State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

July 16, 2015

Meeting Minutes

Members in attendance: Ellen Beck, M.D., Family Practice Physician Representative; Karen Lauterbach, Non-Profit Clinic Representative; Jan Schumann, Subscriber Representative; Marc Lerner, M.D., Education Representative; Paul Reggiardo, D.D.S, Licensed Practicing Dentist; Jeffery Fisch, M.D., Pediatrician Representative; William Arroyo, M.D., Mental Health Provider Representative; Ron DiLuigi, Business Community Representative; Pamela Sakamoto, County Public Health Provider Representative; Alice Mayall, Subscriber Representative; Elizabeth Stanley-Salazar, Substance Abuse Provider Representative; Wendy Longwell, Parent Representative.

By Phone: Sandra Reilly, Licensed Disproportionate Share Hospital Representative

DCHS Staff in attendance: Jennifer Kent, Director; Karen Baylor, Substance Use Disorders and Mental Health Services Division; Denise Galvez, Policy and Prevention Branch; Norman Williams, Adam Weintraub, Office of Public Affairs.

Public Attendance: 23 members of public attending.

TOPIC	NOTES
I. Opening Remarks and Introductions	**Ellen Beck, MD, Chair** facilitated introductions of members, introduced Bobbie Wunsch, Pacific Health Consulting Group, as co-facilitator. Funding for Bobbie's assistance is provided by The David and Lucile Packard Foundation. The legislative charge for the advisory panel was read aloud.
II. Meeting Minutes	
a) Review and Approval of May 22, 2015 Meeting Minutes	The chair asked members to review the minutes. Members requested that the minutes be distributed with the meeting announcement and agenda ahead of the meeting. Minutes were approved.

b) Tracking Document	**Chair:** The draft tracking document is being circulated. It includes topics for deep dive discussions. The document lists each topic, along with the number of votes it received for including the item as a priority, potential dates for the topic discussion, person responsible/next steps and recommendation. The document is intended to record progress and recommendations over time. **Member**: In the recommendation section, there might be three areas, initial recommendation, DHCS response and final recommendation. **Member**: Using the last Deep Dive as an example, it would be good to hear the Department's response and specifics on the topic. **Chair:** Within this meeting, there is an opportunity to further discuss mental health and substance abuse. We will talk more about a process later in the day. If people are okay with the basic tracking document, please send any ideas for improvement by email to the chair or to Bobbie Wunsch.
III. Update on Timeline and Planning Process for SB 75 (Coverage For all Children) and Budget Language with panel suggestions	**DHCS Director**: The Governor signed an on-time budget, with two special legislative sessions, one of which is to address the need to continue a tax on health plans (in existence since 2008). It is important, as failure to pass it will create a large hole in the state health budget. The federal government has changed how the state can administer the tax, which broadens the tax and makes it more complicated. Through the budget, all children, regardless of documentation, will be eligible for full scope Medi-Cal as of May 1, 2016. This will be about 170,000 children, 140,000 of whom are already known to DCHS through emergency Medi-Cal and CHDP (the Child Health and Disability Prevention program). This expansion will require significant administrative and IT changes to ensure we identify services eligible for federal participation vs state General Fund. Also, DHCS will be working with counties on eligibility, creating aid codes, etc. DHCS will also be working with health plans over enrollment, network review and rates. This also dovetails with the CCS discussion for later today. There are children who have state-only CCS and will now be covered for full scope Medi-Cal benefits and managed care. This adds a layer of complexity but overall this is very exciting. Additional updates will come forward as we have them. **Chair:** Are there suggestions or recommendations related to the issues raised? **Member:** Will coverage result in true access to care since there are long waits for services in many places? **Chair**: We do have an area of discussion related to access. This may be a recommendation under that topic area. **DHCS Director**: This is not a problem isolated to Medi-Cal. There are places where this is not a problem and other geographies where we struggle to ensure access. There are places where health plans are covering medical school loans to bring doctors to their area. We will especially look to FQHC clinics to fill gaps. Of the 170,000 children, 140,000 are already in the system and may be receiving episodic care. We will be working hard to bring them

