DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
February 8, 2018
10 a.m. – 3 p.m.

MEETING SUMMARY

Attendance

Members Attending: Maya Altman, Health Plan of San Mateo; Lisa Davies, Chapa-De Indian Health Program; Sarah de Guia, CA Pan-Ethnic Health Network; Anne Donnelly, Project Inform; Michelle Gibbons, County Health Executives Association of CA; Kristen Golden Testa, The Children's Partnership/100% Campaign; Carrie Gordon, CA Dental Association; Michael Humphrey, Sonoma County IHSS Public Authority; Sherreta Lane, District Hospital Leadership Forum; Anna Leach-Proffer, Disability Rights CA; Anne McLeod, California Hospital Association; Marty Lynch, LifeLong Medical Care and California Primary Care Association; Farrah McDaid Ting, California State Association of Counties; 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; Brenda Premo, Harris Family Center for Disability & Health Policy; Jessica Rubenstein, CA Medical Association; Jonathan Sherin, LA Department of Mental Health; Bill Walker, MD, Contra Costa Health Services; Anthony Wright, Health Access California.

Members Attending by Phone: Chris Perrone, California HealthCare Foundation; Herrmann Spetzler, Open Door Health Centers.

Members Not Attending: Bill Barcellona, America's Physician Groups; Kirsten Barlow, County Behavioral Health Directors Association of California; Michelle Cabrera, SEIU; Richard Chinnock, MD, Children's Specialty Care Coalition; Paul Curtis, CA Council of Community Behavioral Health Agencies; Bradley Gilbert, MD, Inland Empire Health Plan; Kim Lewis, National Health Law Program; Cathy Senderling, County Welfare Directors Association; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers.

DHCS Attending: Jennifer Kent, Sarah Brooks, Adam Weintraub, Anastasia Dodson, Alani Jackson, Jacey Cooper, Lindy Harrington, Ryan Witz, Dina Kokkos-Gonzales; Don Braeger, Nathan Nau, Sarah Eberhardt-Rios, Morgan Clair.

Public in Attendance: 16 members of the public attended in person and 109 attended by phone.

Welcome and Introductions
Jennifer Kent, DHCS Director
- Purpose of SAC, SAC Changes for 2018 and Feedback on SAC Improvements
- Introduction of New Members

Director Kent welcomed everyone to the first meeting of SAC for 2018. As discussed at the previous meeting, the membership has changed somewhat beginning with this meeting. She recognized the service of past members and welcomed new members joining SAC. She thanked a group of SAC members who provided feedback on SAC agendas in order to offer topics that interest the broad range of members and offer opportunity for interaction and dialog. She referenced a revised charter that was distributed for review. She thanked the foundations, TCE and CHCF, for their continuing strong support and Blue Shield of California Foundation for its past support. She also thanked Brad Gilbert and Inland Empire Health Plan for sponsoring lunch for today's meeting.

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

The follow up issues were distributed with the agenda.

Questions and Comments

Anthony Wright, Health Access California: Was the dental State Plan Amendment (SPA) submitted and approved?

Jennifer Kent, DHCS: The SPA was submitted and is pending at Centers for Medicare & Medicaid Services (CMS).

2018-19 State Budget
Jennifer Kent, DHCS

Director Kent reported on the state budget released on January 10, 2018. There are no proposed reductions and DHCS is seeking authority to continue Proposition 56 supplemental rate augmentations for specified providers as included in last year's budget and one additional proposed increase for home health agencies in the fee-for-service and waiver programs. One change will be reflected in the May Revision to include an adjustment based on the reauthorization of Children's Health Insurance Program (CHIP) because the federal approval included a higher Federal Medical Assistance Percentage (FMAP) rate than were used for budget assumptions. TThere are increasing federal concerns about 340B programs, and DHCS has proposed elimination of the 340B drug program in Medi-Cal. DHCS is holding ongoing meetings with stakeholders impacted by this proposal

Questions and Comments

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Health centers rely on the 340B Pharmacy Program revenue. Does the budget proposal include any discussion about how to replace those funds?

Jennifer Kent, DHCS: We have not proposed anything. We are happy to discuss ideas on that.

Anne Donnelly, Project Inform: Ryan White providers also rely on 340B funds and we are opposed to that proposal in the budget. What is the process for discussing the loss of funds?

Jennifer Kent, DHCS: The proposal is in the trailer bill with DHCS language. The mechanism for discussion is through the department and through the legislative committee process.

Kristen Golden Testa, The Children's Partnership/100% Campaign: When you mentioned that DHCS may look at the Prop 56 payments and utilization, I am interested in your thoughts on this. As I recall, there are concerns that provider coding could evolve from past practice to take maximum advantage of supplemental payments and that the new coding will skew utilization data. Are you seeing changes?

Jennifer Kent, DHCS: We are only making payments on the Fee-For-Service (FFS) side right now, and that is a small piece of the overall data. CMS has not approved managed care organization (MCO) payments, so they have not begun to do supplemental payments. This is a conversation we need to have but we don't have a specific proposal of changes. We need to be deliberate to ensure the supplemental payments have the intended impact. However, we don't want to complicate the process given it is a one-year approval.

