DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
July 18, 2018
10 a.m. – 3 p.m.

MEETING SUMMARY

Attendance
Members Attending*:* Maya Altman, Health Plan of San Mateo; Paul Curtis, CA Council of Community Behavioral Health Agencies; Lisa Davies, Chapa-De Indian Health Program; Anne Donnelly, Project Inform; Carrie Gordon, CA Dental Association; Michael Humphrey, Sonoma County IHSS Public Authority; Anna Leach-Proffer, Disability Rights CA; Anne McLeod, California Hospital Association; Farrah McDaid Ting, California State Association of Counties; Kim Lewis, National Health Law Program; Marty Lynch, LifeLong Medical Care and California Primary Care Association; Steve Melody, Anthem Blue Cross; Linda Nguy, Western Center on Law and Poverty; Gary Passmore, CA Congress of Seniors; Chris Perrone, California Health Care Foundation; Brenda Premo, Harris Family Center for Disability & Health Policy; Jessica Rubenstein, CA Medical Association; Kiran Savage-Sangwan, CA Pan-Ethnic Health Network; Bill Walker, MD, Contra Costa Health Services.

Members Attending by Phone: Kristen Golden Testa, The Children's Partnership/100% Campaign; Anthony Wright, Health Access CA.

Members Not Attending: Bill Barcellona, America's Physician Groups; Michelle Cabrera, SEIU; Richard Chinnock, MD, Children's Specialty Care Coalition; Michelle Gibbons, County Health Executives Association of CA; Brad Gilbert, MD, Inland Empire Health Plan; Sherreta Lane, District Hospital Leadership Forum; Erica Murray, CA Association of Public Hospitals and Health Systems; Cathy Senderling, County Welfare Directors Association; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers; Jonathan Sherin, LA Department of Mental Health; Stephanie Welch, Department of Corrections and Rehabilitation; Anthony Wright, Health Access.

DHCS Attending: Jennifer Kent, Mari Cantwell; Sarah Brooks, Adam Weintraub, Sarah Eberhardt-Rios, Jacey Cooper; Lindy Harrington; Ryan Witz; Brian Hansen; Marlies Perez.

Guest Presenter: Sarah Hesketh, California Association of Public Hospitals and Health Systems

Public in Attendance: 23 members of the public attended in person and 42 public members attended by phone.

Welcome and Introductions
Jennifer Kent, DHCS Director

Director Kent welcomed the group and mentioned that public comment will be accepted throughout the agenda as well as at the end of the meeting. She also welcomed Paul Curtis as the new representative from the CA Council of Community Behavioral Health Agencies. Director Kent thanked The California Endowment and the California Health Care Foundation for their continuing support of SAC meetings and CA Hospital Association for sponsoring lunch.

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

Follow-up issues from the previous SAC meeting were distributed with the agenda, including additional information on the budget item appropriating additional funds for county services to the homeless. There are links provided for the budget information as well as other items included in the follow-up chart sent out to members and posted for the meeting.

Update on State Budget Fiscal Year (FY) 18-19 and Other Updates

- **Access Assessment**
- **Title X**
- **Timing of New 1115 Waiver and 1915(b) Waiver Discussions**

Jennifer Kent, DHCS

Director Kent provided updates on the State Budget. On Proposition 56, the budget includes $500 million, an increase over last year for supplemental payments to physicians to increase rates up to 85% of Medicare rates for the original 13 procedure codes plus an additional 10 codes. For Dental Prop. 56 supplemental payments, the total is about $210 million. This includes the increases for all of the previous codes plus additional increases for general anesthesia, periodontal, and orthodontic codes for youth aging out of foster care.

Supplemental payments were continued for women's health care ($50 million). The Legislature also approved supplemental payments or additional funding augmentations for home health services, pediatric day health care, pediatric subacute and PACE (Programs of All-Inclusive Care for the Elderly). Some of the changes require federal approval. There was also an augmentation for Community-Based Adult Services (CBAS) facilities. Other items include a $3 million appropriation for the California Health Interview Survey to add questions on long-term care for seniors and children. The Breast and Cervical Cancer Program treatment caps were removed. There was a $50 million augmentation to counties for individual with serious mental illness who are homeless or at risk of being homeless.

Lastly, there were Prop 56 funds ($220 million) that were reallocated in 2018-19 for physician and dental loan repayment.

