DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
May 17, 2018
10 a.m. – 3 p.m.

MEETING SUMMARY

Attendance

Members Attending: Maya Altman, Health Plan of San Mateo; Kirsten Barlow, County Behavioral Health Directors Association of California; Michelle Cabrera, SEIU; Michelle Gibbons, County Health Executives Association of CA; Brad Gilbert, MD, Inland Empire Health Plan; Kristen Golden Testa, The Children's Partnership/100% Campaign; Michael Humphrey, Sonoma County IHSS Public Authority; Sherreta Lane, District Hospital Leadership Forum; Kim Lewis, National Health Law Program; Marty Lynch, LifeLong Medical Care and California Primary Care Association; Steve Melody, Anthem Blue Cross; Erica Murray, CA Association of Public Hospitals and Health Systems; Linda Nguy, Western Center on Law and Poverty; Gary Passmore, CA Congress of Seniors; Chris Perrone, California HealthCare Foundation; Jessica Rubenstein, CA Medical Association; Cathy Senderling, County Welfare Directors Association; Bill Walker, MD, Contra Costa Health Services; Stephanie Welch, Department of Corrections and Rehabilitation.

Members Attending by Phone: Anne Donnelly, Project Inform; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers.

Members Not Attending: Bill Barcellona, America's Physician Groups; Richard Chinnock, MD, Children's Specialty Care Coalition; Paul Curtis, CA Council of Community Behavioral Health Agencies; Lisa Davies, Chapa-De Indian Health Program; Carrie Gordon, CA Dental Association; Anna Leach-Proffer, Disability Rights CA; Anne McLeod, California Hospital Association; Farrah McDaid Ting, California State Association of Counties; Brenda Premo, Harris Family Center for Disability & Health Policy; Jonathan Sherin, LA Department of Mental Health.

DHCS Attending: Jennifer Kent, Sarah Brooks, Adam Weintraub, Anastasia Dodson, Sarah Eberhardt-Rios, Carolyn Brookins, Tanya Homman,

Public in Attendance: 18 members of the public attended in person.

Welcome and Introductions
Jennifer Kent, DHCS Director

Director Kent welcomed the group and opened with a remembrance on the loss of two important contributors to stakeholder advisory groups. Herrmann Spetzler, CEO, Open Door Community Health Centers and SAC Member passed away suddenly. He had been an active participant in the SAC since its inception. Also, Nick Anas, MD, Vice-President and Physician-In-Charge, Children's Hospital Orange County, Former Chair, Children's Specialty Care Coalition and California Children's Services (CCS) Advisory Group Member passed away. Both will be greatly missed. California Health Care Foundation (CHCF) created a tribute to Herrmann Spetzler that can be viewed at the following link.

Director Kent thanked The California Endowment and CHCF for their continuing support of SAC meetings, and Anthem Blue Cross for sponsoring lunch at today's meeting.

Follow-Up Issues from Previous Meeting and Updates
Adam Weintraub, DHCS

Follow up issues were distributed with the agenda. There were no additional questions or comments.

2018-19 May Revision - State Budget
Jennifer Kent, DHCS

Director Kent reported on the May Revision for the 2018-19 state budget and highlighted a few items from DHCS. The Medi-Cal caseload projections are down overall due to the economy being better and employment being higher. Fluctuations include a drop in the family/child enrollment category, an increase in seniors' enrollment and steady enrollment in the Persons with Disabilities category. Overall, Medi-Cal enrollment is projected to be slightly lower at 13.3 million beneficiaries for the Fiscal Year (FY) 2019-20 budget year.

Other items of note include:

- $50 million allocation to counties for seriously mentally ill and homeless/at risk homeless population as bridge funding to No Place Like Home funding.
- $254 million to pay counties for historical mandate claims related to seriously emotional disturbed children (AB 3632).
- Proposition 56 physician supplemental payments were lower than expected and there is a high-level proposal to the Legislature. DHCS proposes to move $190 million to the Office of Statewide Health Planning & Development (OSHPD) for loan repayment for physicians, specifically targeting loan repayment for physician commitment to ongoing, higher level of Medi-Cal participation as well as some specific geographic areas. DHCS is working to come up with projections of costs for dental supplemental payments under Prop. 56 and will propose a similar concept targeting ways to increase provider participation. Prop. 56 Women's Health payments and other Prop. 56 payments are not proposed to

change.

- A 50% rate increase for Home Health services through the fee-for-service system and the home and community-based services (HCBS) waivers.
- $898 million in General Fund savings over the next two years from the Children's Health Insurance Program (CHIP) reauthorization in Congress that occurred after the January budget announcement.
- The proposal to eliminate the use of 340B pharmacy reimbursements for Medi-Cal beneficiaries remains the same from January.
- The Drug Medi-Cal Organized Delivery System (DMC-ODS) includes lower fiscal projections based on implementation delays in counties.
- $620 million in federal disputed claims in the budget. The policy changed, and the federal government now requires that the state repay the disputed claim while the dispute is settled. There are also $180 million in disallowed claims due to an Office of the Inspector General audit.
- A policy change to offer Hepatitis C treatment according to national clinical standards.
- $10 million for a program with Department of Corrections and Rehabilitation. There is a small population (1,100 individuals) in reentry facilities with less than one year to serve. They are receiving job training and drug treatment and are not eligible for Medi-Cal. DHCS is seeking approval to enroll them in Medi-Cal Managed Care (MMC) but will pay the plans with state-only funding.
- Establish directed payments to cost-based reimbursement clinics not eligible for the Rural Health Clinics/ Federally Qualified Health Centers wrap.

