State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

November 1, 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; Ron DiLuigi, Business Community Representative; Diana Vega, Parent Representative.

Members Not Attending: Liliya Walsh, Parent Representative; Wendy Longwell, Parent Representative

Attending by Phone: 28 stakeholders called in

DHCS Staff: Jennifer Kent, Adam Weintraub, Morgan Clair, Joanne Peschko

Others: Dharia McGrew, California Dental Association; Danielle Cannarozzi, LIBERTY Dental Plan; Mary Ader, County Behavioral Health Directors Association of California; Kristen Golden Testa, The Children's Partnership; Rebecca Boyd Anderson, Partnership HealthPlan of California; Kelly Hardy, Children Now; Kelli Boehm, Political Solutions; Jessica Rubenstein, California Medical Association.

Opening Remarks and Introductions	Ellen Beck, M.D., MCHAP Chair welcomed members, DHCS staff and the public and facilitated introductions. Karen Lauterbach read the legislative charge for the advisory panel aloud. (See agenda for legislative charge.) http://www.dhcs.ca.gov/services/Documents/MCHAP_agenda_110117.pdf Dr. Beck called the meeting to order. Minutes from September 12, 2017 were approved unanimously. http://www.dhcs.ca.gov/services/Documents/091217MCHAPMinutes.pdf *Jennifer Kent, DHCS:* In response to the fires across 9 California counties, the Department requested and obtained Section 1135 waiver authority. The Department submitted a letter to the Centers for Medicare & Medicaid Services (CMS), seeking to waive Children's Health Insurance Program (CHIP) premiums for individuals in those impacted areas for October, November, and December, as well as for anyone that has share of cost or is working disabled. We are also seeking payment flexibilities for Skilled Nursing Facilities and other licensed facilities in those affected areas. Approximately 1.2 million children are covered by the CHIP allocation in Medi-Cal. 98% of CHIP beneficiaries will continue to receive coverage under the Medicaid program because of a federal maintenance of effort to cover them through 2019. However, the remaining 2% are not protected by this federal requirement. This population is estimated to be approximately 32,000. Based upon our CHIP allotment and projected expenditures, DHCS anticipates that our federal CHIP funds will be exhausted in late December 2017 or early January 2018. If CHIP is not reauthorized, the Department will need to determine how to cover the small population, which would cost approximately $9 million per month. Governor Brown signed Senate Bill (SB) 220, which makes technical changes to AB 357 (which established the MCHAP). The Department is continuing to develop the Governor's budget for January. The Department is working through implementation of the Proposition 56 payments, and has submitted State Plan Amendments (SPAs) to CMS addressing supplemental provider payments for physician services, dental, women's health, Intermediate Care Facilities for the Developmentally Disabled, and HIV/AIDS waiver providers. The only SPA approved so far is the HIV/AIDs waiver program. There are 13 physician codes

	for the physician's supplemental payment program. Once the Department receives Federal approval, payments will be retroactive to July 1, 2017. *Ellen Beck, M.D.:* For SB 75, what happens when children age out? Is there a process? *Jennifer Kent, DHCS:* We cover SB 75 children through age 19. There is not a provision that authorizes the Department to provide care after they age out. DHCS' website lists transitions and new enrollees by county reports. Enrollment has been keeping pace with our projections, which is about 9,000 -10,000 children enrolling every month. Once they age out and they don't have any subsequent documentation status, they can apply for limited scope Medi-Cal, and if eligible, we would transition them into an emergency aid code depending 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. Coverage is limited for those without documentation status, however, providers get creative with how to deliver care, either through Federally Qualified Health Centers (FQHCs) or county Safety Net Clinics (SNCs). They can provide coverage and benefits that Medi-Cal otherwise can't. *Ellen Beck, M.D.:* The Panel should explore or suggest coverage options for young individuals, especially those with serious diseases, and the continuity of care after they age out of SB 75. *Jennifer Kent, DHCS:* Some of the advocacy groups were working in the Legislature last session to increase coverage for full-scope benefits through age 26. *Bertram Lubin, M.D.:* I wanted to mention SB 63, which is very much related to pediatrics. *William Arroyo, M.D.:* Regarding Proposition 64, this Panel has been very interested in raising awareness around the different substance use disorders (SUDs). Has the Administration assumed any new revenue for the fiscal year? If so, how might that impact DHCS? *Jennifer Kent, DHCS:* There were General Fund (GF) loans that have to be paid off before any revenue is distributed according to the allocations in the initiative, and I think it will be a while