Questions and Comments SAC Members

Carrie Gordon, CA Dental Association: CDA is pleased with all the programs and incentives in the budget. What is the timeline for roll out on loan repayment?

Jennifer Kent, DHCS: We are meeting next week about some of the mechanics of how the money will transfer and we will create a timeline for the program roll-out. We will know more over the next few months about the full roll-out timeline – probably over the next year.

Carrie Gordon, CA Dental Association: CDA would like to urge all qualified providers be included in this program. Some loan programs are limited to citizens and CDA would urge that it not be limited to US citizens.

Jennifer Kent, DHCS: The language does not specify citizens. The priorities are a focus on serving Medi-Cal population at a certain percentage and willingness to serve the population for some length of time.

Chris Perrone, California Health Care Foundation: On loan repayment, some health plans are also doing loan repayment programs. Do you have early thoughts on what the lessons from those programs might be or how you might interface or build on those approaches?

Jennifer Kent, DHCS: Brad Gilbert of IEHP has talked to staff about lessons learned. We have not yet engaged with the other health plans.

Chris Perrone, California Health Care Foundation: Is the increased budget for supplemental payments only for this budget year? It seems unlikely to change provider behavior given such a short timeline. What is your thinking about this challenge?

Mari Cantwell, DHCS: Yes, it is a challenge. Because the provider payments are based on Prop. 56 funding, we are limited. The money didn't flow until the end of 2017, so we are continuing the previous payments until new payments are approved. We are looking to assess whether this resulted in new providers, or in increases in the Medi-Cal population served. We do understand the limitations of this approach.

Linda Nguy, Western Center on Law and Poverty: Considering there are counties without any Denti-Cal providers, will there be geographic targets?

Jennifer Kent, DHCS: No geographic specifications are being considered but we may look at relocation for dental providers to move to counties with more need.

Linda Nguy, Western Center on Law and Poverty: Yes, there may not be the pool of providers in some small counties, but consideration of geographic regions may be a way to increase access. Can you give a brief update on the State Plan Amendment (SPA) submitted to CMS related to periodontal rates and reductions to dental hygienists?

Jennifer Kent, DHCS: I will need to follow up on that for specifics.

Federal Outlook
Jennifer Kent and Mari Cantwell, DHCS

Mari Cantwell, DHCS provided a federal update on the Access Assessment that was part of the Medi-Cal 2020 Waiver submission. There is little to report because the last CMS discussions on this topic were in January 2018. Talks are scheduled for August and DHCS hopes to move forward. CMS has been in receipt of the proposal since April 2017.

Questions and Comments SAC Members

Kristen Golden Testa, The Children's Partnership/100% Campaign: Given it is so late in the timing for this waiver, do you have a proposal to recommend going forward?

Mari Cantwell, DHCS: We still intend to do the assessment design as submitted. In regard to impact on 2020 discussions, the timing may mean we may not have information that's as complete as we might have had prior to beginning discussions for what will happen post-2020. We have other data to rely on as well.

Kristen Golden Testa, The Children's Partnership/100% Campaign: It seems there won't be a baseline, or will you still look back at data prior to the waiver? Can you report back after August meeting?

Mari Cantwell, DHCS: The proposal was based on using current, 2016 data - which is mid-waiver, not really prior to the waiver. Once we know if we are moving forward, we may update the data from 2016 to another timeframe.

Kim Lewis, National Health Law Program: Are you proposing going forward with the existing proposal?

Mari Cantwell, DHCS: They have to approve the design in order for us to implement the assessment. I hope the August discussion will get us on track. The concern was about the timelines, and the influence of the network adequacy requirements, but we think the concern is based on confusion about what we proposed.

Questions and Comments SAC Members

Kim Lewis, National Health Law Program: Is there a California response to the proposed rules on public charge?

Jennifer Kent, DHCS: We believe a response will be coordinated by the Governor's office.

Network Adequacy and Managed Care Final Rule Implementation Key Components
Mari Cantwell, Sarah Brooks, and Jacey Cooper, DHCS
Slides: http://www.dhcs.ca.gov/services/Documents/NetworkAdequacy.pdf

Mari Cantwell introduced the discussion and reviewed the significant amount of work that was required to develop, compile and submit the Network Adequacy reports under the Final Rule.