Anne McLeod, California Hospital Association: How will payments be made for supplemental payments now that it is approved?

Lindy Harrington, DHCS: On the physician side, supplemental payments began January 2018.

Jennifer Kent, DHCS: Supplemental payments to physicians are being made to the specified codes with claims submitted as of January. For past claims back to July 2017, we will re-adjudicate claims for the provider codes beginning in April and the payments will roll out in weekly check runs. I will follow up on the dental side to let you know the timing.

Steve Melody, Anthem Blue Cross: Managed care organizations are going through the same process. We will re-adjudicate claims going back to July and then include the supplemental payments going forward.

Home Health Rate Adjustment and Proposition 56 Update
Lindy Harrington, DHCS

Ms. Harrington provided an additional update on the Proposition 56 supplemental payments. CMS approved the FFS payments and we are awaiting CMS approval for managed care organization payments. We expect approval shortly. There will be an All Plan Letter (APL) to managed care organizations in March detailing how to make the payments. Using part of Prop 56 funds, DHCS has proposed to also implement a 50% rate increase for Home Health and Home and Community-Based Services programs as part of the Governor's budget. If approved this would be effective in July, pending CMS approval, and would be an ongoing rate increase totaling $64.5M. This is in addition to the other provider increases.

Questions and Comments

Anthony Wright, Health Access California: Can you speak more about how DHCS will monitor or track the impact of Prop 56 payments to ensure they improve access?

Lindy Harrington, DHCS: We will look at trends in utilization going forward compared to past data.

Jennifer Kent, DHCS: In some cases, we will also look at utilization for specific kinds of issues and we will look for an increase in providers.

Anthony Wright, Health Access California: Are these the main benchmarks – increasing utilization and providers? Are there other metrics? Depending on what the data shows, are you open to making changes?

Lindy Harrington, DHCS: Right now, it is difficult to say given we don't have data yet. Over the spring, we will have a discussion of what should happen for FY18-19. We will have limited data over the budget approval time-period. Going forward, we want to be sure we don't create new delayed implementation problems due to changes.

Kristen Golden Testa, The Children's Partnership/100% Campaign: It seems you also won't have managed care data to impact budget?

Lindy Harrington, DHCS: The word is out, and plans have communicated broadly, so will that be enough to change behavior? We won't have data, but it could be that some improvement will result from anticipated payments.

Jennifer Kent, DHCS: The dental increase was an across the board increase while the women's health increases were very targeted. Some of those increases will be easier to track and measure. One lesson we have learned is that it can be difficult to impact change at the provider level if we keep changing the process every few months. The implementation and operational changes take time and create a lag. The data for the

May Revision will be very interim and will not be a full picture. We are open to ideas and input given all the constraints.

Carrie Gordon, CA Dental Association: What is the best process for opening the discussion over the next few months to understand the trends and make the right changes?

Jennifer Kent, DHCS: We don't know yet because we don't know what the data will show. We are committed to share the data but don't know yet whether any change would be warranted. If early data doesn't show any change, will we know whether that result is because the data is so uncertain or whether we need to make changes?

Managed Care Final Rule Implementation – Directed Payments
Ryan Witz, DHCS
Slides available:
http://www.dhcs.ca.gov/services/Documents/FinalRuleUpdates_SAC_020818.pdf

Ryan Witz provided an overview on proposed directed payments. The changes are required because the Final Rule does not allow the pass-through payment methodologies used in the past. There are three allowable payment methods going forward: 1) value-based purchasing models; 2) delivery system reform and/or performance improvement initiatives; or 3) minimum or maximum fee schedules and uniform dollar or percentage increases. There was a transition period allowed by CMS to implement the change and California will use pass-through payments under the transition for a subset of hospital payments. Hospital, physician and dental directed payments are proposed as a five-year proposal; however, Prop 56 payments are on a year-to-year approval process. He reviewed the specific sub-pools and proposed payment methods for each of the groups listed below. The hospital directed payment proposals are not new funding; they replace the payment methods under AB85, Medi-Cal Expansion, Seniors and Persons with Disabilities, and the Hospital Quality Assurance Fee (HQAF). The proposals do not include sites with all-inclusive rates, such as Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and tribal clinics. The DPH Quality Improvement Program includes quality incentive aspects for receiving payments, which is similar to PRIME in the waiver, however they do not duplicate the waiver incentives. The proposal includes:

Hospital Directed Payments
- Designated Public Hospital (DPH) Directed Payment Program
- DPH Quality Improvement Program
- Private Hospital Directed Payment Program

Physician Directed Payments
- Prop 56 Physician Directed Payments (for 13 E/M codes)

Dental Directed Payments
- Proposition 56 Dental Directed Payments

Questions and Comments

Erica Murray, CA Association of Public Hospitals and Health Systems: It is important to emphasize this is replacing existing funding and the size of these supplemental payments is quite substantial. With the quality incentive program, we are building on the successful strategy beginning with Delivery System Reform Incentive Payments (DSRIP) to tie payments to performance measures and continue to drive transformation. These programs are all based on actual utilization encounter data, so it will be very important to ensure the hospitals can provide accurate utilization encounter data. This must go through managed care so for providers without any contract with managed care organizations, there is now a strong incentive to develop a contract to access supplemental payments. California Association of Public Hospitals and Health Systems has prepared a fact sheet on measures in the quality payment program.

