State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

April 18, 2017

Meeting Minutes

Members Attending: Jan Schumann, Subscriber Representative; Karen Lauterbach, Non-Profit Clinic Representative; Paul Reggiardo, D.D.S., Licensed Practicing Dentist; Pamela Sakamoto, County Public Health Provider Representative; Elizabeth Stanley Salazar, Substance Abuse Provider Representative; William Arroyo, M.D., Mental Health Provider Representative; Ken Hempstead, M.D., Pediatrician Representative; Marc Lerner, M.D., Education Representative; Terrie Stanley, Health Plan Representative; Ron DiLuigi, Business Community Representative; Diana Vega, Parent Representative

Not Attending: Ellen Beck, M.D., Family Practice Physician Representative; Wendy Longwell, Parent Representative; Liliya Walsh, Parent Representative

DHCS Staff: Jennifer Kent, Sarah Brooks, Adam Weintraub, Morgan Knoch, Julia Logan, Maria Jocson, Liane Winter

Guests: Sen. Richard Pan, M.D., Marlon Lara, Dr. Pan's staff

Others: Bobbie Wunsch, Pacific Health Consulting Group; Kelly Hardy, Children Now; Dharia McGrew, California Dental Association; Nichole Schirm, Community Health Group; Peggy Hoover, Partnership HealthPlan; Sandra Poole, Molina HealthCare; Sydney Ryden, Health Net; Alex Ayala, Western Center on Law and Poverty; Daniela Johnson, NorCal MHA SAFE; Sandena Badu, NorCal MHA SAFE; Linnea Koopmans, County Behavioral Health Directors Association of California; Nena Garcia, Teachers for Healthy Kids; Lisa Eisenberg, CA School-Based Health Alliance; Kristen Golden Testa, The Children's Partnership; Kiran Savage, California Pan-Ethnic Health Network; Kelli Boehm, Political Solutions; Hellan Roth Dowden, Teachers for Healthy Kids

Public Attendance: 17 members of the public attended.
Attending by Phone: 40 stakeholders called in

Opening Remarks and Introductions	*Jan Schumann,* MCHAP Vice Chair welcomed members, DHCS staff and the public and facilitated introductions. The legislative charge for the advisory panel was read aloud by Pam Sakamoto. (See agenda for legislative charge.)

	http://www.dhcs.ca.gov/services/Documents/041817MCHAPMeetingAgenda.pdf
Meeting Minutes, Follow-Up, Opening Remarks by Director Kent	Minutes from January 18, 2017 were approved. http://www.dhcs.ca.gov/services/Documents/011817_MCHAP_Summary.pdf Director Kent thanked The California Endowment for use of the conference room space. *Jennifer Kent, DHCS:* We're developing the Department's Estimate that will be released with the Governor's May Budget Revision, which should be released by May 15. When the American Health Care Act (AHCA) was pending, we released a fiscal analysis. It was our best attempt to put parameters around what the pending federal proposal would have meant to the state program and state budget. Model trends from this analysis showed that within the first year of full implementation, the AHCA would cost the state $5 billion, and trending outward to 2027, about $18 billion a year. Since Medi-Cal only spends about $19 billion of General Funds (GF) now, it's a significant cost to the state with no accompanying flexibility. We are watching the CHIP (Children's Health Insurance Program) Reauthorization carefully. We assumed the authorization was going to drop from the 88% federal share now down to the more traditional 65% split. To the extent that CHIP is not reauthorized or the funding changes, there would be state budgetary impacts. We have been monitoring concerns that we have heard anecdotally from county welfare directors and community-based organizations around people feeling uncomfortable about enrolling their children into full-scope Medi-Cal coverage due to potential federal changes on immigration. To date, as our caseload and numbers continue to show, we have not seen any decrease in enrollment for the SB 75 population; in fact, it continues to grow. We have about 180,000 children enrolled today under SB 75. *William Arroyo, M.D.:* The enrollees for SB 75 have not leveled off and are in alignment with projections that the state made a few years ago? *Jennifer Kent, DHCS:* During the last budget, we estimated 9,000 to 10,000 children enrolling a month. We're currently on pace. We always thought that there would be 190,000 to 200,000 enrolled during the first year implementation, which will end in May. We're currently at 180,000 enrolled. *William Arroyo, M.D.:* There are no areas of the state where it has decreased at all? *Jennifer Kent, DHCS*: Based on county and statewide growth numbers, there has not been anything statistically significant in the

	caseload. *Elizabeth Stanley Salazar*: What steps is the Department taking on the prevention treatment side and Proposition 64? *Jennifer Kent, DHCS:* For background, Proposition 64 is the legalization of recreational marijuana use. The Department was given an initial $5 million to conduct outreach and education around youth. We are working with our colleagues from the Department of Public Health (CDPH), who are much better positioned to conduct those activities than we are. Jan Schumann introduced the Panel's draft letter of support for CHIP Reauthorization. He also introduced the public comment letter on the CHIP Reauthorization sent by Children Now, the Children's Defense Fund of California, and the Children's Partnership. *Jennifer Kent, DHCS:* CHIP reauthorization would most likely be taken up this fall. *Marc Lerner, M.D.:* It would be helpful to distinguish communications we'd like to share with representatives at the state and federal level. How do we direct the most useful message to the appropriate audience? *Jan Schumann:* Our legislative charge is making recommendations to DHCS for better care to children and their families. However, this federal legislation may reduce budgetary items and resources. *Jennifer Kent, DHCS:* We will be communicating with both Congressional leaders as well as the federal Administration about the CHIP reauthorization and pushing for as high a funding match as possible. The MCHAP can send a letter to DHCS and copy the Congressional delegation and the state Legislature, sharing the fact that you are concerned. *Ron DiLuigi:* We should determine if there other factors that the Panel could emphasize in the letter. *Jennifer Kent, DHCS:* At the federal level, we're concerned about CHIP not getting reauthorized. There's a Maintenance of Effort (MOE) for children's coverage under the Affordable Care Act (ACA) through 2019. From a program standpoint, I think children would have coverage, but from a state fiscal perspective, obviously we would have concerns. For children that are in the higher income level within the CHIP structure, you do have families that are working and are contributing premiums to cover their children. That seems to be an important message that may not be fully appreciated in terms of covering a higher income population that is contributing. If that were woven in to some of your advocacy at the federal level, I think that would be important.

