

State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

October 18, 2018

Meeting Minutes

Members Attending: Ellen Beck, M.D., Family Practice Physician Representative; Jan Schumann, Subscriber Representative; Karen Lauterbach, Non-Profit Clinic Representative; Kenneth Hempstead, M.D., Pediatrician Representative; Marc Lerner, M.D., Education Representative; Terrie Stanley, Health Plan Representative; Diana Vega, Parent Representative; William Arroyo, M.D., Mental Health Provider Representative; Ron DiLuigi, Business Community Representative; Nancy Netherland, Parent Representative; Julie McReynolds; Parent Representative.

Members Attending by Phone: Pamela Sakamoto, County Public Health Provider Representative

Members Not Attending: Elizabeth Stanley Salazar, Substance Abuse Provider Representative; Bertram Lubin, M.D., Licensed Disproportionate Share Hospital Representative; Paul Reggiardo, D.D.S., Licensed Practicing Dentist;

Attending by Phone: 32 stakeholders called in

DHCS Staff: Jennifer Kent, Sandra Williams, Katie Tkachuk, Theresa Hasbrouck, Bonnie Tran, Adam Weintraub, Morgan Clair

Others: Nathan Davis, California Children's Hospital Association; Sean O'Brien, UnitedHealthcare; Cassia Martinez, Partnership HealthPlan of California; Nadyne Bergerson, Partnership HealthPlan of California; Kelly Hardy, Children Now; Dharia McGrew, California Dental Association; Elizabeth Evenson, California Association of Health Plans; Hellan R Dowden, Teachers for Healthy Kids; Kelli Boehm, Political Solutions.

<p>Opening Remarks and Introductions</p>	<p>Ken Hempstead, M.D., MCHAP Co-Chair welcomed members, DHCS staff and the public and facilitated introductions. Jan Schumann read the legislative charge for the advisory panel aloud. (See agenda for legislative charge.) https://www.dhcs.ca.gov/services/Documents/MCHAP_agenda_101818.pdf</p> <p>Minutes from June 28, 2018 were approved unanimously. https://www.dhcs.ca.gov/services/Documents/062818_MeetingSummary.pdf</p> <p><i>Adam Weintraub, DHCS:</i> Responses to the follow-up list have been posted to the MCHAP web page.</p> <p><i>Ken Hempstead, M.D.:</i> The idea of the website survey is fantastic. Would data be available by the next meeting?</p> <p><i>Adam Weintraub, DHCS:</i> The results are still coming in. We'll have more reliable data in about 6 months.</p> <p><i>Jennifer Kent, DHCS:</i> DHCS received approval from the Centers of Medicare & Medicaid Services (CMS) for most of the supplement payments that were added in the budget last year.</p> <p>We are finalizing the administrative component of the Prop. 56 loan repayment program. There will be \$190 million for physician loan repayment and \$30 million for dental loan repayment.</p> <ul style="list-style-type: none"> • Physicians must be licensed and in good standing with the medical board, finish residency within the last five years, and patient caseload must be at least 30 percent Medi-Cal patients. Additionally, physicians must maintain that caseload for at least five years; contracts with Medi-Cal managed care plans (MCPs) and/or safety net providers or Federally Qualified Health Centers (FQHCs) will be monitored. In exchange, DHCS will pay up to \$300,000 in loans. We will award around 125 applicants a year. • Dental providers will have similar terms in addition, we will offer practice relocation for dental providers who go into a service area in which there are five or less dental providers or clinics. There will be a longer commitment if the entire practice is moved to a different area. <p>If we have more applications than slots available, which we anticipate, we will have additional criteria to help balance the awards.</p> <p>Second, the Care Coordination Advisory Committee has recently met and examined the various assessments used in the Medi-Cal program what assessments are used for, who is using the</p>
---	--

assessments, etc. The committee will convene its last meeting at the end of October. The 1115 waiver expires in December 2020, and the Specialty Mental Health waiver expires in August 2020.

Assembly Bill (AB) 340 required DHCS to convene a workgroup around childhood trauma and exposure to trauma, and to look at screenings for childhood trauma. The result of that workgroup will be a recommendation to DHCS for changes in our assessment and screening tools as it relates to childhood trauma exposure and could lead to legislative or budgetary changes if necessary.

DHCS is also getting ready to release a telehealth policy to clarify what providers can bill in Medi-Cal. We are trying to address emerging technologies and facilitate consultation and access to certain providers in a better and timelier way. We'll issue a draft All Plan Letter (APL) within the next week or so along with other provider-related guidance across the department.

Ellen Beck, M.D.: There's a new telehealth law for all school districts that would partner with a healthcare provider to provide telehealth services to students. Is there any overlap?

Jennifer Kent, DHCS: There's not necessarily an overlap. We get involved if the child is a Medi-Cal beneficiary and they are receiving services through a school location.

Julie McReynolds: As you expand services, will there be mechanisms in place to monitor continuity of care? When Medi-Cal patients transfer to a new provider, are there mechanisms in place to ensure that there's both continuity and quality of care?

Jennifer Kent, DHCS: There are provisions if you are a new Medi-Cal patient and change plans, if you have an existing relationship with a physician. There are also provisions for children transitioning from California Children Services (CCS) into Whole-Child Model (WCM), for up to 12 months. We have very clear guidelines for both plans and providers for what constitutes continuity of care.

As of July three plans offered the WCM for CCS beneficiaries: CenCal (Santa Barbara and San Luis Obispo counties), California Alliance for Health (Monterey, Santa Cruz, and Merced), and Health Plan of San Mateo. For Phase 2, CalOptima and Partnership HealthPlan will go live in January as long as they meet all their milestones and metrics.