Questions and Comments

Brad Gilbert, MD, Inland Empire Health Plan: On the loan repayment, we've had success in the Inland Empire and brought in 270 providers through a targeted approach. I am interested to hear more on the targeting, the area you are targeting and the Medi-Cal participation rate. What are the criteria? We want to be helpful from our experience.

Jennifer Kent, DHCS: We are talking to OSHPD since we don't run loan repayment programs, but we have a clear idea of what we want to accomplish that goes beyond just providing loan repayment to practice in California. We want this to be applicable to both Primary Care and Specialty Care. The methodology might be that they need to demonstrate annually that they have contracts with Medi-Cal managed care and Medi-Cal patients, without being too burdensome. Depending on the average loan amount, (most have $250K in loans), the funding would cover about 600-700 physicians.

Steve Melody, Anthem Blue Cross: The new network adequacy rates would help indicate where there are insufficient physicians.

Michelle Cabrera, SEIU: What were the challenges getting supplemental payments out to physicians?

Jennifer Kent, DHCS: There are operational issues with a 40-year-old claims system we have to program and it is not as nimble as we would like and we had to get federal approval. We are proposing another $500 million supplemental for already-qualifying claim codes (excluding psychiatry that is already done) to come up to 85% of Medicare. Also, ten preventive codes will have new supplemental payments (such as well-child) to bring them to 100% Medicare. The total is $1.2 – 1.3 billion for supplemental payments in FY18-19.

Steve Melody, Anthem Blue Cross: When would this be final?

Jennifer Kent, DHCS: We need budget approval and a state plan amendment (SPA) to be approved by federal government. We believe that using the same method that CMS has already approved will speed approvals up.

Michelle Cabrera, SEIU: Are you tracking the impact this is having?

Jennifer Kent, DHCS: The only way to track impact is through utilization because that gives us information on actual care. We chose standard exam visit codes used across physician types. There is not any evaluation given this is a one-year supplemental payment program.

Chris Perrone, CHCF: Is loan repayment matched by federal payments? Does it require approval?

Jennifer Kent, DHCS: No. We previously tried to have a federal loan repayment program through the waiver for the Steven M. Thompson Physician Corps Loan Repayment Program and they were never approved. There was guidance several months ago indicating it would not be approved.

Anthony Wright, Health Access California: Is there preliminary utilization data?

Jennifer Kent, DHCS: There is internal data that show it is lower than we projected in the budget, but it is not lower overall. We can't see the impact at this point; it will be next year before we can tell if the program is working. We think we have the targets adjusted to impact physicians. The psychiatric codes were low, and we will work to raise awareness with providers to ensure they are aware of the payments.

Anthony Wright, Health Access California: Is the philosophy to stay broad or target?

Jennifer Kent, DHCS: We are using both philosophies. There are targeted funds, such as the psychiatric codes and home health increases. On the other side, we are choosing simple approaches because if we make it too complex, the money may be difficult to distribute.

Brad Gilbert, MD, Inland Empire Health Plan: The struggle with this has been timing. We told providers about supplemental payments, but they didn't see any money until

February 2018. It will take some time to see the impact. Another reality check is that we already pay 100% Medicare rates for psychiatrists and they don't even take that. There is a serious shortage. I do think eventually we will see an uptick with this program.

Kim Lewis, National Health Law Program: Does this cover Specialty Mental Health?

Jennifer Kent, DHCS: No.

Anthony Wright, Health Access California: On the lower overall Medi-Cal caseload, beyond the economy, do you think the federal climate on immigration enforcement is impacting willingness to sign up?

Jennifer Kent, DHCS: We don't see impact in the SB75 enrollment population. On emergency room coverage, I don't have information on enrollment, but we are able to capture that data for claiming. Also, we are watching the Public Charge guidance being discussed for future impact.

Michelle Cabrera, SEIU: Can you elaborate on the county allocation bridge funding mentioned in the budget?

Jennifer Kent, DHCS: We can provide the budget bill language. This money cannot supplant Medi-Cal Specialty Mental Health funding. We want to be flexible and are trying to target items not otherwise paid for by Medi-Cal. For example, this could be used for a flexible housing pool in Whole Person Care or in other counties, it can be used for housing vouchers or mobile outreach teams. Counties are thinking about the link between public safety and behavioral health services. Each county may have a different need, so it is meant to offer support through a short-term bridge, for what is not otherwise covered by Medi-Cal. The $50 million is not a lot across the state.

Michelle Cabrera, SEIU: The idea of doing more in the realm of housing is important and I hope there will be a review of the impact for policy implications going forward.

