State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

January 31, 2018

Meeting Minutes

Members Attending*:* Ellen Beck, M.D., Family Practice Physician Representative; Jan Schumann, Subscriber Representative; Karen Lauterbach, Non-Profit Clinic Representative; Wendy Longwell, Parent Representative ; Kenneth Hempstead, M.D., Pediatrician Representative; Marc Lerner, M.D., Education Representative; Terrie Stanley, Health Plan Representative; Bertram Lubin, M.D., Licensed Disproportionate Share Hospital Representative; Ron DiLuigi, Business Community Representative; Diana Vega, Parent Representative.

Members Not Attending: Liliya Walsh, Parent Representative; Paul Reggiardo, D.D.S., Licensed Practicing Dentist; Pamela Sakamoto, County Public Health Provider Representative.

Members attending by Phone: Elizabeth Stanley Salazar, Substance Abuse Provider Representative; William Arroyo, M.D., Mental Health Provider Representative.

Attending by Phone: 30 stakeholders called in

DHCS Staff: Jennifer Kent, Norman Williams, Bambi Cisneros, Adam Weintraub, Morgan Clair, Joanne Peschko

Others: Dharia McGrew, California Dental Association; Kelly Hardy, Children Now; Kelli Boehm, Political Solutions; Jessica Rubenstein, California Medical Association; Hellan Roth Dowden, Teachers for Healthy Kids; Logan Anderson, Teachers for Healthy Kids; Reena Hudson, United Healthcare; Elizabeth Evenson, California Association of Health Plans; Sophie Scheidlinger, Health Plan of San Mateo; Susan McLearan, California Dental Hygienists' Association; Amber Kemp, California Hospital Association; Kim Flores, Senate Office of Research; Lynn Thull, California Alliance of Child and Family Services; Anna Hasselblad, United Ways of California.; Lisa Murawski, Assembly Appropriations Committee.

Opening Remarks and Introductions	Ellen Beck, M.D., MCHAP Chair welcomed members, DHCS staff and the public and facilitated introductions. Theresa Stanley read the legislative charge for the advisory panel aloud. (See agenda for legislative charge.) http://www.dhcs.ca.gov/services/Documents/MCHAP_agenda_013118.pdf Dr. Beck called the meeting to order. Dr. Beck spoke of her last meeting as Chair, and discussed the evolution of the MCHAP. Minutes from November 1, 2017 were approved unanimously. http://www.dhcs.ca.gov/services/Documents/110117_MCHAPMinutes.pdf *Adam Weintraub, DHCS:* Responses to the follow-up list have been posted to the MCHAP web page. *Jennifer Kent, DHCS:* Governor Brown's budget was released on January 10, 2018. Some of the notable items include an additional $230 million being added to Proposition 56 revenues for supplemental payments and rate increases for physician and dental payments. There were one-time allocations made by the Legislature last year to Prop. 56 funding. These supplemental payments need annual approval for use of funds. There were additional Prop. 56 funding allocated for a fifty percent rate increase for home health providers in the fee-for-service (FFS) system for the home and community-based services waiver. No Proposition 64 funding has been allocated to DHCS at this time. DHCS is seeking referrals to identify clinicians with expertise in trauma to serve on an advisory workgroup. AB 340 created an advisory workgroup to update, amend, or develop tools and protocols for screening children for trauma within the Early and Periodic Screening, Diagnosis, & Treatment (EPSDT) benefit. The link to the bill language can be found here. The Children's Health Insurance Program (CHIP) reauthorization came after the Governor's budget was proposed. Therefore, the May Revision will have to reflect the reauthorization and the enhanced funding that was provided by Congress for additional years. *Bertram Lubin, M.D.:* Can you elaborate on AB 340? *Jennifer Kent, DHCS:* AB 340 is very specific; the intent of the bill is to evaluate our current screening tools for children and whether these tools are appropriate at identifying trauma or

	behaviors associated with trauma exposure. If refinements are needed, the workgroup will suggest changes. *Ken Hempstead, M.D.:* Can you send an email with a brief description of the requirements? *Karen Lauterbach:* What are the savings from the CHIP reauthorization? *Jennifer Kent, DHCS:* We don't have an estimate yet, but it will be in the hundreds of millions of dollars. *Ellen Beck, M.D.:* In terms of services around the state, was there anything in the Governor's budget that you hoped would be there or are concerned about? *Jennifer Kent, DHCS:* Our budget was pretty easy from the standpoint that DHCS has no proposed reductions in services or eligibility, but is instead proposing rate increases. We're lucky enough to have a really good economy this year, but Governor Brown continues to warn about his reservations on the economic health of the state. *Ellen Beck, M.D.:* I'd like to see extra funding for SB 75, especially if it would add an additional year for children aging out. In terms of the legislative update, are there any bills we would want to look at? *Marc Lerner, M.D.:* For AB 11 on developmental screening, what are the levers of change associated with this bill? Who is responsible for overseeing that work is done, and in the absence of support, how would this process happen? *Marc Lerner, M.D.:* Within the physical health side, the developmental screenings exist and are not being routinely done. How does DHCS see this, in terms of supporting a practice that will give us a practical and measurable performance? *Jennifer Kent, DHCS:* It's not for a lack of a benefit that's available, but rather how do we move responsibly to assess or refer children. It's not that we're unable to pay for it, but that providers are unaware what to do. *Marc Lerner, M.D.:* There are processes for creating quality improvement and monitoring the work that's happening. Who

