State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

January 27, 2016

Meeting Minutes

Members Attending: William Arroyo, M.D., Mental Health Provider Representative; Ellen Beck, M.D., Family Practice Physician Representative; Ron DiLuigi, Business Community Representative; Jeffery Fisch, M.D., Pediatrician Representative; Karen Lauterbach, Non-Profit Clinic Representative; Marc Lerner, M.D., Education Representative; Wendy Longwell, Parent Representative;; Paul Reggiardo, D.D.S, Licensed Practicing Dentist; Sandra Reilly, Licensed Disproportionate Share Hospital Representative**;** Pamela Sakamoto, County Public Health Provider Representative; Jan Schumann, Subscriber Representative; Terrie Stanley, Cal-Optima – Health Plan Representative; Elizabeth Stanley-Salazar, Substance Abuse Provider Representative; Liliya Walsh, Parent Representative

Attending by Phone: There are no members participating by phone

Not Attending: Alice Mayall, Subscriber Representative

DCHS Staff: Jennifer Kent**,** Rene Mollow, John Zapata, Adam Weintraub

Guests Attending: Rhea Schumann, daughter of Jan Schumann

Others: Bobbie Wunsch and Laura Hogan, Pacific Health Consulting Group

Public Attendance: members of the public attended.

Opening Remarks and Introductions	*Ellen Beck*, MD, MCHAP Chair welcomed members and the public and facilitated introductions. Terrie Stanley, a new MCHAP member, was introduced, representing Cal-Optima Medi-Cal managed care health plan. Ms. Stanley introduced herself and highlighted her background in neonatal intensive care.
Meeting Minutes, Follow-Up and Election of Chairperson	The legislative charge for the advisory panel was read aloud by Rhea Schumann (MCHAP member Jan Schumann's daughter) who is visiting the Capitol to learn about government. (See agenda for legislative charge.) http://www.dhcs.ca.gov/services/Documents/MCHAP_MeetingAgenda_Jan272016.pdf Minutes were reviewed and approved. http://www.dhcs.ca.gov/services/Documents/111615_Meeting_Summary.pdf *Adam Weintraub, DHCS* reported on the nominating process for the chair position. One nomination for chairperson was received so there is no need

	for formal balloting. A motion to approve Ellen Beck as MCHAP Chair was made by Marc Lerner, seconded by Ron DiLiugi and passed with unanimous vote.
Director's Update Jennifer Kent	*Jennifer Kent, DHCS*: Governor Brown released the proposed 2016-17 budget on January 7th. It is a positive budget from the perspective of health. The general fund augmentations are good news. Although the budget may not be all that is wanted, it is much more positive to be in an era of expanding resources. The budget is predicated on financing from renewal of the managed care organization tax. A final agreement on a restructured $1B tax is still pending and is a significant focus for DHCS. The Governor continued the CCI (a seven county Dual Eligible Medicare-Medi-Cal managed care demonstration program). In addition, the budget includes financing for the administration's commitment to extend full scope Medi-Cal benefits to all children up to age 19 as an optional benefit. This is an important step forward. In addition, the 1115 Medicaid waiver, Medi-Cal 2020, was approved by CMS on Dec 30th. It is a $6.4B financing mechanism especially important to public hospital reforms. Included in the waiver is a Whole Person Pilot (WPP), based on San Diego Project 25 targeting the 25 highest 9-1-1 users for intensive case management to lower health care costs. The WPP is a competitive initiative to target this high strata of health care users to deliver care in a better way. This will include supportive housing health services, housing navigation and other community and social services. In addition, there is a $750M dental transformation initiative that includes three components: 1) provider incentives to increase Denti-Cal capacity and/or recruit new providers; 2) incentives to increase "Dental Home" continuity of care and preventive care and, 3) incentive payments for caries risk assessments. *Questions:* *Ellen Beck, MD*: Is the dental program competitive like WPP? *Jennifer Kent, DHCS*: The WPP is competitive to the counties. It is about $300M per year and limited to counties. Dental is directed to Fee for Service (FFS) dental providers. It will help increase the number of providers becoming a new Denti-Cal provider or increasing their patient slots open to Denti-Cal beneficiaries. It is not competitive and the county is not involved – individual dentists will join Medi-Cal or increase capacity – and receive incentive payments. *Wendy Longwell*: Can you repeat the information about supportive housing? *Jennifer Kent, DHCS*: The housing component of the WPP will not pay for housing such as rental subsidies. It could pay for supportive services to wrap around high-need individuals. For example, it could pay for staff located in housing complexes who can offer case management and health services for medication management or other complex medical conditions. There were a number of items that did not get included in the waiver such as work force development. *Wendy Longwell*: Is the supportive housing through the state or counties? *Jennifer Kent, DHCS*: It is through the counties. This will be handled similar