	William Arroyo, M.D.: Thank you for that tip. *Marc Lerner, M.D.:* If funding from the 1115 Waiver is cut, certain programs, such as the county-based substance use programs, would be more vulnerable. Can you comment on that? *Jennifer Kent, DHCS:* Our analysis on the AHCA focused on the costs per capita proposal and the methodology. Another problem in the AHCA proposal was the phase-down of the enhanced Federal Medicaid Assistance Percentages (FMAP) for the expansion population. As a state, we're making contributions to the costs for that expansion population; we're at 95/5 right now and we will phase down to 90/10 percent. Under the proposal, if someone lost coverage for more than 30 days, they could reenter into Medicaid, but at 50/50. We did some analysis around the churn of that population and the Congressional Budget Offices' assumptions. Essentially, 42 percent of the population would churn on an annual basis, which meant that after two years, only a very small residual population would be at the 90 percent match. The other component in that proposal was they made that population subject to a 6-month determination instead of an annual determination; that contributed to the 42 percent churning. *Jan Schumann:* In interest of time, this letter will be forwarded to the June meeting for formal action. We do invite comments to be submitted by the public. Director Kent swore in two new members, Dr. Ken Hempstead and Diana Vega. The Panel voted by acclamation to approve Dr. Beck as Chairperson for the 2017 calendar year
Behavioral Health Recommendations and Discussion	Jan Schumann introduced the behavioral health revised draft recommendations. Presentation materials available at: http://www.dhcs.ca.gov/services/Documents/MCHAP_BehavioralHealthRecs.pdf Jan Schumann asked for comments from Elizabeth Stanley Salazar and Dr. Arroyo. *Elizabeth Stanley Salazar:* There have not been these type of recommendations on Mental Health and Substance Use Disorders (MHSUDs) for children on Medicaid. We should give these recommendations serious consideration for closure today. *William Arroyo, M.D.:* I appreciate that there is an effort to highlight SUD treatment services, which are more urgent than ever. I'm hoping that DHCS will consider restructuring services so they are more readily available to children and youth statewide. *Marc Lerner, M.D.:* I want to echo Dr. Arroyo's comments regarding

	the importance of advancing the focus on SUDs for children and adolescents. Our discussions could align with Proposition 64 discussions. For example, in item 4a, mandate and reimburse, I would make sure that this is a recognized connection to marijuana use as well as have a source of support that's aligned with DHCS' efforts. Additionally, we should recognize key elements to allow for the provision of care. For example, for the provision on SUD billing codes, one of the critical elements that activates provider action calls for a need for provider education. I'm pleased with the discussion on the breadth of services, which requires outpatient, inpatient and continuum of care. We need to continue to provide evidence-based interventions and not be held within a budget-neutral format as we think about how we're going to move forward in this area. We can't separate the SUD concerns from the mental health concerns as we deal with children and adolescents. *Jan Schumann:* Are you suggesting we add in the second sentence of 4a: improve screening for depression and substance use? *Marc Lerner, M.D.:* Yes. I would highlight on this line marijuana use. *Elizabeth Stanley Salazar:* Mental health issues, particularly for adolescents and children, are intertwined with emotional health and substance use in the communities. Mental health is carved out and in silos, or has been designated as someone else's responsibility. The SUD system has been grossly underfunded for years and the provider network does not exist so how can it work with mental health if it doesn't exist? The issue now is cross-system functioning and coordination. I would petition the Department to really think about how to provide the overarching leadership that demands system interagency guidance and a purview that brings various carve outs together, not only for MHSUDs, but for primary care as well. This is the world we would like to see continue under managed care and the ACA. *Diana Vega:* The collaboration between schools and providers is important for children and adolescents, especially those with experience in MHSUDs. *William Arroyo, M.D.:* As we think about the continuum of services for MHSUDs, we should consider including early intervention and using more preventative services. This will help avoid costs further downstream to other systems. The cost avoidance piece is not weaved into this. If we can convince the state legislature to invest more upfront, it may very well improve the state's budget going forward. In addition to sending this letter to DHCS, we might also want to send this letter to other key individuals or organizations that have responsibilities for budgets and services that could be impacted if we do a good job. *Jan Schumann:* Who would you suggest adding?

	William Arroyo, M.D.: Secretary Dooley of the California Health and Human Services Agency (CHHS) has a very broad area for which she's responsible. There's also the Secretary of the Department of Corrections and Rehabilitation (CDCR), among others, who have an interest in seeing that children get the kinds of healthcare that they need. *Jan Schumann:* Would you suggest copying those individuals on the Department letter, or send individually? *William Arroyo, M.D.:* There are health, education, human services, public safety and criminal justice committees in both houses in the state Legislature that would cover that landscape. *Jan Schumann:* In your first recommendation, you mentioned advanced screening. Would you place this item under 4d? *William Arroyo, M.D.:* I would include it under the screening and reimbursement section. *Elizabeth Stanley Salazar:* You mentioned something very important, Dr. Arroyo, which is prevention. This letter is about services and is very treatment oriented with some reference to prevention and outreach. We should undertake a discussion of prevention, particularly with the opportunities that exist with new funding. I think there will be significant challenges with Proposition 64 in terms of the impact, but from a treatment and prevention point of view, it's going to have significant funds for prevention and early intervention. *William Arroyo, M.D.:* To Elizabeth's point, wherever the letter mentions "treatment", we should write in "prevention and treatment". At a future meeting, we may have a more in-depth discussion on prevention. *Pam Sakamoto:* We need to look at collection of data on the services provided. The data should be collected statewide to be comparable across the entire state. The Medi-Cal dashboard shows quite well where we've made improvements but all of this information should be incorporated into the dashboard with the outcomes and evidence-based measures. *Jan Schumann*: Where would you recommend placing that? *Pam Sakamoto:* I would place it under 4, for the outcomes measurement data and how it's collected. We have a lot of electronic records throughout multiple service systems that seem to be more like paper charts in electronic systems. We need to look at exchanging the information because children will be receiving services at multiple different sites.