Anne Donnelly, Project Inform: We want to thank the Governor and you, Jennifer, for removing restrictions on Hepatitis C treatment. Is the reentry program with Department of Corrections one time or ongoing?

Jennifer Kent, DHCS: The program is ongoing for Department of Corrections, but it is unclear if DHCS will continue to operate this on an ongoing basis.

Managed Care Final Rule Implementation: Update on Key Components and Quality Strategy Report (QSR)
Sarah Brooks, and Anastasia Dodson, DHCS
Presentation slides: http://www.dhcs.ca.gov/services/Documents/QSR_Presentation.pdf

Sarah Brooks offered a brief follow up to previous updates on network certification and the report on network adequacy posted on the DHCS website. There are four areas of impact for DHCS in the Managed Care Final Rule: Medi-Cal managed care health plans (MCPs), County Mental Health Plans (MHPs), Drug Medi-Cal Organized Delivery Systems (DMC-ODS) and Dental Managed Care plans (DMC). The report on network certification for all four areas will be submitted to the Centers for Medicare & Medicaid Services (CMS) by July 1. Network certification documents and any corrective action plans (CAPs) will be posted on the website following submission.

Questions and Comments
Kim Lewis, National Health Law Program: You have been collecting health plan proposals since March. Are there issues? What is the plan to correct any issues? Will CAPs be posted? Is this the same for mental health?

Sarah Brooks, DHCS: If a plan is not in compliance, we work on a corrective action plan requiring them to come into compliance. Separately, beneficiaries are allowed to go out of network when plans are not in compliance.

Kim Lewis, National Health Law Program: Do beneficiaries know about the option to go out of network?

Jennifer Kent, DHCS: County Mental Health Plans are held to same standards as MMC plans. If there is no contract, the plan, including the County Mental Health Plan, is still responsible for beneficiary services, but they would be paying a provider for services out of network. It would be the county's responsibility to find another provider out of network as well as pay them.

Linda Nguy, Western Center on Law and Poverty: Can you give us an idea of how plans are doing with compliance?

Sarah Brooks, DHCS: We have had back and forth with the plans since they were due March 19 and the majority of plans are in compliance.

Anthony Wright, Health Access California: How many alternative access standards requests do you have and what are criteria for granting alternative access standards requests? Is it public?

Sarah Brooks, DHCS: I will follow up to get the number of requests; there were some that were previously approved. We have a process in place to look at alternative access standards by using a number of data bases to identify whether there are other providers available. We require plans to provide information on why they are not using available providers; it is not a check-the-box process. We have a check list we utilize and that can be made available.

Jennifer Kent, DHCS: There are some alternative access requests on the County Mental Health side also. It is the same criteria: Are there providers? If no providers, we allow

alternative access standards; if there are providers, were there good faith negotiations? In some geographies, there are not providers. We want to use telemedicine opportunities to help with this, especially psychiatry.

Chris Perrone, CHCF: How do you see telehealth fitting into network adequacy? Is it explicit? Do plans use it?

Sarah Brooks, DHCS: It is allowable, and we do see plans using it in their alternative access standard requests.

Kim Lewis, National Health Law Program: For specialty mental health for children, when providers are traveling long distances to serve children in the HCBS system, does this have to meet timely access and distance standards? How is it included in the geo-mapping? There was some confusion around this.

Sarah Brooks, DHCS: If the provider travels, there is no requirement for a standard to be in place. The standard only applies when a beneficiary travels.

Jennifer Kent, DHCS: The availability of those providers is taken into account and they still have to meet timely access standards.

Kirsten Barlow, County Behavioral Health Directors Association of California: It is helpful clarification to hear that it is the consumer travel, not the provider travel that must meet the standard. We are not anticipating problems, but unique to Mental Health Plans is the rehab SPA that allows billable time in the community as opposed to a consumer coming to a site to receive care, so it remains to be seen how that plays out in demonstrating network adequacy.

Anastasia Dodson reported on Medi-Cal Managed Care QSR that was posted for public comment. The managed care final rule requires each state Medicaid agency to implement a written quality strategy to assess and improve the quality of health care and services furnished by all Medicaid managed care entities. It impacts all organized delivery systems, including MCPs, County MHPs, DMC-ODS and DMC plans. DHCS received 11 comment letters related to the report and we are reviewing to see how we can incorporate them before submission to CMS in July.

Ms. Dodson reviewed the three different quality reports for delivery systems that have been required over time and are publicly available: 1) DHCS Strategy for Quality Improvement in Health Care report is broader than the new, required report. It has been done for many years and will continue; 2) Medi-Cal Managed Care QSR in previous years has been limited to MCPs, and links to many other back-up documents and is referenced in the new report; 3) Medi-Cal Managed Care QSR is the new report required by CMS. Going forward, the second report will be integrated into the new report and that will be ongoing. The new report will have a consistent approach across all managed care systems. The federal Requirements for the QSR include:

- Network adequacy standards
- Goals and objectives for continuous quality improvement, a description of the quality metrics, performance targets, and performance improvement projects
- Arrangements for annual, external independent reviews, through contracts with External Quality Review Organizations (EQROs)
- Transition of care policy, known as Continuity of Care at DHCS
- Plan to identify, evaluate, and reduce health disparities
- Policies regarding sanctions for plan non-compliance
- Definition of ‘‘significant change“ for future reporting

For MCPs, there are seven focus areas for quality improvement, such as postpartum care, childhood immunization rates, diabetes care, control of hypertension, tobacco cessation, reducing health disparities and fostering healthy communities (which includes specific look at opioids). DHCS requires MCPs to develop and implement performance improvement projects (PIPs) to address the quality improvement focus areas.