Plans submitted geo-maps for their entire service area – even where no current beneficiaries may be residing. When there were no providers, plans make an Alternative Access Standards (AAS) request. Over 10,000 alternative access requests were approved. It is a big number, however that is because it is for every ZIP code affected, every plan and every provider type (39 total). Nine plans did not meet initial requirements for time and distance out of a total of 59 possible county/plan combinations. They have corrective action plans (CAPs) in place. Some of this is due to a time factor – there were last-minute submissions of access information that could not be reviewed within the time we had available. We expect all the CAPs to be resolved within six months or they will move to sanctions. Plans must provide out of network services within the timely access standards until the CAP is resolved or alternative access approval is granted.

The Drug Medi-Cal Organized Delivery System (DMC-ODS) process was a bit different because this is new. This only covered the six DMC-ODS counties in operation prior to July 1. All of the provider network certification and time/distance reporting requirements are new activities for mental health and drug services at the state and local level. We used a similar process to validate geo-access maps and other requirements. All six counties are currently under CAPs.

Specialty Mental Health also required the same process. This is a big lift for counties and for the state. DHCS created a methodology to calculate provider-to-beneficiary ratios currently and in the future to determine how many providers are needed. This also incorporates tele-psychiatry. We are looking to improve the process in the future. For example, we will refine the certification methodology and reporting instructions, the forecasting and timely access monitoring. Four Mental Health plans are under CAPs; two counties passed (Alpine and Mariposa passed). The issues were in provider ratios/capacity.

There are six dental managed care plan options to validate. There are two counties (Sacramento and Los Angeles) and three plans in each. All plans met time and distance standards. There is no mandated requirement for specialists in dental but DHCS looked at this across plans. All plans complied with network requirements although there were CAPs issued for timely access and time/distance requirements.

Legislation required public reporting for all information related to compliance. There is a new website with information posted. DHCS will post on the website:

- Letter to CMS - Attestation of network certification compliance
- Network Certification Results - Assurance of Compliance document
- Approved Alternative Access Standards
- CAP findings and Plan responses

Questions and Comments SAC Members

Anna Leach-Proffer, Disability Rights CA: How does access play out for consumers under CAPs for out of network services? Can I continue to see the out of network provider once the CAP is resolved?

Sarah Brooks, DHCS: You would be able to keep the appointments made under the CAP. Once the CAP is resolved, ongoing care out of network will be up to the plan to determine.

Anna Leach-Proffer, Disability Rights CA: I am concerned this will cause confusion and it would be helpful to provide some public guidance on how to navigate this situation.

Sarah Brooks, DHCS: Thanks for the suggestion; we will consider that.

Kim Lewis, National Health Law Program: Is there a place we can review the methodologies you reviewed?

Mari Cantwell, DHCS: The certification documents are on the website for all areas of adequacy and they include the methodology.

Kim Lewis, National Health Law Program: Is there an obligation for plans in a particular ZIP code to let people know about the availability or need for them to access out of network services?

Sarah Brooks, DHCS: Our process is to collect policies and procedures for the training of their consumer representatives and we will do secret shopping to validate. However, as Anna mentioned, it may be useful for us to review this and consider additional messaging, so beneficiaries know what they can ask for.

Kim Lewis, National Health Law Program: How can you meet the geographic access when you did not meet provider capacity?

Mari Cantwell, DHCS: You could have five providers in a county that all meet time/distance, however this may not be enough providers to serve the number of beneficiaries.

Kim Lewis, National Health Law Program: Therefore, you could travel within the required distance, but they don’t actually have appointments? Do you check that they take patients?

Mari Cantwell, DHCS: We do random sampling to be sure they are actually available – not just theoretically available. We added the ratio methodology that is not in the requirements because we had this concern as well.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Did you coordinate with DMHC?

Sarah Brooks, DHCS: Yes, we have ongoing coordination with DMHC on network adequacy and we have ongoing discussions about additional opportunities to share information.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Are there other ways in SUDs that services are captured? For example, many Federally Qualified Health Centers (FQHCs) do mental health or substance use services, but are not under contract. Is this captured?

Jennifer Kent, DHCS: No, only providers under contract with the county are reflected. It would not show up just because it is a Medi-Cal provider unless there is a contract.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: You mentioned that telehealth is an alternative means for specialty care access, however, increasingly telehealth is a standard way to access services.

Mari Cantwell, DHCS: Yes, telehealth is counted as a standard way to meet the requirements. In addition, it can be used as an alternative access option. It is both.

Farrah McDaid Ting, California State Association of Counties: Thanks for the three-month forbearance for counties on the ODS side to finalize contracts. On the provider slides, I am not clear if providers can operate across multiple plans?