	would review this process? For a non FFS plan, billing or not billing may not lead to additional revenue. *Ellen Beck, M.D.:* It sounds like there's a consensus on the Panel about the importance of children getting a physical exam and a need for a consistent mechanism for evaluation. It sounds like this is a step towards that. This might be a topic to return to, or to have recommendations come from this group as how to be truly effective. What I'm hearing is that there are tests for it, and there might be funding for it, so what are we recommending? Our voice may be of value. *Jennifer Kent, DHCS:* For the trauma screening bill, it's not that there isn't a screening tool today; we have a whole host of people who can screen. What happens when a child goes for screening and has indicators that require additional follow up? How do you legislate that? That's the crux of the difficulty. We have the delivery systems, but there are gaps in how the children are moved across the delivery system, or in some cases, we don't have providers that are fully cognizant of the resources that are available. *Marc Lerner, M.D.:* We know of these services and how they are funded. There are some limitations. A lot of the social determinants of health are outside the behavioral health and mental health systems. *Jennifer Kent, DHCS:* I also wanted to mention that the Governor's budget includes an allocation for the Home Visiting program to promote child health and well-being through the Department of Social Services (DSS). *Terrie Stanley:* How do you determine the screening results and the path for referral? There are tools available, but where do you send the screenings? There is so much involvement from different people. I think a value to you is to start setting some of those parameters for best practice. *Ellen Beck, M.D.:* For some of our most disadvantaged communities, there's an issue with screening. I would start from the minute the child appears in the waiting room, and provide a breakdown of the different services through *promotoras*, community health providers, and navigators. *Bertram Lubin, M.D.:* This is a complex issue. There's a shortage of providers, so we need to look at new models of

	workforce development. We're seeing children getting expelled in kindergarten who should have been identified much earlier. *Kelly Hardy, Children Now:* The Governor's budget includes $27 million for a voluntary Home Visiting pilot program in the first year, and over time, about $159 million will be reserved for the pilot's total costs. This is a really great pilot to build on and a really good investment.
Election of MCHAP Chairperson for 2018	*Ellen Beck, M.D.:* Our next agenda item is to elect the new chair. *Adam Weintraub, DHCS:* We provided the Panel members with statements of interest from Drs. Hempstead and Lubin. The Bagley Keene Open Meeting Act requires the selection of a chair by those attending in person, by a roll call vote. We'll ask both candidates to give a brief statement. *Ken Hempstead, M.D.:* When I put forth my statement to nominate for this role, I wasn't aware of who would also put their name in. I couldn't be more thrilled that Dr. Lubin is running. I would be happy to withdraw my nomination. *Dr. Lubin, M.D.:* This is a wonderful Panel. I've been attending these meetings for quite a while before I could be considered for this role. I would be honored to have this role if we're all comfortable with it. *Ellen Beck, M.D.:* That was so gracious of you, Ken. We implemented the suggestions you made two meetings ago and increased the interaction with Director Kent and the Panel. I really feel that these are important to the Panel's evolution. I really value the recommendations you've made because it has helped this group grow. Is the panel comfortable with Dr. Lubin becoming chair? *Jan Schumann:* A few years ago, I stepped into the role as pro-tempore. I highly suggest that you both work together to ensure that the continuity remains. *Adam Weintraub, DHCS:* The statute requires a roll call vote. All members voted for Dr. Lubin as Chairperson.

Panel Member Term Determination	*Adam Weintraub, DHCS:* SB 220 requires that panel members shall serve a term of three years. The terms are staggered, and the statute specifies that the length of the current term should be determined by lot. I have ping pong balls with 2018, 2019, and 2020, and will ask the panel members to draw a ping pong ball from an opaque bag. *Ellen Beck, M.D.:* You can seek an additional term if you choose to, or you can decide to remove yourself from the Panel. Members who do not regularly attend MCHAP meetings may be removed by the Director in consultation with the chair. The Panel members drew lots: Ken Hempstead – 2018 Diana Vega – 2020 Wendy Longwell – 2018 Bertram Lubin – 2019 Karen Lauterbach – 2019 Terrie Stanley – 2020 Ron DiLuigi – 2018 Marc Lerner – 2019 Jan Schumann – 2019 Ellen Beck – 2020 Pam Sakamoto – 2019 William Arroyo – 2018 Paul Reggiardo – 2018 Elizabeth Stanley Salazar – 2020 Liliya Walsh – 2020
School-Based Clinics in a Community Context – Ellen Beck, MD, Janet Seabrook, MD, MBA, CEO of Community HealthNet Health Centers, and Rick Oser, Principal at Lemon Grove Academy for the	Dr. Beck introduced the next topic on school based health centers (SBHCs). *Ellen Beck, M.D.:* Schools can be the center of the community, and we need care for both children and families. That care can be provided at SBHCs. DHCS can only do so much, but there are also health plans, associations, counties, and the Department of Education. The two speakers I have invited today can help teach us on this subject. Dr. Janet Seabrook is CEO of Community HealthNet Health Centers, based in Gary, Indiana. She has spent her career creating a very innovative system and works with the schools and community. I've asked Dr. Seabrook to talk about the SBHCs in a community context. Mr. Rick Oser is a principal at an inner city school and he'll be talking to the Panel about a Comprehensive Wellness Plan (CWP) model from a principal's perspective, and how schools deal with these