Maya Altman, Health Plan of San Mateo: Managed care plans hope to convince the UC hospitals to contract with us. We haven't gotten traction there. Can you offer thoughts about this? What is the size of the supplemental payments?

Erica Murray, CA Association of Public Hospitals and Health Systems: It is difficult to discuss this issue globally because each system is different. However as this rolls out, we hope hospitals will see that the supplemental payments do help close the gap on their costs. What they will ultimately see is what they earned vs. what they could have earned with contracts.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Can you speak to what percent of the revenue these funds make up?

Erica Murray, CA Association of Public Hospitals and Health Systems: I need to follow up.

Ryan Witz, DHCS: The total is over $2B annually with both federal and nonfederal share.

Anthony Wright, Health Access California: This is pending at CMS? Is there precedent with other states? Is there any change at CMS that impacts the approval?

Ryan Witz, DHCS: There are other states approved and we are optimistic this will be approved. We are very close on the quality incentive program. On the DPH directed payment program, we had to do additional work to refine the original submission, so we are less clear about that one. We have had continuity in CMS staff and guidance.

Anthony Wright, Health Access California: I don't understand the rationale for the specific groupings of counties and classes of DPH within pools.

Erica Murray, CA Association of Public Hospitals and Health Systems: We couldn't have one pool or class, so we were looking at replacing the previous funding, and how to layer the varying reimbursement methods to create a proxy for consistent funding that was not costs.

Maya Altman, Health Plan of San Mateo: What if the payment method changed over time?

Erica Murray, CA Association of Public Hospitals and Health Systems: Yes, they can change from FFS to capitated rates and change classes.

Mr. Witz also provided an update on the private hospital directed payments. This is a simpler proposal with the pooled amount separated into only two sub-pools and it is all FFS. There is a similar methodology for creating a proxy PMPM and that is then adjusted based on actual encounters.

Questions and Comments

Anne McLeod, California Hospital Association: Thanks to staff at DHCS for their work and perseverance on this. This has been stressful to work through with so much money at stake. There was a learning curve at CMS about the delegated model and the reasons for contracted provider arrangements. It is important to note the funding amounts reported here are 50% provider funded.

Sherreta Lane, District Hospital Leadership Forum: The district hospitals are likely to face this in coming years as well.

Mr. Witz also provided an update on the physician payments. This is $790M total and includes primary care physicians, specialty physicians and mental health outpatient providers. Similar to previous pools, the providers ineligible to receive directed payments include the FQHCs, RHCs and tribal clinics. There will be a uniform dollar increase for 13 codes paid to managed care plans -- 10 primary care/specialty and 3 mental health outpatient procedure codes. This is close to approval and we expect payments to the plans in March or April.

Dental providers will receive a uniform percentage increase. This only applies to Sacramento and Los Angeles where dental managed care is implemented. The total is $22M through risk-based payments for managed care plans and represents increases of 40% for selected procedures. This is not duplicative of payments in the Dental Transformation Initiative.

Timeline

- June 2017: DHCS submitted proposals to CMS

- August 2017 – January 2018: DHCS responded to three rounds of questions
- March 2018: DHCS to release APL detailing the directed payment arrangements for managed care plans
- March/April 2018: DHCS to pay directed payments to managed care plans for physicians and dentists.
- End of FY18-19: DHCS to pay managed care plans for hospital directed payments

Questions and Comments

Kristen Golden Testa, The Children's Partnership/100% Campaign: Can you review the dental payment structure?

Ryan Witz, DHCS: The physician side has specific dollar amount increases for 13 codes. On the dental side, the specific dollar amount is based on 40% percent of the Schedule of Maximum Allowance (SMA) for the eligible dental procedure codes.

Carrie Gordon, CA Dental Association: Can you explain the five-year timing for the dental managed care side approved annually?

Ryan Witz, DHCS: There is a requirement to conduct an evaluation prior to approval of the next plan. CMS suggested we come in for a longer timeline to ensure there is time for the evaluation prior to renewing. The dental and physician payments are tied to state budget allocations, so it requires that we approve that each year.

Jennifer Kent, DHCS: CMS will approve the framework and we reserve the flexibility year to year.

Carrie Gordon, CA Dental Association: I am concerned about delays on the FFS side every year based on the need to approve this annually that will create a lag in payments.

Ryan Witz, DHCS: We are tied to annual allocations.

Jennifer Kent, DHCS: The process is new to CMS and to states. We can no longer direct managed care plans to pay specific providers anything. By going through the approval of the framework, it will make subsequent years easier.