California has received additional money, \$140 million dollars, from the federal government for the treatment and prevention of opioid use disorder in the state. This is on top of the \$90 million that we received through a previous federal action. We are proposing to use the latest round to help pay for substance use counselors in rural hospital emergency rooms; expand the use of Medication Assisted Treatment (MAT) in jails, and include training and technical assistance for the courts and probation departments. There's a continued effort to purchase and distribute naloxone to anyone who feels that they need it, including community-based organizations. Additionally, we will continue to support the tribal work that we've been doing as well as the Hub & Spoke approach.

Ron DiLuigi: What is the source of funding?

Jennifer Kent, DHCS: The federal government. The Obama Administration signed the \$90 million CURES Act grant, which was the State Opioid Response Grant. In subsequent federal grants, it's now the State Targeted Response (STR) Grant.

Jan Schumann: Is any money being allocated to high schools and colleges for educational purposes and for naloxone distribution to school resource officers?

Jennifer Kent, DHCS: Yes, there is a provision around youth education and outreach. DHCS' website includes a request [link](#) for naloxone.

Director Kent provided an update on gubernatorial transition. Departments and Agencies prepare transition briefings for the new governor's transition team. It involves key litigation, legislation, audits, and other issues. The Department has already submitted a workload budget, essentially what it takes to run our department based on the current programs.

William Arroyo, M.D.: How does the transition affect the direction of any waivers given that they need to be prepared by 2019?

Jennifer Kent: The new governor will be placing new policy advisors and other staffers into their jobs upon entering office and current employees will continue with standard program operations until those transitions are made.

The federal government has officially released the draft of the public charge rule. DHCS' attorneys are coordinating with the

California Health and Human Services Agency (CHHS) and the Governor's office because it impacts broadly impacts government and policy. DHCS and the Department of Social Services (CDSS) issued an All County Welfare Directors [letter](#) as initial instruction to county eligibility workers and other caseworkers who have the most contact with beneficiaries with questions around public charge issues. We will be putting out additional guidance or FAQs as we know more. I'm happy to circulate copies of those once finalized.

Adam Weintraub, DHCS: Based on requests from panel members, we provided a link to the draft rule in the Federal Register.

Ellen Beck, M.D.: Later in the meeting, I would like us to consider a letter from the MCHAP, and perhaps who that would go to, within the two month comment period. Also, I know that we already track changes in enrollment but I think given recent developments, it would be helpful to be more aware of recent enrollment changes over the next year.

William Arroyo, M.D.: The President signed into law "Families First," which was primarily for the foster care population. How would the funding flow?

Jennifer Kent, DHCS: They extended the STR grants for five years, adding it onto the grant funding we've already received and all new funds would continue to flow from DHCS.

Ron DiLuigi: Regarding Assemblymember Wood's letter on monitoring care coordination, do you have anything to add?

Jennifer Kent, DHCS: The care coordination discussion has been broad and not specific to population or delivery system. Health plans have a responsibility based on law to help individuals locate and access a dental provider. We're entering the phase of asking the plans to demonstrate they are implementing the requirement. We are also requiring plans to pay for non-medical transportation (NMT) to any appointment, whether the plan pays for the appointment or not. It's intended to facilitate use of other services, such as dental.

Marc Lerner, M.D.: The other concern about the public charge rule is understanding the vulnerability for U.S. citizens whose parents don't have the same status. I'm concerned that we're going to have

	<p>a large number of children who are born here but because of the fear from their parents, they won't receive services.</p> <p><i>Ellen Beck, M.D.:</i> Related to Marc's point, there are statewide organizations – free and charitable clinics, free legal clinics – and it might be easier to link to the statewide organization to address what you were saying; to identify resources in different cities or communities. Related to SB 75, I'm concerned about young people who are aging out. Is there any guidance recognizing that they are about to transition out? Perhaps there's a case manager working on a statewide basis to provide guidance, to identify other possible resources, to recognize that this change is occurring.</p> <p><i>Ken Hempstead, M.D.:</i> Going back to Proposition 56 and all the great news on the payments; this is not just about putting more dollars in providers' pockets. If the perception remains that Medi-Cal doesn't pay well, so physicians are choosing to not be Medi-Cal providers, we may not improve the provider base. Is there something that the California Medical Association (CMA) or some other entity could communicate to make sure that we're advertising these successes? Regarding telehealth, an unintended consequence could affect the only specialty practitioner in a certain county. Regarding the AB 340 update, I think everyone understands the importance of (Adverse Childhood Experiences) ACES and screening for ACES, but on the other hand, until we have a scalable plan of intervention I think there's a real downside. If I'm screening someone about something, and a positive comes up but I have nothing to offer them, which not only frustrates them but traumatizes them again because I've brought up their issue. We've had similar issues with providers; bringing up some of the issues with families can bring up their own issues from their own ACES.</p> <p><i>Theresa Stanley:</i> Even our population is asking for different methods and modes of interaction. As long as we have the same standards across the board for telehealth in terms of credentialing, access, and availability, those sorts of things are really important.</p> <p>Director Kent swore in two new panel members, Nancy Netherland and Julie McReynolds.</p>
<p>Panel Member Observations of DHCS Website</p>	<p>Draft letter can be found here: https://www.dhcs.ca.gov/services/Documents/Draftrecs_DHCS%20Website.pdf</p> <p><i>Ken Hempstead, M.D.:</i> We took a deeper dive into communication</p>

with DHCS and beneficiaries by reviewing the website. We took time individually and as a group to discuss this issue. We had limited input to put the letter together, and I'm aware that there is additional input that members would like to provide. It would mean that if there were substantive changes to what was in the draft letter that the next steps would be going back to revise the letter, bringing back the letter to the next meeting and having a formal approval.