Sciences and Humanities	issues, including challenges and outcomes. Dr. Seabrook's presentation can be found here: http://www.dhcs.ca.gov/services/Documents/SBHC_Community Context.pdf *Janet Seabrook, M.D.:* I am a family practice physician and did a residency training program. As a National Health Service Corps Scholar, I completed my first three years in a health center. During that time, I found out that Gary, Indiana was without a health center. Community HealthNet operates five health center locations throughout Lake County, and has operated a SBHC at Calumet High School since 2008. The strategic planning and discussions to start a SBHC took an entire year. The work group was composed of school administrators, school nurses, school social workers, facilities maintenance, health center staff, legal staff, and the health plan. The question we had to answer was what the overall goal of the SBHC, and was it to only serve students (Model 1), or students and the public (Model 2)? Barriers to model 1 included sporadic student utilization, school nurses might feel they are being replaced, and concern regarding sustainability of a student-only health center. Barriers to model 2 included safety concerns, and the possibility of privacy concerns. Community HealthNet and the Lake Ridge School District decided to move forward with model 2. Safety concerns were addressed by having a separate entrance for the public; a resource officer was placed at the high school; Community HealthNet contracts with an unarmed security personnel during clinic hours; and the clinic staff participate in the school's safety drills. Dr. Seabrook provided anecdotal cases on how the SBHC assisted the student body, including support for students after a former student committed suicide. In 2017, there were 2,817 medical visits. It's imperative that a SBHC have community and school district support. SBHCs can be an economic driver for the community; there are reports that show for every federal dollar invested, there's $11 in economic impact.

	Ellen Beck, M.D.: Are you fully billing Medicaid? *Janet Seabrook, M.D.:* We bill Medicaid. *Ellen Beck, M.D.:* Were the health plans satisfied with this experience? *Janet Seabrook, M.D.:* We looked at ways to engage the community and the school district to get more participation in health care services. The health plan wanted to know why this particular district had low vaccination rates and high teen pregnancy rates. *Bertram Lubin, M.D.:* You mentioned the return on investment. How was this calculated? *Janet Seabrook, M.D.:* You can find this information on The National Association of Community Health Centers. Community health centers are a cost-effective health care option for underserved communities. Capital Link breaks down the economic impact. *Susan McLearan, California Dental Hygienists' Association:* Was there any consideration for providing dental services? *Janet Seabrook, M.D.:* We have dental services at two locations. *Diana Vega:* You mentioned a concern about nurses being replaced. Did this actually happen? *Janet Seabrook, M.D.:* No. We worked very hard to have a relationship with the school nurses. We did not change the workflow for afterschool nurses. *Diana Vega:* When do the students typically see the nurse? How were the students able to increase their achievement rates, either because their health was better or they had more behavioral interventions? *Janet Seabrook, M.D.:* Just as before, if students were ill in class, the students would see a nurse. *Diana Vega:* Are routine health services offered? *Janet Seabrook, M.D.:* We do not do routine checkups during

	school hours. We usually schedule sports physicals for Saturdays or after school hours. We like to save the 8 a.m. – 4 p.m. schedule for those who are truly ill. *Karen Lauterbach:* Do you see a difference in the types of visits, such as family planning? *Janet Seabrook, M.D.:* What we're seeing is typically what we see in our other clinics as well, including: hypertension, asthma, and diabetes. We do stress family planning at our clinic. We also do a big district registration, so parents can sign up ahead of time to treat their children throughout the year. *Karen Lauterbach:* Do you see this as having an impact on teen pregnancies? *Janet Seabrook, M.D.:* Yes, as well as sexually transmitted infections. Rick Oser, principal at Lemon Grove Academy, presented on the Comprehensive Wellness Program (CWP) at Lemon Grove District Schools. The presentation can be found here: http://www.dhcs.ca.gov/services/Documents/Lemon_Grove_CWP.pdf *Rick Oser:* Lemon Grove Academy is in a small suburb of San Diego. The community is primarily working class, low-income. The work that Dr. Beck has done for our school is immeasurable. We started a CWP over 13 years ago. We were looking at the needs of the community and developed a strategic plan to address those needs. There are seven schools in the district. In 2006, the CWP was presented to the School District Governing Board. The Governing Board approved the project and asked that we find funding. We wanted to design a model that would address student, staff, family, and environmental well-being, and also incorporate Maslow's hierarchy of needs. We identified issues that needed to be addressed, including childhood obesity, instability, emotional and mental health concerns, and feelings of safety. During my first year with the school district, we conducted a survey on feelings of safety and found that 48 percent of fifth graders did not feel safe outside of school. About 38 percent of students had moved two or more times in the year.