	before we see revenues. If there are revenues, it would be in another Department's budget, or retained at the Department of Finance (DOF) level. *Ron DiLuigi:* Is everything on target for the California Children's Services (CCS) transitions? *Jennifer Kent, DHCS:* We are still continuing to move along with the CCS transitions. The first counties and plans targeted to go live – in July 2018 and January 2019 – are on track. We released plan readiness documents and we're working on notices. We can share those draft documents. We're working with the counties and health plans around data transfers. We've been sending the health plans fee-for-service (FFS) data on the CCS population for about a year so they can identify trends with certain populations. *Karen Lauterbach:* As a follow-up question to the CHIP reauthorization, do you feel confident that the reauthorization will happen soon? *Jennifer Kent, DHCS:* The Department cannot speculate. *Karen Lauterbach:* There doesn't seem to be a lot of opposition to the CHIP reauthorization. As a Panel, is there anything we could do to help move it forward? *Jennifer Kent, DHCS:* Mari Cantwell, state Medicaid Director, just returned from her meeting with the National Governors Association. Others at this meeting felt confident that CHIP would get reauthorized. We are optimistic that CHIP will be reauthorized, but we're unclear when CHIP will be reauthorized. *Paul Reggiardo, D.D.S:* Will funding be retroactive if CHIP is not reauthorized in January? *Jennifer Kent, DHCS:* To our understanding, funding would be retroactive. *Ellen Beck, M.D.:* Please review the bills of interest. Many of the bills on this list overlap with what we have discussed. Not only should we review these bills before each meeting, but we should consider how to move forward, such as deciding to write a letter in support or opposition to a bill. For future meetings, I would like to ask the Panel to review the legislative list prior to the meeting.

	Adam Weintraub, DHCS: This list is compiled by Children Now. *Bertram Lubin, M.D.:* This is a wonderful list. I would appreciate if Jennifer could provide some guidance on what to support. *Jennifer Kent, DHCS:* The Administration -- and DHCS is part of the Administration -- has a very different process for how bills are analyzed. I can explain what each bill does or the impact the Department would see. *Bertram Lubin, M.D.:* Dr. Beck, can we include on future agendas a subcommittee to cover these bills?
Development of Goals and Objectives for 2018	*Ellen Beck, M.D.:* The rest of this meeting is devoted to structure and objectives. We can advise the Department, write letters to the Governor in support of bills, or make recommendations on a bill to the Department. *Terrie Stanley:* As I look at some of these bills, there are governing bodies or advisory boards being created that are tasked with addressing issues within the bills. How does the MCHAP interact with those other bodies or entities? Should we hold an annual retreat where we all get together to share ideas? *Ellen Beck, M.D.:* That's a very good suggestion. *Karen Lauterbach:* There are a lot of things we need to figure out in terms of legislative updates. Something might look very good at face value, but it might have a huge administrative burden. I'm not opposed to looking at bills, I just want to make sure we're very clear with what we're supporting and the process of supporting the legislation. We could spend hours reviewing legislation, so we need to focus our efforts. *William Arroyo, M.D.:* I have an opposite point of view in that legislation shapes medical care in the state and nationally. Each one of these bills has an impact on the services that children receive and for the Administration. However, the devil is in the details with some of these bills. *Ellen Beck, M.D.:* It's similar to calling the 'Clean Air Act' great, but in reality it gives people permission to pollute. We need to look into the details of these bills. What I'm hearing is if we choose to do this, legislative review should be related to a topic that we think is really important rather than looking at all the bills