Mari Cantwell, DHCS: If the same provider shows up in all plans, they are clearly not a full Full-Time Equivalent (FTE) for each plan, but we don't have a method to account for that. We are working to ensure we don't assume an FTE for every provider reported.

Chris Perrone, California Health Care Foundation: This is really important work that is being conducted by state staff, counties and plans. In the FTE calculation, is the amount listed the amount actually dedicated to Medi-Cal? How do you get the information to know how much time is dedicated to Medi-Cal? Also, could we hear from a plan about their experience with the requirements?

Sarah Brooks, DHCS: The provider would be considered one FTE and that is where our dialogue with Department of Managed Health Care (DMHC) will help assess this. We only collect information on the Medi-Cal side and DMHC has the commercial side. We are also collecting other information on available appointments that will help to clarify this.

Steve Melody, Anthem Blue Cross: This is not the first time we have reported network adequacy, but this does include new rules and new data requirements. It was a major undertaking to gather and report all the requirements. In many cases for us, it is not an actual lack of network but a lack of data we have or have collected through provider credentialing. Especially with a delegated model, we have gaps in the information we could report.

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: On the 10,000 alternative access approvals, does this include mental health?

Mari Cantwell, DHCS: No, that is only the managed care health plans. There are only a handful on the mental health side.

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: On language access, what is the ongoing monitoring of language access?

Mari Cantwell, DHCS: We are continuing to refine the monitoring process for language access. Counties are reporting the number of providers in the network with bilingual capacity. Language access is also part of quarterly monitoring and other regular monitoring. As we go forward, we will be looking at whether there are timeliness issues related to language needs for getting appointments.

Linda Nguy, Western Center on Law and Poverty: To the previous comment, I want to encourage DHCS to require notice to beneficiaries about out of network services. You mentioned reviewing member services training, is this also true for county mental health plans?

Mari Cantwell, DHCS: Yes, we will look at the scripts for call center staff.

Linda Nguy, Western Center on Law and Poverty: How will the CAPs be listed publicly if they are resolved? Will it show up?

Mari Cantwell, DHCS: If a CAP is complete, it will be available publicly, but will show as closed.

Bill Walker, MD, Contra Costa Health Services: As we move to integrate mental health/substance use services and primary care with warm hand-offs, how do we incorporate that into the assessment of networks?

Mari Cantwell, DHCS: Part of that is the approval for FQHCs to bill Medi-Cal for mental health and substance use as part of county contracts. We need to move toward putting contracts in place so services at FQHCs will be counted. Similarly, on the dental side we have challenges and want to ensure those services come into the network assessments.

Jennifer Kent, DHCS: It will require that a county contract is in place for it to be counted as part of the plan's network submission.

Kim Lewis, National Health Law Program: On the Specialty Mental Health side, how are you determining the prevalence rate and estimated need of SED/SMI for network adequacy?

Mari Cantwell, DHCS: We looked at various reports, including a needs assessment in 2012 with prevalence estimates and data from previous contract information. We looked at the prevalence rate in the general population and used that to calculate the need in Medi-Cal. We are using the best information we have and hope to identify additional ways to refine this going forward.

Jennifer Kent, DHCS: In the future, we hope to pull data on diagnosis codes and use other research on the methodology to validate the 2012 data. The 2012 data is the most recent we have.

Kristen Golden Testa, The Children's Partnership/100% Campaign: I also want to underscore the need for more guidance to providers and consumers to know about out-of-network access. It seems from the slides that there were plans that were not in compliance for many of the pediatric specialty care categories and that it reflects more of a systemic problem rather than one-off gaps. How long can a plan be out of compliance? What is the plan to address these gaps?

Sarah Brooks, DHCS: Yes, there is a higher incidence of pediatric provider CAPs. This was a newer requirement for plans, but they are working through the gaps. There is a six-month period to complete the CAP before we take additional steps, and we expect most or all of the CAPs will be closed out within the six-month timeframe.

Mari Cantwell, DHCS: We are loading the actual alternative access standards that were approved and the CAPs by plan. They are significant documents, so it is taking some time to finalize this.

Public Comment

Meaghan McCamman, California Primary Care Association: I want to follow up to mention that community health centers provide significant levels of primary care-based substance use and mental health services (MH/SUDs). The take up of contracts with the county will be a slow process and I want to encourage identifying ways to document the level of primary care-related MH/SUDs prior to contracts being in place.