	to a previous waiver program, Health Care Coverage Initiative. Counties will apply and outline a plan for specific diseases or other focus area. We don't know how many counties or regional group of counties will be funded with the funds available. *Ron DiLuigi*: What is DHCS' perspective on the Duals project. There were expectations about enrollment and cost savings. Is there a reset coming? *Jennifer Kent, DHCS*: The enrollment in CCI has not achieved what we wanted. We have had outside help to assess the difficulties, from SCAN Foundation, through rapid-cycle Field polls and information about beneficiary preferences. There are about 140,000 enrolled now. We are working with providers and others to improve enrollment. Once someone is in the program, there are very few disenrollments. We are working with CMS and plans to get the program streamlined and working to be sure beneficiaries understand the benefits of the program. Plans are working to educate beneficiaries and some have even added benefits, like Cal-Optima adding dental benefits. This is the 3rd year of the demonstration and we have sent a nonbinding letter to CMS suggesting a discussion of additional two-year timeline. We are working hard to make this a success.
Follow-Up on SB 75 – Coverage for All Children **Ellen Beck** **Jennifer Kent** **Rene Mollow**	*Ellen Beck, MD:* At the last meeting, we gathered input from community leaders and worked as a group to develop a set of SB75 recommendations that were sent to Director Kent. *Jennifer Kent, DHCS*: It was great to receive the letter. The recommendations are exactly what the Advisory Group should be doing. You were formed to advise us. The letter was substantive and I appreciate receiving it. Let me review the recommendations and update you on each topic. *Rene Mollow and Jennifer Kent, DHCS* <u>Set a start date now for CalHEERS enrollment to begin</u>: The system changes were scheduled to occur in April. Now, functional changes will happen May 16th. If there are further delays in the scheduled release date, it is possible for the functionality for the SB75 expansion to be released separately. We are continuing to say 'no sooner than May 1st' and when the date is closer, we will announce the effective date. Some communities are advising families to apply now. When an application is received, eligibility is retroactive to the 1st day of the application month so they will be eligible for the month of May. CalHEERS is a shared IT system with Covered CA and it is also attached to county eligibility systems. There are concurrent changes that have to occur. As technical staff create code, there is testing and it has resulted in some delays. We have been clear that this release cannot be pushed to the next release date, which is 2-3 months later. <u>Allow those known to Medi-Cal through restricted coverage to select a managed care plan 60 days</u> <u>before full scope coverage begins</u>: We don't have the system elements in place to accomplish this. To the extent that we can align a pattern of provider/health plan and encourage a beneficiary to make a health plan choice immediately, we can speed things up. Managed care enrollments only occur monthly, so if you enroll May 15th, we can't enroll you in a health plan until the next month. Beneficiaries have coverage but