	related to children. If we have a topic that we think is important, what are the relevant bills that are related to that topic? *Ron DiLuigi:* The cautions have been well stated. We don't have staff that's able to support this huge process. I wouldn't oppose this group wanting to take positions, but we would want to be very cautious with lending our support. We need to determine a way to focus and prioritize the issues. *Elizabeth Stanley Salazar:* If we choose to focus on a particular area, we may want to reach out to a sponsoring organization or advocacy group that could speak to the details of the legislation. If we're going to support legislation, we should understand it thoroughly. *Ellen Beck, M.D.:* We received feedback from Dr. Hempstead suggesting more interaction and conversation at the meetings, and having Director Kent ask the Panel questions or raising issues that the Panel can weigh in on. I'm hoping to create a draft ballot and add some objectives to this ballot, followed by a mini vote from the Panel. Adam and Morgan will compile the results, and then in the afternoon, we'll talk about the results and where to go from here. Dr. Beck provided the Panel with an overview of topics she hopes to explore in 2018. In terms of structure, when we first started, we were different. We had come out of the Healthy Families Program (HFP). There was a Managed Risk Medical Insurance Board (MRMIB) that made decisions about contracting. We were very much advisory. We recommended long-term goals and writing letters to the Governor. When the MCHAP formed, we didn't always have the quality and depth of relationship that we have now with DHCS. I would like to say how grateful I've been for the quality, depth, and relationship we have now with DHCS. That doesn't mean we shouldn't speak out. I think we should say things that are hard to say sometimes. I think it's very important that we raise issues and find solutions. Structurally, I have found that having the conversation with the Director at the beginning of the meeting gives us access that very few people in the state have. We should continue selecting topics but it's also important to be flexible. For SB 75, when the Panel discussed the importance of this bill, we had a meeting with leadership and people around the state to help guide the Department in certain areas. I feel like we had input as a Panel. If, at the next meeting, some

	catastrophic budget cuts happen, we have to be flexible and discuss where cuts should or shouldn't occur. We need to ensure that parent representatives' voices on the Panel are really heard. Perhaps there should be an agenda item every meeting where the parent members can talk about any challenges they've come across in the past three months. Another thing that I have been very pleased with is the diverse backgrounds of Panel members. Even if we're slightly out of our areas of expertise, we learn about new issues and act beyond our areas of expertise to continue to advocate for the children and families. Additionally, the more that we can include adults in the conversation since children are connected to adults, and the more we can provide families services and therapy, the more effective we'll be. *Adam Weintraub, DHCS:* I wanted to offer a little insight into the framing of this document that you received; we solicited comments from the members prior to the meeting and received feedback from two members. There are many blank lines that have been included on the ballot for additional topics that arise from this discussion. We'll add suggestions to the list and ask the members to rank their top priorities for next year. We will total the priorities and provide the results following lunch. *Ellen Beck, M.D.:* Feel free to make suggestions about content areas as well as structure. This is an open-ended conversation about where we go from here. We're hoping that at the end of our meeting today, we've narrowed the list down. *William Arroyo, M.D.:* I'd like to underscore the low-hanging fruit. To that end, I'd like to remind everyone about the political momentum in this country and state, and that is the opioid crisis. We should certainly discuss this, as well as Proposition 64. If we overlook these two issues, we will undercut our own effectiveness and efficiency. There was a lead article in the Los Angeles Times entitled, "The quiet crisis among African Americans: Pregnancy and childbirth are killing women at inexplicable rates." Maternal mortality in 1987 was 7.2 deaths; in 2013, there were 17.3. There's more than a two-fold increase in death rates during childbirth. That may be beyond our purview, but I think it's an important piece of data that we should consider.