Mari Cantwell, DHCS: It is good information for us to have to understand the services provided. For us to certify, to consider it part of meeting network adequacy requirements, services must be through a contract.

Katie Murphy, CA Department of Social Services: What is the effective date for out of plan CAPs, related to appeals?

Mari Cantwell, DHCS: The CAP is effective until the plan is in compliance. The CAPs started as of July 1 and plans must allow out of network services until they are in compliance. Even beyond that date, if someone has scheduled appointments, they are allowed to go ahead, but at some point following plan compliance, they would be required to come into the plan's network. There is a lot of information on the website that is helpful on this topic and the individual CAP will be available by next week with information on the exact standards and CAPs for each plan.

Anthony Wright, Health Access CA: What is the timetable to know if Prop. 56 payments are having any impact? Will that be picked up though network adequacy?

Mari Cantwell, DHCS: It is more likely to appear through utilization, rather than through network adequacy. It is most likely that current providers will take additional Medi-Cal beneficiaries. We will look at this during the next budget cycle – around May 2019.

California Children's Services (CCS) Status Report
- **Implementation of Whole Child Model in 6 counties**
- **Update on CCS Pilot Project in San Diego**

Jacey Cooper and Sarah Eberhardt-Rios, DHCS
Slides: http://www.dhcs.ca.gov/services/Documents/WCM_SAC.pdf

Sarah Eberhardt-Rios provided an update on the Whole Child Model (WCM) Phase 1. Care for CCS eligible children is currently provided through a bifurcated system, with specialty services through the county and primary care and behavioral health through the managed care health plan. The WCM integrates Medi-Cal managed care and county FFS specialty care into one system.

As of July 1, three health plans in six counties are implementing the WCM in Phase 1.

Phase II will add Partnership HealthPlan and CalOptima. In addition, on July 1, 2018, a CCS Accountable Care Organization Model demonstration project pilot at Rady Children's Hospital - San Diego will be implemented for five conditions. Similar pre-implementation activities were conducted for this pilot.

Questions and Comments SAC Members

Kim Lewis, National Health Law Program: Some children have difficulty accessing Durable Medical Equipment (DME) and medical supplies, is there any coordination and assurance for this through the model or did you review this as part of network adequacy to assure coordination and services through the model?

Jacey Cooper, DHCS: Senate Bill (SB) 586 does provide for continuity of care for DME. We also provided additional guidance in the APL for how plans should ensure DME and we looked at it within network adequacy to ensure there was an adequate DME network in place to meet the needs. We require plans to go out of network to receive DME to ensure access to services.

Kim Lewis, National Health Law Program: For those enrolled in plans as of July 1, was there notice to beneficiaries about their ability to go outside the network on this?

Jacey Cooper, DHCS: This was included in the FAQ and we have tried to be very transparent about this. I will need to follow up on what exactly was included in the beneficiary notice. We are working with Family Voices to make sure it's being appropriately communicated.

Jennifer Kent, DHCS: It would be in a Service Authorization Request (SAR) ahead of time, so the plans know ahead of the child being enrolled what services they were receiving from what providers.

Jacey Cooper, DHCS: We educated plans early on about MTP, and brokered conversations at the local level.

Public Comment

David Fein, CAMPS: How many CCS kids are participating in the Rady pilot?

Sarah Eberhardt-Rios: There will be 400.

Update on Health Homes Implementation
Brian Hansen, DHCS

The Health Homes initiative launched July 1, 2018, with two plans in San Francisco. This is a program with active engagement and outreach to enroll beneficiaries. There have been weekly calls with plans for the past six months. We are working with San Bernardino and Riverside to launch January 2019. In addition, the SMI eligible population will launch in San Francisco in January 2019 – more than 50 percent of the total expected beneficiaries. The remaining counties will implement in July 2019.

Questions and Comments SAC Members

Steve Melody, Anthem Blue Cross: Related to the policy on integrating Health Homes and Whole Person Care, I am concerned about confusion among members and providers. How will that policy roll out? Is this unique to San Francisco? The policy was completed at the last minute and has required changes. This is the right thing to do but merging the programs is complex.

Brian Hansen, DHCS: This policy is expected to be the model to be used going forward. There will be additional technical assistance to clarify what is or isn't duplicative and how to inform members about these issues. San Francisco is the place where we are working this out and then will communicate to the other plans.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Where did you end up on rates and the rate structure for the program?