	We identified that 39 percent of the community did not have a medical home, so that was the urgency to create a SBHC. In surveying our families, we realized that preventive medical health care was important. We're close to Mexico, so a lot of families took trips across the border to receive health care. When I first came to the elementary campus, the school was at the bottom of the district with an Academic Performance Index (API) of 677. Over time, we saw a significant increase. When comparing schools in the district, Golden Avenue (Lemon Grove Academy) stood out. The CWP contributed to the changes. The interventions and strategies in place were helping the students and families. While looking at 2004-2012 data, we saw a significant change. All the schools in the district saw increases, but Lemon Grove Academy saw the biggest changes. We looked at the California Healthy Kids Survey (CHKS) for school connectedness and perceived safety. Indicators for safety, school connectedness, high expectations from staff, and peers treated with respect increased over time. From my perspective, we saw a significant increase in student attendance, achievement, and parent engagement. We serve only students and their families. If a family member is on a student emergency card, which means they have access to the school, then we'll serve the SBHC and the dental clinic. Our long-term intent is to open up the SBHC to the community. *Bertram Lubin, M.D.:* I'm curious, do you have the numbers of how many African Americans graduated? *Rick Oser:* We have a really difficult time tracking our students. After middle school, half of our students will go to a charter, and the other half are assigned to go to a low-performing high school. We do know that our grade point averages for students as they transition into high school are remarkable. The manpower involved in following the students as they go from high school to high school is difficult. We provide students with different classes to give them a taste of the future, including introductions to health care professions. *Ellen Beck, M.D*.: Have you encountered any barriers or frustrations in terms of safety issues? Is traffic on the campus an issue? We're trying to find a way to bill for children's care, and learning how school districts can do that. Can you please list the pros and cons of the CWP?

	Rick Oser: There are so many pros to it that it's hard to measure the cons. A con is that on Tuesdays and Thursdays, the parking lot is full and the office staff is impacted a little more. Safety is always a concern and something that we keep an eye on. Funding is obviously a challenge, and we spend a lot of time grant writing as the budget situation continues to evolve. *Elizabeth Stanley Salazar:* Expanding access is important. In terms of the SBHC in Gary, Indiana, is that the only health plan in the community? *Janet Seabrook, M.D.:* There were three managed care plan (MCP) entities; Anthem was just added. *Kim Flores, Senate Office of Research:* I would like to know more about the funding at Lemon Grove Academy. *Ellen Beck, M.D:* The funding comes from grants, private foundations, and donors. Currently, it's not a model that bills Medi-Cal. Many of the adult patients who are served do not qualify for Medi-Cal. Our hope for the clinics, both for screening and the treatment, is to build a mechanism to bill Medi-Cal. *Marc Lerner, M.D.:* FQHCs are facing a funding cliff on February 8, 2018. I urge you to make individual comments in advocacy. Chronic absenteeism is part of the academic challenges and risks. Has this been assessed, starting with 2006? *Rick Oser:* Yes, we do measure this on a monthly basis. *Janet Seabrook, M.D.:* We also measure chronic absenteeism. *Jan Schumann:* Do you offer a parent and teacher program for school connectedness? If not, how do you get the parents involved? *Rick Oser:* We have a PTA, which has been a driving force throughout the community. Every other Friday we host a school pantry program, which parents volunteer at and monitor. At any time during the day, you'll see families on campus volunteering. *Hellan Roth Dowden, Teachers for Healthy Kids:* We're holding a webinar, "Using Every Student Succeeds Act to Address School Health Issues" that might be of interest to the Panel. On funding, California is expanding a State Plan Amendment (SPA)