	stay in FFS until the next month. Allow children enrolled in local programs, including Kaiser Child Health and Healthy Kids, to transition directly into the Medi-Cal managed care plan where they are currently enrolled: Beneficiaries must apply for Medi-Cal though the regular system. A plan can't legally determine eligibility – only counties can confer eligibility; therefore, all children must come in through the county application process. Once an application is complete, we also want to preserve beneficiary choice of the plan they want to enroll in. We won't be defaulting into the plan they were already in without an affirmative choice by the family or using the default algorithm if they don't choose. Simplify the application and message carefully/ Provide clear statements about confidentiality: We agree with you. We are developing Frequently Asked Questions and other documents to help create the clearest explanation possible and ensure readability at 5-6th education/grade level. They will be translated into all threshold languages. We are sharing these documents with stakeholders for review. We are endeavoring to make it the most approachable language and to allay fears about immigration issues. On confidentiality, we are making it clear the information will only be used for determining eligibility (e.g. DOB, address, income). We have to run through our system and the federal hub to match up for eligibility. It is not used for any other purpose than eligibility – not anything else. The only use of the federal hub is to verify income using tax returns. Fund outreach and enrollment in trusted environments and build on existing outreach and enrollment systems that are in place and working well: We are working in partnership with foundations to support outreach and they continue to be interested in this area. The state will not be funding outreach activities. Continue to engage stakeholders in communication and transition planning: Yes, absolutely. There are multiple stakeholder groups including MCHAP and we will continue to engage. Waive premiums for restricted Medi-Cal: The state budget is better but we are not in a position to make this exception. We will treat these families the same way we treat all other families. Expand the 1296 work group to include Medi-Cal consumers and SB75 targeted populations: I am interested in hearing any specific constituency you think is missing. The stakeholder group is set in statute similar to MCHAP and would be difficult to change, however we are happy to invite others and include them. *Questions:* *Marc Lerner, M.D*: I understand the process of eligibility better as it relates to the issue of confidentiality. Information may have to go forward through federal hub as you describe. I think it would be useful to have some of the trusted voices from the legal community to help advise on specific language. *Rene Mollow, DHCS*: We are talking to legal aid representatives. The application uses language that is required. What we are doing is to work to

	make sure families understand the requirement through FAQ and other documents. We have other state-only programs for undocumented individuals and that is helpful here. We are also working closely with the local coverage programs and foundations to develop language and materials they can use to support the communication. *Marc Lerner, M.D*: It is especially important to have that partnership and to know that trusted voices are in the community. *Ron DiLuigi*: One item that was not included in the final letter was the issue of federal incentives to upgrade the eligibility system. SB75 is an opportunity for a paradigm shift in eligibility and enrollment systems given the fact that all children are covered in California. With this switch is there a way to accomplish a paradigm shift away from the old eligibility and enrollment system? In December, CMS put out final rules on eligibility modernization. Can we make permanent the 90% match level? *Jennifer Kent, DHCS*: Yes, we are using that opportunity here. The CMS funding is the money that is building CalHEERS. It is shared with Covered CA and we have a piece of the system and use 90-10 funding. *Ron DiLuigi*: For children, the only eligibility task to accomplish is the means testing. We don't need much of the previous information. Is there more that we can do to move away from the old system that frightens people away. *Ellen Beck, MD*: What would you want to see in the application? *Ron DiLuigi*: I would want a very simplistic application that requests income information only and is less threatening. *Ellen Beck, MD*: Can DHCS clarify the issue of verification? Isabel Dominguez referenced the difficulty individuals have with confirming income or housing costs. People who have to verify the rental or income information may be afraid to do that because they do not want to put their employer or landlord in that position. *Rene Mollow, DHCS*: There is no separate application for this group of children. People do have the ability to self-attest the information on the application if they don't have verification. If the information coming back from federal hub is inconsistent, the county will follow up to verify the information and sort out the differences. We don't have to get a piece of paper - people can call with their information. As to the information we get, if it is at or below income level for Medi-Cal, that is all we need. *Ellen Beck, MD*: If a family writes down 'I earn $100/week,' is that sufficient? My understanding is that counties have a process to verify income. Will counties be advised to be less intense for these children? *Rene Mollow, DHCS*: The counties will handle these applications the same way they do others. *Ellen Beck, MD*: Will the county be guided to accept self-attestation?