Brian Hansen, DHCS: There are not tiered rates – there is one case mix rate. The tiers of intensity for services was built into the case mix. There were assumptions built into the rates that has been discussed with the plans. There were rates for dual-eligibles and non-duals, and assumptions for SMI enrollees that were included. The case mix rates are fixed and have been communicated to plans.

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: When will the information on housing be collected and available? Will this data be public?

Brian Hansen, DHCS: We will collect data on a monthly or quarterly basis and it will be posted but there will be a lag before the information is available. I do not have a timeline for when it will be public.

Anne Donnelly, Project Inform: When the SMI population comes into the program, is there is a rate change?

Brian Hansen, DHCS: One factor in the set of assumptions for rates is the SMI population. Engagement activities were another set of factors in the assumptions we used to produce one case mix rate.

Linda Nguy, Western Center on Law and Poverty: How is enrollment going in San Francisco? I would encourage a webinar in the coming months to raise awareness now that the program is operational.

Brian Hansen, DHCS: The program has only been live for 18 days, but yes, folks are enrolling.

Public Comment
There were no questions or public comment.

Global Payment Program Update
Lindy Harrington, DHCS
Sarah Hesketh, CAPH
http://www.dhcs.ca.gov/services/Documents/GPP.pdf

Lindy Harrington presented an overview of the Global Payment Program (GPP). The GPP establishes a statewide pool of funding for the remaining uninsured by combining federal Disproportionate Share Hospital (DSH) and uncompensated care funding, where select Designated Public Hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher value, and preventive services. This includes public hospitals only and represents about $2.2 billion.

Questions and Comments SAC Members

Gary Passmore, CA Congress of Seniors: As the population ages, there are many services provided at hospitals such as monitored cardiac rehabilitation that are not inpatient services or traditional physician visits. How does that impact the GPP?

Sarah Hesketh, CAPH: We hear from both older and younger patients that they want to do more without having to see a provider. Our aging population and the demands of younger patients need to be in multiple modalities.

Chris Perrone, California HealthCare Foundation: How much alignment is there for hospitals between GPP and PRIME?

Sarah Hesketh, CAPH: Yes, hospitals are trying to align across the initiatives. The GPP is focused on the uninsured, but the changes and improvements are across all patients.

Chris Perrone, California Health Care Foundation: I am interested in how this program informs the larger Medi-Cal program. For example, how to pay for in-lieu services? Does this program and its findings inform those decisions?

Mari Cantwell, DHCS: All the waiver programs are meant to help us pilot and demonstrate what is effective to drive change for its applicability across Medi-Cal. There is consistency across the goals of the programs. Part of the problem now is that we have so many programs and we want to bring more cohesion.

Lisa Davies, Chapa-De Indian Health Program: Through GPP, are there new relationships formed between hospitals and clinics or new practices for care coordination?

Sarah Hesketh, CAPH: I don't know how many new relationships are forming, but GPP is strengthening the existing relationships.

Anthony Wright, Health Access: We are focused on GPP hospitals. Are there things being done to encourage counties over the last two-years, so we can have a better case?

Mari Cantwell, DHCS: I think there is a real possibility of keeping this going and we do need to keep the momentum going to have a story to tell at the end of the waiver period for CMS. This may be one of the easier items to argue for continuation. The hospitals are clear that to keep this flexibility in the future, they can't operate business as usual – we need to build a case via improved results. I think we are seeing hospitals embrace that.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: The hopeful results may point the way to an FQHC-related alternative payment methodologies approach with CMS. The transformation of the FQHC system is also important.

Kim Lewis, National Health Law Program: In some areas, the points go up and in others the points go down. What are the changes in point values you expect and what are the points based on? Mental health seems to be going up, not down?

Lindy Harrington, DHCS: We want to see the values go down – the units are total services provided. The point value will go down over the five years, so they won't achieve the same points if they do the same level. For the most part, things are moving in the right direction but there are certain elements that are not yet moving. We are only at the midpoint.

Sara Hesketh, CAPH: Data challenges have been significant on the mental health side and that may be part of this.

Public Comment

Jillian Mongetta, DHCS: I have been sitting in on evaluation interviews. The GPP program is allowing the hospitals to build more robust nontraditional services across all populations. Many are speaking up about how this is changing care for all patients, even though the focus is on uninsured.