	into a regular continuum of care and meaningful access. **Member:** On the second issue related to CCS complexity, this is going to entail MOU relationships between the county and the health plan and the state. The state needs to engage, not from a disciplinary perspective, but deal with difficulties upfront, with oversight and close attention. **Chair**: I have a recommendation from a previous experience through a project with Healthy Families enrollment in San Diego. In the situation where the children would be citizens but not the parents, we interviewed the parents as to why their children were not being enrolled even though the children were eligible as citizens. The parents told us that they were concerned about immigration because the parent was undocumented. We need to outreach to families through trusted services, so they understand they do not need to live in fear for enrolling their children. This is a tremendous opportunity to sign up all kids for insurance, perhaps by working closely with foundations. **Facilitator**: To work on this topic of access, enrollment and engaging parents, I suggest we invite health plans, community health centers, Kaiser's children's health program and some advocacy organizations to the next meeting to talk about these issues. **Member:** We have a 30-year history in Solano County working on access. When Partnership came on board, pediatric providers were required to become CHDP-enrolled and this improved quality and follow-up. When CCS was carved in, we worked in a collaborative way so children could receive specialty as well as pediatric care. We have to be specific about access issues to make progress; we need to use technology and telemedicine. There are situations where we only have 12 specialty providers in the whole country so we can't ensure geographic access. We need to align the particular access issue with possible solutions to work toward a resolution using a continuous quality method. **Member:** A friendly amendment to the suggestions for the next discussion is to invite people from immigration communities to a Deep Dive discussion. **Chair:** I am hearing follow up on two issues: accessibility to enrollment and accessibility to provider networks. This may be scheduled together or as two discussions. **DHCS Director**: If we want to have discussions with health plans, DHCS, immigrant communities and others, it should be the only agenda item at that meeting. There is a role for foundations in the discussion as well. **Member**: Part of our panel responsibility is communication between DHCS and families. This is an opportunity to get comment from families as well as plans and others. We should consider strategies for bringing access. There is a requirement for schools to communicate coverage opportunities and I'd like to see some of those messages integrated as well as the opportunity of associating school-based health centers with this work to address access broadly. **Motion adopted:** Use one of the next two meetings to do a deep dive on this issue of access and network adequacy.

	Chair: I want to return to the issue of network adequacy **Member:** We could do some work as a subcommittee and report back to the advisory panel. There should be people from different parts of the state as part of the subcommittee because network adequacy is different in different areas of the state. **Member:** Network adequacy is also related to mental health as well as physical health. **Member:** I'm sure DHCS is keeping a record of networks and adequacy; counties are reporting; plans are reporting. I would really like to consider data, draw conclusions and maybe make recommendations. I would like to understand networks in a more detailed way. **Facilitator**: DHCS collects a lot of data and can speak to network adequacy. We could start with data and work with a subcommittee of two or three people. Wendy, I hope you will be one of them, others could volunteer to look at this issue. **Member**: Six years ago we were looking at not enrolling any more children. It is awesome to see us moving from not enrolling any more children to now talking about making sure that they have access to coverage, so this is a very defining moment for this panel. **Member:** There are multiple data points and studies from foundations, audit reports and experts working on this. In terms of process, can we use the data that others are creating both internal and outside of DHCS to identify recommendations we can piggyback on? **Member:** Up in our area, we have lost providers as we transitioned to managed care. Is there data about providers that have been lost from the system? **DHCS Director:** DHCS does not track that granular level of data. Health plans are more likely to have local information. It is important to remember we are serving 12.5 million people and there is access. There are always going to be improvements to make; there are always going to be challenges, but I never am comfortable with the discussion that there is no access in Medi-Cal, because that is absolutely not the case. For providers who decide not to take Medi-Cal, it's an economic decision. The plans work hard to keep their networks with adequate capacity. We believe that, by and large, in most areas, there is capacity, but not everyone wants to use the available providers. **Member:** I agree there is access and lots of care provided. I also believe this panel is here to help make improvements. And, the solutions may be beyond Medi-Cal. **Chair:** The next meetings will focus on all children getting enrolled, network adequacy and core measures. I think we may need several subcommittees that we can discuss later in this meeting and then we will figure out the order for the next three meetings and come back to the whole group.