	Rene Mollow, DHCS: If the self-attestation information is compatible with federal hub, that is all we need. It does not have to be exact. *Ellen Beck, MD*: On housing, do they self-attest residence? *Rene Mollow, DHCS*: Yes. *Ron DiLuigi*: Can you comment about how different what you are doing might be from my goal of simplification? *Rene Mollow, DHCS*: If a family reports an income at or below Medi-Cal and the federal hub says the income for the family is at or below, that is all we need. *William Arroyo, MD*: As the panel does its work, we are struck with the data within DHCS and our challenge to make inquiry into certain data sets. For SB75, will service data collection mirror the current population served by Medi-Cal? Will it be possible to peel off SB75 beneficiaries and services? Will data reflect funding of infrastructure at the provider level, such as translators? *Jennifer Kent, DHCS*: We don't provide service-level data because it is not HIPAA compliant. There will remain a flag on SB75 beneficiaries and we know who they are. For the purpose of service level data, these will be managed care beneficiaries and we will not be matching up local service information. The plans do track that information and provide it to us for rate calculations but not specific to SB75. *William Arroyo, MD*: My concern is that it is difficult to do a thorough evaluation of whether the population is being served because they are lumped together with other populations in the data. Can we explore how to evaluate this population? *Jennifer Kent, DHCS*: We are trying to treat them like other kids. I am not looking to highlight them or report out separately on them. *William Arroyo, MD*: For example, let's say Cal Optima immunization rates are above benchmarks in the aggregate but how would we know if the SB75 population is benefiting at the same level? If this coverage is doing what we expect? *Ellen Beck, MD*: I think it is risky to highlight this group. *William Arroyo, MD*: This is aggregate data. If the initiative is not doing what we expect it to do, we might be able to correct it. I am concerned about putting a vulnerable population into a group that is less vulnerable for data reporting. *Rene Mollow, DHCS*: We are covering this group today under PRUCOL. We know from our systems that they are undocumented. We look at health outcomes and prevention services, but we don't look at them by immigration status.

	William Arroyo, MD: I raise this issue to strategically address disparities. *Karen Lauterbach:* To circle back to the issue of verification, we have not had any issues and this has been fine in practice. I don't see this as a barrier. We do need computer systems to work well. The families are participating in Medi-Cal already in many instances and I don't think it will be foreign or new for many of them. *Jeffery Fisch, MD*: I do keep coming back to the recommendation that we should make this system very simple to increase access. Can you send the general application to me? *Ellen Beck, MD*: I agree and would like to see that the letters, documents and application be sent to the whole advisory group. Also, is there a representative that is undocumented on the immigration work group? Is there a liaison to MCHAP on the work group? *Rene Mollow, DHCS*: We send a link to encourage everyone to participate. We can work on how to better coordinate information sharing and we welcome your involvement. *Jennifer Kent, DHCS*: If you want a member to attend the immigration work group or attend 1296 workgroup, you can tap someone to participate and report back. *Ellen Beck, MD:* I am interested *Karen Lauterbach*: I am interested; *Jan Schumann:* I am interested *Jan Schumann*: I am concerned that there is continuity of care when a family moves from one county to another so they can keep their provider. I look forward to working with DHCS to accomplish this. *Jennifer Kent, DHCS*: It is unlikely that a family can maintain a provider in another county. If there is a need for a special instance of ongoing treatment for a condition or a need for a continuity of care arrangement, the plan needs to contract. It also relies on the provider being willing to contract with the plan in the new county. *Wendy Longwell*: Where I am, crossing county lines can be two blocks away. Sometimes when families move and notify the county, they are canceled in the transition before the eligibility and care is transferred and it results in a gap in coverage. On another topic, people fill out the application in Spanish but the follow up letters often are not in Spanish. We see lots of families coming in seeking help because the information arrives in English. Can you work to make counties aware that if the application is in Spanish, the follow up should be in Spanish. *Jennifer Kent, DHCS*: Perhaps we can follow up with you. When a family indicates a preference, the follow up should acknowledge that. Sometimes there is no indication of language. We struggle with follow up and language. The instance you reference is clear and it should be sent in the right language. It is our job to make Medi-Cal as easy and accessible as possible.