For MHPs, there are two quality improvement focus areas -- penetration rate and time between inpatient discharge and step-down service. DHCS requires each MHP to complete two PIPs, one clinical and one non-clinical. There are a wide range of PIPs going on in counties, such as improving timely access to outpatient services (Sacramento) and vacancy adjustment and notification systems (Los Angeles). MHPs are required to focus on population need, gather stakeholder input and produce consumer focused outcomes using the Plan-Do-Study-Act model.

Questions and Comments

Kim Lewis, National Health Law Program: It could be helpful to have an appendix that lists the various reports and timelines that roll up into the QSR.

Anastasia Dodson, DHCS: Thank you.

Kristen Golden Testa, The Children’s Partnership/100% Campaign: How do you measure disparities?

Sarah Brooks, DHCS: It varies by plan. For example, all the External Accountability Set Measures are now broken out by demographic, so we can see disparities by each indicator. This will help a health plan focus their PIP on disparities.

Brad Gilbert, MD, Inland Empire Health Plan: What we aren’t seeing quite yet is the integration of measures across the systems – like the MCP and MHP. For example, could we look at measures of how members are moving across systems, going back and forth, how efficient it is, by looking across the systems?

Sarah Brooks, DHCS: Thank you for flagging that; it’s an excellent idea for us to look at.

Anastasia Dodson, DHCS: Internally, DHCS is starting to look at measures that cut across systems on foster care and tracking mental health to primary care.

Cathy Senderling, County Welfare Directors Association: What is the timeline for a PIP in a county?

Anastasia Dodson, DHCS: The timeline is driven by the EQRO and counties can choose to do the PIP across multiple years. On the MHP side, they need to have PIP results prepared for the EQRO review.

Kim Lewis, National Health Law Program: We are doing an intensive analysis on the MCP and MHP as well as looking at the issue of services under the carve-out. There are some places with high levels of coordination and integration and other places where it is not happening.

Michelle Cabrera, SEIU: Do the plans propose to DHCS what their projects are? Is DHCS considering suggesting to plans where they are deficient and what improvement goals they should work on for beneficiaries?

Sarah Brooks, DHCS: Yes, we do that now. The plans aren't allowed to just pick; it must be based on data where there is an area of concern. The focus areas mentioned are based on our review of data and where we see improvement is needed. For example, immunizations has been a difficult measure and there are 14 plans focusing on this to improve overall performance.

Michelle Cabrera, SEIU: That is helpful. The information is so high level that it is difficult to see what is happening and whether we are moving forward across the whole program.

Sarah Brooks, DHCS: We do publish HEDIS technical reports that are on the website, but they are dense and I agree there may be a way to report this out in a way that is easier.

Chris Perrone, California HealthCare Foundation: I have a proposal from a researcher who wants to study past PIPs and see if there are demonstrated improvements. Have you done that already? Can you share what you have done?

Sarah Brooks, DHCS: We have worked on the process with plans over the past five years. There used to be more flexibility for plans to pick a PIP and now it is data-driven and consistent across the plans. Our thinking has evolved over time.

Michelle Cabrera, SEIU: The option to have something in between this high level and the 1,000-page technical report would be welcome.

Kim Lewis, National Health Law Program: It seems there needs to be more consistency across the board in the PIPs. There is no way to compare across them to consistently see quality.

Anastasia Dodson, DHCS: We will post the stakeholder comments and can look back at that as we go forward.

Ms. Dodson reported on the DMC-ODS process. There is a less established methodology and data standard for this area. DHCS is developing quality measures for DMC-ODS through a two-part process to improve data collection: 1) Develop relevant data collection and reporting system; and, 2) Beneficiary initiation engagement in SUD treatment. There is an EQRO process underway that will help develop measures and quality areas. We will be looking at information quarterly to develop more standardization in this area. Pilot counties are developing PIPs that may be combined with MHP QI in some counties. Going forward, we will work toward a more standard approach for DMC-ODS similar to MCPs.

Questions and Comments

Brad Gilbert, MD, Inland Empire Health Plan: On ODS, I agree there is a gulf between this system and MCP. I would be interested in working to identify where there is relevant overlap and how to connect MCP and county ODS. This area is the most difficult.

Maya Altman, Health Plan of San Mateo: It seems we are working on quality in silos of MH, ODS and MCP. We need to encourage working across these areas and building bridges. Currently, working together is mostly ad hoc and anything that can facilitate that would be helpful.

Anne Donnelly, Project Inform: Do the groups that review the PIPs and quality reports include consumer advocates?