IV. Deep Dive: Integration: Substance Use Disorder Services	**Chair**: This discussion is a follow-up of last meeting's deep dive on mental health to add a presentation on substance abuse. We have Denise Galvez (Policy and Prevention) and Karen Baylor (Director SUD/MHS) with us. After the presentations, we will discuss both substance abuse and mental health. Elizabeth Stanley-Salazar will introduce this topic.
a) Presentations	**Elizabeth Stanley-Salazar**: Historically, California has not had a benefit for substance abuse connected to health care. It has operated through a block grant as a social model program delivered as recovery services as opposed to a treatment service. Substance abuse disorders are now an essential benefit through the ACA and this will improve service delivery. It will take time because this is an underdeveloped system of care; we have no provider networks, no administrative structures and lack partnerships with mental health. In our practice at Phoenix House, we have integrated mental health and substance use disorder, yet we see huge gaps. Mental health practitioners do assessments and leave out substance abuse and substance abuse disorder practitioners don't know how to diagnose. Only 10% of people who need treatment are getting it nationwide, as well as in California, so this is a positive and exciting time as we move to a true benefit. Data indicates we have youth who are seriously impacted by substance use and we also see that prevention is working. **Karen Baylor and Denise Galvez:** provided a presentation based on ***The Integration: Substance Use Disorder Services for Youth*** slides available on the MCHAP website.
b) Discussion Recommendation and Next Steps for mental health and substance use disorder service	**Member:** What is the prognostication about the restructuring or continuation of the block grant? **Karen Baylor:** We are seeking a Drug Medi-Cal waiver and are looking to repurpose this funding to expand services even further. We have heard that we have at least a couple of years of continued block grant dollars. After that, we are not sure what will happen with any SAMHSA reorganization, and with the new administration. **Member:** What are the gaps in services; how will this grow and be strengthened? **Karen Baylor:** As discussed, this has never been a robust benefit. The ACA allowed us to expand services, and, together with allegations from CNN about nefarious characters providing treatment services, offered us an opportunity to convene stakeholders and create a soup to nuts continuum and coordination of care. We are asking for a waiver that includes a requirement that providers have an MOU with health plans, so that there is someone with oversight over the client's needs. Fifty counties have asked to opt-in to be part of the waiver. It will start in the Bay Area, move down to Southern California, move to Central Valley and then through the rest of the state. **Member:** Why does it appear there is a decrease in amount of prevention funding in the years between 2010 and 2013-14 in terms of prevention service? **Denise Galvez:** The field as a whole has gone from individual prevention to

	community-based services, and the data are now collected differently in the system. For example, instead of a class on prevention, there might be a policy to reduce the number of alcohol outlets in an area. **Member:** I want to underscore the dearth of services in this area. In the last national survey, alcohol was a huge issue (22% of youth drank five drinks in a row in the previous month) and, based on that, in California we should have 400,000 youth in treatment. Marijuana also a big issue with 23% using in the last month. Yet, we have almost no services for young people. Health plans have no services. We are underserving this population and losing youth. **Karen Baylor:** We agree and this is why the waiver is important. The waiver will allow us to build a continuum of care. Residential treatment will be covered. We are on the cusp of huge changes because we know the demand is great. **Member:** We have the opportunity to build an organized delivery system. This is going to take time. We know that kids are seen by primary care physicians, and there are many people who interact with the kids. There could be a strategic initiative to engage health plans and engage those who are not providing treatment services for early intervention. Those of us who are providing treatment are seeing children at the endgame. Managed care and primary care physicians have responsibility to identify. **Member:** Is there an evaluation component around prevention? **Denise Galvez:** Yes, the evaluations are done county by county for block grant services, and they have to be submitted to the state. Annually our technical assistance provider has a conference, and this year's topic is evaluation. **Chair:** Do you currently have a plan for how you want to engage the health plans and the counties who have not signed on yet to the waiver? **Karen:** Yes, we are starting technical assistance with the Bay Area and are looking for submitted implementation plans to gauge actual interest. My sense is that if we can make it work financially for the counties that is what will make the decision. Each county will have to work with the health plans. We are working with the health plan association, the hospital association and a robust stakeholder process to develop the waiver. **Chair:** More agencies are becoming aware of the block grant. Many may not be aware of the existing prevention funding. **Member**: I am concerned about counties level of care achieving a balance of seriously mentally ill services vs mild-to-moderate services where we get early intervention. As we roll out substance abuse benefits, ensuring all levels of service is an important area of advocacy for all of us in counties. In 2009, the CHDP process offered a health assessment guideline on social emotional development which was essentially a quality tool. As plans set up to do this work and train workforce to do appropriate screening, it will be helpful to have expert recommendations on the quality tools, beyond SBIRT, whether the NIAA alcohol screening guide or other tools for high quality