Managed Care Final Rule Implementation – Network Adequacy and Certification
Sarah Brooks, Nathan Nau, Anastasia Dodson, Dina Kokkos-Gonzales, Don Braeger, DHCS
Slides available: http://www.dhcs.ca.gov/services/Documents/FinalRule_NA_SAC.pdf

Sarah Brooks offered an overview of guidance Final Rule for Network Adequacy for Managed Care Plans (MCO), Mental Health Plans (MHP), Drug Organized Delivery

System (ODS), and Dental Managed Care. Standards are set for various providers, including physicians, pharmacy, long-term services and supports and hospitals to report and certify network adequacy. AB205 implemented the final rule to:

- **Change** county categories to reflect population density rather than population size
- **Authorize** alternative access standards process to be permitted and use of telehealth to meet standards
- **Establish** a 90-day timeline for reviewing alternative access standard requests
- **Require** annual demonstration of network adequacy compliance
- **Sunset** the network adequacy provision in 2022, allowing for reevaluation of the standards.

She reviewed the specific time and distance and timely access measures. She explained how standards are categorized by county population density and types of specialists included. Core specialists are listed. There are different time and distance requirements the plans must meet for the specialties depending on the population density. For example, in a dense county, a plan might have to have a provider within15 miles and 30 minutes of a patient, while a rural county standard is 60 miles and 90 minutes. Ms. Brooks reviewed similar requirement parameters for outpatient mental health, ODS and opioid treatment. Skilled Nursing Facilities and Intermediate Care Facilities are subject to timely access but not time and distance standards.

Questions and Comments

Jonathan Sherin, LA Department of Mental Health: What about time and distance requirements for other behavioral health providers not listed, such as psychologists?

Sarah Brooks, DHCS: We did look at the requirements, including other specialists. This does not imply that other types of providers are not in the MCO network – these are just the core specialists called out for timely access requirements.

Sarah Brooks presented information on Alternative Access requests from managed care plans for the time and distance standards if the plan has exhausted reasonable options to obtain providers to meet the time and distance standards, or if DHCS determines the plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access. Telehealth may be used as a means of determining alternative access standards. DHCS is developing a formal process for Alternative Access requests and review.

Questions and Comments

Sarah de Guia, CA Pan-Ethnic Health Network: What do you consider to be exhausting reasonable options?

Nathan Nau, DHCS: We require that they submit information on the area and why they are not able to contract with any providers. We go through their information and use additional data sets to see if there are alternatives available.

Sarah de Guia, CA Pan-Ethnic Health Network: Why don't hospitals have timely access standards?

Jennifer Kent, DHCS: It is not included because you don't make an appointment to go to a hospital.

Brenda Premo, Harris Family Center for Disability & Health Policy: Does time and distance include a consideration for the situation where a provider exists, but is not accessible for someone with a disability?

Sarah Brooks, DHCS: We do have requirements for plans on physical access, however, those requirements are not part of these standards. We take that very seriously.

Brenda Premo, Harris Family Center for Disability & Health Policy: We have had a focus on primary care and it is getting better, however specialty care remains very difficult.

Sarah Brooks, DHCS: That is very helpful. We will continue to work with you on this.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Where does language access fall into standards?

Nathan Nau, DHCS: Language access is not a network adequacy element, but we do have requirements and a process in our annual audit process that does cover language access.

Chris Perrone, California HealthCare Foundation: In follow up to Sarah de Guia's question about reasonable options, and given that contracting with providers includes rate disputes, how will DHCS determine this? If a plan offers Medicare rates and the provider won't accept it, what will you do? What request from a provider is too much?

Nathan Nau, DHCS: It is situation specific. We plan to hold internal meetings to work through a list of issues, including this one. We expect there will be rate issues and after internal consideration, we may deny an alternative access request if we determine it is not reasonable.

Sarah Brooks, DHCS: We can come back with more details on this as we move forward.

Chris Perrone, California HealthCare Foundation: Do you have standard provider FTE ratios for plans?

Nathan Nau, DHCS: Yes, we have ratios for both PCP and specialists. For network certification, we have ratios they are required to meet for specific population size and geographic areas.

Gary Passmore, CA Congress of Seniors: Why are only pediatric dentists listed?

Sarah Brooks, DHCS: That was the only category required in the final rule.

Anthony Wright, Health Access California: With regard to Alternative Access rules, how does this interface with DMHC timely access standards?

Sarah Brooks, DHCS: We are working with DMHC to coordinate overall and to align timelines and decisions for approval of Alternative Access.

Anne Donnelly, Project Inform: Is the core specialist list a required list for each plan?

Sarah Brooks, DHCS: Yes, each plan must have the specialist or an alternative access plan.

Kristen Golden Testa, The Children's Partnership/100% Campaign: What happens when there is no provider in a geography?

Sarah Brooks, DHCS: In that case, the plan proposes an alternative access plan. They might request a 20-mile standard for a specific area if no providers exist within the standard listed. For example, Kaiser often has a central facility with all providers. They have a comprehensive provider system, but providers are not spread across a county geographically. They have to meet timely access standards.

Ms. Brooks reviewed the statewide implementation approach.

