State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

September 12, 2017

Meeting Minutes

Members Attending*:* Ellen Beck, M.D., Family Practice Physician Representative; 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; Kenneth Hempstead, M.D., Pediatrician Representative; Marc Lerner, M.D., Education Representative; Terrie Stanley, Health Plan Representative; Bertram Lubin, M.D., Licensed Disproportionate Share Hospital Representative; Wendy Longwell, Parent Representative; Diana Vega, Parent Representative.

Attending by Phone: 26 stakeholders called in

Not Attending: Ron DiLuigi, Business Community Representative; Liliya Walsh, Parent Representative

DHCS Staff: Jennifer Kent, Adam Weintraub, Anastasia Dodson, Anna Lee Amarnath, M.D., Christina Moreno, Bambi Cisneros, Sean Mulvey, Morgan Clair, Liane Winter, Fiona Castleton.

Others: Katherine Barresi, Partnership HealthPlan; Amber Kemp, California Hospital Association; Danielle Cannarozzi, LIBERTY Dental Plan; Yvonne Choong, California Medical Association; Ann Kuhns, California Children's Hospital Association; Lishuan Francis, Children Now; Krystal Moreno, Wilke, Fleury, Hoffelt, Gould & Birney, LLP; Elizabeth Evenson, California Association of Health Plans; Erin Kelly, Children's Specialty Care Coalition; Lynn Thull, California Alliance of Child and Family Services; Ben Johnson, Legislative Analyst's Office; Cassie Upchurch, Partnership HealthPlan of California; Kelli Boehm, Political Solutions; Sheree Lowe, California Hospital Association

Opening Remarks and Introductions	Ellen Beck, M.D., MCHAP 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/MCHAP_Agenda_091217.pdf Dr. Beck called the meeting to order. Minutes from June 28, 2017 were approved. http://www.dhcs.ca.gov/services/Documents/062817_MCHAP_MeetingMinutes.pdf *Jennifer Kent, DHCS:* The Department is developing the State Budget for January. Last week, DHCS issued guidance around frequently asked questions on the Deferred Action for Childhood Arrivals (DACA). Individuals with DACA status will not see a change in their Medi-Cal status. The California Health and Human Services Agency (CHHS) has sent a letter urging members of Congress to extend the Children's Health Insurance Program (CHIP) before federal funding ends on September 30, 2017. Due to the pending federal proposals to repeal or replace the Affordable Care Act, if some version of this legislation is enacted, each state must decide on the populations to cover, benefit package costs, and provider rates. With the fiscal analyses DHCS provided on the Better Care Reconciliation Act and the American Health Care Act proposals, the lost federal revenue for California would be approximately $16 billion a year by 2027. It is highly unlikely that the state could identify and secure those kinds of tax revenues. In order to effectuate significant general fund savings, significant cuts would need to be made to the Medi-Cal program. For SB 220, DHCS staff worked closely with Kelly Hardy from Children Now on providing technical amendments to Sen. Pan. SB 220 is now enrolled and is awaiting Governor Brown's signature. At the last MCHAP meeting, we shared SB 75 enrollments; the August SB 75 transitions and new enrollees by county data is available on the DHCS web page. With the recent federal anti-immigrant sentiments, we have heard anecdotal reports but have not seen evidence for enrollment declines and are still on track to meet DHCS' projections. *Ellen Beck, M.D.:* What happens to children who transition out of SB 75? Do the benefits cease? *Jennifer Kent, DHCS:* It depends on the individual and on their immigration status. There are 16 categories of permanent-resident or

	people permanently residing in the U.S. under color of law (PRUCOL) under the larger eligibility requirement. If you have no documentation status, coverage is limited, however, providers get creative with how to deliver care, either through Federally Qualified Health Centers (FQHCs) or county Safety Net Clinics (SNC). They can provide coverage and benefits that Medi-Cal otherwise can't. *Ellen Beck, M.D.:* We should think about the maintenance of care for adolescents with chronic diseases and what happens when they age out. As an advisory panel, do we suggest legislation that would allow continued coverage to adolescents? *Karen Lauterbach:* How many Medi-Cal children qualify under CHIP? *Jennifer Kent, DHCS:* 1-2 million qualify and are identified through aid codes. *Karen Lauterbach:* CHIP funding won't expire until January? *Jennifer Kent, DHCS:* Our general working assumption is that it will not get reauthorized by the end of this year. *Bertram Lubin, M.D.:* How much would it cost the state if CHIP didn't get reauthorized? *Jennifer Kent, DHCS:* Several billion. DHCS' assumption in the state budget is that CHIP will be reauthorized, but not at the current 88 percent federal share. *Elizabeth Stanley Salazar:* Have you seen a trend in overall providers who are enrolling or disenrolling? *Jennifer Kent, DHCS:* It's complicated. About 80-85 percent of the Medi-Cal population is enrolled in managed care. Health plans must share their network with us, but providers in a contract with a health plan don't necessarily have to go through our provider enrollment. *Ellen Beck, M.D.:* To what extent can pharmaceutical prices be negotiated? *Jennifer Kent, DHCS:* We have 'Best Price' and a State Supplemental Rebate program. Drug manufacturers that have agreed to pay supplemental rebates are included on the State's Contract Drug List (CDL). If there's a generic alternative, we put efficiency factors in the plans' rates. Regardless of whether there's a rebate for a certain drug, both the FFS and managed care plans (MCPs) have to provide any drug that is medically necessary once approved by the Food & Drug Administration. *Ellen Beck, M.D.:* For the majority of beneficiaries covered by Medi-Cal, the medication is provided through the plan. Is it possible to tell