	screening. **Chair:** I invite each person state a short or long term takeaway that you would like to see occur as a step forward. • Look at opportunities for physicians to have direct referral to county system. • Engage with DMHC director and staff and managed health care plans related to this. By the time the young people get to me they are incarcerated, way beyond prevention. • From the oversight perspective, the idea of MOUs working between counties and the state, and putting all this together is good. And still we need to maintain a healthy skepticism. When you see a county mental health system, you've seen one county mental health system. The oversight/assessment role is essential. • I'm at an advantage, because my Kaiser Permanente system is well integrated. We need to reach out to our providers and mental health colleagues within health plans to partner together and with county/community systems. My biggest problem is helping people with severe mental health issues because a closer partnership the county system is needed. • The Department should be focusing on quality measures, education of providers, consultation methods and cooperation between mental and physical health providers. • We talk a lot about prevention, and the environmental model of prevention, but parents often do not know what is going on. Parents are shocked about what children are exposed to and have access to everyday. • I would like to underline the money issues. We need to reimburse for case management so that coordination with schools and others really happens. • I need to see more clarity from the state about the levels of care and definitions of need (moderate, severe). Otherwise, patients are bouncing between systems. Also, we have to look at hospital capacity for severe need patients under age 18. • We should support primary care provider collaboration. Everything starts with the medical home provider and we need to be involved before they are categorized as moderate, etc. • Beneficiaries also need education about services. Stigma varies from community to community and is a barrier to access to care. • Promote the use of peer health promoters, in middle and high schools. These are peers who have been through it and can discuss it with others. Work with collaborative models for physical and mental health. Long term, I recommend we get rid of carve outs because consistency across the counties is problematic. • We do general prevention. I would like to see targeted prevention to

vulnerable groups who are experiencing mental health concerns and are at risk for substance use disorders, such as ADHD consumers.

Panel members are asked to sign up for subcommittees:

- Network Advocacy
- Mental Health and Substance Abuse
- Dental Recommendations.

Community Comments:

- **Dr. Lubin, Benioff Children's Hospital Oakland**: We are 73% Medi-Cal. A lot of hospitals are looking at social determinants of health. We have an FQHC within the hospital just for children. Within that, we have about 100 navigators trained from the community. We look at social determinants such as housing, jobs, food, access to health care – all the things that contribute to the illnesses we are discussing. This is something worth the committee looking at. We would like to be involved in a future presentation – Dr. Dana Long from our organization. Also, as you do committee work, please consider how to involve us from the audience in a range of topics.
- **Alison Buist, Children's Defense Fund:** The Auditor's report talked about the lack of DHCS data for network adequacy so I would you to talk about that. Also, could you talk about new phone system and the 45,000 calls dropped by the department as to whether this is part of the information you are relying on about sufficient network adequacy?
    - **Director DHCS:** We agreed with some and disagreed with some of the audit report findings. They did not say we did not have adequate networks. They took issue with the process we use. We should discuss this offline. We have a lot of data and millions of encounters – marshalling that data into meaningful information is difficult. They did not look at all components of monitoring for network adequacy. Yes, there are problems and we are always trying to improve. However, we do not think the report was fully indicative of what we do.
- **Kathy Dresslar, The Children's Partnership:** I didn't hear whether you are coordinating between mental health and substance abuse, particularly early intervention programs and anti-stigma campaigns?
    - **DHCS:** Yes, there is an Interagency Prevention Advisory Council (IPAC) with representation from mental health and substance abuse meeting quarterly. Also, given that substance abuse prevention monies go out throughout the county and we have them do strategic plans, many counties are moving to comprehensive plans including mental health and primary care.
- **Kelly Hardy, Children Now**: Also, can you talk about whether there are milestones with a timeline leading up to May 2016 implementation of coverage for all children?