	Ellen Beck, MD: Patients constantly bring in letters because they don't know what it means. I am happy to know you are working on readability and hope you encourage counties to do this as well. Rene Mollow presented an update on timelines and implementation. We are working to meet the May 1st timeline. There are upcoming meetings and webinars. The next immigration work group planning meeting is February. 8th. There is an SB75 eligibility and enrollment plan webinar February 18th. There is a 1296 work group on March 11th to report out of the work group efforts related to SB75. We do provide regular updates through the immigration workgroup. On January 20th, we held a provider webinar and we will have a provider bulletin out soon. We are in the process of finalizing FAQs on the initiative as well as notices on public charge and other topics that will be posted on the SB75 website. http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/sb-75.aspx We are finalizing three notices: 1) a general notice; 2) a notice of action to inform the change in coverage; and, 3) plan enrollment information. Following stakeholder input and final approval, notices will go for readability review and translation. We are still working against a May 1 start date and there will be a system trigger date notice to Department of Finance closer to time. *Jeffery Fisch, MD*: Are you talking to plans about the estimates of new beneficiaries they should expect? It may have disparate impact depending on region. We are all concerned there may be coverage without access. Can you let us know what has been done to prepare? *Jennifer Kent, DHCS*: We are putting plans through readiness review, and to the extent needed, network augmentation. We know network capacity now and internally we are coordinating between eligibility and readiness to assess any needed increases. This is a small transition compared to some others and DHCS is tracking this. *Ellen Beck, MD*: I am impressed with your efforts and DHCS efforts to make this real and to welcome our input. Can we have a report/update at upcoming meetings? *Pamela Sakamoto*: If you know the 140,000 with limited scope coverage, can you put them into counties and plans now? *Rene Mollow, DHCS*: We know them by county. They will be given plan choice if they are in a county with multiple plans. Once they are converted over to full scope Medi-Cal, they will receive a choice packet to choose the plan. *Pamela Sakamoto*: Is this available to plans so they can work on network adequacy? *Rene Mollow, DHCS*: Yes, we have weekly calls with the plans and there has been a lot of discussion on this topic. *Adam Weintraub, DHCS*: There has been a lot of discussion about different stakeholder groups. We will put links in summary but if you want to get the

	information faster, you can go to DHCS and click on stakeholder page to get specific information on each stakeholder work group. DHCS Stakeholder Groups: http://www.dhcs.ca.gov/provgovpart/Pages/StakeholderEngagement.aspx AB 1296: http://www.dhcs.ca.gov/Pages/AB1296EligibilityExpansion.aspx Immigration Work Group: http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/AB1296_Immigration.aspx *Ellen Beck, MD*: I had a conversation with Richard Figueroa from The California Endowment and he mentioned that the foundation will be funding outreach efforts across the state. He also mentioned the "All In" program, http://www.allinforhealth.org/ working to let schools know about SB75.
Member Updates and Follow-Up Dental Sub-Committee Behavioral Health Sub-Committee Network Adequacy Sub-Committee Enrollment and Renewals (Report Available) - DHCS	*Ellen Beck, MD:* We have asked each subcommittee to report on their progress. Each group is at a different stage of development. We will ultimately have recommendations from each subcommittee to go to DHCS. **Dental Sub-Committee** Paul Reggiardo passed out a written report. He reported that there are nine recommendations coming from the sub-committee. To frame the recommendations, he noted that 50% of children at school entry have had dental disease; about 1 out of 3 children have untreated dental disease; and, about 4% of school-age children have urgent dental needs and are in pain. This is taking on a very important issue. We want a Denti-Cal system that is effective. Denti-Cal is only 1.4% of the overall Medi-Cal program but oral health is very important to overall health. The changes needed to address the issues are not broad-brush – they are small and finite but important to improve so the program works. He reported on the rationale for each recommendation listed. • **Increase provider reimbursement by targeted changes in the Schedule of Maximum Allowances (SMA) in the fee-for-service program to incentivize provider participation and retention in the Denti-Cal program:** Targeting reimbursement increases will be more effective than general increases. • **Simplify and streamline the Denti-Cal provider enrollment application and recertification process to more closely mirror that of commercial benefit carrier provider contracting**. This recommendation has been included in other reports as well and DHCS is working on it but this is important to include. • **Reduce unnecessary administrative claim payment and treatment authorization requirements so that the Medi-Cal dental program more closely resembles that of commercial benefit carriers**. • **Assess and report on actual network capacity and set beneficiary utilization goals:** It should be reasonable to set 60-65% utilization rate goals as other states and commercial plans have done. • **Engage within the Department of Health Care Services transparency and opportunities for stakeholder participation in the planning and implementation of the Dental Transformation Initiative within the Medi-Cal 2020 CMS Federal Section 1115 Continuation Waiver:** We are encouraged by the waiver proposal.