- Network Adequacy Data Validation: DHCS will leverage various tools and systems to analyze encounters, utilization, and network composition. DHCS will perform data validation. DHCS will also require deliverables submissions.
- Technical Assistance and Corrective Action DHCS will provide technical assistance to Plans regarding requirements to demonstrate network readiness and enforce any corrective action as needed.
- Network Certification DHCS will submit Network Adequacy Certifications to CMS annually as required by the Final Rule.

Nathan Nau, DHCS provided specifics on network adequacy data validation and walked the group through examples of the process for primary care and core specialists. There are a number of provider data systems and processes listed below, telephone verification by DHCS staff and External Quality Review Organization (EQRO) Validation Studies available. Data has been submitted for 2017 to a data warehouse and is available for analysis such as utilization trends.
Data systems:

- Post Adjudication Claims and Encounter System (PACES)

- New Provider and Encounter Data Files
- Data Quality Team
- Encounter Data Quality Measures – 25 metrics
- Percent of rejected encounters
- Amount of time between date of service and submission date to DHCS
- Utilization trends – Actual visits to adjusted expected visits
- Comparison of medical records to encounter data sent to DHCS

Mr. Nau also walked through a plan network certification example and reviewed network certification components, including the five areas listed. Mandatory providers include FQHCs, midwives and others. He reviewed a specific example of network certification for a core specialist.

- Physician and Primary Care Provider Ratios
- Core Specialists
- Behavioral Health Treatment Provider
- Mandatory Provider Types
- Time and Distance Standards

The internal operational analysis includes:

- Review of annual medical audit findings
- Policy and Procedure
- Validation Study Results
- Linguistic Services
- Provider Directory Reviews – Physical Accessibility

Anastasia Dodson reviewed the specifics on dental managed care network adequacy requirements. Dental Managed Care contracts already included both adult and pediatric dental network adequacy requirements and required a ratio of 1:2000 for primary care dentists to beneficiaries and total network dentists of 1:1200. Since Dental Managed Care only operates in Sacramento and Los Angeles counties, no alternative access standard requests are anticipated. DHCS has updated the quarterly reporting template for plans to measure compliance with routine and specialty appointment times, and provider-to-beneficiary ratios. We will work with plans on any issues that arise similar to the physician process.

Dina Kokkos-Gonzales presented the Mental Health and Substance Use Disorders (MH/SUDS) network certification process. This differs from those described so far given there are no existing, comprehensive provider files (such as those on the medical managed care plan side) at the level needed to certify networks. The data validation approach will be based on network data reported quarterly for the organization, site and rendering provider. Beyond this, DHCS will request that supporting documentation be submitted, detailed below. The MH/SUDS certification verification and alternative access process will mirror as closely as possible the medical managed care plan network certification process.
Supporting documentation:

- Geographic access maps and accessibility analyses
- Analysis of the expected utilization of services
- Analysis of the language line utilization
- Analysis of the availability of community-based services (i.e., where the provider travels to the beneficiary to deliver services)
- Evidence of sufficient access to American Indian Health Facilities
- Grievances and appeal logs and resolutions related to availability or timeliness of services
- Provider agreements with network providers and subcontractors, including contracts for interpretation, language line, and telehealth services
- Plan's provider directory/directories
- Results of beneficiary and provider satisfaction surveys related to network adequacy or timely access
- Policies and procedures

Don Braeger reviewed the Drug Medi-Cal Organized Delivery System (DMC-ODS) approach to network adequacy certification. Since DMC-ODS is a new system, most counties will be certified prior to coming into managed care as part of their implementation process. For the counties that came on line from February – June 2017, DHCS will use an alternate process. In subsequent years, counties will go through the same process described for MH/SUDS. Similar to MH/SUDS, the level of data available is not comparable to the physician side. Therefore, pre-implementation review will use the following components:

- Project utilization estimates from historic utilization and prevalence data from the DMC-ODS County implementation plans.
- Use this data to determine the number of providers to serve the projected utilization
- Develop time and distance mapping based on enrollment and provider lists from the readiness review.

Questions and Comments

Brenda Premo, Harris Family Center for Disability & Health Policy: We receive 3-5 calls/month from wheelchair users looking for a provider where they can transfer and use the dental chair. We haven't looked at anything on the equipment requirements for this accessibility. I am surprised by the level of complaints on this. Sometimes dentists feel concerned about taking the patients because of the safety issues.

Anastasia Dodson, DHCS: I would like to have more information about these examples and whether they are managed care or FFS, and which geographic areas.

Kristen Golden Testa, The Children's Partnership/100% Campaign: How is timely access verified? What information do you get from the plan and how does that validate timely access? Is this reported publicly?

Nathan Nau, DHCS: For timely access, we don't get data from the plan. On an annual basis, we audit the plans on timely access. We just launched the EQRO process to monitor timely access by quarter, by plan, by reporting unit (usually county level) using a tool that providers submit. The annual audit findings are on the website, but since timely access is just starting, it will be reported publicly starting in the third quarter of 2018.

Michael Humphrey, Sonoma County IHSS Public Authority: Following up on Brenda's comment, why aren't physical and program access topics, like sign language, called out on the slides for certification? I think of access standards in many more dimensions than the ones presented.