	Marc Lerner, M.D.: I'd like us to reconsider the "Milestones, Goals and Objectives for 2015" document that was discussed at the March18, 2015 MCHAP meeting. I just want to cross off where we are in terms of this document. *Elizabeth Stanley Salazar:* One of the things that's troubling to me in regards to SUDs and mental health is how underdeveloped and how small a service it is statewide. There's a lack of providers and competency. We had a network adequacy committee that discussed these issues. We're at a juncture where there is an opportunity where we can take advantage. There is a growth of managed care in states, yet a separation of services remains; children fall through the cracks when we can't decide who is responsible for the diagnosis. We need to advise on stronger linkages. I would like to see a dialogue with managed care organizations, FQHCs and improving access. We're now under federal rules for network adequacy. Only now are we coming into compliance. Underneath, there's a workforce issue; there's a severe lack of psychiatry, lack of adequate providers and counselors At the practice level for children, we need to have an integration of practice in the mental health and substance use disorder areas. *Marc Lerner, M.D.:* We still have structural barriers within DHCS regarding billing of the same client within a day, and/or percentages of time. *Ellen Beck, M.D.:* Are you referring to structural barriers specifically related to mental health and substance use disorders, or structural barriers related to parity? *Marc Lerner, M.D.:* I'm referring to barriers within mental health and substance use disorders. *Ron DiLuigi:* Dr. Beck's focus each meeting on the charge is important. I would like to hear DHCS' perspective on how we could focus our efforts to fulfill our role as an advisory panel. As I think of health care and where it could potentially be going, I think the issue of higher quality and lower cost is still imperative. Several FQHCs completed a study looking at integrated health care. I don't know if their assessment is completely accurate, but if you take a look at the various states in the report, California was conspicuously absent.

	There are certain areas of health care that are moving at a very slow pace. DHCS has the potential to impact that through pilots or funding. The way California works with counties presents potential for some lags. FQHCs are another set of potential laboratories working very closely with county health systems. When I think of things we might want to focus on, there's a lot of programs we've launched, but how well is it going? Are there ways to quicken or enhance these endeavors? Maybe there's a way we could enhance integration. *Ellen Beck, M.D.:* Are you saying looking at innovative models, either around the state or elsewhere, that address integration? Perhaps looking into transdisciplinary areas and which models already exist? How do you create an innovative pilot? If the Panel has an idea for an integrative model to support, we should learn the structural steps that results in a pilot project. *Ron DiLuigi:* Yes, looking at the innovative models, but also looking at what has already been launched. *Ellen Beck, M.D.:* And learning from those models. *Ron DiLuigi:* The state works with all of the systems, whether they are county or managed health care. *Diana Vega:* For SB 75, there's a difficulty in the transition of care between pediatrics and adult medicine; a case manager should be in charge of educating families to help adolescents transition out. Also, the communication between family members and physicians is sometimes lacking, especially around complex issues. *Ellen Beck, M.D.:* I'm hearing two suggestions: one is related to SB 75. Not only should we extend and transition care into adulthood, but how do we add case managers into the equation? And the second suggestion is how to do a better job having more effective communication between health care providers and families, but especially around complex issues like dental and mental health. How do we ensure families receive information, and improve the communication? *Bertram Lubin, M.D.:* This is an advisory panel. What's important to know is what are the issues we would like to advise on? What we're discussing is important but how does that get translated into a bigger picture? We're a Panel that advises;

	we're not going to write a bill. I just want to be sure we keep that focus. What is this group all about? Does the Director want advice from us? *Ellen Beck, M.D.:* Up until now, our process has been thinking of topics, going into depth on these topics as we realistically can with limited resources, and creating a set of recommendations to DHCS to which the Director responds. That doesn't mean that's how we should move forward. *Jennifer Kent, DHCS:* Some of these discussion topics are very broad, but the panel might be able to provide valuable advice on more focused issues. We recently testified in front of the Little Hoover Commission (LHC) as a follow-up on Denti-Cal. The LHC was surprised to understand that the dental no-show rate for pediatric patients is 50%. We then hear from members of the press that we have really low utilization rates. Is this a transportation issue, a convenience issue, or an hours-of-operation issue? Some of things I would like to talk about is practical advice or perspectives from your own practice or community: What do you think drives access problems? I struggle with the coordination and transition between health care delivery systems because it is not perfect. As a state, how do we make it better? If you have a child enrolled in 5 different delivery systems, it's not practical to have a coordinator for each delivery system. We need to think about improving care coordination. I would welcome advice on these issues as they are measurable and improvable. I can't say that we're going to do a lot on workforce. I don't think I will have a lot to contribute in the single-payer discussion. Those are big issues that may or may not be practical for the Panel to focus on. I welcome all advice, but some of the issues that are inconsequential to the general public are huge improvements on a practical level. *Ellen Beck, M.D.:* I would certainly hope that we could see an evolution in the first part of the meeting where you ask us for advice. If you just returned from meetings and are struggling with how to execute an issue, we could provide you with input *Karen Lauterbach:* The deep-dives gets us stuck on one issue for a long time and doesn't allow us to focus on topical areas. One of the beauties about our Panel is that we have beneficiary representation, and we don't do enough to tap into their knowledge. Maybe the parent representatives are receiving letters in the mail, or they have questions about benefits. We have members on the Panel that could speak about these

