In some cases it has been enormous. Staff time and coordination was a significant investment. For DSRIP 2.0, the projects should focus on relevant issues for the overall transformation of the system. If we don't align the projects with the overall transformation of the system, we risk these being a distraction.

Bill Walker, Contra Costa County Health Services: These investments have come at a critical time when we were making other investments in our systems – it allowed leveraging of our own investments.

Sarah DeGuia, California Pan-Ethnic Health Network: I know that a large percentage of patients you serve in the public health system are non-English speaking. I read that you can develop language assistance services through the DSRIP. Has that been done and will it be a part of the next DSRIP?

Erica Murray, California Association of Public Hospitals and Health Systems: I know that many sites did include interpretation in their projects. For example, they are using video-interpretation web system so that there is a real time interpreter available. Many systems used the DSRIP to join this Health Care Interpreter Network system.

Lisa Tran, Harbage Consulting: How do you fund these projects when you don't get the money until you reach milestones? In some states there is planning money available that can drive the investment in the early infrastructure needs. It is critical to structure projects so that they can get progress milestones payments up front.

Erica Murray, California Association of Public Hospitals and Health Systems: Back in 2010, the Waiver was agreed to in November 2010, but no details were worked out for another 6 months. CMS was still connecting hospital finance experts and quality improvement experts to understand what they wanted. The DSRIP was approved in April of 2011 when almost the entire planning year was over. It is really important to think ahead so we do not repeat this for DSRIP 2.0.

Catherine Douglas, Private Essential Access Community Hospitals: When the designated systems were working on these projects, did your systems and hospitals collaborate with the local Medi-Cal plans to dovetail efforts?

Erica Murray, California Association of Public Hospitals and Health Systems: Most of that coordination happens at a local level. When we were developing the metric for the projects, we relied very heavily on measures used by MCO's like HEDIS.

Christina Ghaly, Los Angeles County Department of Health Services: There was close collaboration at the county level.

DSRIP-like Ideas Included in Other States' 1115 waivers

Presentation Slides are available at:

http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Renewal_Workgroup_DSRIP.aspx

Peter Harbage and Lisa Tran reviewed DSRIP programs in other states, including shared traits across all approved DSRIPs, small vs. large DSRIPs and trends within DSRIP over time. Some key points include:

- A lot of programs focused on building integrated delivery systems, improving efficiency and connecting major service providers.
- Development and selection of projects need to be transparent.

- In California, collaborative could mean internal to the hospitals. In other states, this is more about linking with downstream providers.
- DSRIP is new work for better outcomes – not necessarily more money and now means “earning” the money through improvements.
- DSRIP sets incentives to meet milestones; milestones become progressively focused on process to outcomes. In NY, increasingly they are looking at population health goals (outcomes for whole population).
- Mostly, CMS has approved hospital-only waivers but there are some exceptions in TX and NJ that include other health care providers. NY includes social service providers. CA is the only state that is public hospital only.
- CMS may now be much more focused on standardized measures.

Questions/Comments from Members:

Catherine Douglas, Private Essential Access Community Hospitals: In TX and NY, their approach is much more regional. Rather than just focusing on transforming certain delivery systems, there seems to be as large a focus on making sure the safety net providers within a whole region are meeting whole-person needs. Is that correct?

Peter Harbage, Harbage Consulting: There are definitely different kinds of DSRIP programs. California is more hospital specific. In some smaller states, that model is being duplicated. In the larger states, you have implicit or explicit trends towards the regional approach you mention.

Barsam Kasravi, Anthem Blue Cross: Integrating with other providers resonates with Anthem. For the pilots that funded collaboration, where did the money go? How did they share the funds across partners?

Lisa Tran, Harbage Consulting: In TX and NY, they establish a lead agency and they are responsible for distributing the funds across partners. They have to establish a fund distribution methodology.

Jon Freedman, LA Care: What is the share of the funding in the NY DSRIP? What percentage of budgets are we talking about?

Peter Harbage, Harbage Consulting: The margins are so thin at a lot of these hospitals, even though the percentage isn't that large it still makes a big difference. I do think there is a competitive aspect to this. The fact that sites are competing against each other motivates them to achieve.

Jon Freedman, LA Care: We are now 20+ years into managed care in CA, what is the intersection between a DSRIP and what is going on with the rest of the healthcare dollars in managed care? Risk sharing, consumer satisfaction, lowering cost? Where is the intersection in the California environment?

Peter Harbage, Harbage Consulting: I don't see a whole lot of intersection between these things in California. Managed care will continue and DSRIP is about quality.

Sarah Brooks, DHCS: I do see that there is a lot of overlap between DSRIP and the managed care world. The desired outcomes are certainly aligned and there is opportunity to bring the two discussions closer together. We have a working group to discuss plan-provider incentives tied to the waiver and there are additional opportunities for overlap.