Jan Schumann: My idea was to come before the panel with that letter and to make amendments based on observations that I've done in the last couple of days.

Ken Hempstead, M.D.: We can certainly do that, I'm just recognizing that we wouldn't be prepared to finalize that letter today.

Ellen Beck, M.D.: I just want to reinforce that shouldn't preclude a really informed conversation today with all sorts of suggestions and those amendments.

Adam Weintraub, DHCS: Many of the discussions we've had leading up to this set of recommendations, DHCS has already started implementing. The fact that a formal recommendation isn't voted on today doesn't mean we won't still make progress towards these goals.

Jan Schumann: From the 'individuals' tab on the DHCS website, one of the first things that I noticed is when clicking on Drug Medi-Cal, you get a log-in box. Additionally, under the "Frequently Asked Questions" section, when clicking on the Youth Services hyperlink, it has nothing to do with individuals such as foster youth or adolescents; it appears that it is solely intended for county mental health plans staff and not for an individual subscriber. A link to dental information should be included under the "Medi-Cal Beneficiary Information" section. The "Guide to Benefits" should be included in the top portion. When clicking on this tab, it doesn't show dental as one of the top ten covered benefits; you have to scroll down to realize that dental is a covered benefit. It is appropriate at times for things to be repetitive on a website. Additional resources under the "Resources" section should include for foster youth, college youth options, electronic annual notices sent by the counties and DHCS.

Other recommendations is making the website more accessible and more up to date to the web standards issued by the

Department of Technology. There are newer templates available that remove dual columns. I ran the website through a website accessibility checker, unfortunately it came back with a score of less than 80 percent. I would recommend that the panel urge DHCS to become more compliant with website accessibility. There is also a state standard that DHCS must be in compliance by July 2019.

Ellen Beck, M.D.: I just had a few edits for the letter. For the second section, I would prefer that it say “Ensure literacy levels on the website are at the 6th grade reading level, in addition more accessible to families or individuals with limited education and/or literacy levels.” Related to that, offer audio options in different languages, so they can listen to how to apply to Medi-Cal. You can either read it or press a button so you can listen to it. The chat feature would be phenomenal. But the last thing to actually make an edit to, when it says: “Additional pages should be added to the website,” I would prefer it say “including.”

Ken Hempstead, M.D.: What are your thoughts on returning to the letter itself? A lot of what I’m hearing Dr. Beck say is small edits. Do we want to take those edits and change the letter?

Ellen Beck, M.D.: I would modify the letter to include the comments. We’ll need to bring the letter back for a final vote.

William Arroyo, M.D.: There are many programs within Medi-Cal, all of which have different eligibility criteria depending on multiple factors. For the letter, how comprehensive do you want this website to be?

Jennifer Kent, DHCS: There are thousands of pages on the website. Our website always has room for improvement. In some cases, people want a vast amount of detail, but it’s a really complex program to break down. If we’re also trying to make it accessible in terms of literacy, it gets really hard. We also have providers and sophisticated data researchers that use the website. We have very complex financing mechanisms on the website. I would caution to carefully target what you want on the website to be improved.

Ken Hempstead, M.D.: In terms of the formal letter, it may be worth having general principles for our recommendations. Some of the smaller things like a link not working is also useful, but all of that stuff quickly turns over. As a group providing feedback, what are some of the general principles we want to emphasize?

William Arroyo, M.D.: If our task here is for the consumer benefit, is that separate and apart from the enrollee or from a provider? How should our task be focused?

Ken Hempstead, M.D.: I think we've been primarily focused on the beneficiary. What Director Kent was saying was that we could easily have many meetings with the providers' interaction with DHCS, but what we're focusing on is the beneficiary.

Jan Schumann: In speaking of access for beneficiaries, one recommendation I would like to add is allow beneficiaries to log-in to review their explanation of benefits (EOB) and billings submitted on their behalf for Medicare and Medi-Cal to see what has been covered. Anthem and other health plans provide it for their enrollees. Before we make that recommendation, we should invite someone from the Department of Technology to determine if that's feasible.

Ken Hempstead, M.D.: That sounds like a big ask.

Theresa Stanley: Are you talking about FFS covered services or any services?

Jan Schumann: For the services billed to Medi-Cal. I can log into Anthem and download and EOB if I need to. It also helps prevent fraud, to see if anyone has been using your identity and getting medical treatment under your name.

Ken Hempstead, M.D.: I'm guessing part of the reason she's bringing it up is if that's going to be a big project and 90 percent of that is through a plan, and the plans are already providing that information or should, then why would DHCS do that?

Theresa Stanley: Perhaps you were speaking of only those services that don't go through a managed care plan (MCP). MCPs do have portals and mechanisms for members to go in to see that. I think you're talking about anything that would be the responsibility of the FFS side of Medi-Cal.

Jan Schumann: As you log into the Medi-Cal website as a beneficiary, you can have links to your local plan administrators to log into their website as well.

Ken Hempstead, M.D.: We're recognizing that it's a big ask, Director Kent provided a few examples of where the end user does have a need for that information. Maybe you are super motivated

and you do want to look into it, but for the average beneficiary, why would they need any of that?