	issues. If the parent members on our Panel don't understand the benefits, we can't move forward on some of the bigger issues. *Ellen Beck, M.D.:* In addition to allowing time for Jennifer to ask questions to the Panel during each meeting, there should be some time to address issues affecting parent members on the Panel. For the deep-dives there was a big learning curve for us around important topics, but I also agree that we can get bogged down. *Karen Lauterbach:* Yes, I think we should adjust our structure. *Adam Weintraub, DHCS:* During the transition between the HFP and current form, the deep-dive concept was formulated as a way to address the learning curve. There was also a question that came up around the recommendations. This was written in the statute; if the Panel makes recommendations, the Department is required to post them on the website. This became a natural baseline structure. *Marc Lerner, M.D.:* We have touched on a number of the proposed goals and objectives from 2015. I'm slightly concerned about the list we're about to vote on, and one of the topics is "adolescent health care". Yes, adolescents should receive health care. We should narrow our focus. *Ellen Beck, M.D:* I would encourage you to write in an answer to narrow your focus. The purpose today is to not only prioritize issues, but to gather and assess areas we should be focusing on. *Jan Schumann:* The recommendation for subscriber updates at each meeting would fit perfectly under the "Member Updates and Follow-Up" section on the agendas. Also, I would recommend on topics that we do review, we have the wording on the agenda that says "Review/Recommendations". For the topic on utilization management, I would like to see an update on patient satisfaction. For topic S, Parent/Guardian/Family Communication with Providers and DHCS", I would like to see the wording "with providers" removed. Overall, communication both with the Department and also with the providers is very critical. I have a recommendation for another topic related to treatment authorization requests (TAR) and reviewing the procedures related to that, and understanding the process related to the pharmacy. If the patient needs a prescription but didn't get approval for the TAR, the patient still needs that

	medication according to the doctor; there are issues on the back end that need to be taken care of for TAR. *Ellen Beck, M.D.:* That's a very practical recommendation. *Adam Weintraub, DHCS:* Just a point of clarification for stripping 'providers' from item S, Diana Vega specified that providers were a focus for that item. Should Jan's recommendation be a separate item, or would you be content to have providers removed? *Diana Vega:* I do not recommend removing the word "providers". *Ken Hempstead, M.D.:* My comments were posted in the addendum and I invite everyone to take a look. This discussion is exactly what I was hoping for. Given the limited time we have here and all of the topics to cover, we should review some of this information before the meeting, which would allow more time for discussion at the meeting. Finally, I'd be very interested to see models of school-based care that Dr. Beck mentioned. For utilization management, what are the new priorities we could devote resources to? *Ellen Beck, M.D.:* For utilization management, what kind of questions would we be addressing? *Ken Hempstead, M.D.:* It's slightly problematic in that utilization management is extraordinarily broad. It's how we're approaching this issue and advocate for this issue with all of our areas of expertise. I don't expect a deep-dive into this issue. *Pamela Sakamoto:* We have a lot of problems to deal with, from limited resources to limited trained staff. From a public health perspective, we want to focus on the client, family, and the integrated health care providers in order to provide the best outcomes for our children. I do not see our care system as integrated. I really think we need communication and getting to the root cause, so care is at the right place, right time, and right provider. A lot of our programs collect good data, but have difficulty sharing it. Also, I know a lot of parents are acting as their own care coordinators. *Ellen Beck, M.D.:* I'm happy you reinforced broadening integration. As I look at our list, it says integrative care models – existing and integrative, but it's integrative care AND existing and innovative models.