	These can be seen as pilot programs for California and other states to learn from. It is important for the program to be successful. • **Retract the Medi-Cal Department of Health Care Services All Plan Letter 15-012 (Revised 8/21/15) and the Denti-Cal Provider Bulletin Vol 31, No 12 (August 2015) regarding modified General Anesthesia and IV Sedation policies.** • **Establish and utilize the expertise of an independent *Medi-Cal Dental Program Evidence-Based Policy Advisory Committee,* the purpose of which would be to assess and make recommendations to the DHCS regarding the delivery of Denti-Cal services:** This would increase transparency and provide input to decisions beyond DHCS staff and consultants. • **Provide increased case management services to Denti-Cal beneficiaries and their families to overcome obstacles of limited oral health literacy, cultural attitudes and beliefs, transportation challenges, appointment compliance, follow-through with professional recommendations, and other barriers to good oral health.** • **Dismantle or completely replace the current managed dental care model in Sacramento and Los Angeles counties with a redesigned system.** *Ellen Beck, MD*: I suggest we make comments now, review each recommendation carefully between now and the next meeting and discuss them again at the next meeting. I don't see an orthodontia benefit recommendation, which I would like to see. I don't see enough about integration of primary care and oral health. Perhaps there is another recommendation to be included related to integrated approach. *Pamela Sakamoto*: I think the recommendations are great and agree primary care should be part of this. CHDP is an excellent example of coordinating between physical health and dental care. These recommendations are an excellent start and should be moved forward. In regard to cosmetic orthodontia, I think that is farther down the road. We should focus on prevention and treatment dental, not cosmetic with the $740M budget. *Paul Reggiardo, DDS:* I like the idea of the panel digesting and coming back to this at the next meeting. On orthodontia, there is complex and has to do with what is covered through EPSDT. There is no accepted definition of medically necessary orthodontics under the ACA. *Wendy Longwell*: On recommendation #2: it is important to streamline enrollment and we need to increase providers who do more than cleaning. A mother came to me to find a provider. By the time she found a provider, it was so serious that her son now will have all his teeth pulled. *Pamela Sakamoto:* Made a motion to forward the report to MCHAP and bring it forward on the agenda for the next meeting. *Ellen Beck, MD:* Following our discussion at the next meeting, we will work to develop a letter to DHCS similar to the SB75 memo. Thank you for this work.

	Jennifer Kent, DHCS: I am familiar with most of the recommendations and I appreciate the thoughtful input. Rates are difficult for us and I also appreciate your approach for targeted rate increases tied to outcomes we want to achieve as opposed to broad increases that may not accomplish what we need. *Adam Weintraub: DHCS:* Since these are sub-committees acting as informal work groups, we don't need formal motions to accept the report or place discussion on the agenda. **Behavioral Health Sub-Committee** *Elizabeth Stanley-Salazar*: We are not as far along in developing recommendations for a variety of reasons. Part of this is because it is unclear what the system of care for behavioral health services across the state actually is. I will begin with the Substance Use Disorder carve out. We are fortunate now to have an organized system waiver for Substance Use Disorder Services (SUD) secured by DHCS. However, we have never really had a system of behavioral health care for adolescents or children. Where do we start? There is no network of providers to develop the system. We have a long way to go to secure providers and develop that system. We are interested in accelerating that process. In Mental Health (MH), we have had a carve-out and now have a new partner in health plans. Those different entities are learning to work together. They are working to define mild-moderate but the siloes make it difficult to integrate. Dr. Linette Scott, the Chief Medical Information Officer, joined us today. We have wanted data and now understand we should align ourselves into topic areas that DHCS is working on, such as use of psychotropic meds, organized delivery systems. In the dashboard presented by DHCS, we have received MH utilization data for county specialty mental health services. We have an interest in looking at data on mild-moderate in managed care plans as well. We are also pleased that Terrie Stanley joined our group and she brought in depth information to the group. I will review our discussion and would like your reaction to our requests – not yet recommendations. We have an enormous challenge. There is a huge amount of data at the state, provider and county level. The difficulty is to bring the data forward in a focused way, complete an inquiry for the purpose of decision making. In addition, HIPPA is a challenge and behavioral health services have additional confidentiality restrictions that make data-sharing difficult. We want to support integration of services, primary care and MH/SUDS integration. There are structural barriers to this integration. For example, there is no EPSDT code to activate the SUD benefit; there is no mechanism in the EHR system to capture depression screening. Areas of interest: • Standards • Utilization of services/encounters • Outcome data using core child measures. • We have legislation to require depression screening as a new core child measure but there are structural barriers to activate this and know if it is happening. • Reasonable screening measures, including depression and SBIRT • Implementation of organized system of care for drug Medi-Cal in counties. This is an opt-in system at the county level.