Anastasia Dodson, DHCS: Except for SAC, we don't have a single group across all the managed care delivery systems to review these reports. We got feedback on this report from advocates, and each delivery system has venues that include consumer advocate input. Part of the current work is to build data sources and systems that span across the systems. We hope to have a broader dialog once the basic measures function better.

Bill Walker, MD, Contra Costa Health Services: We recently put MCP, Behavioral Health and delivery systems on the Epic electronic medical record system and soon will have ODS as well. We know this will improve care and reduce duplication. Perhaps this is an opportunity to improve economy of scale on quality reporting as well. Can we work with you on this?

Anastasia Dodson, DHCS. We would like to hear more on your thinking and determine if that is a local effort or has broad implication.

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: Going back to MHPs, are there performance goals or targets for the focus areas?

Anastasia Dodson, DHCS: Yes, the penetration rate and time between inpatient discharge and step-down service. The MHPs are designing specific PIPs based on local stakeholder input.

Anastasia Dodson reported on DMC plans. There are three focus areas for quality in DMC plans: 1) Improve oral health of all beneficiaries; 2) Increase utilization of dental visits, particularly preventive dental services among children; and, 3) Reduce incidence of caries/tooth decay among all beneficiaries. DMC plans are required to have two QIPs per year, such as beneficiary and provider outreach efforts, and community education. DHCS is looking to collect and share information.

Ms. Dodson offered detailed information on the area in the report that focuses on reducing health disparities across the different systems. This will help identify PIPs across systems. Currently, the systems are in different places with this work. MCPs have begun to identify and address certain disparities and complete a PIP on a plan-specific health disparity. The EQRO is completing a comprehensive health disparities analysis to more accurately identify health inequities. MHPs and Substance Use programs are required to implement a Culturally and Linguistically Appropriate Services (CLAS) Plan that includes objectives for reducing health disparities. DMC plans are leveraging data report and in some cases pilot programs within the Dental Transformation Initiative to identify and address racial and ethnic disparities in pediatric dental populations.

Ms. Dodson reviewed the stakeholder feedback that DHCS received on the QSR. There was general input to continue to develop quality improvement measures and implementation processes for DMC-ODS and MHPs. Also, there were suggestions to stratify populations in the quality goals and as discussed, develop inter-system care coordination and align and merge data collection and quality improvement across delivery systems. There was also input related to expanding efforts on evidence-based clinical guidelines and integrating efforts to address health disparities across systems. Some comments may be useful beyond the report. All the comments will be published. She mentioned the web site location for the report.

Questions and Comments

Kristen Golden Testa, The Children's Partnership/100% Campaign: When will the EQRO analysis be complete?

Sarah Brooks, DHCS: It is a separate report and I will follow up to let you know.

Brad Gilbert, MD, Inland Empire Health Plan: On evidence-based clinical guidelines, what is that stakeholder comment about? Is this about getting information out to our network or about measuring the extent they are using these guidelines?

Anastasia Dodson, DHCS: The input was about health plan guidelines for

preauthorization practices for a referral decision. It was about DHCS requirements and oversight of plans.

PAVE 3.0 – On-Line Provider Enrollment System
Tanya Homman, DHCS

Jennifer Kent introduced Tanya Homman and the DHCS effort to move away from paper-based Medi-Cal provider enrollment system to an online system – Provider Application and Validation for Enrollment (PAVE). There are 26 different provider application types and 70 provider types.

Tanya Homman reported that the paper system was very challenging for providers and resulted in 80% of enrollment applications needing to be returned for additional information. The PAVE system is intended to correct for this. So far, the rate of return for additional information through PAVE is cut to 30%. Ms. Homman offered a list of provider types that can use the system since 2016 as well as a list of provider types being added in Summer 2018. There are 180,000 enrolled providers; about 80% of managed care providers also are enrolled in the Fee-For-Service system; PED receives 2,400 applications per month and increasing.

There is a quality rating for the system and ratings are good at 4.36 out of possible 5.0 rating.
There is a 90 or 180-day clock, depending on the provider type, that starts with provider application. However, under the paper system, in some instances it can take up to two years to gain approval because of multiple back and forth communications and onsite visits.

48 percent of providers who can enroll through PAVE today are choosing to apply through PAVE. If no returns are required, applications can be processed within 40 days and even when additional follow up is needed, we are averaging 90 days to completion. We want to reduce this further when we are not managing both paper and new systems. She offered links to the PAVE website and tutorials. In addition, there are areas built into the application system to allow tracking of progress; what attachments are still needed for completion; how to get answers to questions; and providers can access video tutorials and information about how to successfully complete the application more efficiently.

Questions and Comments

Kim Lewis, National Health Law Program: Can you say more about the monthly monitoring?

Tanya Homman, DHCS: The ACA required monthly monitoring to look at exclusion databases. Providers who were excluded in another state or had a negative action can be searched across all states. We also work with the managed care division. They send a file of providers enrolled and we run against excluded provider databases. There is a very, very low incidence of any problems.

Chris Perrone, California HealthCare Foundation: Do managed care-only providers have to enroll through PAVE?