Jan Schumann: Sometimes in the real world we actually end up getting bills from those providers, and we're not sure if they actually submitted it to Medi-Cal or not. Then we have to reach out to the provider and ask why they haven't billed Medi-Cal.

Jennifer Kent, DHCS: It's usually for individuals with other health coverage, not 100 percent Medi-Cal.

Ken Hempstead, M.D.: I'm just trying to consider whether the need would justify such a large investment, and there might be other investments we feel even stronger about.

Adam Weintraub, DHCS: Having good information about a beneficiary's coverage and the services that have been billed is valuable, but may fall outside the statutory authority of this body. The kinds of changes Jan is referring to would affect all beneficiaries, not just children or families. It also addresses sharing information across different systems of care.

Jan Schumann: That's why I was asking about hearing from Department of Technology to see if it's an object to go forward with as a recommendation.

Ken Hempstead, M.D.: As we consider what the topics are going to be as we look into 2019, we could decide as a panel whether we wanted to hear more about that. In terms of trying to help move this letter forward, it sounds like that would be too much to tackle with that particular effort. We've received some good input. We will make some edits to this that we will send out to the group, so we can get closer to our final draft, which then we will be able to publish 10 days before our next meeting and formally vote on it.

Ron DiLuigi: You asked for general input, but then got way beyond it so I don't want to add anything more to it at this point.

Ken Hempstead, M.D.: Can I encourage you to submit your feedback to the group as we redo this draft?

Ron DiLuigi: Yes.

Nancy Netherland: Has the website been reviewed by focus groups of the targeted consumers? I've found that the website is not always that accessible. Have other stakeholders groups

	<p>reviewed the content before it's published?</p> <p><i>Jennifer Kent, DHCS:</i> On our next presentation, Sandra Williams can talk about it. We have a Consumer-Focused Stakeholder Workgroup (CFSW) that's subject to statutory creation. CFSW reviews a lot of notices to beneficiaries. We do not have focus groups for the website. We don't have the budget or resources to do that. The single state application for DHCS and Covered California and the changes that were done through CalHEERS was a more notable project, and that was a lot of time, effort and money that was expended on that particular piece. If there is a single targeted communication piece that you want to talk about, the panel needs to identify that first instead of focusing on broader things. We don't have the bandwidth to respond to that.</p> <p><i>Jan Schumann:</i> Maybe we can form a subcommittee where we can come back with a more formal recommendation.</p> <p><i>Pam Sakamoto:</i> Originally, the MCHAP members were asked for input from themselves or others. I did seek comment from different members and parents that I work with on the website, and they gave me no information back other than it works just as well as other state websites. If we're asked to do this again, we can seek our own focus groups of mixed clientele.</p> <p><i>Ken Hempstead, M.D.:</i> So in effect we were the stakeholder group doing the focus group work. The panel will have an opportunity to put in their last thoughts to this and of course review the latest draft.</p>
<p>Presentation of myMedi-Cal Publication</p>	<p>Links to presentation material: https://www.dhcs.ca.gov/services/Documents/myMedi-Cal_MCHAP_101818.pdf https://www.dhcs.ca.gov/services/Documents/Pub68_myMedi-Calcomparison.pdf</p> <p><i>Sandra Williams, DHCS:</i> The myMedi-Cal publication, previously referred to as Pub 68, is handed out at every application. The latest substantive changes to Pub 68 were in 2009, pre-ACA. When I came to DHCS in 2015, I was hoping we could devote some time and effort to updating the Pub 68, which was becoming obsolete quickly.</p> <p>Sandra talked about the objectives for the redesign:</p> <ol style="list-style-type: none"> 1. Update content 2. Improve usability and flow

3. Distribute myMedi-Cal in all threshold languages and ensure accessibility.

Katie Tkachuk talked about the rebranding efforts. With the rebrand, the team wanted to focus on a design that was well-defined, more personal, and more marketable.

Ken Hempstead, M.D.: Where on the DHCS website is the link to myMedi-Cal?

Jennifer Kent, DHCS: It will be on the front landing page.

Ellen Beck, M.D.: For someone who has limited literacy or is having trouble understanding, simply being able to hear what is written here will be huge. For those who are not familiar with using a screen reader, there could be a button on the website that says, "If you would like to hear this rather than reading, click here."

Sandra Williams, DHCS: We've talked about things like this with our translation vendor. It would be upon request, and we can talk to the Office of Communications about receiving those requests.

Karen Lauterbach: How long is the document now? You said it was previously 40 pages.

Theresa Hasbrouck, DHCS: It's now 24 pages, and that includes cover pages as well. It's really 20 inside pages, front and back.

Adam Weintraub, DHCS: It's also laid out in a fashion that's less word heavy.

Theresa Hasbrouck, DHCS: We also decided to do a web page in conjunction with the myMedi-Cal publication, with all of the links and resources available on this page.

Jan Schumann: Was there a reason to stay with two columns, or is it more apt for readers to see the information in a single column format? Also, CMS' version of myMedi-Cal marks important topics to bring the reader's attention to certain areas of the benefits that might be important to them. Maybe in a future version, include things like that in the document.

Ken Hempstead, M.D.: Are you able to make quick updates to the website version that are reflected in print, or do you have to wait to make that change until it's reflected in the print versions?