- The opioid epidemic and looking at incidence of substance exposed infants
- Integration issues

Hot Topics for Follow Up Discussion

- Billing code for EPSDT
- Service data from managed care plans
- SBIRT roll out and penetration in primary care, ED
- Cultural diversity and its relationship to work force issues

The subcommittee will hold the next meeting as a phone call several weeks prior to the MCHAP date, in dialog with Dr. Scott, to bring forward recommendations. We would like to schedule a deep dive discussion and plan to bring forward recommendations.

Marc Lerner, MD: My thanks as well to Dr. Scott for the data she brought forward. I have some additional comments to add. Much of this occurs in the context of a focus on vulnerable youth, resource families with youth receiving foster care. There is now a HEDIS measure to address psychosocial care measure that links billing data with BH services and other primary care interventions beyond just medications. One concern from providers is that the management of mental health in primary care has been medication focused. This data is being collected by DHCS for foster youth and may show us an alternative way to look at the mild-moderate population. We spoke briefly about developmental behavior screening as an important harbinger in young children and the challenge in using EHR data instead of chart review to get at this data.

Ellen Beck, MD: These are excellent areas of focus – tapping into depression screening; the opioid issue is enormous.

William Arroyo, MD: There is low hanging fruit data from health plans with respect to the mental health benefit and that service data would be very useful.

Elizabeth Stanley-Salazar: Terrie Stanley mentioned an uptick BH services at Cal-Optima with the mild-moderate benefit in managed care.

Terrie Stanley: We are tracking this because it is new and are very interested in following this. For many plans, there has been a huge focus on Duals and I appreciate the work this advisory group is doing to help bring back to the focus on this population.

Marc Lerner, M.D: There has been increasing attention on a recommendation for parent screens for depression, prenatal and postnatal.

Ellen Beck, MD: I appreciate the attention to pregnancy. Other important areas include over-prescription of antipsychotic medications, benzodiazepines, and opioids; availability of counseling and therapy services, needs of adolescents and encouraging use of screening tools in primary care, such as PHQ 2 and 9.

Elizabeth Stanley-Salazar: The uptick since mental health parity occurred has been an increase in ED use. It has been dramatic in other states.

Marc Lerner, M.D: I think we need aspirational targets as a good goal for our recommendations.

Wendy Longwell: I have learned that hospitals choose who they admit into programs. Some teens sit for weeks in the hospital to find a placement and may finally go home without treatment – until an episode starts the whole process over again. I am not sure if you spoke about this but we need to look at the adequacy of the provider network here.

Ellen Beck, MD: You mentioned a deep dive agenda item for the next meeting?

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Elizabeth Stanley-Salazar: Yes, it will depend on the availability of data and Dr. Scott. We will plan for this over the next 1-2 meetings.

Jennifer Kent, DHCS: If dental is set for the next meeting, that might be enough. In addition, it would give us some time to prepare the BH data to set this for the meeting after next (May 2016). We appreciate the subcommittee work to focus their inquiry and we can support the work of the committee when we narrow the scope first.

Ellen Beck, MD: Our work is not finished with this set of recommendations and we do not need to feel that we can't return to these topics for additional recommendations.

Ron DiLuigi: I appreciate the target areas that we have talked about. I am interested in hearing more about the work to tie organized systems of care and county mental health to identify issues.