Sarah Brooks, DHCS: No, we sent an All Plan Letter (APL) about this to provide direction. We allow the MCP to choose how provider enrollment will happen – through the plan or through the Provider Enrollment Division. In some places, there is a moratorium, such as in LA for DME and pharmacy providers, and in that instance, enrollment must be through the plan.

Maya Altman, Health Plan of San Mateo: San Mateo Health Plan has always required providers to enroll through the state system. As a plan, can we check the system to track the application? Recently, we had an orthopedist group agree to take Medi-Cal, but the application is in limbo. Is there an ability to track what the problem is?

Tanya Homman, DHCS: Not today, you would have to send an email. We hope down road that MCPs will be able to create an account within PAVE and link their Plan providers to the account, so you can check on progress.

Sherreta Lane, District Hospital Leadership Forum: Hospitals are in the same boat and would like to check on emergency room or other providers.

Tanya Homman, DHCS: In the future the hope is that we will be able to connect the health plan and its contracted providers through PAVE. The federal government determines the application fee annually, with updates each January. The current cost is $569 but not all providers are required to pay a fee Individually Licensed physicians and licensed providers/ do not have a fee, including physician groups but others like DME's or pharmacies are required to pay the fee. Who it applies to is also set by federal law.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: Can you update us on ODS provider enrollment?

Tanya Homman, DHCS: We are not seeing any issues related to ODS provider enrollment. PAVE is looking good and testing started this week. Testing so far is resulting in minimal issues.

Jennifer Kent, DHCS: DHCS is always looking for providers to sign up for user testing.

Whole-Child Model in CCS
Sarah Brooks, Jacey Cooper and Sarah Eberhardt-Rios, DHCS
Presentation slides: http://www.dhcs.ca.gov/services/Documents/WCM_Phase1.pdf

Sarah Eberhardt-Rios offered background on CCS-eligible conditions, services and operation. Currently, Medi-Cal beneficiaries who are in CCS receive care in a bifurcated arrangement between MCP and FFS. There was legislation to integrate care through

MCPs under the WCM in 21 counties for full scope Medi-Cal children. The plan will manage all aspects of the care – both CCS benefits and Medi-Cal benefits – and this will improve care coordination, provide full CCS benefits and increase consumer protections. Counties will retain CCS eligibility and the MCP will coordinate care. There will be two phases. In July 2018, three plans/six counties will implement, and, in January 2019, two plans/15 counties will implement for a total of about 30,000 children. Other counties will remain under the current CCS model.

She reviewed the timeline and implementation approach over the past year, including Stakeholder Engagement, Workshops, Plan Readiness, County Readiness, and Member Notification. There are ongoing monthly calls with MCPs and counties and quarterly stakeholder meetings. There were a series of workshops over the past year on family engagement, complex care and the Medical Therapy Program specifics. DHCS conducted plan readiness, county readiness, beneficiary notifications and FAQs. Also, a webinar is being offered this week. A comprehensive transition plan is in place for how care will move from the county to the plans. Both an APL and CCS Letter were sent to the respective partner to offer guidance about implementation. Many of the documents were circulated for comment and we have incorporated many of the suggestions. Data sharing is supporting implementation, such as past claims notices and authorization requests. Going forward, MCPs are required to have family engagement advisory groups and DHCS will contract with Family Voices to provide family/beneficiary support and engagement.

Questions and Comments

Kim Lewis, National Health Law Program: How much overlap of the networks between the existing CCS network and the MCPs exists in the phase one and two counties? Will beneficiaries receive information about whether their CCS provider is in the network and how to request continuity of care?

Sarah Brooks, DHCS: Our analysis shows there is significant overlap but not 100% overlap of the networks. We will follow up with you on the actual levels of overlap. The beneficiary notices have included information on continuity of care options and member rights.

Bill Walker, MD, Contra Costa Health Services: Is there a Phase Three of all the remaining counties?

Sarah Eberhardt-Rios, DHCS: There is no Phase Three at the moment; nothing is planned.

Chris Perrone, California HealthCare Foundation: At one point, there was discussion of only certain CCS diagnoses being included. Is this all care for all beneficiaries?

Sarah Brooks, DHCS: Yes, it is all beneficiaries.

Chris Perrone, California HealthCare Foundation: It seems the risk of unexpected, outlier

high costs is high. Is there any protection for plans for unexpected high costs?

Sarah Brooks, DHCS: The rates are set based on experience. If there is a very high cost beneficiary, we will work with the plan on that. However, blood factor is carved out.

Maya Altman, Health Plan of San Mateo: We are pleased about this. We have been piloting for several years and are pleased to see this move ahead. We have an active CCS Advisory Group.

Michelle Gibbons, County Health Executives Association of CA: There are mini-models within WCM implementation with differing staffing models being used across the counties. Some plans are subcontracting with counties for CCS staff, like San Mateo. In other places, the plans are hiring staff and have no relationship with county staff.

Adam Weintraub, DHCS: There will be a webinar with more details and we are circulating the link to SAC members. It will be recorded and posted.