	○ **DHCS**: Yes, there are milestones and a timeline. • **Chair:** We want to have input from non-committee members in the subcommittees. I don't think we will have membership beyond the panel to keep them small.
V. Selection of Next Deep Dive Topic	A decision will be made shortly as to the order of the deep dive topics. We will also need to come back to the dashboard and membership in three subgroups: network adequacy, mental health/substance abuse, and dental issues. People should consider which group they want to serve on.
VI. Update on CCS RSAB Process and DHCS Proposal for CCS	**DHCS Director:** Tomorrow, there is a CCS stakeholder advisory meeting facilitated by Bobbie Wunsch. This is the second meeting on the proposal to move CCS children into county organized health services for both their primary care and CCS needs in Partnership, CenCal, Central CA Alliance for Health, CalOptima - and San Mateo already has CCS carved in. Comments are posted. We are hearing a lot of concern about the impact to CCS and there is concern about making sure that services are retained and enhanced. Within California our system serves both California children as well as children from other states. We have the size and resources to allow specialty centers to survive. We will share documents for the meeting, including legislative language that encapsulates next steps, our responsibilities, goals for the plans, service delivery and consumer protections related to continuity of care and other issues. It is incredible that this program has been in place since 1927, the oldest health service in the state. It has significant impact to the children relying on it and to the state. It is great that we have Wendy Longwell, Pam Sakamoto and others who serve on both this panel and the CCS committee. There is concern and some opposition about ending the carve-out exemption. When this has come up in the past, the exemption has been left in place. The Secretary and I believe that there has got to be progress in terms of moving the children into an organized system as collaboratively as possible. We want people to understand how we came to the decision to move ahead. We need to maximize and improve services in terms of consistency. **Member**: There is not much opposition to the whole child model but the speed at which we are moving. Medi-Cal managed care plans are trying to catch up with what is already moving into managed care. I think we need to do it differently than other transitions – we need to wait until readiness is clear and then enroll children into managed care. **Member:** There are issues related to funding and staffing. CCS is setting the standard for all children, not just CCS children. The systems have issues but speaking from a county that is carved-in, I think enforcing the consistency, maximizing telecommunications from the state level is essential. **Member**: I have a CCS child and I think you are on the right track. Change is hard. The focus on quality and the medical home is the right track.
VII. Member Updates and Follow-	

Up	
a) Pediatric Dashboard Sub-Committee	**Member:** We have not met in the past month. We have one scheduled for July 29th. We are a little confused as to what our role is.
b) Process for Discussing Dental Recommendations	**Chair:** We should discuss the process is for developing and finalizing recommendations to DHCS. There is also a question of whether the committee is subject to the Brown Act? **Facilitator:** For the next meeting, we will lay out ideas for a process, such as, What is the decision making process; is it consensus vs majority of people present or of the whole group; what happens to the recommendation? I will offer a document to respond to, first to Ellen and Jennifer, then the group. I will incorporate the requirements for open meetings into the draft for discussion. **Member:** Things are moving in a good direction, with committees; basing discussion on data, creating a decision making process. **Chair:** It is important to get to a place of actionable recommendations. There is a sheet circulating for people to indicate interest in serving on different committees. I will serve as ex-officio to all committees. Network Adequacy: Jeff Fisch, Wendy Longwell, Alice Mayall, Pam Sakamoto, Sandra Reilly Mental Health and Substance Abuse: Marc Lerner, Jan Schumman, Bill Arroyo, Liz Stanley-Salazar Dental: Paul Reggiardo, Marc Lerner Dashboard: In addition to current members, add Karen Lauterbach, Alice Mayall, Pam Sakamoto **DHCS Director:** What are the needs for committee staffing? This raises concerns about the capacity and appropriateness of DHCS staffing and participating in subcommittees. How is DHCS staff expected to be involved? **Chair:** The subcommittees are not expected to last long. For example, the dental committee will review materials, come back with recommendations and a timeline, and we respond and then final recommendations. We need someone from the Department to lend their input, data, help with scheduling, and a telephone or space. **DHCS Director:** We would take what has been provided to you already and other existing reports. It is important for DHCS staff not to make recommendations to DHCS, but staff can provide administrative facilitation and provide data within reason. **Member:** You might want to consider a two-person subcommittee to avoid open meeting rules and simplify the process.
c) Mental health and substance abuse	

VIII. General Update	
a)Enrollment and Renewal Report Available	May enrollment numbers are on the website. We are at 12M total with 9M in managed care and 3M in fee for service. (http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptJune2015.pdf). We continue to struggle to implement the technology side to this. Some of the advocates have been working with us to improve functionality. It is difficult, expensive and frustrating. It is at the heart of the efforts, to make it easier on all of us to provide the data we are all looking for.
b) 1115 Waiver Efforts that Highlight Children and Families	The Department has a work plan for the implementation. We have weekly meetings to move forward with the federal government. The discussions have been productive, but it is still a long way off. In September we will know a lot more.
IX.Sept. 10 MCHAP Meeting Next Steps	Dr. Beck thanked everyone for their passion and commitment to the children and families.