	Ron DiLuigi: We should include early intervention and prevention in this letter, especially if we are going to undertake a deep-dive into this matter. The legislature is well aware of Proposition 64 and the additional revenues, so this area is very important. *Elizabeth Stanley Salazar:* Maybe we should include prevention in the last paragraph and say that this will be taken up at another deep-dive. *Jan Schumann*: We will take this up in further discussions. I will summarize the revisions that we have so far: • Revision 1,by Dr. Lerner, to revise 4a. The last sentence should include additional wording after 'depression' to include 'depression and substance use screening (including marijuana use)' • Revision 2, by Dr. Arroyo to include CC to the Secretaries of the CDCR and the CHHS, and the following legislative committees: Human Services, Public Safety, and Health. • Revision 3, by Dr. Arroyo and Elizabeth Stanley Salazar, to change any mention of 'treatment' to 'prevention and treatment services'. • Revision 4, by Pam Sakamoto, on 4f to include wording for collection of outcome data on a statewide basis. • Revision 5, by Elizabeth Stanley Salazar and Ron DiLuigi, to note in the closing paragraph the Panel will take up prevention during a future deep-dive presentation. All revisions were approved by voice vote. Jan Schumann asked the panel to approve the letter as a whole. The panel approved the motion. *Marc Lerner, M.D.:* How might we anticipate getting feedback from DHCS on the reaction to the letter, including how we might be able to track and support the recommendations? *Jennifer Kent, DHCS:* With today's revisions, I will sit down with MHSUD leadership and parse through the letter and ask what is feasible, a reach, or beyond our ability to successfully do on our own. I would suggest that we should review the letters that you have drafted in the past and provide updates, either semi-annually or annually. For example, 'here's the progress we've made on certain items, here are the things we are still struggling with.' If there's a regular agenda feedback item, I think that would keep us on task and keep the Panel involved. *William Arroyo, M.D.:* If I could backtrack a little, I would recommend carbon copying Sen. Pan because of his interest in the expansion of MHSUDs treatment services in schools. I would also carbon copy the Senate Mental Health Caucus, which is led by Sen. Beall.

	Jan Schumann: Since we've already taken a vote, I'll have to reopen public comment if we were going to consider that. *Hellan Roth Dowden, Teachers for Healthy Kids:* We applaud these efforts to combine schools and health. We would welcome you to look at the underpinning of how these programs work with the existing LEA billing option program, which is going to be expanded for more mental health. I brought some comparisons with how California does in receiving funding from the federal government for these programs and other states. (Handout posted with meeting materials.) The second thing I wanted to mention is that it might be interesting to talk to the state of Colorado where they've had a marijuana initiative. They've done work to see whether or not it increased usage among children within the schools and found that there wasn't an increase. Sarah Mathew with the Colorado Department of Education would provide insights on the study's findings. Colorado took some of the funding from the marijuana initiative and funded certain school-based services, including school nurses. We could fund the new collaboration between mental health in schools with funding from Proposition 64. Teachers for Healthy Kids works with over 135 school districts in the state, and we have found that it's generally a problem working between schools and counties. If services were provided at the school sites, you could serve the children much more effectively. San Diego has an excellent program with their county in terms of collaboration. *Kristen Golden Testa, The Children's Partnership:* I noticed the letter mentioned a barrier to access being one of interpreted services in multi-cultural delivered services, but it wasn't really in the recommendations. Perhaps it could be used under recommendation 4. There are some rules in the federal managed care regulations that require interpretive services, so perhaps the specific recommendation be around monitoring and enforcement to make sure that's happening. The Children's Partnership is embarking on some research relative to mental health for children in immigrant families. The environment for these children is particularly toxic right now, who are facing the very real possibility of deportation of their family. It's a big issue for our Medi-Cal population right now and deserves focus. We'd love to share with you some of our findings about how that can be assessed. One general note, I noticed that this letter was mostly in verb form but not who is to do these things. It might be helpful to indicate what is a DHCS responsibility. *Daniela Johnson, NorCal Mental Health America (MHA) Sacramento Advocates for Family Empowerment (SAFE):* As a family advocate and parent of children that have special needs, I just wanted to applaud Dr. Arroyo for opening the door for further discussions of prevention. It impacts our entire state. These children will grow up and if we take care of them now, we will have successful, contributing members of society instead of having a large homeless population,

	drug addicts, and other barriers keeping them from being successful. *Christina Hildebrand, Voice for Choice Advocacy*: The number of special needs children, and mental health isn't always a special need but it goes into that grouping, is growing in California. Our budget cannot support the way it's exponentially growing. The Panel should definitely look into preventative care. The other piece that is becoming evident on the legislative calendar is home visiting; I would ask that you look at the least restrictive and least invasive way of doing the preventative assessment, and that it not necessarily be done with home visiting. Jan Schumann: Seeing no further public comment, we will close comments at this time and open it up for Panel discussion for additional revision amendments that the Panel would like to bring forward. We will revise the adopted letter with revision 6, to include a copy to Dr. Pan and the Senate Mental Health Caucus. The revision was adopted and the Panel approved the letter as amended.
Discussion Lead by Sen. Pan, M.D.	Jan Schumann introduced Sen. Pan. Jan read Dr. Beck's comments: "Dear Dr. Pan, "Thank you for creating our panel and for joining us today. My apologies for not being present. "In the face of federal challenges, I want to reinforce our support for courageous actions taken by the Legislature to maintain and increase Medi-Cal benefits, to ensure the physical, emotional, oral, and social health and well-being of all Californians. We support California's leadership in protecting our most vulnerable, with bills such as SB 75 that serve and keep safe ALL Californians." *Sen. Pan, M.D.:* Thank you for having me here. When I authored the AB 357, we were essentially transitioning Healthy Families and enrolling it into Medi-Cal. I discussed with DHCS at the time that children were about 20 percent of our Medi-Cal spending. About half of all children are covered by this program. One of the questions I've heard is what's going on with the single-payer proposal. To me, as a pediatrician and father, it's so important that we have a Panel like this. We need to be sure that children have a voice and that we have groups that will advocate on behalf of children and look at the particular needs of the children. There were several different issues that you wanted me to comment on. One was about possible Medicaid changes. If there's anything to