Home and Community-Based (HCBS) Alternatives Waiver Implementation
Sarah Eberhardt-Rios, DHCS
http://www.dhcs.ca.gov/services/Documents/HCBA.pdf

Ms. Eberhardt-Rios provided an update on the 1915(c) waiver that manage the provision of HCBS to eligible Medi-Cal beneficiaries who would otherwise receive care in a facility if not for the nursing and support services they receive in the community setting of their choice. This can allow states to focus on certain populations.

Questions and Comments SAC Members

Chris Perrone, California Health Care Foundation: What is the objective for the delegation of the administration?

Sarah Eberhardt-Rios, DHCS: We are looking for more local presence and resources and wanted to extend the capacity, beyond what DHCS can accomplish, through Waiver Agencies.

Jacey Cooper, DHCS: These are some of the most complex cases in Medi-Cal. Doing care coordination from Sacramento or Los Angeles doesn't allow the touch we think is needed for patients. Going to this delegated model will enhance care coordination and services.

Chris Perrone, California Health Care Foundation: Are there any concerns or considerations you are watching for in this delegation?

Jacey Cooper, DHCS: Within every waiver, there are performance measures that we will be monitoring. In addition, DHCS wants to monitor health outcomes via dashboards specific to this waiver program.

Sarah Eberhardt-Rios, DHCS: We are looking for increased care coordination at the local level.

Kim Lewis, National Health Law Program: Is there a report out on initial results from the dashboard?

Jacey Cooper, DHCS: Not yet, but we will keep you updated as we develop. This is the largest waiver we directly oversee, and we don't have a specific date for public reporting. The performance measures are already on the website.

Kim Lewis, National Health Law Program: Is there only one Waiver Agency per geography? Since you plan to double the slots, will you expand the number of agencies?

Jacey Cooper, DHCS: There are some places, such as LA, that have multiple agencies. We wanted to ensure quality and didn't want to have so many agencies that they would have a very small number of enrollees. Each agency had to demonstrate capacity for growth in the RFP, to allow for the expanded capacity in the waiver. We don't have a schedule of expanding the number of agencies, but we have the flexibility to reopen if needed.

Michael Humphrey, Sonoma County IHSS Public Authority: I am very happy with this transition. There is great value having this at the local level. There has been such a disconnect between IHSS and this waiver program and having this at the local level will help create needed connections between those programs. I am concerned about continuity and consistency from one Waiver Agency to another, given the different organizations and approaches for people moving to new areas of the state and having to change Waiver Agencies. I received some feedback that information has been slow to move between agencies and there may be a need for more planning on transitions. At the Olmstead Advisory Committee, I raised my concern that the requirement to have an MSW as the social worker is a threshold that is challenging. It could be many different master's level social work categories, MFCC or LCSW could work just as well.

Gary Passmore, CA Congress of Seniors: Can you comment on the requirement for training at the local level for those providing services through the waiver, even though the IHSS program serving the same people has no training requirements?

Jennifer Kent, DHCS: The services being provided are very different. Many IHSS are family members who are providing direct care, whereas Waiver Agencies are providing coordination and case management.

Maya Altman, Health Plan of San Mateo: In San Mateo there are only 60 people eligible and that was not sufficient for the health plan to really focus on adequately. Now, we have

a single Waiver Agency, the Institute on Aging that covers several counties. They achieve better economy of scale and we are able to work with a single agency on these goals. This reduces provider and consumer confusion.

Public Comment
No Public Comment

Care Coordination Advisory Committee Creation and Purpose
Jacey Cooper, DHCS
http://www.dhcs.ca.gov/services/Documents/CareCoordination.pdf

Through internal and external stakeholder engagement, DHCS will work to implement a core set of care coordination standards and expectations for Medi-Cal managed care health plans (MCPs) and their partners. Additionally, this work will inform standards for other delivery systems as well. Medi-Cal has many layers that make care coordination more complex. The goal is to implement a core set of standards and expectations for Medi-Cal managed care health plans (MCPs) and their partners, regarding appropriate care coordination activities and requirements. This will look across the full spectrum, such as screenings, data, etc.

The timeline is through 2018-19. An advisory group will meet August-October 2018 The process to date has been to look at existing policies, talking to other states and conducting key informant interviews around the state to evaluate current practices.

Questions and Comments SAC Members

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Will you produce a summary paper based on focus groups and the themes you heard?