Neal Kohatsu, DHCS: As Peter said, population health is a hot topic at CMS and this will require partners.

Manel Kappagoda, ChangeLab Solutions? Coming from a public health position, I would love to get a bit more detail on what is happening in NYC at a population health level. How do they think they will influence the systems in NYC to improve population health? Is there money available for housing?

Lisa Tran, Harbage Consulting: Yes, some incentives are available. Many providers in NYC are using the DSRIP to try to fund additional housing and include social service providers. There are many examples to share.

Christina Ghaly, Los Angeles County Department of Health Services: There are lessons from NY, however, given the differences related to managed care and we need to be careful about what is applicable to California.

Anne McLeod, California Hospital Association: The public hospitals have really blazed the way and we want to ensure they maintain the level of funding to continue. What about the other 1/3 of patients that are being served in private hospital systems? How can we broaden the work to support this population?

Jon Freedman, LA Care: Waivers require alignment of many things. It is one thing to identify the federal funds, but it is a totally different thing to come up with the non-federal fund. In California, there is no interest in dipping into the general fund. This becomes a critical point of alignment to think through, but it may pit systems against one another. Federal administrations have wanted to close down the creative mechanisms for financing. How do we finance the public hospitals – this is a huge issue here in California.

Lisa Tran, Harbage Consulting: The NY DSRIP is designed to introduce creative ways to finance public hospitals.

Christina Ghaly, Los Angeles County Department of Health Services: Many more pressures are being put on public hospitals to make this work. We have to identify the overall goals and the ways to get more money into the system.

Lisa Tran, Harbage Consulting: There are many mechanisms for securing IGT's. In TX, for example, providers were left to their own devices for securing their IGT's. I think the lesson we're learning in TX is that understanding the mechanism early on is important.

Catherine Douglas, Private Essential Access Community Hospitals: So much of this is IGT driven. IGT's have been used across providers – we should explore that. Yesterday was the provider incentive workgroup. We talked about shared savings as a potential

funding mechanism. Can DSRIP be used to reach a broader swath of the Medi-Cal population?

Tricia McGinnis, Center for Health Care Strategies: How the four priority areas within SIM will work into the planning on DSRIP program. The synergy of the programming will be important for the state, stakeholders and the federal government. Alignment with the MCOs, the plan provider incentives, and the housing issues are all important to mesh together. Figuring out the priority populations is also key to the success of the DSRIP. With a population approach, figuring out the incentives will be important, especially as we move to more of an outcomes focus. Greater alignment with population health – how it fits into care transformation work.

Barsam Kasravi, Anthem Blue Cross: ACO's are a means of encouraging hospitals to better coordinate and integrate together. This could be a potential model.

Al Senella, Tarzana Treatment Centers: I have an interest on the behavioral health side with mental health and substance use. What role should it play in this renewal? It is a significant discussion in the current waiver and should be a significant issue for the next DSRIP. The cost of these patients is high. How can we envision how behavioral health could be integrated or supported in this next iteration?

David Lown, Safety Net Institute: We have a number of our systems that are engaged in behavioral health integration projects through DSRIP. This is a part of the current 7 health systems in SNI. It is certainly part of building the integration of the entire health system. How do we link in and integrate these services, especially with high utilizers?

Al Senella, Tarzana Treatment Centers: I am aware of the integration attempts, but not aware of any incentives for mental health or substance use care.

Molly Brassil, County Behavioral Health Directors Association of California: CBHCA is happy to be included in this work group, as we have been thinking about how BH fits in the DSRIP dialogue. Through the recent implementation of Cal MediConnect, we've been thinking a lot about how do you incentivize the shared accountability and coordination between systems? We have unacceptable disparities in life expectancy for SMI populations. What types of measures should be in place? Perhaps there is something we've learned from Cal MediConnect that would be applicable to the DSRIP.

Lisa Harbage, Harbage Consulting: We do see direct incentives for BH built into other state waivers.

Don Kingdon, Harbage Consulting: The current waiver is a good first step as well.

Christina Ghaly, Los Angeles County Department of Health Services: LA County participated in including BH and MH issues in DSRIP, but there is much further to go. How do we make sure there is significant participation in BH/MH in the discussion?

Erica Murray, California Association of Public Hospitals and Health Systems: Let's make sure that we keep this issue in the context of everything that is happening right now – Cal SIM, DSRIP, whole person care initiatives.

Bill Walker, Contra Costa County Health Services: The larger issue is mental health managed care. What does that mean and how to we integrate this into the discussion?

Molly Brassil, County Behavioral Health Directors Association of California: Can there be more than one DSRIP program in a waiver?

Peter Harbage, Harbage Consulting: Theoretically, yes. Just need approval from CMS.