Network Adequacy:
Jeffery Fisch reported that this is a large topic and there have been many previous inquiries. We are still in process to determine the specific focus for the group and do not have recommendations to present today. The work will include the full spectrum of network adequacy of physical health, dental and mental health. We plan to pull in real life case examples to make this clear.

The inquiry will cover three areas: pre-enrollment status, care delivery and post care environment.

Pre-enrollment Issues: This includes 1) accurate determination of eligibility and the value of point of care eligibility; 2) prompt processing of eligibility; 3) identifying system barriers to eligibility; 4) incentives for enrollment; 5) timely processing; 6) assignment of providers aligned to needs and wishes of patients; and, 7) adequate coordination between counties.

Care delivery Issues: Getting the right care at the right place at the right time includes: 1) access to timely primary, specialty, MH and dental adequacy that is based on timely access measurement; 2) geographic adequacy - why patients are seeking care in one place vs another; 3) cultural issues to impede or improve access; 4) utilizing technology to improve access.

General questions included adequate reimbursement to attract providers;

	system barriers for providers; determining measures to define adequacy and are they meaningful and consistent across plans. Post care environment: discharge planning and the interplay of formulary and DME in post-inpatient care. The importance of oversight at the end of the process of care is very important. What would it look like in terms of adequacy; what mechanisms are in place for this. *Sandra Reilly*: We looked at trends for our pediatric outpatient clinic at the hospital. We see an increasing trend of outpatient pediatric patients from outside the secondary service area – defined as 100-120 miles away. I thought it might be anecdotal information but I pulled the numbers and it is true that we are seeing kids from Palm Springs and Mecca. We have more work to do to understand why, but one possible issue is that they are getting the care they needed immediately. *Wendy Longwell*: You want someone who knows your child. We chose to travel 2.5 hours to see a provider who is responsive. My previous experience was phone tag and delay. Parents will travel to get good care for their child. *Elizabeth Stanley-Salazar*: What about access to specialty care as an adequacy issue? This can be very difficult and the communication is exhausting. *Marc Lerner, M.D*: I want to address the lack of access while kids are in the process of going through denials. It is placed on families to take on care while the denial process moves along to identify the right agency to pay for care. There should be a no-wrong-door approach for families when the benefit exists and is clinically important. Look at denials and the kinds of services being denied is an important factor. *Pamela Sakamoto*: The state is working toward accessing technology and activating telemedicine codes so that the FQHC can operate as a medical home and be connected by technology to keep the number of trips to long distance providers down to a minimum. This can be enhanced to connect more remote clinics to specialty care providers. *Jeffery Fisch, MD*: I ask that members forward questions/topics for this inquiry. *Ellen Beck, MD*: May I suggest the presentation of this issue at the July meeting? *Jeffery Fisch, MD*: We feel we can't take one aspect out at this stage. We may focus the inquiry further. *Ron DiLuigi*: Each of the topics needs to operate for care to be effective. *Jennifer Kent, DHCS*: I heard a broad range of topics. *Ellen Beck, MD*: The broad inquiry is great as a beginning and process, and as you move to recommendations, it will need to be specific enough so they can be acted upon.

	Ellen Beck, MD: The pediatric dashboard work is complete and therefore was not on this agenda.
Public Comment	*Gayle Matthew, California Dental Association*: I want to thank the panel for the attention to dental. The issues these recommendations address are a concern to CDA. We look forward to the continuing discussion. We are happy that network adequacy is also addressing dental. *Gail Yen, Children Now*: Thank you so much for the attention to children's health. We appreciate DHCS response to the MCHAP recommendations on SB75. Yesterday, 15 organizations sent a letter to DHCS on child core indicators.
Upcoming MCHAP Meetings/ Next Steps	March 16, 2016: Deep dive on dental May 11, 2016: Deep dive on behavioral health July 12, 2016: Deep dive on network adequacy September 13, 2016 November 15, 2016 *Ellen Beck, MD*: Thank you to Director Kent for coming to the meetings and staying the entire time. Thank you to the members and subcommittees for their efforts and commitment and to Rhea Schuman.