	drug manufacturers to base rates on the rest of the Medi-Cal rates? *William Arroyo, M.D.:* There has been at least one failed ballot initiative each session for years trying to address this. *Kenneth Hempstead, M.D.:* How are there still 22 health plans in the state if it's so difficult to make reimbursement rates? *Jennifer Kent, DHCS: We closely monitor our health plans and the costs and utilization that their rates are based on.* When we review their fiscal records, we do not have any plans that are in fiscal trouble. *Kenneth Hempstead, M.D.:* It would be more alarming if you saw health plans dropping out. *Jennifer Kent, DHCS:* Correct. 16 of the 22 health plans are public, non-profit local health plans, which are solely created for taking care of the Medicaid population. There's also a robust commercial presence in California. There are indications that these plans still want to be part of the Medi-Cal program. *Terrie Stanley:* From a health plan perspective, there's a limited amount we can keep in terms of profitability requirements. Plans try to be as efficient as possible. *Diana Vega:* How would the cuts to CHIP affect families? *Jennifer Kent, DHCS:* It depends on a variety of factors. We need to see when and how the CHIP is reauthorized. We are assuming they are reauthorizing CHIP at 65%. *Diana Vega:* What if the federal funding is cut under the Affordable Care Act? *Jennifer Kent, DHCS:* It would cost the state billions of dollars and we would need to determine if we should continue covering the optional population. *Marc Lerner, M.D.:* Patient navigators help families feel more comfortable when receiving services. Where is California in terms of identifying funding to help backfill the federal funding that was paying for these patient navigators? *Jennifer Kent, DHCS:* There's no new state General Fund to backfill this and it would need private, philanthropic funding.
Issues in Care of Adolescents: **Adolescent Healthcare in Medi-Cal Managed**	**Dr. Beck introduced the section on issues in care to adolescents and asked for input on barriers and solutions to achieve care for adolescents.** *Jennifer Kent, DHCS:* For this section, we wanted to present on the continuum of services provided to adolescents.

Care – Anna Lee Amarnath, M.D. **Family Planning, Access, Care, and Treatment (Family PACT) Program- Christina Moreno** **Transition Planning with California Children's Services – Bambi Cisneros**	**The adolescent healthcare in Medi-Cal managed care presentation can be found here:** http://www.dhcs.ca.gov/services/Documents/Adolescent_Healthcare.pdf Dr. Amarnath provided an overview of children and adolescents served by managed care. Dr. Amarnath discussed opportunities to address health behaviors and chronic conditions. There are a number of different strategies to increase adolescent engagement in their healthcare, including member incentives, training more peer health educators, increasing adolescent participation in health plan advisory groups, and expanded use of social media. Health plans also are collaborating with external partners to deliver health education. A few examples include the Peer Health Exchange, an organization that trains college students to deliver effective health education to public high school students. Another health plan is in the process of receiving DHCS approval to partner with the local Boys & Girls Club to provide health education to adolescents. Welltopia is a DHCS website that provides health information to the public, including information targeting adolescents. Think, Act, Grow® (TAG) is a national call to action from Health and Human Services to improve adolescent health care, and uses a framework that helps organizations and individuals working with adolescents prioritize activities that improve adolescent health. *Ellen Beck, M.D.:* Thank you for the presentation. You alluded to some of the challenges to engaging this population. Please suggest one or two focused recommendations that would further these goals. *Anna Lee Amarnath, DHCS:* Nationally and at the state level, there are a lot of barriers to the innovative technology options. Many of our plans are trying to navigate these barriers. *Ellen Beck, M.D.:* So, communicating and interacting with young people and getting the message across? *Anna Lee Amarnath, DHCS:* Exactly. I think there are a number of ways we could be more progressive. *Kenneth Hempstead, M.D.:* What's an example of a member incentive program? *Anna Lee Amarnath, DHCS:* There are certain rules around this; it must be non-monetary. For example, if a member goes in for an immunization, the health plan might reward the member with a small gift card.