	say about what's happening at the federal government is that in this era is that we're not sure what's going to happen. President Trump said that he would have an alternative to the ACA that would cover everyone, yet he supported a proposal that was going to decrease coverage. He said he was going to leave Medicaid and Medicare and Social Security intact, yet the proposals were going to put limitations on Medicaid. That specific proposal failed, but it's hard to say what will happen because whatever is said doesn't necessarily translate into the actual actions that happen later on. It's important that we speak out. It's something that I've been urging people to do because they need to hear about how important Medicaid is. In terms of the state's single-payer bill, it hasn't been heard in committee yet. Fundamentally, the issue has always been about where the funding would come from. If we think about the Medi-Cal budget overall, it's over $100 billion with a good chunk coming from the federal government. If we're concerned about what the federal government will do with Medi-Cal funding, which covers a third of all (Californians), where funding for the single-payer system comes from is a good question. We have to figure out how to make a good paying quasi-single-payer system, Medi-Cal, work better. And that's part of what you're here to do as well. There are groups that are pushing for CHIP to be reauthorized. Funding cuts for this program is not a particularly popular thing to do. I'm going to stay cautiously optimistic and say that it will get reauthorized. If it's not reauthorized, that's going to create a significant amount of pain for both the state and the children of California. In terms of federal immigration issues, one of the biggest challenges that we're going to have is about families who qualify for programs – Medi-Cal, CalWorks, food stamps – but who do not use the services. Even if the child is born in the U.S. and is a citizen, the families may have members who are undocumented and are going into hiding and they're not going to be applying for these programs. Given the tone and rhetoric around immigration, a lot of these families are essentially afraid of applying for government services. They're afraid that immigration will find them and deport their family members. One of our biggest struggles is what to do when we have an increasingly large population of families who aren't trying to access the services and the benefits that come from those services. That's going to create tremendous challenges in many of our communities. If you don't have access to healthcare or delay care, then there could be a spread of diseases like tuberculosis, or you have children that aren't able to perform well at school because they are hungry, or they aren't getting dental care and that will affect their education. To me, these are the bigger issues regarding immigration. Some people have been concerned about the threats from the Trump Administration to deny funding if we become a 'sanctuary state.' The Supreme Court has

	ruled in various cases that it's not the duty of the state or local governments to carry out federal laws; there's a constitutional separation. To compel the state to enforce federal immigration laws is constitutionally suspect, especially if it has nothing to do with immigration. We don't have to help enforce immigration laws, but that doesn't stop the federal government from sending agents in and intimidating people. Even with protections put in place, I think the general fear will be a challenge. It's a time of great uncertainty. People are recognizing that we need to push back on some of the more draconian proposals and that we need to protect the gains we've made in getting expanded healthcare coverage for everyone in the state and across the country through the ACA. The most recent Census data, especially for states that implemented the Medicaid expansions, show that states have been able to cut their numbers of uninsured significantly. We need to continue that progress. We also need to make the existing systems work better. We need to make the Medi-Cal program work better and that's what I hope all of you will work on. We have our California Children's Services (CCS) program to serve children with special needs and we need to look at better coordination of care. How do we coordinate across the systems: mental health, developmental services, social services, etc.? What role will Medi-Cal play to help bring the systems together so we can provide better quality care and the most cost-effective care? That's the continuing task for this body and I appreciate all your efforts in doing that. *Jan Schumann:* Thank you Dr. Pan. In respect of Dr. Pan's time, I'll open up discussion to just panel members with very brief comments or questions. *William Arroyo, M.D.:* Of course you're familiar with Proposition 56 and the limited reimbursement for those physicians participating in the Medi-Cal program in California. In many parts of the state, families cannot access specialists and even primary care doctors because of the low reimbursement rate. I am hopeful that the state Legislature may work some budget magic to make those physicians who are willing to serve the population more whole in terms of reimbursement. I was wondering if you could comment on that. *Sen. Pan, M.D.:* I helped fight for Proposition 56 so we could raise tobacco tax for two reasons: the first being to reduce tobacco usage, and to also provide funding to help support the Medi-Cal program and improve access to care. We recognize that rates are a problem. We looked at the Denti-Cal side; we had numerous reports showing that it's a fraction of what dentists get paid as well as other Medicaid programs compared to commercial. We know on the physician side, we're 48th or 49th in the country, and that there are significant access to care problems. I was particularly disturbed by a report that came out from UC Davis showing that people who were on Medi-Cal, their cancer outcomes were the same as those uninsured, and much worse

	than people who had commercial insurance. We have a challenge in terms of specialty care; I'm a primary care physician who still practices at a community health center. The community health centers do have a small advantage in that they can get some additional Federally Qualified Health Center (FQHC) funding to be able to help supplement the Medi-Cal rates that they receive. Although, you can only provide very limited specialty care through FQHCs, so whatever specialists they receive is through the Medi-Cal program. It's no secret to those who take care of lots of Medi-Cal patients that if you really want to get someone into a specialist quickly, you have to go through the emergency room. The ER then forces the specialist to see them while the patient is in the ER. That's not a good way of doing things. In terms of the Proposition 56 funding, we need to honor what we told the voters; they wanted to see improvements and access to care in our Medicaid program with the funds. *Jan Schumann:* In interest of your time, I would like the panel members who have additional questions to submit their questions to Dr. Pan. *Sen. Pan, M.D.:* I can hear one more question. *Marc Lerner, M.D.:* In regards to our citizens and residents who are feeling anxiety about immigration, we've been working with DHCS to seek increased coordination, particularly around information between health, education, and other systems. I'm wondering if you can assure us that there are protections for the information as it begins to be shared and that it doesn't end up with Immigration and Customs Enforcement. We have unique school identifiers, and critical information in schools' electronic systems, and if we're going to put our mental health records and other records together, that would be something that makes both the provider community as well as our community members concerned about the access to that information. Where is California at in terms of protections? *Sen. Pan, M.D.:* I think some of the other agencies are able to better address some of these issues. Certainly we want to protect that data as much as possible, but many of the programs like Medi-Cal are a federal/state partnership. We can certainly try to protect safety, but if we have a program that's funded by the federal government, we may have agreements with the government that require data sharing. Attorneys would have to look at what degree we can shield data that then could be used for immigration purposes. This is a complex, multi-layered question and people need to look at each of the different programs. If you're data sharing between different programs, each program has its own relationship with the federal government that may or may not need to share data. Our government does require some degree of data sharing for oversight purposes and fraud reduction. What those are, I can't say. Certainly it's an issue that needs to be looked at.