Jennifer Kent, DHCS: All the work presented here is focused on coming into compliance with the federal managed care final rule. We do have many ways to monitor health plans. This network adequacy certification is not the only compliance oversight of plans. There are contractual requirements between plans and providers and other ways the issues you raise are addressed.

Brenda Premo, Harris Family Center for Disability & Health Policy: I want to give DHCS and Sarah Brooks credit on this topic. We are developing a tool, right now only for primary care, that will ultimately be on a web site to establish a base for the data and offer transparency about accessibility.

Linda Nguy, Western Center on Law and Poverty: I would appreciate the opportunity to comment on the network adequacy APL. I hope our comments related to certifying each individual delegated entity are helpful. Hopefully our comments were useful on the Mental Health side. What will the stakeholder process look like; how can we engage?

Dina Kokkos-Gonzales: Our intent is to mirror the information notice with the APL.

Jennifer Kent, DHCS: I understand the point that this is not the way we normally have done this. We can take that back and consider changing.

Steve Melody, Anthem Blue Cross: We appreciate the back and forth that was part of developing the process and we accept these standards. Beyond what is listed here in the formal certification, the reality in the marketplace is that exceptions are made all the time to achieve access. If a member needs a dermatologist and it is 20 miles away or is a non-contracted provider, we have an access unit that handles that on a case by case basis to be sure members get the care they need.

Sarah Brooks, DHCS: Yes, that is a great point. We are making changes all the time to improve access, such as the recent non-medical transportation that was implemented last year.

Erica Murray, CA Association of Public Hospitals and Health Systems: I am curious about the Workforce for the Future Commission and the dialog there, such as behavioral health. In particular, the lack of adequate workforce and ways to grow the pipeline that relate to network adequacy. Is there anything to be learned from that process for input here?

Sarah Brooks, DHCS: Yes, there are certainly providers we already know have shortages and we are developing data that will be useful to monitor and develop ideas on that.

Kristen Golden Testa, The Children's Partnership/100% Campaign: How often is the data reported on network adequacy?

Sarah Brooks, DHCS: There is a monthly data file. There is an annual network certification process. Separately, there is a quarterly validation process and starting in 3-4th quarter, you will see updated information reported in a dashboard.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Is the timely access data broken out by children/adults?

Nathan Nau, DHCS: The validation is by children, adults, and other elements as well. I am not sure what will show up on the dashboard. We can take that back.

Anthony Wright, Health Access California: On the audit for timely access, is this a secret shopper or a records request?

Nathan Nau, DHCS: We get information from monthly provider files and send to the EQRO. They contact providers directly.

Jennifer Kent, DHCS: Separately, there are chart audits and secret shoppers – it is 3 separate things.

Maya Altman, Health Plan of San Mateo: I know how challenging this is for the plans. For behavioral health and ODS, it seems this will be really challenging to get this information. What is your sense about being able to get accurate information? How do you see this playing out?

Dina Kokkos-Gonzales: This is a new process for the mental health plans and ODS world to collect this kind of robust data. We expect plans will comply. If plans can't certify because they don't meet network adequacy requirements, we would issue a corrective action plan. While the plan addresses the corrective action, beneficiaries are permitted to receive services out of network.

Maya Altman, Health Plan of San Mateo: Is that new for them to offer service outside the network?

Jennifer Kent, DHCS: Yes, we are getting ready to issue information next week about how we will certify the network and what will happen if there is not an adequate network. Beneficiaries will be able to receive services with a non-contracted provider and the county mental health plan will pay for it.

Jonathan Sherin, LA Department of Mental Health: Around California and in Los Angeles, there is a massive homeless population with serious mental illness. We are investing in street outreach to engage them in care. It is difficult to think about what network adequacy would be in that context?

Jennifer Kent, DHCS: Our approach at the state is to try to monitor the general approach to a network so it is adequate. With a broad brush, is the network adequate to care for the population? It doesn't get as granular as you suggest; we are not ensuring a network that reaches the special population you are referencing. You make an excellent point that this approach does not necessarily get at secondary or tertiary levels of need.

Jonathan Sherin, LA Department of Mental Health: I am raising it because this is an intentional move in LA to direct resources to this population.

Chris Perrone, California HealthCare Foundation: What is your perspective on providers vs provider full-time equivalents (FTEs) as the measure? If there are multiple plans in a county, they may be counting the same providers and contracting with the same providers. How do you think about this notion of 'provider' as the measure of adequacy, given that providers offer service in many contracts?

Nathan Nau, DHCS: We are in the process of finalizing the methodology. We are able to look at all plans to assess the pattern for a provider; to look across the plans.

HCBA Waiver and Introduction of New DHCS Division Chief of Integrated Systems of Care

Jacey Cooper and Sarah Eberhardt-Rios, DHCS

Slides available: http://www.dhcs.ca.gov/services/Documents/HCBA_Waiver_SAC.pdf

Jennifer Kent introduced Sarah Eberhardt-Rios, the new Division Chief of Integrated Systems of Care. Ms. Rios comes to DHCS from San Bernardino County. The new division combines the long-term care work with California Children's Services (CCS), Child Health and Disability Prevention Program, and Genetically Handicapped Persons Program.