	Bertram Lubin, M.D.: I'm surprised you didn't mention school-based options in your presentation. *Anna Lee Amarnath, M.D.:* Some health plans do partner with school-based centers to provide services, but must ensure services are not duplicative. *Elizabeth Stanley Salazar:* For the depression screening measures, can DHCS look into updates for any metrics on Substance Use Disorders (SUDs)? *Anna Lee Amarnath, DHCS:* We don't currently have an SUD metric on our required metric set, however, all of our plans are participating in a statewide drug utilization review program, and it's an opportunity to gather data from the different plans on services provided. *Elizabeth Stanley Salazar:* We should include preventive screenings and early intervention on the primary care side on our wish list. *William Arroyo, M.D.:* There are SBHCs that not only serve the youth, but serve everyone across their life span. It's a great service for low-income neighborhoods. *Anna Lee Amarnath, DHCS:* I know there are some complications around SBHCs, primarily with duplicative services. *Ellen Beck, M.D.:* One of my goals is to reduce barriers in schools and outside of schools. *Marc Lerner, M.D.:* We need to address mental health services, and how the data is captured from the health plans. It seems like there might be a good opportunity for health plans to develop data measures on developmental screenings. *Terrie Stanley:* Health plans definitely support the idea of screening. **The Family PACT overview presentation can be found here:** http://www.dhcs.ca.gov/services/Documents/OFP_FPACT_Presentation.pdf Christina Moreno presented on the Family PACT program. The program is designed primarily to assist individuals with a medical need for family planning services. The overall goal of the program is to ensure low-income women and men, including adolescents, have access to health information, counseling, and family planning services to reduce the likelihood of unintended pregnancy and maintain optimal reproductive health. Some of the issues and challenges that adolescents face is getting services after school since many places are not open, or there's a lack of transportation to the appointments. Solutions include improving

	sexual health education in schools, conducting peer-to-peer youth outreach, having family planning services accessible in schools or clinics close to schools, reimbursement for transportation, and having support from local government leadership. *Ellen Beck, M.D.:* Do you know the percentage of teens who are being served in schools? *Christina Moreno, DHCS:* We don't know that. *Ellen Beck, M.D.:* It might be valuable to know, if this data is easy to acquire. What are the main barriers to providing clinical services in schools? *Christina Moreno, DHCS:* Education is a barrier. Schools used to have nurses, and this is something that definitely needs to come back. *Ellen Beck, M.D.:* On slide 6, the graphic is broken down by different age groups for adolescent clients. Why has this population declined? *Christina Moreno, DHCS:* We've seen a decline of adolescent clients as they move out of the Family PACT program into Medi-Cal managed care. *William Arroyo, M.D.:* Do you have any special outreach for homeless youth? *Christina Moreno, DHCS:* No, not in our program. *Jan Schumann:* On slide 15, there needs to be opportunities for partnership between the California Department of Education (CDE) and DHCS. *Diana Vega:* Could you elaborate on the peer outreach for schools? *Christina Moreno, DHCS:* It's in our benefit to collaborate with public health partners because of prevention funding and other programs. It's our best avenue for school-based, community group outreach. **The transition planning within California Children's Services (CCS) presentation can be found here:** http://www.dhcs.ca.gov/services/Documents/CCS_Transitions_MCHAP.pdf Bambi Cisneros presented on transition services for adolescents aging out of the CCS program. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Transition planning is the process of preparing adolescents and families to move from a pediatric to an adult model of health care.

	Jennifer Kent, DHCS: The waivers listed on slide 7 are very specifically organized around medical conditions or have restricted eligibility based on an individual's disability and their personal care needs. Bambi Cisneros provided an overview of the patients', MCPs', and DHCS' perspective on issues and challenges within the CCS program. She then discussed the strategies and best practices for transition planning. *Ellen Beck, M.D.:* Do we know how many adolescents are transitioning yearly? *Bambi Cisneros, DHCS:* There are slightly less than 200,000 children enrolled in the program. A brief data run shows about 7,000 adolescents are transitioning out yearly. *Ellen Beck, M.D.:* What would be your priority for this transitioned population? For example, are the patients successfully finding providers? *Bambi Cisneros, DHCS:* Ensuring that this population has the information and knowledge as they transition out of the program. We need to make sure that the information is received at the appropriate levels. *Wendy Longwell:* I'm a parent of a son who went through the transition process. A DHCS nurse made an appointment to discuss the different programs. I would like to see this type of outreach for other families. We need to make sure there's a continuity of coverage once adolescents are transitioned out. *Pam Sakamoto:* It would be nice to know which waivers someone in the CCS program qualifies for. *Jennifer Kent, DHCS:* We'll provide the web page link with the waiver programs. *Bertram Lubin, M.D.:* One of the major problems in this population is access to physicians. There aren't resources available to find a physician, so they end up in emergency rooms. It would be interesting to see how many transition out of the CCS program and find care, and the level of satisfaction for the care they receive.