	<p><i>Adam Weintraub, DHCS:</i> It's theoretically possible to change it on the website but then we also need to update the 16 threshold language versions, which requires us to go through Maximus. We've looked at some technical approaches that would enable us to do that more quickly. It will never be an on-demand process because of the translation that's involved.</p> <p><i>Jennifer Kent, DHCS:</i> You can't get too far between your online version and your print version because we don't want counties sitting on a stockpile of written versions that don't reflect online versions.</p> <p><i>Theresa Hasbrouck, DHCS:</i> We were very strategic in how we were going to approach this long-term. We're looking to do more annual updates and not have a stockpile of millions of documents that we have to use before printing more because we want to be cost effective.</p> <p><i>Adam Weintraub, DHCS:</i> It's one of the reasons we incorporated the landing page. If a phone number or web address changes, it's a more flexible place to get the supporting information.</p> <p><i>Ellen Beck, M.D.:</i> One other small suggestion for the myMedi-Cal website is including an "Español" link. Acronyms and words like "non-MAGI," or "BIC" were used to shorten the number of pages, but it would be nice to know what the definitions are. Will it be possible on the website for people to press on the word and see the definition?</p> <p><i>Theresa Hasbrouck, DHCS:</i> That's a great suggestion and we'll look into it.</p>
<p>Discussion of Goals and Objectives for 2019</p>	<p><i>Jennifer Kent, DHCS:</i> We had a request from a coalition of children's groups on the Medi-Cal Children's Health Dashboard. I don't think we're ready to have a full discussion on all of the different recommendations but I just wanted to flag that we have put up the latest quarterly reports. I also talked to our Chief Medical Information Officer and others who are responsible for the data reporting within the department, and we have certain components which we can be responsive to around mental health data. We have been publishing a greater number of datasets through CHHS' Open Data Portal, which can be put into the dashboard. There are other components of this request that are simply not dashboard friendly; the network adequacy by the MCPs is not a dashboard-friendly metric.</p>

Ken Hempstead, M.D.: We need to identify issues the panel wishes to address. We have two main items under consideration: talking about the mother/infant opioid use disorders and also updating the dashboard.

Adam Weintraub, DHCS: If the dashboard is a subject the Panel would like to explore further, we can talk about how to do that. Elizabeth Stanley Salazar, who was unable to attend today's meeting, was interested in seeing what types of programs the department has to target the perinatal population. We can invite DHCS staff to the January meeting to talk about what's in place and whether there are gaps in that system and what's being done to address them. We also distributed the list of priority topics that the panel discussed back in January, in case the Panel would like to explore one of those topics.

Ken Hempstead, M.D.: As a panel, we tried to explore where some of our priorities might be. We came up with as many of our own ideas as possible and [presented those to the group](#). I think we were able to vote for three different items for where our priorities might be.

Diana Vega: I think we have not yet resolved the communication issue. Last time we talked about letters that are sent to beneficiaries. Communication between providers and patients. I don't think we talked about how to solve or suggestions we can provide to DHCS. For example, letters that are sent out to beneficiaries in regard to their benefits.

Ken Hempstead, M.D.: I think the concern is that we're still not done with communication. Specifically, you're calling out some of the letters going out to beneficiaries in terms of benefits.

Diana Vega: Letters from DHCS to the beneficiaries, and general communication between the patients and doctors; how can we improve that?

Ellen Beck, M.D.: I just want to support what Diana said. The fact that 9 members voted for topic S -- Parent/Guardian/Family Communication w/ Providers/DHCS -- we would look at letters that were particularly frightening for patients, dig deeper into literacy problems, and provider/patient communication. There was a shared sense that we needed to improve provider/patient communication. I think we should stay on this communication topic.

Ron DiLuigi: There were a number of things that members felt strongly about. I think topics like WPC and social determinants of health care are important. The other topic that I'm curious about is input sought by DHCS. We all believe that's a worthy effort. From DHCS' perspective I'm curious about what is on tap, and what you would like us to dig into.

Adam Weintraub, DHCS: I cannot speak for the Director or the policy team. Most of the new Medi-Cal 2020 programs have been implemented. We're gathering information about the extent to which they improved care, reduced costs, and addressed objectives. We're starting to look at possible elements of another waiver. Director Kent spoke about the Care Coordination Advisory Workgroup, which will formulate a proposal and bring it back out for public comment by summer 2019. Other things DHCS is looking at is implementing the WCM in CCS.

Ron DiLuigi: Who knows what priorities will open up with the new Administration? My sense is that this was a legitimate and credible effort, and the categories where we have a lot of votes should be where we focus our attention. DHCS looks at care coordination in a very broad sense. The thing that drove a lot of interest at the time when we did the voting was specifically the coordination and integration of care between physical health care and behavioral health care. I would not like to see that get lost in the broader category. There was a sense of urgency coming from the panel on that issue.

Ken Hempstead, M.D.: We're hearing about provider-to-provider communication, and then Diana brought up the provider and patient communication. Would these be under our charter? We're here to advise DHCS, which is a little different than advising providers.

Adam Weintraub, DHCS: One of the reasons we brought in the MCPs when we first started talking about this topic was because 80 percent of the Medi-Cal population is in managed care. They talked about how they handled their communications with all beneficiaries, and that's a very different issue from the point that Diana raised regarding how an individual provider might communicate with a beneficiary about their child's care. We talk more in terms of systems than oversight of each individual instance of care. We can issue broad guidelines for care, but to the extent that it reaches each examining room on every occasion, that might be a micro issue and I'm not sure what the panel can bring that's widely applicable.

Ken Hempstead, M.D.: I think everyone here can agree that's important. We would need to figure out a way on how to create a usable recommendation to apply to that. That's the challenge. It's awfully hard to do.