	Jan Schumann: Any submitted panel comments will be entered into the meeting minutes, and we'll have Dr. Pan respond at a future time, if that's appropriate? *Sen. Pan, M.D.:* Yes. *Elizabeth Stanley Salazar:* SUDs treatment services have been underfunded and there are no treatment guidelines. You can't just throw money at it, we have to build the foundation. I would hope that we could have a leadership panel, committee, or advisory body that could bring together treatment guidelines for the state so that providers, workforce, and primary care could respond. *Paul Reggiardo, D.D.S:* This is directed to both Director Kent and Sen. Pan: if we switch to Medicaid block grants, is there a threat to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit? *Jan Schumann:* We'll enter that into the record and have Sen. Pan do a more formal response. We thank you for your time, Dr. Pan. If there are any additional comments or questions for Dr. Pan, we can submit those in writing to his office and he'll respond at a future date.
Network Adequacy Standards for Medi-Cal Managed Care	Presentation materials available at: http://www.dhcs.ca.gov/services/Documents/NetworkAdequacy_MCHAP.pdf Jan Schumann introduced Sarah Brooks. *Bobbie Wunsch, Pacific Health Consulting Group:* We're having this discussion because we had a network adequacy committee that Dr. Fisch ran. Sarah's discussion on network adequacy will give a foundation for what's going on at the state and federal levels. The committee can reconvene under Pam Sakamoto's leadership to think about how we want to do a deep-dive on this topic. Sarah discussed the elements of plan oversight. The federal and state governments set forth regulations and statutes, which are set forth in contracts between DHCS and managed care plans. DHCS is responsible for making sure that plans are compliant with the requirements set forth in the contracts. If the plans are not in compliance and after DHCS has provided technical assistance to the health plan, if they continue to have areas of concern, then we enter into a Corrective Action Plan (CAP). DHCS works with the independent External Quality Review Organization (EQRO) on network adequacy, Healthcare Effective Data and Information Set (HEDIS) measures, and encounter data. HEDIS is an indicator of network adequacy. For example, cervical cancer screenings are HEDIS measures, which helps determine if

	beneficiaries are getting access to the care they need. DHCS does create an External Accountability Set (EAS). We annually issue a new EAS, and includes HbA1C measurements, and all of the different HEDIS measures and indicators that we're looking for the managed care health plans (MCPs) to report to us. The EAS focuses on three domains of care: Quality of care, access to care, and timeliness of care. The EQRO works with DHCS to provide technical assistance on quality improvement efforts. The EQRO collects HEDIS data from MCPs and produces rates to measure how the MCPs are performing, which include timeliness and access to care. DHCS reviews how the MCPs are performing, or whether a CAP is needed. *Elizabeth Stanley Salazar:* For technical assistance or CAPs, what if the lack of access is due to lack of providers, which is not within the plans' control? What interventions or steps are taken at that point? *Sarah Brooks, DHCS:* We have alternative access standards. If, for example, we have a rural area where there aren't any providers, then the health plan can submit an alternative access standard request. We will review to make sure that the health plan made a good faith effort to go out and contract with all of the providers that may be in the area. If there are no providers in the area and there is no other method, then we will approve a different standard of access for them in that area. *Elizabeth Stanley Salazar:* I was just at the National Council of Behavioral Health and I attended a panel discussion regarding the lack of psychiatrists in the U.S. There's definitely a gap. When you reach that kind of gap, does it have to go to legislation? What happens in terms of addressing that issue? *Sarah Brooks, DHCS:* Your question might be more around how do we approach producing more providers of a certain type? *Jennifer Kent, DHCS:* Or what does the plan do if they need 10 additional psychiatrists to cover the complete population? We'll give them a CAP which they have a single psychiatrist under contract and there's access concerns, Sarah's team would look into the community and the service area where the plan is. We know there are 8 psychiatrists in the area, so we'll ask the plan to talk to the other psychiatrists from that area to show that there was a good faith effort to contract with those other psychiatrists. If those other psychiatrists don't want to contract, then we go to a larger area of adjacent counties or facility-based psychiatrists. We'd request that the plan talk to the additional psychiatrists. There are different factors that we put the plan through first to make sure that there is an effort to contract with providers in the area as well as looking at adjacent areas if necessary,

	which usually solves the problem. We also look at other modalities, such as telemedicine. *Ron DiLuigi*: In general, I've read that the network adequacy aspect for these new regulations are now being delegated by the states. Are these new regulations going to protect the standards? *Sarah Brooks, DHCS:* That's a great question that I'll address in a few slides from now. Sarah Brooks discussed the network adequacy monitoring elements, which include: readiness reviews, annual network certifications, medical audits and surveys, data submissions, and the CAP process. Monitoring enhancements were added so the Department would rely less on manual updates and more on automated updates to understand how the MCPs are performing. DHCS has automated the Post-Adjudicated Claims and Encounters System (PACES) data and the provider files system. The Medicaid managed care final rule is the first overhaul of the managed care regulations since 2002 and aligns the Medicaid managed care program with other health insurance coverage programs, adds consumer protections, improves state accountability and transparency, and includes Long-Term Services and Supports (LTSS). *Marc Lerner, M.D.:* Can you give us an example? I don't recognize the term. *Sarah Brooks, DHCS:* Community-Based Adult Services (CBAS) or adult day healthcare, or nursing facilities, which is what we would refer to as LTSS. *Marc Lerner, M.D.:* Could you describe provider screening? *Sarah Brooks, DHCS:* An example of provider screening is making sure that a provider has not been convicted of a certain felony. *Ron DiLuigi:* Are those major provisions within the final rule? *Sarah Brooks, DHCS:* These are all major provisions within the rule. *Jennifer Kent, DHCS*: Other parts of our delivery system that are coming in compliance with the rule have a much more significant workload associated with compliance as opposed to what has been done in managed care to date. We've had modifications but not wholesale implementation activities for SUD, county mental health, and dental managed care. The mental health system changes will be significant.

	Sarah Brooks, DHCS: With respect to network adequacy standards and development, the final rule set forth requirements, but it allows states some flexibility in setting their own standards. The requirements expand to additional provider types: Specialists, OB/GYN, behavioral health, pharmacy, pediatric dental, LTSS services that require the beneficiary to travel to the provider. The requirements for these provider types require time or distance and timely access. For our rationale of proposed standards, we reviewed what standards were already in place, provider types and services, county population and size and how many providers needed to be available in certain areas based on population size. We released a network adequacy proposal in February and collected comments. We are continuing to update the proposal and have made some changes based on the feedback we've received. There aren't always specialists available in a certain area, so we placed counties into categories: rural to small, medium, and large counties, setting different standards depending on how large the county was and how far a beneficiary would have to travel to the appointment. These standards in the time and distance category are all new. *Bobbie Wunsch, Pacific Health Consulting Group:* Are time and distance based on public transportation or by car? *Sarah Brooks, DHCS:* We have Geographic Information Software (GIS) mapping, which allows us to look at how long it would take a beneficiary to get to their appointment in a car or with public transportation. *Terrie Stanley:* Even within certain areas of California that are smaller, it's still not going to be feasible. *Sarah Brooks, DHCS*: One comment we receive frequently is most every county has an urban area and a rural area. *William Arroyo, M.D.:* There are rural parts of Los Angeles County. *Terrie Stanley*: There are certain areas that DHCS will need to look at. *Sarah Brooks, DHCS:* We have alternative access standards for some types of providers. We received many public comments for pharmacy regarding county population size, and we've considered only having one standard for pharmacy because there are options available such as overnight mailings. When we're discussing mental health standards, we're monitoring adult versus pediatric populations separately. While the standard would be the same, we're looking to make sure that there are adequate standards for adults and for children. *Jennifer Kent, DHCS:* For pediatric dental, we are only talking about