Ken Kizer, UC Davis: Reminds me that we had these discussions 30 years ago. And while we have made some progress, there is much to be done. I have three comments:

- High utilizers – it will be clear that there is little hope of doing much for the high utilizers unless we address the mental health and behavioral health issues. We have to do a better job of addressing social determinants of health. If we don't aggressively address these things in the waiver, we will be failing our populations most in need. We need great flexibility in order to be successful.
- CMS will have an expectation that more demonstrable progress be achieved for the next DIRIP. The requirements are getting progressively more complex. As we design and think about how the waiver will be set up, it must reflect those increased requirements.
- Integration of BH/MH into primary care is insufficient. We need to create capacity that doesn't exist in the specialty care systems.

Manel Kappagoda, ChangeLab Solutions: What do you mean by social determinants of health and population health? How do we do this in DSRIP?

Ken Kizer, UC Davis: Transportation, food security, environmental justice, education, housing, etc are all included in social determinants of health.

Bill Walker, Contra Costa County Health Services: You cannot ignore behavioral health issues. Health homes or care management system for high utilizers. Do we have enough providers? MHSA should fund things other than boutique programs for impact. We should no longer have two managed care programs (mental and physical).

Jon Freedman, LA Care: DSRIP has to play a role in aligning care across the continuum. New populations are enrolled in Medi-Cal now with a different set of problems.

Michelle Cabrera, SEIU: How and what we are tracking, measuring, counting and incentivizing drives how we create or increase disparities. We need to understand where disparities exist and push plans to respond.

Catherine Douglas, Private Essential Access Community Hospitals: The solution in LA will be a great solution for LA, but not for Kern. I think community needs assessments are essential to figuring out what should be included in the DSRIP.

Wendy Soe, DHCS: CMS does not want a wish list. Come with ideas that demonstrates what the state needs and why. How can the 1115 be a vehicle to get you where you want to be? What do the data show?

Barsam Kasravi, Anthem Blue Cross: The State quality strategy is a good vehicle.

Sherreta Lane, District Hospital Leadership Forum: District Hospitals were going to participate in the last DSRIP – they didn't participate, but want to participate in the next iteration. Pleased to be part of this workgroup and are pleased to move forward on working together. We agree with the focus on BH. District hospitals vary in size and we may need to tier the approach. As we are talking about a regional approach, are there any details about what we are looking at? Dollars? Incentives?

Wendy Soe, DHCS: January 30th will be a better date for us to answer the question.

Ken Kizer, UC Davis: We need to identify ways to incentivize new technologies such as telemedicine as well as work force issues related to community health workers.

Judi Hillman, Health Access: One telltale difference between DSRIP 1.0 and 2.0 is that there are many more covered patients. What difference does this make? What are we doing as a part of the DSRIP to make sure that folks are making prudent use of their new coverage? There are also many, many remaining uninsured – what does that mean?

Sarah DeGuia, California Pan-Ethnic Health Network: Echo the need to standardize race, ethnicity data collection and target the most needy communities. Also, use team integration and Community Health Workers? Patient experience and patient engagement? Are people getting what they need and are they satisfied with them? How do we gauge this? Can we better understand what impacts their health – how do we assess this and address access to healthy foods, parks and upstream issues?

Michelle Cabrera, SEIU: We are a majority person of color state, we have a huge number of uninsured. Within Medi-Cal, how do we figure out how to tailor to California? How do we reduce cost? High utilizers of course, but we need to do better, not just sustain.

Public Comment

No Public Comment

Potential topics for future meetings:

Bobbie Wunsch, Pacific Health Consulting Group

- Behavioral Health and Mental Health discussion
- Financing the new DSRIP – what are the sources of non-federal match?

- How do we manage the budget neutrality issue?

Neal Kohatsu, DHCS

- Timeline is very short to get the application in. It would be helpful to share white papers, write own ideas, more quantitative we can get, the better.
- Data management and analytics are critical. CAPH/SNI has brought expertise and this has been great. We need more work in this area. I am concerned that systems are moving away from LEAN practices. More intensity in the areas of data collection and reports. We need to narrow our list of desired outcomes.

Peter Harbage, Harbage Consulting

- There have been some issues raised that are not a part of the Department's plan and it makes sense to talk about those and take them off of the table. What should the project be and what is the menu of items that you want to tackle?

Tricia McGinnis, Center for Health Care Strategies

- Hear more from the Department on what they have in their paper. What do they really want to pursue?

Judi Hillman, Health Access

- Are there common issues across workgroups that we can share at each meeting?

Bill Walker, Contra Costa County Health Services

- As the last waiver was the bridge to reform, what is this next one?
- How can we involve the health plans in a more substantive way?

Bill Henning, Inland Empire Health Plan

- What are more details about what DHCS wants to accomplish and what the goals are?

Workforce Expert Stakeholder Meeting Dates:

- Meeting #2 – December 19, 2014
- Meeting #3 – January 13, 2015
- Meeting #4 – January 26, 2015
- Meeting #5 – February 3, 2015 (if needed)