	that would cover SBHCs and allow schools to bill Medi-Cal that will hopefully be finalized by July. Currently, they can only bill for students with Individualized Education Programs (IEPs). I think the SPA would make it a lot easier for schools to bill for services for non-IEP students. I'll send you the information. *Ellen Beck, M.D.:* I'd like to see this posted to the MCHAP web page. I would like to thank both presenters today. Schools are the center of the community.
Discussion of Goals, Plans, and Activities for 2018	Dr. Lubin thanked everyone for their votes. Ellen Beck introduced the next topic. The goal is to have a conversation facilitated by Dr. Lubin about where to go with the topics. Do we want these to be the topics of our future meetings? How do we want to proceed? We wanted to give you the information back on what you voted for:: http://www.dhcs.ca.gov/services/Documents/TopicsforInquiry_2018Meetings.pdf *Terrie Stanley:* Can we spend a moment on topic H, which was specifically an issue because of the possibility of CHIP not being reauthorized? *Adam Weintraub, DHCS:* As I recall, the CHIP discussion was the anchor point for us to talk about it, but I think some of the discussion also centered on the uncertainty of the federal funding situation. This topic allows the Panel to weigh in on some of those larger funding issues. *Bertram Lubin, M.D.:* This is a remarkable list. Given the number of meetings we have each year, we won't be able to cover all of these topics in-depth. I thought today's example of having two speakers bring information about their experiences related to the subject matter is a great way to go. Does the Panel like the idea of having external speakers cover subject areas for our next meeting? Should we cover social determinants of health, or anything else in the top five? *Marc Lerner, M.D.:* The topic receiving the most votes was the communication between parents or guardians and providers or DHCS. Should we explore this topic next? *Bertram Lubin, M.D.:* Could someone who recommended this topic talk a little more about what your thoughts were?

	Diana Vega: I wanted to make sure that there's improvement in communication between providers and families. Ultimately, parents are the ones in charge of taking their children to the doctor. I can look into this more and get in touch with you. *Bertram Lubin, M.D.:* Was the hope that we bring recommendations to DHCS about a change in the way we do things now? *Diana Vega:* Possibly an improvement through parent education, or maybe a liaison for health care providers and families. *Wendy Longwell:* Trying to improve the communication between parents, doctors, and schools is very frustrating as a parent, especially as your child ages. Due to the laws that are in place, your child has privacy rights when they turn 12. If the child has a lot of health issues, this can cause barriers to care. With HIPAA, everyone is so worried about not following the law that they almost go too far in the direction of not sharing important information. Parents can sometimes be the barriers as well. They're afraid of sharing all of the information because what if they are turned into Child Protective Services? We don't want to share everything that goes on with the doctors at school because there's a stigma attached to mental health, yet because the school isn't aware of what's going on, the student is now getting expelled from school, and a whole host of other issues because there's not open communication. Information needs to be shared with parents. Doctors should be part of this conversation as well, and parents should have direct access to the doctors. It's so difficult to get through the nurses to get to the doctors, which causes a breakdown of communication. What if you have a family that doesn't speak English? These are the issues that families, doctors, and schools are all dealing with. *Bertram Lubin, M.D.:* It is a problem we should address. What do you think is the solution? *Wendy Longwell:* Guidelines for doctors to send communication back to the school or primary care doctor. *Bertram Lubin, M.D.:* If you were in charge of the next meeting speakers for this particular subject, who would you invite – a lawyer, someone from the health system or school? *Wendy Longwell:* My sons' primary care doctor has gotten very

	frustrated because he never gets feedback from the specialty care doctors. We need to hear form the specialty doctors – the cardiologists, the neurosurgeons – and ask why information is not shared with the primary care doctor. I don't know why HIPAA should affect the specialists from communicating with the primary care doctor. I would like to hear from schools on what they would like to see changed, and where they get the records they need so they can adequately educate and keep the child healthy while in school. *Ronald DiLuigi:* I'd like to see us address topic Q, integrated care models. What Wendy is speaking about is a situation where she is the navigator. In a true integrated care model, primary care and behavioral health care are integrated. I would like to see an in-depth assessment related to this issue. I'm interested in the innovative models, but if there are existing models where we can learn from the negatives, we could do that, too. *Marc Lerner, M.D.:* DHCS has talked about the efforts that go into creating communications to families. I don't think we have information about the numbers of communications that some families might receive, such as how many notices are sent electronically versus by mail, how many are opened, and what are some of the ways beneficiaries can respond? Director Kent has spoken about her group that takes on communication with families, and the process of language level, and different languages used. I'm wondering if a presenter who is part of that type of experience can talk about that so we can understand. *Ellen Beck, M.D.:* There are huge issues with the literacy levels of the letters going out to families. There's a committee at DHCS that works on literacy, but it's troubling to me that they say the letters are written at the 6th grade level, but when our patients receive these letters, they're often very confusing to parents. There are a lot of issues related to communication, and I think one of the areas where we can have some very specific recommendations would be on how to change the literacy level. I teach at the medical school and I see the problems of how we effectively teach physicians, nurse practitioners and other clinicians on how to communicate effectively. This is one of the areas that needs to be addressed on how we are educating and what is required in terms of that education. Physicians often have a lot of problems in communicating in a language that people really understand. We work with *promotoras*, navigators, and others on communicating. In terms of health records, how