	dental managed care in two counties: Sacramento and Los Angeles. *Sarah Brooks, DHCS:* I wanted to talk a little about the ombudsman role. We did recently consolidate The ombudsman for our Medi-Cal managed care health plans and for our county specialty mental health plans. We felt that it was really important -- for example how would the beneficiary know if they were calling for mild to moderate for the Medi-Cal managed care health plan versus moderate to severe for the county specialty mental health plan? We have been doing quite a bit of work at DHCS around network adequacy. We been working to put in place two measures and metrics in respect to whether beneficiaries are getting access to care. The new provider file will give us information about the providers that are providing services to our beneficiaries. Before, we got information and data from our health plans, but really it was a 'flat file', or a file with just providers listed. Now, we're able to get information that shows us details from the health plan all the way down to each provider. *William Arroyo, M.D.:* DMHC's recent survey results are stunning in terms of the failures from all the health plans in general. DMHC interpreted many of their findings as the health plans not understanding the specific regulation and policy. Concerning your presentation, are the alternative access standards negotiated with CMS, or are they imposed by CMS? *Sarah Brooks, DHCS:* The state approves the alternative access standards. The federal government has given us authority through the managed care final rule to provide and approve the alternative access standards. We do not go through CMS to get approvals on those. I have seen the DMHC report that you mentioned and certainly we would want DMHC to speak to that report. What I can say is that through our automated system that we put in place, we believe the data that we're receiving now from our health plans is clean data and that we're not seeing the same issues that were set forth in that report. *Jennifer Kent, DHCS:* To Sarah's point on the alternative access standards, we only have 5. For example, there are a couple of ZIP codes that are in alternative access standards for Inland Empire Health Plans (IEHP) because there are no people in the ZIP codes, so therefore managed care doesn't exist in that zip code. We don't do it that often. *William Arroyo, M.D.:* On slides 19 and 20, there are these standards for mental health non-physician professionals but for the SUDs services, there's no attempt to separate a physician from other professionals. I'm wondering how DHCS changes its issue to set up that difference between mental health and SUD categories. *Sarah Brooks, DHCS:* Psychiatrists are included in the specialist category. We were looking at distinguishing between [physician and

	non-physician mental health services. *William Arroyo, M.D.:* On the SUD category, what was the rationale for not separating out a physician who might be involved in SUD? *Sarah Brooks, DHCS:* It would be separated there as well, but it's not included on the slide. I'd like to follow up with you on that. *William Arroyo, M.D.:* I'm very curious because there is an emergence of the use of Medication Assisted Treatment and Substance Use, which would require a physician, physician's assistant, or nurse practitioner for that treatment. *Sarah Brooks, DHCS:* That would follow the same reasoning for our split with psychiatrists. *Elizabeth Stanley Salazar*: For the slide that has all of the categories and final rule, one of the categories is care coordination. I wanted to hear some idea of how you are monitoring the quality or performance as it relates to the mandated requirements for coordination between the specialty mental health plans and the managed care plans, and now the Mental Health Partners in Health in the counties under the drug Medi-Cal waiver, as well as between the specialty managed care plans and the primary MCOs. *Sarah Brooks, DHCS*: The health plans, which includes the specialty mental health plans, are required to send out a health risk assessment prior to enrollment of a beneficiary in the health plan. They are also required to share that information amongst each other, so that's an example of how care coordination would happen across the different entities and different delivery systems. We will review that in our annual audits of the health plans in terms of whether they are collecting that information and if they're sharing the data. Also, if they're using it to stratify beneficiaries as they come in to make sure we're identifying high-risk beneficiaries, and whether the beneficiaries are referred to different programs. *Karen Lauterbach*: When you talked about cultural competency, how is that graded? *Sarah Brooks, DHCS*: In the final rule, the distinguishing factor for California was tied to gender identity. When you looked at cultural competency, we were already in compliance with the different requirements, but we did need to update state contracts and guidance documents to include language around gender identity. *Karen Lauterbach*: Is anything in the final rule in regards to homelessness? Does this fall under the cultural competency? *Sarah Brooks, DHCS*: That falls outside of cultural competency. Housing is not a Medicaid covered benefit, but we're hoping that with

	the implementation of the other programs, we can have a connection to those housing pieces to improve care coordination overall to those beneficiaries. Whole Person Care (WPC) pilots will connect our Medi-Cal MCPs and our county specialty mental health plans in terms of housing. We look into care coordination through the WPC program. *Karen Lauterbach*: For the time and distance slides, in Los Angeles 15 miles can take you a long time in traffic. Is it an either/or provision? *Sarah Brooks, DHCS*: We're still considering this and we did put this out for public comment. Generally, our population travels by public transportation. *Karen Lauterbach*: I would encourage you to think about this. We have beneficiaries who will use the ER because they know they have to be seen, which is not the ideal way to do things. *Terrie Stanley*: Speaking from a plans' perspective, plans really do try to contract with certain providers. It's extremely difficult. There are many providers in the state that may get funding from the state, yet when it comes time to talk to managed care plans, they either will not contract or they want rates that are problematic to the plans. There is no requirement that any provider must contract with the plans. *Marc Lerner, M.D.:* On slide 7, we've had some discussions that if you don't measure items, it's difficult to know how well you're doing. We talked about how development screening is part of the child core set, and on this committee, it was one of our priorities. Some of the topics are not regularly collected. If you look at the managed care plans collecting HEDIS measures and the external performance indicators, I would support attention to the entire child core set. On slide 12, just as access to health care and health care information is difficult to our homeless population, there are cultural barriers to care. By the time the ombudsman is involved, we're going to have a master's level-or-above parent who knows how to find the pathways into the systems. We need to understand how to gain voice without looking for the purified highest level of complaints because they don't know how to get to the right area. As important as those who do get to the ombudsman, I don't think it's an adequate measure in and of itself. On Slide 13, some of the components that are there might be of interest for placement on DHCS' pediatric dashboard. I would think about whether some of these components might be present. When you talk about provider competency, my medical degree says physician and surgeon, and I would not want to harm a single member in this room by attempting to operate on them. If I don't have connections to mental health providers, I'm going to be providing a lot more anti-depressants and prescriptions rather than referrals for cognitive behavioral therapy. Knowing that there are competent