Director's Remarks in Response to MCHAP's Behavioral Health Recommendations Letter	Director Kent's written responses to the MCHAP's behavioral health recommendations are available at: http://www.dhcs.ca.gov/services/Documents/DHCSResponse_BehavioralHealth.pdf Director Kent summarized her written responses to the MCHAP's behavioral health recommendations. *Ellen Beck, M.D.:* Your responses help us know where DHCS has direct effect, and where other partners or entities should step in and assist. While DHCS may not have the authority to implement some of these recommendations, that doesn't mean that the Panel can't advocate these changes through letters or other avenues. *Elizabeth Stanley Salazar:* As a Panel, we wanted idealism with these recommendations. We did not necessarily take into consideration DHCS' authority. Some of these recommendations are not realistic, but idealistic. While reviewing our recommendations and the largeness of them, I would actually focus on tackling some of the smaller recommendations. As a panel, we want to identify issues in the continuum of care and prevention services, and we also need to identify who is responsible for delivering this care. How can the advisory panel take small steps to advise and support the Department in implementing new initiatives that are the most impactful? *Jennifer Kent, DHCS:* It's important to have a visionary view of what health care should look like. It's your responsibility as an advisory panel to look at the horizon to identify services that would be right for children and families. I appreciated the sub recommendations, because they are more actionable. I look at this letter as listing both global goals as well as concrete recommendations. *Elizabeth Stanley Salazar:* I would like to see actionable change with these recommendations. I wonder if there's a dialogue that should occur about the delivery systems making decisions to work together. Where we see success is when our partners work together at the local level. How do we inspire this? We have a lot of intact silos and I think the state departments can remove some of these obstacles. *William Arroyo, M.D.:* How do maximize some of the entitlements in place, especially the federal entitlements? The whole health care landscape in this country is very unstable. Are there ways to incentivize agencies to help children develop more fully, either by legislation, lawsuits, advocacy foundations, etc.? *Wendy Longwell:* I hear from the families I work with, and I think we need more training at the county-level. Families are going through a vicious cycle of not getting the help that they need. *Elizabeth Stanley Salazar:* All of our county mental health plans are required to have meaningful Memoranda of Understanding (MOUs) in

	order to cover beneficiaries receiving behavioral health services. When a handoff of delegating responsibility occurs, there's a lack of coordination. How do we reinforce and strengthen this coordination? *Ellen Beck, M.D.:* Your endeavor is excellent in the sense that we can identify the next steps to take. We have the autonomy to explore some of these obstacles. *Elizabeth Stanley Salazar:* What are our pragmatic next steps?
Member Updates and Follow-Up	Marc Lerner provided updates from a recent Managed Care Advisory Group (MCAG) meeting that he attended, including providing the Panel with an overview of the development screening focus study results. *Ellen Beck, M.D.:* Having updates from meetings that the MCHAP's members attend is important. William Arroyo provided updates from a recent Youth Advisory Group (YAG) meeting that he and Elizabeth Stanley Salazar attended. The CalOMS Treatment (CalOMS Tx) is California's data collection and reporting system for SUD treatment services. *Terrie Stanley:* How does one get the data? *Jennifer Kent, DHCS:* We should have program staff talk to the Panel about what is or isn't included in the CalOMS data set. *Ellen Beck, M.D.:* I have an incomplete list of potential topics to explore; I'd like each panel member to come up with 2-3 additional ideas to work on or follow-up on. I then want the panel members to do a prioritization of the topics at the next meeting. There will be a call for a new Chair as the November meeting will be my last as Chair. *Adam Weintraub, DHCS:* After the November meeting, we'll generate a list for selection of chair and circulate the list ahead of the January 31, 2018 meeting. There will be a selection of Chair at the January meeting. *Jan Schumann:* I suggest we consider one or two additional 2018 meeting dates.
Public Comment	*Lishaun Francis, Children Now:* Children Now sent a letter to MCHAP around the phrasing of the second recommendation in the behavioral health recommendation letter to DHCS.