Diana Vega: I agree that it's hard to police what is going on in a physician's office, but we can maybe set up a guideline. When I brought up the issue of communication between DHCS and the beneficiary, I was referring to the letters that I receive to my home. Some of the parents and families don't have access to the internet. I was confused when we started exploring issues on the website. That's a very extensive website where we have to navigate so many pages. We need concise examples of what letters are sent to the families and how can we improve the language to make it a little bit easier to understand.

Ken Hempstead, M.D.: I think we would agree that that's probably an easier place for us to work.

Ron DiLuigi: I was thinking more in terms of this panel's role advocating on behalf of parents, guardians, and families, and their communication with DHCS. I'm drawn more to the advocacy as it relates to DHCS.

Terrie Stanley: When we had that discussion, it was pretty clear that providers communicating with beneficiaries was outside of DHCS' purview. There were communications that went from counties that were not part of what DHCS does. When we began to look at this issue, it became clear that that wasn't the communication piece we were interested in. Then we suggested to look at the website instead. There is a tool that is done by the plans on a semi-annual basis, the satisfaction survey for adults and for pediatrics. There are questions and responses in there about beneficiary relationships with providers, and whether they feel they are being heard. If the Panel feels that those aren't the right measurements of quality, let's offer up some recommendations for DHCS for what we feel would be more appropriate. Many of those measures are based on NCQA, and we can look at what other states do for quality measures.

Karen Lauterbach: I do have an example that was too late to bring to the meeting about the issue of multiple notices where they are dated the same but have different information. There is certain language that has to go into the legal notices. We can't change it, but it does make me wonder if we can work on more

global recommendations, like making sure notices are packaged together in one document. I was inspired by the previous presentation; sometimes changing the format of something could make it more accessible. So maybe there's an opportunity for us to provide recommendations in terms of that. I do have that sample, so I can share that with the Panel.

Jan Schumann: Does DHCS approve communications before they are sent out by the counties?

Adam Weintraub, DHCS: I know we approve language that is sent out by the MCPs. I would have to verify whether we also have oversight on the county eligibility language.

Jan Schumann: We barely touched the surface on the website. We're talking about low- to median-income families that may not have access to the internet. Karen mentioned bringing samples of notices – I brought one. The sample I brought was issued by DHCS and says, "what you need to know when you apply for Medi-Cal and enroll." It lists the different rights you have, how to contact someone with the first right, but for the other 19 rights, there's no contact information. I also received a pamphlet in the same mailing that says, "Your rights under the welfare programs;" you think it's a really good pamphlet to have – the first page is printed upside down. Only one page of the pamphlet deals with rights. The next page is meant to be a trifold, but it's done on bi-fold instead and printed upside-down. The font sizes need to be changed on these notices. The Notice of Action has areas on it that need to be improved, where they have call outs on different sides of the forms for two different columns. We had nine votes for communication, but communication has barely been touched upon. My other big concern is that we had 23 items listed, and at least six of those items had a vote greater than four or more. Next year we are going to be reducing our scheduled meetings by 33 percent. We cannot cover all these topics with only four meetings.

Julie McReynolds: There are multiple lines of communication you can have with Medi-Cal; you can log into Medi-Cal online. Not only do you get the notices in the mail, but then you are also alerted on your phone that you have a message and you have to log into the website, and that tells you that you have notices. You also can get conflicting notices from a provider. For example, you get notifications that say your child's care is denied. You have no way to back that communication up; where do I call, how was this denied, what do I do?

Marc Lerner, M.D.: I do want to speak to some of the requests from our state advocates for reengaging the dashboard process. I think that is important, and I think they provided an appropriate justification for that work. I'm concerned about the impact of the public charge; where's the data we're going to have on the meaningfulness for children? As we're moving to the WCM, is there an opportunity to look at some of these metrics to see what some of the implications have been? I think we're going to lean on the dashboard in this regard. Strengthening the dashboard's breadth as it relates to the elements of the adequacy across mental health related services and some of the other recommended components, and anticipating the federal requirement for reporting on child health quality measures and moving those onto the dashboard. We've struggled with how to run subcommittees to support this kind of work. Maybe this is work that would happen within DHCS, but how do we touch that workgroup if we're not going to be that workgroup? I'd like to have that addressed.

Ken Hempstead, M.D.: To summarize, I'm hearing the majority of the Panel say is that communication is still an important item that we should continue to work upon, and I couldn't agree more. Perhaps to compartmentalize it slightly, we have put some work into the website and it doesn't mean that we can't opine further as these discussions continue on the website, particularly because of all these forms of communication, it's the easiest to change. Maybe the next subtopic within communication would be these notices. Furthermore, I think the point is well taken about the dashboard and I think we can work in parallel rather than working in series.

Adam Weintraub, DHCS: We can certainly bring a presentation to January's meeting on where we are with the dashboard, what changes are being contemplated, what metrics may or may not be available, with or without changes to the contracts, etc.

Ken Hempstead, M.D.: We can think about a dashboard presentation in January. We discussed the next steps for the website letter. If we're going to be tackling these notices, what do we want to do as a group to prepare for that, or what speakers and presentations would be helpful for this panel to hear? What would be our ask of DHCS for better guidance and information on this notices issue?

Ellen Beck, M.D.: I also have letters that patients have received

that were frightening and wanted to bring. We should send letters to Adam and Morgan. If we have a letter that someone received, we can remove the personal information and make it anonymous and send it in enough time that they can be brought together and look at it to help us identify the process and have a conversation about concrete examples that from there we can come to recommendations.