	professionals who can work with different ages, particularly the 0-5 age group, is very important. Looking at some of the data that helps us to understand our vulnerable populations and whether providers are working with those groups is important. *Ken Hempstead, M.D.:* On slide 5, just to dovetail on the last two comments with data collection, is the state collecting data directly from these providers that we're trying to reach out to and get into the system? Obviously we assume that reimbursement is a very large chunk of this. I'm wondering what kind of surveying of these providers is done to get their perspectives on reimbursements, regulatory, or other barriers to care. *Sarah Brooks, DHCS:* So your question is whether we're surveying the providers as to why they might not be contracting with the health plans? *Ken Hempstead, M.D.:* Yes. *Sarah Brooks, DHCS:* We do collect this information for continuity of care purposes. For example, when we transitioned seniors and persons with disabilities population, we collected a number of data fields including continuity of care. When continuity of care wasn't entered into, we collected information on why it wasn't. Generally, it was because providers did not want to work with the managed care delivery system. I do want to be clear that the data came from the plans. We did not survey the providers. *Ken Hempstead, M.D.:* It's difficult for this group to get that data because by definition, they're not participating. The providers are not under a lot of obligation to spend a lot of time on that. Maybe under another setting, we can work together to get a better understanding of what the barriers really are. *Jennifer Kent, DHCS:* We run two delivery systems with a total of 14 million beneficiaries, with 10-11 million in managed care and 3.5 to 4 million in Fee-For-Service (FFS). Most of those in FFS are not eligible for full-scope benefits, which means they are emergency, limited-scope only. About 1.1 million are dual-eligible, so Medicare is the primary and Medicaid is the secondary. The remaining populations are very small and not mandatorily enrolled in managed care; foster care being the biggest at 80,000 children enrolled. The rest have been found eligible for the program, they're in the choice period and are getting placed into managed care. Our health plans, according to the monitoring that our Managed Care team does, have adequate networks. We have 11 million people in managed care today that are being seen and treated. We are holding the plans accountable for network adequacy. Physicians might not think they are taking Medi-Cal, but they may be in a managed care contract that is actually contracting for Medi-Cal and they might not know it. It gets really complicated. We try not to do surveys because providers might not

	actually know that they are seeing Medi-Cal patients. *Sarah Brooks, DHCS:* A lot of times with the surveys, we've found we can't use the data because of the questions asked. *William Arroyo, M.D.:* I want to go back to something with what Karen raised, which is the homeless population. When someone doesn't have an address, it's impossible to apply the time and distance standards. How many homeless people in California have Medi-Cal and what standards do we apply to that population versus those who have residences? To Dr. Lerner's comments on the usefulness of the ombudsman system, any individual with compromised cognitive function is not going to take advantage of that service. Is there another option for those beneficiaries? *Pam Sakamoto:* In regards to slide 7 on the access issue, you brought up a good point, Jennifer. When we're looking at the pediatric population, there are frequently only a handful of specialists throughout the entire state. The state has been working with telemedicine and connecting physicians, but I think that needs to be addressed further because we have a lot of FQHCs that may not have specialists on hand, but they have the equipment to connect technologically to tertiary centers. I think this issue needs to be explored. Some physicians have done sample areas to see if telemedicine works, typically with the CCS medical therapy programs. These services would address the medical access issues if they were made a standard by the state. *Jennifer Kent, DHCS:* This does not apply to CCS, which is a FFS program. The only place that these standards would apply are in the Whole-Child Model counties. *Pam Sakamoto:* Except I'm from Solano County where we've been carved in since 1994, so they have applied since 1994. *Jennifer Kent, DHCS:* Kind of, yes. MTP is not part of this proposal and neither are any of the other CCS counties that are not Whole-Child Model counties. *Elizabeth Stanley Salazar:* The dashboard is fantastic. I see that there is a mild to moderate rate per 1,000 members per month, but what is it compared to? What are the standards, and how do you go about getting those standards? You mentioned that the mental health specialty plans and the SUD delivery systems will have a heavier lift because they have not operated under the final rule standards. What are your thoughts on this and what will you being doing to monitor? *Jennifer Kent, DHCS:* We're talking to the counties now and they are going to have to meet every single milestone and date that everyone else has to meet.

	Elizabeth Stanley Salazar: Will it be an easier lift for the SUD? *Jennifer Kent, DHCS:* Yes. Part of the waiver required by the federal government required 438 compliance. So they have less work to do, but the county mental health plans have a lot of work to do. *Ron DiLuigi:* When looking at the timeframe for the requested appointment versus the actual appointment, do you ever find that you need to temper some of those requirements based upon wherever you find the standard in a community to be? *Sarah Brooks, DHCS:* For Knox-Keene licensed plans, if there's a standard that's already set forth, they are applicable to Medi-Cal and also to all other commercial plans. For example, with primary care where time and distance is 10 miles and 30 minutes, that's applicable to both Medi-Cal and commercial plans. With the new standards, such as specialty care for time and distance, they will only be applicable to Medi-Cal. It's dependent on whether it's a Knox-Keene standard versus something new that we are proposing today. *Marc Lerner, M.D.:* To emphasize that because we are a pediatric committee, with homeless children, schools are the point of contact. I would be happy to see the school be designated as the home site. There was a comment by Sen. Pan on the issue of cancer treatment quality differences where unfortunately our Medi-Cal members were having outcomes as if they were uninsured. That's a very different measure of performance than provider numbers and ratios. We should consider emerging quality issues other than what have been highlighted in the federal requirements. I would encourage some attention to that with academic quality experts. *Diana Vega:* For the population that doesn't have the means to pay for public transportation or doesn't have a personal vehicle, is there a solution where the physician could counsel them? *Sarah Brooks, DHCS:* For children, we have nonmedical transportation, which are for example, vouchers for buses or taxis. This is different from the nonemergency transportation, where someone with a wheelchair might need to be transported to an appointment. Effective July 1, 2017, nonmedical transportation will be available in all of our Medi-Cal managed care health plans. If a beneficiary could not make it to their appointment, they would contact their health plan and the plan would assist the beneficiary in getting to the appointment. *Diana Vega:* For dental managed care, it's only for Sacramento and Los Angeles, but for medical purposes, it's throughout California? *Sarah Brooks, DHCS:* Correct. *Diana Vega:* How do families access managed care? In my