	do we ensure that there's communication between the specialist and primary care doctor? A specialist would have access to send a message to the primary care physician. The problem is, it doesn't occur. *Terrie Stanley:* Technology is both a blessing and a curse and one of the things Dr. Beck touched on was the interoperability between EHRs, EMRs, and systems that health plans, states and counties use. I can use my ATM card in this country or outside of the United States, and it knows who I am and how much money is in my account at any given time. We are not there in health care. When we rely on antiquated methods of communication like sending a letter, who looks at the mail, who receives the mail, and what happens with the letter? There are instant communication channels available to us, yet we're challenged at the health plan level. Improving communication is a joint effort between the state, the counties, the health plans, and the providers. How do we ensure that our network has tools that they can use to effectively communicate? There's a lot of work DHCS has done on plain language, but I'm not sure that's where Wendy is coming from; she's coming from a place of efficiently getting that data and information from point A to point B. *Wendy Longwell:* I agree that technology isn't there yet. There are multiple portals that need to be connected. When I hear the term, "medical home," we should make it easier for the key person in the medical home to have access to the records so they can share with their providers. When you ask for the records, you are charged. Until technology catches up to get us where we want to be, and all doctors can talk to each other about the shared medical records, we need to make it easier for parents to get those records and transport them so everyone is treating the child the way they need to be treated. *Adam Weintraub, DHCS:* Given that the purpose of this Panel is to advise DHCS, what would DHCS' role be in achieving that system that you're talking about? *Wendy Longwell:* I don't know the answer to this, but we should correct the law that is preventing parents from accessing the records, and not pay $50 to access records. Even if I wanted to send the records to the doctor, I will still get charged. If you're a Medi-Cal recipient, you're not supposed to be charged these fees. We need to ensure that parents are still the medical home until technology gets to the point where we need it.

	Ron DiLuigi: In some instances, it's private health information that could affect how the information is released. *Wendy Longwell:* I'm not referring to the medical side, but rather the lack of communication between primary care physicians and specialty doctors. Those are the issues that I'm constantly battling. What are the policies that are causing this problem? *Diana Vega:* When I proposed this recommendation, it was mostly for parents of children who don't have special needs. When letters are sent to parents about qualifying for services, why are the letters not shared with the medical providers? It would be so much easier for parents who don't speak English to have their doctor read them the letter and walk them through the next steps, even if it's services that have been approved for your child. That was my vision when I proposed this, but not to lessen your point because there needs to be an improvement in the system. There are less fortunate families out there who do not have the resources and who don't have the education or means to read a simple letter. This is something DHCS could take on and include physicians on these notices. *Bertram Lubin, M.D.:* This is obviously an important area. Our question is how to get our hands around it in a reasonable way so we can make a recommendation that Director Kent could take on. *Jan Schumann:* I do respect the conversation regarding communication with providers, but as a subscriber representative, I see a lack of communication from DHCS; we don't get an explanation of benefits (EOB). I think that would be a great starting point for us to discuss, so beneficiaries know what is approved and what's not. *Karen Lauterbach:* I think we're talking about a few different things – we're talking about care coordination, which I don't think falls under DHCS' purview. It's a very important topic, but it's really the coordination of medical care that falls more to the providers and health plans. And I'm also hearing how families understand their benefits, which I think is something we can work on here because it falls under DHCS. I also don't want to duplicate efforts because it sounds like DHCS has a committee that already reviews communications. *Adam Weintraub, DHCS:* There are aspects of our

	communication process which are overseen by a separate committee. A lot of them have to do with the CalHEERs and having consumer review of the notices beneficiaries receive about whether they have been approved for eligibility in the Medi-Cal system, whether their income places them in the Covered California system. When you have members in a family that fall under one category and another family member that falls under a different category, there are specific snippets of language that have been approved by that group. We have a plain-language initiative in the Office of Communications that we have been trying to drive throughout DHCS, both informally and formally. We can discuss with Dr. Lubin what we can provide to the Panel that addresses the communication aspects and our relations with providers and with beneficiaries. It's slightly complicated because 80 percent of the Medi-Cal population is covered by managed care plans, and our main method of oversight there is language within contracts, which is subject to approval by the Centers for Medicare & Medicaid Services (CMS), negotiation with the individual plans, and approval by the contract unit. We can explore and see if there is something we can bring back to the Panel that addresses our role and what levels of influence DHCS has on the different sections of the system. *Karen Lauterbach:* I just want to make sure that we're staying to the mission of our Panel, and it's something we can actually do. *Ron DiLuigi:* The role of this Panel is to identify an issue and fill it out. It's possible that DHCS may not be able to address, but we can still move forward. *Bertram Lubin, M.D.:* We don't want to narrow our reach too much. Are we talking about complex care where there are multiple providers, rather than a primary care setting? Is communication also a problem in a primary care setting; would that be the focus? *Wendy Longwell:* As far as communication, there are still communication issues among primary care physicians. *Ken Hempstead, M.D.:* I appreciate what Karen is saying. We need to consider the deliverables. My guess is that there is not a policy or law that needs to be struck down that's interfering with communication. If I were to guess, it's more of a lack of incentive to communicate, which the Panel could focus on.