Terrie Stanley: Perhaps there's a different approach? I would think that there is a process that DHCS uses when a new Medi-Cal member is enrolled. Rather than trying to gather notices, maybe DHCS should bring: "For a new enrollee, here's what they get, and here's the timeline." For renewals, I don't know if DHCS is involved but I know a lot of that is at the county level, but maybe if DHCS could look at that – what does DHCS do along the way, and then maybe that's where we start? Maybe we should break it up; discuss new enrollees at the January meeting, and other communications for the following meeting.

Nancy Netherland: Maybe some case studies would be helpful. I get a plethora of notices from DHCS and conflicting information from CCS. The type of care that my kids have is a little bit different. I love the idea of seeing what DHCS' standard protocol is. I think it might also be helpful to look at how that looks and plays out in some case studies that we can put together.

Ken Hempstead, M.D.: You have given us some of this material when we were doing our homework?

Adam Weintraub, DHCS: Yes, we have talked about it, but I think we focused on the managed care role in it. But a considerable portion is handled by county eligibility staff. There are an enormous number of pieces in the system, and the routine communication to a new enrollee regarding eligibility, we could spend a lot of time on that and it doesn't get to any of Diana's concerns about communication regarding whether a benefit is covered. Dr. Hempstead: I would also encourage that we ask the panel to submit notices by a certain date. We started asking for letters and notices in June and I was still getting examples last night that should be reviewed. We have to work within our resources and process and legal constraints in order to take these things up.

Ellen Beck, M.D.: In a previous meeting, Director Kent asked us to bring examples.

Adam Weintraub, DHCS: There's ground to be examined on the direct communications regarding what you're supposed to be getting as coverage. There's also the eligibility piece that Terrie mentioned. Some of those are going to be different for different systems of care but we can bring someone in to talk about whatever aspects you want to explore.

Diana Vega: How do we simplify the language in the letters, and how do we improve it? How do we make sure the font and pamphlets are printed in the right direction? Maybe we start with the simple things first.

Jan Schumann: We should look into the annual notices. I also wanted to see if DHCS can provide the top 20 templates that are used such as Notice of Action and call-in notices that those be provided to us.

Julie McReynolds: Would it be helpful to set tangible goals?

Adam Weintraub, DHCS: This is a subject that I wish the Director was here for because she's much more familiar with the backend processes. A lot of what we do is constrained by legal precedent. Lawsuits have been brought over form and content of certain letters, and once you've reached a legal settlement, it's very difficult to alter it without the consent of all of the parties from the original agreement. Ken, is there a benefit in discussing the end targets that the Panel is trying to reach here?

Ken Hempstead, M.D.: Obviously it would be great to have that priority. And again, this is what we attempted to do in the last cycle and it did not go as planned. I propose that if any given member on the Panel has raised a specific issue about a specific type of notice, then the way you get that addressed is by working on that part and providing information. Without that, nothing moves forward. Our next meeting is January 24.

Ellen Beck, M.D.: Maybe we could set a date by which, if anyone is going to contribute a letter or piece of communication, then by that date we take responsibility to send it and get one reminder email.

Ken Hempstead, M.D.: That's exactly what we did last time but it didn't work. I'm just trying to make sure that everyone is on the same page. We get the energy and enthusiasm here, but we don't necessarily get the deliverables. It will be up to each one of us to decide what the priorities are.

Ron DiLuigi: The argument that we want to be focused on something that has an outcome is important. If members have any examples, then those definitely should be submitted. DHCS should engage on some of these as well. Rather than leaving it to the panel members to come up with new topic ideas, isn't there anything within the communication category based on previous feedback you've heard from interest groups or individual complaints? One other thing: if you were to take those items on the list that received four or more votes, you have seven items. I don't want to toss this list out because this is our work, but maybe we should focus on the top seven topics.

Marc Lerner, M.D.: I would love to have Director Kent's reaction on those seven topics, and how DHCS feels we can best engage. We just had the example of folks who came to join us to explain some of the changes in *myMedi-Cal*; it would be nice to understand where we can have our input as well.

Ken Hempstead, M.D.: It sounds like within communication, the notices would be the next worthy sub-target. I don't think we need to get more specific as a group on this topic, but maybe we get more specific as members on what we want to bring to the table. Whether it's specific notices that you're aware of, or specific case studies. I think the ask is reasonable to DHCS to bring the top 10 most common notices being sent.

Jan Schumann: In the past, we've done subcommittees, and I think there's enough interest in this room that we might be able to meet in southern California. I propose that a subcommittee get formed to draft a letter that's more conclusive and includes more members of this Panel that would be more beneficial.

Adam Weintraub, DHCS: When the issue of subcommittees came up a couple of years ago, one of the obstacles that we ran into was that we are not staffed to provide support to this Panel for a subcommittee structure. There's no dedicated budget for the support staff here. We can help with publishing an agenda. I think to limit it to the southern California representatives excludes the input that could come from other interested parties. There are some caveats to using the subcommittee structure from a Bagley-Keene Act standpoint, and from a staff support standpoint. Any more than two members counts as a meeting that must be noticed under Bagley-Keene.

Ken Hempstead, M.D.: So there are some legal issues. Whether

we assign it as a subcommittee, I'm not sure if that distinction is too important. I think it's just a matter of figuring out who has the time and ability to do the work in between the meetings.

Ron DiLuigi: We identified topics of interest earlier this year, and seven topics have four or more votes that have higher level priority. Rather than just looking to the Panel to see which topics are the most important, what if DHCS also looks at the same list and advises on which are important/significant from a department perspective?