	experience, for individuals or families, you really have to become very educated and at times it could be very stressful. Parents aren't always aware of how to access care. *Sarah Brooks, DHCS:* I certainly heard the feedback regarding the ombudsman and cultural competency. Where you can call to get information about how to access managed care can be done through the ombudsman's office, or your health plan. Every health plan has a call center and they are required to have translators available. Our Health Care Options enrollment broker is another place you can call. Certainly we can provide all of this information to the panel. *Jan Schumann:* I urge the panel members to present additional concerns to Sarah in writing so that she can take them into consideration. Would it be appropriate to formalize a letter on behalf of the panel, and to form a subcommittee for the June meeting based on all of the various recommendations we had from today? *William Arroyo, M.D.:* The heavy lift is on the county mental health plan side. For us to only speak to Sarah's piece may be a good idea but it's not covering the entire Medicaid managed care rule landscape, which might require our attention. Perhaps Jennifer would want someone from a specialty mental health plan to speak to the panel. I'm overwhelmed by the requirements that are being imposed on the county mental health plans. *Jennifer Kent, DHCS:* If you're going to form a subcommittee based on today's discussion, you might want to think about what it is you're going into the subcommittee for in terms of an issue, problem, or a set of circumstances that need to be addressed. I see Sarah's presentation as an introduction and how we're organizing ourselves around certain regulations. *Marc Lerner, M.D.:* The minutes should reflect some of the issues and concerns we've had and we can just glean those. I'd rather know in 6 months what you're seeing in data, what you're hearing from plans on some of these elements. *Jan Schumann:* Do we have a motion to submit our meeting minutes to Sarah as official comments from the panel? *Adam Weintraub, DHCS:* As a point of information, the minutes are compiled after each meeting and are shared with the participants. Sarah's team will have access to the minutes as well as our routine follow-up document from the meeting. *Bobbie Wunsch, Pacific Health Consulting Group:* For several months, a subcommittee of this group led by Dr. Fisch was meeting around the issue of network adequacy. Before Dr. Fisch resigned from the panel, he had prepared and presented to the panel a long list of network adequacy issues that the committee had been talking about. We either

	need to set this aside for a while as Dr. Lerner was suggesting, or we need what's left of the subcommittee to go back and look at the list of issues that the subcommittee already compiled and decide if the deep-dive on network adequacy is necessary, or if we need to move on to a different topic for our next deep-dive. *Pam Sakamoto:* In regards to the pediatric dashboard, are there any concerns over access issues? I would also be interested in how we arrived at the fact that Medi-Cal was worse in terms of cancer patients receiving treatment versus non-insured. I wonder about the facilities where patients received their treatment, and how long they waited after their diagnosis to get treatment. Those are issues that are just as important as access to care. There are only three of us that were on the network adequacy subcommittee with Dr. Fisch. I don't think we're ready for a deep-dive based on the changes that have been implemented; we were speaking before those changes on the subcommittee. I think we need to give it a little time to see where the issues are. *Ron DiLuigi:* We should wait a while to see where we are.
Public Comment	*Kelly Hardy, Children Now:* I want to go back to CHIP. I want to mention that there's a lot of concern amongst the stakeholder community around CHIP. The CHIP authorization going forward but at the expense of other cuts to Medicaid. I would just caution the panel to be very careful and make sure that we're speaking about Medicaid and CHIP together. There are many Medicaid parents that are working very hard and we don't want to say that CHIP parents work, but Medi-Cal parents don't work. We are making sure that we're being very careful around that messaging. There's a lot of fear that CHIP will be reauthorized, but at what cost to the rest of the system? *Kristie Sepulveda-Burchit, Educate. Advocate.:* We serve families who have children with special needs. Primarily, those that we serve are low-income and on Medi-Cal. One of the problems aside from having an adequate network of providers is the quality of care and having enough providers who are willing to take the Medi-Cal rate. Recently, a service was restored in July 2016 for acupuncture. Of the two companies that I've queried, IEHP and Molina, IEHP is using a third party organization – American Specialty Healthcare (ASH). They have terrible Yelp reviews as far as the services they offer. Molina isn't caught up in offering acupuncture yet to those who have Medi-Cal. Those are problematic areas. The other issue is chiropractic care was never restored back to the budget, only acupuncture. The other point I would like to make was since the passage of SB 277, and we have people who want to get medical exemptions, and they have Medi-Cal, there are very few limited medical providers who will write a medical exemption letter. Part of the issue is that they get substantial funding from making sure that they have all of their patients up to date on their vaccines, as opposed to they would not get the

	funding that they would like if they have patients that they have to write a medical exemption for. There's no financial interest to be gained here in offering a medical exemption letter, and that's very problematic. I wanted to bring these to your attention and hope that you would consider these as an item on your next agenda. *Christina Hildebrand, Voice for Choice Advocacy:* I would second what Kristie Sepulveda-Burchit just said. From a mental health perspective, there are many ways to treat mental health. There's talk of psychiatrists and medication to deal with mental health, but I would ask that you also include alternative care. So things like acupuncture, chiropractic care, and the different avenues and different forms of therapy, and other types of health care like food and nutrition. All of these play a big role in a child's body and their needs and their mental state. You sort of take a holistic approach when you look at what services are being offered and not just go with the traditional psychiatrist or even psychologist. When you're looking at medication being provided and services being provided under Medi-Cal, in my experience, it goes to the medication much too soon because that's the easy band aid to put on it. I would ask that in your future conversations, that you look at the child as a whole and take into consideration things like food and nutrition and other options that are not medication, which can have long-term effects.
Upcoming MCHAP Meetings/ Next Steps	*Marc Lerner, M.D.:* In regards to bringing up potential content for the next meeting, would that be done by communication with the Chair? *Jan Schumann:* Yes, through the Chair. Meeting Dates for 2017: • June 28, 2017 • September 12, 2017 • November 1, 2017