	Wendy Longwell: I don't know where the problem is, I just know that there's a problem. I would like to look into this issue to see if it's a policy matter or lack of incentives, so we can have direction of where to go. *Ken Hempstead, M.D.:* I suggest that you come up with a few specific issues that you could forward to Director Kent. At the next meeting, Director Kent could provide her experience with the barriers, and where she could use the support from this group to move that forward, and then we can decide how to support her in that. *Wendy Longwell:* I see literacy levels as an issue; writing at the 6th grade level is not enough. *Marc Lerner, M.D.:* In terms of responsibility for looking at communication and emerging trends, California state law designates that the ownership of the medical record is with the physician or the health care system. New Hampshire is a state where the ownership lies with the individual. I'm curious whether that example leads to differences, or new problems and or successes? We might want to explore this. The California state statute stands in the way of this alternative system, and I don't know if that's good or bad. *Ellen Beck, M.D.:* I think it might be worthwhile to create a diagram and provide a spectrum of several examples, scenarios, or questions, such as addressing issues like literacy levels or lack of communication between specialists and primary care physicians. Maybe during a subcommittee meeting, we could flesh out some of these ideas and ask questions beforehand so Director Kent or a colleague could specifically answer our scenarios or questions, including what needs to happen that's not happening. *Kelly Hardy, Children Now:* I wanted to build on what Dr. Hempstead and Dr. Beck just said. Perhaps what might be useful in MCHAP's role regarding communicating with families is to somehow collect information on where communication goes wrong, especially in the notices of action (NOA). I have heard a lot of scenarios where the family will get a NOA and ask what it means. Maybe providing some examples of real life cases where it goes wrong might be helpful. *Bertram Lubin, M.D.:* Great suggestion. Maybe we should convene a small working group to discuss these issues?

	Ellen Beck, M.D.: There's a limit to how many people can discuss topics due to the Bagley Keene Open Meeting Act. *Adam Weintraub, DHCS:* The best way to proceed is if anyone has specific questions or forms where they are aware that beneficiaries or a parent has had a problem with communication, feel free to forward to the mchap@dhcs.ca.gov mailbox. We have planned to have a call with the Director and the new chair to discuss the procedural aspects of MCHAP and what we can do without advance meeting notice, and what we can't do. We can talk through the general issues that are raised, and put together a proposed set of speakers that could include representatives from DHCS, or representatives from the county behavioral health offices, or maybe a health plan could discuss where communication is handled in their organization. It sounds like we're are considering a narrower version of some of the deep dives we have done previously. We can bring that to you in the April agenda. Depending on how focused your questions are, we can put it up for a vote or schedule a time for discussion for how the Panel wants to narrow it for action at the next MCHAP meeting. Does that seem like a reasonable approach? *Bertram Lubin, M.D.:* That sounds good to me. I think we can make some progress on this issue. We need input from members' experiences. *Ellen Beck, M.D.:* We should invite members of the community to speak to their personal experiences and the challenges they faced, in addition to speakers who represent other forms of expertise. If any member has suggestions, send to the MCHAP mailbox. *Adam Weintraub, DHCS:* I also wanted to mention that DHCS oversees a manual, Pub 68 that goes out to all new beneficiaries when they are enrolled. The Office of Communications tried to streamline and simplify some of the language, and clarify the way that some of the different sections relate to each other. We're in the final stages of preparing that. This is one of the different areas in which DHCS is directly involved in communication with the beneficiaries and can help set a friendlier tone in a more useful document.
Member Updates and Follow-Up	*Ron DiLuigi:* We received the legislative bill tracking document from Children Now. Is that something we would have to specifically agendize to discuss?

	Adam Weintraub, DHCS: We distributed it to the members in advance at the time we received it. If it was received less than 10 days before the meeting, the Panel can't take formal action on it. Anything for formal action must be placed on the agenda 10 days before the meeting date. If you wanted to discuss it during the public comment period, and bring it back, that could be something you can do. That would be the appropriate way to handle it and stay within the law. *Bertram Lubin, M.D.:* I'm glad you clarified that because we get comments from people that ask us to bring up certain issues at the MCHAP meetings. *Adam Weintraub, DHCS:* Elizabeth Stanley Salazar observed a webinar that was put on by DHCS regarding mental health parity under the Managed Care Final Rule issued by the Centers for Medicare & Medicaid Services (CMS), and had asked for a brief update on that subject because it overlapped with a number of different areas that the Panel has been interested in when building consistency across different aspects of the systems of care. Bambi Cisneros is here from Health Care Delivery Systems to provide a brief update on that subject. *Bambi Cisneros, DHCS:* The Medicaid Mental Health Parity Final Rule implements many of the parity requirements from the commercial plan experience to the Medicaid program. The State had undertaken many months of analysis across delivery systems to identify limitations or restrictions on mental health and substance use disorder services that are more restrictive than medical/ surgical services. Most of the findings from the parity analysis resulted in changes to the specialty mental health delivery system. We are working with the Medi-Cal managed care health plans and counties to implement the necessary changes. More detailed information on the analysis and findings can be found in the Mental Health Parity Compliance Plan. The Compliance Plan Summary is updated when our targeted activities are met. The mental health parity compliance plan and summary documents have been posted to the DHCS website. We have submitted the managed care contract to CMS in October along with our Compliance Plan. We are awaiting feedback from CMS on both documents.