Jacey Cooper offered an overview of the 1915 (c) waiver that was renewed in 2017, the Home and Community-Based Alternatives (HCBA) waiver. 1915 (c) waivers are renewed every five years. This waiver allows DHCS to manage complex patients in the community who would otherwise be in facilities without the additional services offered

through the waiver. Prior to this 2016 renewal, DHCS engaged in a broad stakeholder engagement process, technical workgroups and two comment periods prior to submitting the waiver.

Items that changed include:

- Waiver name: The name of the waiver program changed from the Nursing Facility/Acute Hospital Transition and Diversion Waiver (NF/AH) to HCBA Waiver.
- Waiver capacity: There currently is a wait list for waiver enrollment. In 2017 there are 5,500 slots, increasing to 8,974 in 2021. The increased slots will increase the capacity and ensure most vulnerable beneficiaries can participate
- Reserved capacity: DHCS reserves capacity at 60% of the waiver for those in residing in an institution and those turning 21 and transitioning from other programs such as CCS.
- Aggregate cost limit: The previous waiver operated under an individual cost limit that changed to an aggregate cost limit.
- Level of care consolidation: The levels of care went from nine to three.
- Waiver integration: The In-Home Operations Waiver will be integrated into the HCBA waiver. There is no change in services for participants.
- Shift to Organized Health Care Delivery System (OHCDS) model: This is a significant change. DHCS will contract with waiver agencies to conduct both administrative and comprehensive care coordination services under the waiver. The advantages include increased waiver capacity, enhanced care management services, improved participant access to services and improved quality control.

Notices on awards for selected waiver agencies will be announced in February and agencies will implement in April 2018. Some areas may have more than one waiver agency. It is anticipated that almost 90% of the state geography will be covered. For areas of the state where no waiver agency exists, DHCS will provide all functions. There are only 42 beneficiaries in the geography with no waiver agency.

Ms. Cooper reviewed the administrative services responsibilities and the comprehensive care management services. There will be a readiness review is to validate that the organizations are able to meet waiver and contract requirements, such as staffing, provider network, policies and IT. All waiver agencies will use a common case management system. With this transition to waiver agencies, DHCS is building an internal unit and other mechanisms to implement a strong performance monitoring process.

Questions and Comments

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Do you expect all applications to move forward?

Jacey Cooper, DHCS: Not all applicants will move forward. We will post all the applications and those awarded and their geographies next week.

Maya Altman, Health Plan of San Mateo: Can you talk about the kinds of organizations applying?

Jacey Cooper, DHCS: There were counties, home health agencies, community-based organizations. There was interest but no applications from managed care plans.

Michael Humphrey, Sonoma County IHSS Public Authority: Congratulations on the statewide coverage for everyone except the 42 beneficiaries. Where there is not coverage, will you engage the surrounding counties to see if they are interested in expanding?

Jacey Cooper, DHCS: Yes, we are reaching out to existing applicants. We can re-post if needed for a new round of application in those counties.

Michael Humphrey, Sonoma County IHSS Public Authority: At the recent Olmstead meeting, there was robust discussion about the changes. Some agencies did not apply and now will be displaced because of the rigorous requirements, such as insurance and staffing. Can you discuss the follow up to that discussion?

Jennifer Kent, DHCS: Based on the feedback we received at the Olmstead meeting, some members did reach out to discuss whether some requirements, such as master's level social workers and billing capacity, should be changed. We discussed internally whether changes were warranted. In spite of the concerns raised, we decided not to change the staffing levels or other requirements. We wanted to be sure we could put full confidence in the waiver agencies to care for a fragile population and to conduct the billing and other responsibilities.

Michael Humphrey, Sonoma County IHSS Public Authority: I'm glad you took time to consider that. I think the approach is a good one. What do beneficiaries know about the changes ahead for them? Are they prepared? What will change for them? Will they have choices? For example, a local beneficiary has the option to be their own case manager. Will that continue?

Jacey Cooper, DHCS: Waiver agencies will be responsible for notifying beneficiaries and let them know who to talk to. We have tried to get the word out via advocates and stakeholder organizations. DHCS has not reached out directly to beneficiaries because we didn't know what the statewide coverage would be. Now that we know we have waiver agencies, we will reach out and waiver agencies will reach out. I will have to get back to you

Jennifer Kent, DHCS: We hope waiver agencies will want to preserve self-directed beneficiary involvement as much as possible. Not everyone will have that desire but where it exists, it should continue.

Update on Adult Dental Benefit Restoration Data
Alani Jackson, DHCS
Slides available:
http://www.dhcs.ca.gov/services/Documents/AdultDentalRestoration.pdf

Alani Jackson presented an update on the adult dental benefits. There was partial restoration of adult dental benefits in 2014 and fully restored benefits as of January 2018. Notifications were posted and sent to Medi-Cal head of households to notify them about the restoration between October – December 2017. DHCS submitted SPA 17-027 on November 8, 2017 and it is still pending CMS approval. DHCS has sent provider bulletins every month since November, posted on the provider website and updated the provider handbook. There will be additional updates to the provider handbook with the update of the dental Manual of Criteria from Current Dental Terminology (CDT) 13 to CDT 16, estimated in March 2018.