Dental Program Update including Adult Dental Restoration, Utilization Report and DTI
Carolyn Brookins, DHCS
Presentation slides:
http://www.dhcs.ca.gov/services/Documents/MDSD_DentalUpdate.pdf

Carolyn Brookins offered an update on the $740 million Dental Transformation Initiative (DTI) included in the waiver. She offered specifics on each of the four domains in the initiative:

- Domain 1 Goal: Increase statewide proportion of children ages 1-20 enrolled in Medi-Cal who receive a preventive dental service by 10 percentage points over a five-year period.

  In Year 1, there was an increase for preventive services of 4.6 percent and Year 2, a cumulative increase of 7.36 percent (partial data). The number of providers and clinics providing preventive services increased over the two years. The top procedures were fluoride varnish, topical fluoride, cleaning, sealants and space maintainers.

- Domain 2 Goal: Diagnose Early Childhood Caries (ECC) by utilizing Caries Risk Assessments (CRA) to treat it as a chronic disease for children age six and under. Eleven pilot counties are participating in a model to prevent oral disease in lieu of more invasive and costly restorative services. Providers are paid through a CRA bundle (CRA + Nutrition Counseling + Motivational Interview) and services must be provided on the same day. There are now 166 providers participating in the counties.

- Domain 3 Goal: Increase Continuity of Care for Children.

There are 17 counties participating. Utilization of preventive dental services increased 7.46 percent in Domain 3 counties, and 3.74 percent in non-Domain 3 counties as well, due to activity in Domain 1.

- Domain 4 Goal: Local Dental Pilot Program (LDPP) will address one or more of the three domains through alternative programs, potentially using strategies focused on rural areas including local case management initiatives and education partnerships.

  There are 14 pilot projects approved under Domain 4. There will be an evaluation in year three.

The DTI annual report:
http://www.dhcs.ca.gov/provgovpart/Pages/DTIAnnualReports.aspx

Ms. Brookins offered an update on adult dental utilization. There is a 76% increase in the number of treatment authorization requests (TARs) processed when comparing January – March of 2017 to the same period for 2018. Adult dental utilization shows modest increases; however, since providers have up to 12 months to submit claims, this is still preliminary.

She also reported on the change in dental intermediary contract. The previous fiscal intermediary contract has been split into two contracts: one is for a Dental Administrative Services Organization (ASO) and the other is the Dental Fiscal Intermediary contract. Other updates included:

- Proposition 56: There were 40% supplemental payments across specific categories of dental services in FY 17/18 for providers who bill the Dental FI or DMC plans.
- Streamlined provider enrollment applications for dental providers from four separate documents (40 pages) to one (15 pages); reduced the days required for new provider enrollment to 15 days; increased new provider applications from 42 to 69 – 27 providers.
- The Dental Fiscal Intermediary contract included a reduction in TAR turn-around time from 15 to 5 business days. Currently, the average turn-around is 1.4 – 3.5 days.
- Dental data is available at: http://www.dhcs.ca.gov/services/Pages/DentalReports.aspx.

Questions and Comments

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Do we have data on how many adults on Medi-Cal had a visit? Data specific to adults over age 65?

Carolyn Brookins, DHCS: Of all adults on Medi-Cal, 21% are receiving at least one annual visit. I don't have data on seniors, but I can follow up on that. The number of adults receiving services is increasing each month (January – March).

Susan McLearan, California Dental Hygienists' Association (public attendee): Are there metrics that would demonstrate the population is getting healthier – other than visits and services? If this is a pilot, will effective programs be sustained?

Carolyn Brookins, DHCS: There is no health improvement data. The DTI is funded under the waiver and is time-limited. We have exceeded federal benchmarks and have received additional funding added to the pool of money. We have the ability to expand successful domains within the waiver timeline through 2020.

Chris Perrone, California HealthCare Foundation: To confirm the turnaround on TARs, you reported on the new average days, what was the actual turn-around before the contract change? How did the change happen?

Carolyn Brookins, DHCS: The actual turn-around was 19-40 days. The changes were accomplished through administrative simplifications, auto-adjudication for some services and increasing the number of staff processing TARs.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: The DTI in the waiver has been impressive for kids, are there other initiatives outside the waiver to improve utilization and services for adults?

Carolyn Brookins, DHCS: The restoration of adult dental benefits began recently. We will have data later this year on progress and trends based on those expanded benefits and services.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: If we get to a new waiver, we might consider adults in a new waiver.

Kim Lewis, National Health Law Program: Was the increase in preventive services to children related to increased numbers of providers taking Medi-Cal?

Carolyn Brookins, DHCS: There was a slight increase in provider numbers, but the emphasis was to increase the caseload number of children in existing provider practices to reduce wait time and get preventive services before there was a need for restorative services. The incentive payment was based on opening up more visits for Medi-Cal patients.

Kim Lewis, National Health Law Program: Were there certain areas of the state? Do you know where this happened?

Carolyn Brookins, DHCS: We are looking at that now.