	Marc Lerner, M.D.: Will you send those links? *Bambi Cisneros, DHCS:* Yes. *Ellen Beck, M.D.:* When a child is at an FQHC and needs a child psychiatrist visit, it can take months to get a child psychiatry visit. Are you looking into access issues? *Bambi Cisneros, DHCS:* Network adequacy is one of the required elements of parity, and more broadly, the Medicaid Managed Care Final Rule. Statewide standards are based on the counties' population density, and DHCS has identified core specialists for whom network adequacy standards apply. *Ellen Beck, M.D.:* The standards in place – would they be voluntary? What would happen if a health plan or clinic does not follow those standards? *Bambi Cisneros, DHCS:* They are going to be required across the State. We are issuing an All Plan Letter for guidance to the managed care health plans. Separately, the Department will also issue an Information Notice to the counties. We will work with the plans and counties very closely to implement the requirements, and we will hold them to those standards, including imposing corrective action when needed. *Bertram Lubin, M.D.:* If there are any member questions related to this, we could place it on the April agenda. *Ellen Beck, M.D.:* One member update that I wanted to share that's related to our next meeting was a report from the Ombudsman's Office. If we have time on our next agenda, I would like to have a representative from the Ombudsman's Office present. *Adam Weintraub, DHCS:* I believe that there's a plan to post an Ombudsman dashboard in the first quarter of this year, and we can share that with the Panel in advance of our planning for the April meeting. *Bertram Lubin, M.D.:* I didn't ask this question when Mr. Oser presented on Lemon Grove Academy's CWP, but where does DACA fit in? Has this affected school attendance? *Ellen Beck, M.D.:* Lemon Grove Academy goes up to middle

	school, so DACA is less of an issue for younger students. We are certainly seeing an incredible level of uncertainty and fear for young people at college. *Marc Lerner, M.D.:* The next Medi-Cal Managed Care Advisory Group (MCAG) meeting is on March 8, 2018. I'm unable to call in and wanted to ask if anyone on the Panel can attend this phone call? *Ellen Beck, M.D.:* I think the literacy group that Jennifer talked about might be another group that we might want to have a liaison for. *Adam Weintraub, DHCS:* We distributed in the materials for this meeting a list of other stakeholder groups that intersect with the interest of the MCHAP. The MCAG is listed on that document. *Bertram Lubin, M.D.:* I'm wondering if there's somewhere on the agenda to place a quick run through of Children Now's legislative bills document. *Adam Weintraub, DHCS:* This is not a DHCS document. As a general rule, unless an initiative by the Administration is included in the Governor's budget, it is a standing policy that DHCS doesn't weigh in until we have done a full bill analysis and presented it to the Legislature. That's partly why we ask Children Now to provide their watch list. Children Now is not subject to the same budget development rules that the Department is. *Ellen Beck, M.D.:* We, as a Panel, are always welcome to comment, recommend, or write letters. *Ron DiLuigi:* How do we accommodate this, as a standing agenda item? If we did have a specific question, or there was a bill that we wanted to support, we wouldn't want to preclude it by the parameters of it not being on the agenda. *Adam Weintraub, DHCS:* For discussion, we do have a standing Item in the opening for a legislative update. If you wanted to bring the bill up for discussion, that would be the time to raise it. If there was a desire to take a vote and make a formal recommendation, you would need to let us know at least 10 days before the meeting day so we could agendize it. Any formal action of the Panel requires a 10-day agenda notice.

	Ron DiLuigi: I wanted to briefly talk about the California Children's Health Coverage Coalition's letter that was submitted to the Panel; all of the priorities in the attachment were compelling issues and certainly of interest to the Panel. The Children's Health Coalition is asking the Department to weigh in on the one element, but I'd like to hear the Department weigh in on all of the elements. *Adam Weintraub, DHCS:* We can clarify and include in the follow-up items and get guidance from the Director on that. If in preparation for the next meeting there's a desire to explore that issue more deeply, we can place it on the agenda. *William Arroyo, M.D.:* Regarding the screening instrument; I worked with the sponsor of that bill for hours trying to fine tune it. They were extremely well-intended, but they didn't understand the responsibilities of the specialty mental health plans. The first iteration of that effort died in the Legislature. The next iteration, which was introduced by Assemblymember Arambula, did make it through the Legislature, although it's not in the form that the prior bill came forward. This is merely instruction for DHCS to convene a group. Having said that, having worked in the mental health field and having published in the area of children's trauma, there is no single instrument for children across the lifespan. We know children can be traumatized as young as 1 day old. The way they screen for that is very different from a 13 year-old. It will be a challenge to come up with a single instrument.