Ms. Jackson offered information on adult dental utilization and trends from 2014-2017 in both dental managed care and FFS. The total 2017 adult population eligible for benefits is 9M, with most, 8.35M, served through FFS. Dental utilization trended up a bit after the partial restoration in 2014 and is trending up for 2017 in both managed care and FFS. The top utilization visits and procedures were annual visits, treatment, diagnostics and exams. Annual utilization hovers around 20%. She noted the procedures that were also included in Prop. 56 supplemental payments, such as annual exam and amalgams. Because the restoration of full benefits is so recent, there is not full utilization information available; however a chart of authorization requests submitted in January shows pent-up demand. There will be more robust data available in the future. The Fiscal Intermediary (FI) received 34,000 requests a day, estimated over 170,000 weekly for treatment and is meeting contractual requirements for processing treatment authorizations. The FI contract has been split into two contracts who assumed operations on January 29, 2018; an FI for claims processing (DXC) and an Administrative Services Organization (Delta Dental).

Questions and Comments

Marty Lynch, LifeLong Medical Care and California Primary Care Association: On the annual utilization data, what is the normal utilization for populations outside Medi-Cal? What utilization are you shooting for?

Alani Jackson, DHCS: I don’t have comparison for California outside of Medi-Cal. We would like to see more than 20% utilization. There is room for improvement. For children, we want to see about 48% annual utilization and it should be similar for adults.

Carrie Gordon, CA Dental Association: Generally, adult utilization is 50%, perhaps higher for those with commercial coverage; higher for children.

Carrie Gordon, CA Dental Association: It is hard to compare the years here or understand the trend given the partial and then full restoration of benefits. Do you have utilization prior to 2009?

Alani Jackson, DHCS: I can check to see if we have the data.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Looking at the data, I am surprised to see more extractions than amalgams. How do you interpret that?

Alani Jackson, DHCS: I can take that back and get some thoughts for you.

Carrie Gordon, CA Dental Association It could be because extractions were covered; amalgams were not previously included.

Anthony Wright, Health Access California: Can we get more detail about the people getting any visit? What is the unique number of people getting an annual visit or other service?

Alani Jackson, DHCS: These are the top procedures for the years depicted and they overlap. A person might show up here as getting an annual visit and a treatment visit. We can follow up.

Herrmann Spetzler, Open Door Health Centers: In rural areas, we are having trouble meeting demand for adult dental services. We hear from lots of angry adults who have heard there is a restored benefit but can't get service. We are excited about the restoration of benefits but there are workforce issues, especially in rural areas.

Jennifer Kent, DHCS: Thank You.

Michael Humphrey, Sonoma County IHSS Public Authority: Do you have a breakdown of utilization data by county?

Alani Jackson, DHCS: No, we don't have that data. There is utilization data posted via the CHHS open data portal for FY 14, 15, 16 that allows analysis by county. There are pages on the DHCS website with dental reports. We can send the link out for the data portal. Once we see claims coming in, we can return with more information on 2017.

Lisa Davies, Chapa-De Indian Health Program: Does this data include FQHC and Tribal clinics?

Alani Jackson, DHCS: Yes.

Linda Nguy, Western Center on Law and Poverty: Is it possible to get denial and approval rates and top procedures for TARs?

Jennifer Kent, DHCS: Yes, we can do that. There is a lag in the data, sometimes up to a year. Not all the TARs are due to the restoration of benefits. We don't want it to be misrepresented as all due to the restoration.

Anthony Wright, Health Access California: This is very exciting. With the turnover of the contracts and the restoration of benefits, is there an opportunity for integration of dental and physical health benefits?

Jennifer Kent, DHCS: The separation of contracts is about splitting the administrative functions for dental. We are in process of renewing and updating FFS claims across DHCS. There is a conversation we could have about that, but it is not about dental and physical health per se. These are usually 5-year contracts with 5 1-year renewals.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: We are working hard to integrate physical and dental health benefits. There is a ready-made opportunity with FQHCs to support integration and highlight best practices.

Alani Jackson, DHCS: We have talked in the past about including FQHC data and in this data, the dental program consultants completed a crosswalk of ICD-10 codes to CDT codes to integrate the FQHC data.

Carrie Gordon, CA Dental Association: Providers are impressed with the turn-around so far. There is a concern that managed care numbers don't look as good as FFS and that they are both so low. We definitely need to attend to the capacity issues in the system.

Jennifer Kent, DHCS: We released a report yesterday that outlines multiple initiatives and a full complement of activities within the dental program. We are happy to share the report.

Brenda Premo, Harris Family Center for Disability & Health Policy: We are doing well with the health plans we are working with and improving access with managed care. For the future, there is more to do to realize full access.

Public Comment

There is no public comment.

Next Steps and Meetings in 2018
Jennifer Kent, DHCS Director

- May 17, 2018
- July 18, 2018
- October 25, 2018