Jacey Cooper, DHCS: We will make a presentation at the first meeting of all this information, but not a white paper. All the information will be publicly posted.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Will part of the work be around WPC, HH, SMI, and aging – all the different places with coordination responsibility?

Jacey Cooper, DHCS: We will put forward a model of care – from wellness to assessments across the aid codes – to standardize across those areas, as well as point of care management and how we can embed that across the delivery system.

Gary Passmore, CA Congress of Seniors: Will you include the newly authorized Medicare Advantage plans?

Jacey Cooper, DHCS: How this will be handled will be part of the Advisory Committee discussion, but we haven't dug into this yet.

Paul Curtis, CA Council of Community Behavioral Health Agencies: Are you looking both at Mental Health and full integration of physical/mental health systems?

Mari Cantwell, DHCS: That is something that came up in the sessions and interviews. We want to discuss all of the issues, including the idea of pilots that might move forward on full integration. We will want to partner with counties on this conversation.

Paul Curtis, CA Council of Community Behavioral Health Agencies: Are you still taking applications for the Advisory Committee?

Jacey Cooper, DHCS: No, however the meetings will be public.

Anne Donnelly, Project Inform: Did the Ryan White HIV/AIDS Program system come up in your conversation and can we include their care coordination in the discussion?

Jacey Cooper, DHCS: It didn't come up often, but programs that counties manage and how we can better coordinate county programs with plans did come up. We met with many public health directors and heard about places this is working well.

Kim Lewis, National Health Law Program: This is a big issue with nuances for each population, including coordination with non-health sectors such as regional centers, foster care and others. It will be important to structure the conversation with great transparency and participation from multiple stakeholders because it can't be collapsed into a single system – even though standardizing Medi-Cal will be a big help. I hope you are looking at expertise across systems and in other states.

Jacey Cooper, DHCS: Yes, we have been looking at many systems and other states. We will be speaking with many people beyond the Advisory Committee as well as those participating directly.

Linda Nguy, Western Center on Law and Poverty: Will consumers be on the Advisory Committee?

Jacey Cooper, DHCS: There are consumer organizations included. In addition, we are thinking about focus groups with beneficiaries.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: There are expectations of plans for case management from DMHC. Will we have a single set of expectations across DMHC and DHCS?

Jacey Cooper, DHCS: The issue of Medi-Cal creating different policies did come up a lot. We will be looking at that – whether we will decide to align completely is uncertain. Also, each system and part of the delivery system has its own assessment system and there is assessment fatigue. We will need to be careful because there are important reasons for many of these requirements.

Public Comment

Dharia McGrew, CA Dental Association: Thank you for this ambitious effort. Dental is one of the areas that is fragmented in Medi-Cal. There is increasing information about the strong connection between periodontal disease and other poor health, so we want to advocate for dental to be included.

Update on DMC-ODS Waiver Implementation
Marlies Perez, DHCS
http://www.dhcs.ca.gov/services/Documents/DMC-ODS.pdf

Ms. Perez announced that California will receive $137 million over two years through the State Opioid Response grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). It spans prevention, treatment and recovery services with 25 different projects to expand DHCS' Medication Assisted Treatment (MAT) Expansion Project. Information is now posted on the DHCS website.

She then presented a detailed update on the DMC-ODS waiver implementation. Forty counties have opted-in and 19 counties are currently providing services (77 percent of population). Eight new counties went live in July 2018. There are also a number of other states with approved 1115 waivers to redesign substance use disorder service delivery systems.

Questions and Comments SAC Members

Kiran Savage-Sangwan, CA Pan-Ethnic Health Network: There is an integration plan required – can you describe more about that?

Marlies Perez, DHCS: That was about how all aspects of the 1115 waiver are integrated together and it is completed.

Kim Lewis, National Health Law Program: Do you have statewide information specific to age about services through the waiver?

Marlies Perez, DHCS: The evaluation will release information on services by different demographics for Medi-Cal waiver services only.

Kim Lewis, National Health Law Program: For the counties you highlighted, there was a focus on residential. Are there other services for youth you can speak to – new or innovative services?

Marlies Perez, DHCS: Yes, most of the services for youth are outpatient and there are different types of providers, settings, and curriculum emerging for youth. Overall, we are trying to build up outpatient settings. There is more to do with youth and many counties are including this as a quality improvement area.

Public Comment
No public comment.

Next Steps and Meetings in 2018
Jennifer Kent, DHCS Director

The next SAC meeting is October 25, 2018.