Jennifer Kent, DHCS: What I would say especially around communication and notices is I'm not supportive of starting a completely parallel process that is already occurring in the department. The CFSW concentrates on notices. If the Panel wants to delve into notices, someone from this panel can be nominated by the group to attend and we can put you in contact with the CFSW so that MCHAP member can be the representative and bridge between MCHAP and that work. For WPC, I'm not supportive of MCHAP having its own WPC workgroup when we have a much broader discussion happening between DHCS and stakeholders around what WPC looks like vis-a-vis a new waiver. If someone from MCHAP wants to be that point of contact, attend those meetings and come back to the group to discuss, that would be completely valid and I would facilitate that. I don't want to set up standalone efforts within MCHAP because it's duplicative of what is also occurring on a much larger basis. I would look at all of those things in the lens of whatever the Panel's priorities are and we will put you in contact with DHCS staff. You will be the bridge to the larger effort that may not have a child-specific contact as of yet.

Marc Lerner, M.D.: I'm appreciative of that direction. There was some participation from the Managed Care Advisory Group that I had sat in on a couple of times. We could look at who might be representatives on these other groups, and perhaps we can get some guidance from you on which of these groups could potentially have an MCHAP participant engage back to us for a child-centered perspective. I'm not sure if you have a group that is addressing the dashboard?

Jennifer Kent, DHCS: No, the MCHAP is the primary entity that works with the child dashboard.

Marc Lerner, M.D.: That's one topic we should be thinking about how we would go forward and whether we would do that

	<p>potentially with a single member and then have representatives from DHCS and state advocates to have that conversation.</p> <p><i>Jan Schumann:</i> Regarding what Director Kent mentioned on being supportive of us going to different meetings, will DHCS make sure that panel members' expenses are covered?</p> <p><i>Jennifer Kent, DHCS:</i> There are stipends available for MCHAP meetings themselves, but if MCHAP members are attending other DHCS meetings, those expenses aren't covered since it's not part of the panel's charge.</p> <p><i>Ken Hempstead, M.D.:</i> Because we don't have resolution on this, I'm going to ask that you keep an eye out for an email from DHCS. There will need to be more discussion within the greater context of communication, and where we may need to settle our focus on for the next chapter of the communication work. And maybe that does still come back to notices, but with an increased awareness of where that work would be valuable and where it wouldn't be.</p>
<p>Member Updates and Follow-Up</p>	<p><i>Ellen Beck, M.D.:</i> We had a lot of energy around bringing notices to the next meeting but we don't want to function in parallel with the CFSW, my suggestion would be as one of the components for the next meeting, we send notices to Morgan and Adam by a certain date. And then, if we have a set of recommendations, it's not only going to the Director, but it's going to CFSW. One of us could be a representative to that group and bring our concerns. Then we would be working together. I still think we can raise ideas, you just don't want us going off into this issue separately.</p> <p><i>Jennifer Kent, DHCS:</i> I think that's a great idea.</p> <p><i>Adam Weintraub, DHCS:</i> The current set of recommendations which were considered at this meeting arose out of Dr. Hempstead's attempt to summarize the responses we got with regard to the website, and to draw some general principles from the observations about places where help wasn't immediately adjacent to a confusing concept, or language was too confusing, or a link was not in an obvious place. I think we can take a similar approach here where in members raise specific concerns about forms, we can abstract those recommendations for best practices for forms that could be provided to that parallel workgroup along with the department.</p> <p><i>Ken Hempstead, M.D.:</i> We're back to communication and notices. So look out for information about trying to hone down</p>

that plan and see if we can't get individual commitments from the members. Hopefully we'll have better accountability this round so we can in enough time for the next meeting.

Adam Weintraub, DHCS: If you have examples, please send to MCHAP@dhcs.ca.gov by Nov. 15 so that we have plenty of time to create a draft recommendation abstracted from that.

Ken Hempstead, M.D.: Pencil in Nov. 15 and maintaining momentum on this as we move forward is critical.

Ellen Beck, M.D.: I had really hoped we could take a position on the public charge and then maybe write a letter to Director Kent, but to also the Governor as MCHAP. That's something we have the autonomy to do, even though our main role is to advise. I would ask the group if they felt strongly about it; I would like to draft something that could be sent around if we approve it in principle today. By the next meeting, it will be in law. The comment period is now for two months. I would be open to drafting something saying that the health of children would be seriously affected by doing this, so please don't do this.

Ken Hempstead, M.D.: I have two questions about that. One, what would the mechanism be since we do have this timeframe and we're not going to meet again? And two, is it useful?

Ellen Beck, M.D.: It would be us taking and making a statement.

Jennifer Kent, DHCS: The Panel sent a letter on the Children's Health Insurance Program reauthorization and it went to Congress. I think you can use that as your template.

Terrie Stanley: I don't know what the protocol is but I know that sometimes letters say: "supporters include."

Jennifer Kent, DHCS: When the federal government does rulemaking, they have to acknowledge how many comments they received.

Ken Hempstead, M.D.: Is there a mechanism to do this in a timely period?

Adam Weintraub, DHCS: I'm not sure if we can take formal action as a body under law, but there is nothing that would stop each individual member from following the link that was provided from the Federal Register page and individually registering their

	<p>viewpoint on their proposal.</p> <p><i>Ellen Beck, M.D.:</i> On the previous letter, DHCS wasn't involved. We wrote it and sent it around.</p> <p><i>Terrie Stanley:</i> Can we agree as a group today to allow Dr. Beck to send something representative as the MCHAP?</p> <p><i>Ellen Beck, M.D.:</i> I will write the letter and send it around to the panel members for their consideration.</p>
Public Comment	No public comment.