AB 340 (Arambula) Workgroup on Trauma Screening
SAC Members Kim Lewis, National Health Law Program with County Health Executives Association of California, County Welfare Directors Association of California and County Behavioral Health Directors Association of California

Kim Lewis provided background on AB340. It was legislation sponsored by Californians for Safety and Justice to address earlier identification of children with Adverse Childhood Experiences (ACEs) and trauma and offer earlier services. There is an EPSDT mandate as a broad entitlement under federal law to identify and treat children for all types of needs. Theoretically, EPSDT should cover trauma identification, however, it has not been a focus. There is a low penetration rate of developmental screens in California and many states. The provider pool is broad – schools, clinics, providers -- and it is not a requirement to be a Medi-Cal provider to offer EPSDT screening.

The new law required DHCS and DSS to put together an advisory work group. It met for the first time April 20 to look at existing tools for trauma screening, how are they being used and in what settings. The group will adopt or develop a tool to be used for identification and, if possible, to be used consistently across systems. This could be used in child welfare and other systems where there is a high incidence of trauma. The bill requires recommendations to DHCS and to the legislative health budget subcommittee. Where there is a need for additional resources, a legislative process would be required to implement the recommendations.

The workgroup includes varied disciplines. The recommendations are due in May 2019. Following that, an ongoing or existing workgroup will periodically review the tools adopted. The bill had a trauma definition for the work group. This is an opportunity to fine-tune a screening tool to be used by various staff and increase the likelihood of screening and identification.

Cathy Senderling, County Welfare Directors Association reported that CWDA is very pleased about this bill – for children in CWS but also on behalf of children living in poverty. We have embraced this issue and want to offer support for our members. The work group is quite varied and high caliber. CWDA participates in a subgroup that will set agendas, review tools, such as existing tools for Mental Health or in health plans.

Michelle Gibbons, County Health Executives Association of CA reported that the public health world is part of this because we know that ACEs are correlated with chronic disease. We were heartened to hear a public health and prevention approach because trauma impacts multiple sectors. We are looking forward to addressing trauma.

Kirsten Barlow, County Behavioral Health Directors Association of California, also reported it was a good conversation. We were pleased to see the group include academics. An important issue is that while screening is critical, we are also concerned about what follows that identification. It is not always clinical interventions that are required. The initiatives might be a variety of approaches in schools and environments beyond the clinical setting.

Questions and Comments

Jennifer Kent, DHCS: On reflecting on the meeting, we highlighted comments from the

Shasta County Public Health Director, who reported local high ACE rates. She noted the cyclical nature of abuse and that we need to think about the adult population as well.

Brad Gilbert, MD, Inland Empire Health Plan: There are needs for screening, deeper assessments and interventions. We need validated tools like PHQ 2 and 9 – the established tools for depression. The tools considered here should be validated to be used across disciplines and we need to consider the follow up. For me, the stunning findings on adult chronic diseases make this a compelling topic.

Kim Lewis, National Health Law Program: Screening is the first step to lead to additional needs assessment and treatment.

Kirsten Barlow, County Behavioral Health Directors Association of California: The academics also emphasized the importance of developmental appropriateness because the ACE will change over the life span.

Jennifer Kent, DHCS: There are ongoing ACEs and single events that can be traumatic and cause later impact. It is important for practitioners and other providers.to understand all of the potential ACEs and trauma. The next meeting of the advisory group is June 21.

Public Comment

Hellan Dowden, Teachers for Healthy Kids: In your report you mentioned a budget item for deferred audit findings. Are you appealing those?

Jennifer Kent, DHCS: Yes, that was a total amount for disputed claims. We are working through the dispute and/or the appeals.

Dharia McGrew, California Dental Association: Thank you for the dental report and early information on adult dental utilization. The reduction in the TAR processing time is significant and we appreciate the effort. We suspect the TAR increase represents pent up demand although the data doesn't yet show utilization based on this. We remain concerned that TARs are a barrier to care and urge DHCS to look at ways to reduce TARs. Providers are reporting lower rates of adults actually receiving their treatment services. We understand the need for program integrity and ability to track problems but want to balance the need for TARs because they limit access.

Kim Flores, Senate Office of Research: Has DHCS looked at a timeline for opening discussion on the next waiver?

Jennifer Kent, DHCS: There is internal thinking on next steps for the waiver. We do know that DTI will no longer be allowed based on CMS guidance. There are several elements of the waiver we are proud of and would be interested in continuing in some format – WPC, GPP and the DMC-ODS. Also, our entire managed care program is in the waiver so there will be something as an outgrowth of the waiver. We won't be ready to start engagement on this for about a year – early 2019. We need to file an extension at least six months

ahead of expiration and need draft waiver concepts in early 2020.

Susan McLearan, California Dental Hygienists' Association: Research indicates the effectiveness of preventive dental care. A recent study followed adults over time to show a reduction in restorative services. Is there ability to use Denti-Cal data to validate the effectiveness of prevention and reduce the cost to the state?

Jennifer Kent, DHCS: DHCS is unlikely to do this internally given our staffing, and academics are better suited to do evaluations with DHCS data. We can share data when there is direct benefit to Denti-Cal.

Next Steps and Meetings in 2018
Jennifer Kent, DHCS Director

The next SAC meetings are:

- July 18, 2018
- October 25, 2018