	Adam Weintraub, DHCS: If we find a cluster of responses around a certain topic, like adolescent health care, that will give us some guidance and we can fine tune the topics in 2018. *Diana Vega:* Can you revise the wording to SB 75? What I meant to say was the transition of care from pediatrics to adulthood. *Ellen Beck, M.D.:* The idea is to not only extend care to adulthood, but how do you transition the care to adulthood? *Diana Vega:* Correct. *Elizabeth Stanley Salazar:* The care and case management, the transition, and consumer engagement; these are core principles of best practices for delivering care. All of these issues come from the same fragmented structure. Could we develop a way to use a lens to apply all of these core components and somehow link it back to initiatives that are already out there? We appreciate Dr. Reggiardo's work with the dental recommendations because he kept grounding it back to legislation and created a reference point. Is there a way where we can evolve to have a clear set of principles revolving around best practices, and reference it in our work around initiatives that already exist? *Ellen Beck, M.D.:* Should we add a topic similar to "Guidance for best practices"? How should we capture this? Is this a structural change, or is it content-related? *Elizabeth Stanley Salazar:* We should develop principles for Whole Person Care for children, and link those to current initiatives. *Ellen Beck, M.D.:* Jan Schumann has suggested that we select our top five choices. *Paul Reggiardo, D.D.S.:* I'm having difficulty understanding how I would answer this. Some of these are structural questions about how we operate, and some are a little off subject like the opioid crisis, which is important but it's not addressing specifics on advising the Department. How do I prioritize to five? *Ellen Beck, M.D.:* It's challenging. I'm wondering if it's too soon to choose topics. Or, as Adam suggested earlier, would doing

	some prioritizing give us information on topics that we feel might be important to discuss? What are five topics we all would like to focus on? If other people have other suggestions from a facilitative point of view, I would welcome those ideas. It feels a bit early to narrow these topics, but the idea is to go through this and give ourselves some information about what we feel is most important. We could decide to pull from this list the items that are structural. I'm not sure what's best. *Elizabeth Stanley Salazar:* These could be grouped, like the access to models of care and maintaining coverage. Marc Lerner, M.D.: There are advisory groups within the Department that address some of these topics already. Ellen Beck: That was Terrie Stanley's point - knowing which groups are doing what, and how to link to them structurally. *Paul Reggiardo, D.D.S:* I think these topics should be judged on the merit of suggestion rather than prioritization. *Ellen Beck, M.D.:* Later today, we have a period of time where we have member updates. Maybe there's a way, if a member has a specific topic they would like to raise, that it's judged on its own merit. *Terrie Stanley:* In working with the Department, the issue now becomes providing value-based care. How does this Panel support DHCS' work around value-based care? In a big picture, a better use of the Panel's time is to assist and help DHCS around the issues they're focusing on. *Ellen Beck:* What does value-based care mean to you? *Terrie Stanley:* The Department spends billions of dollars annually on a whole host of programs. Has any particular program added value? When DHCS is in front of a legislative body, would the Department want assistance from this group or other groups in order to prove that the programs implemented are value-based? If the Department feels they aren't seeing value from a particular program, what could be done to correct that? *Ellen Beck, M.D.:* So what programs add value for children and families?

	Pamela Sakamoto: I would think you'd have to define value. Is it based on the number of appointments kept? Value in this case can be subjective. I can survey families and ask if we did a good job, and if we didn't where can we improve? If the families say you did a good job, you have no value to report other than one positive mark. *Terrie Stanley:* If the Department put a certain amount of funding into a program over several years, has this been a judicious use of funding? Could we as a Panel help the Department in that area? *Adam Weintraub, DHCS:* We worked with the Chair over a series of telephone conversations to help choose topics that get to the interests of this Panel. We hoped this list would be an instrument to help guide the Panel. If it's the sentiment of the Panel that it's too soon to go forward with this list, then we can address it. *Ellen Beck, M.D.:* When we did the prioritization that Dr. Lerner addressed, we selected topics and had the members place dots next to each item. That was the facilitation used at that meeting. We made a decision this time to try something different and to get clarity about certain issues. *Marc Lerner, M.D.:* We also had children's advocacy groups that were represented on the 2015 ballot. I would like to have their input included on this list. *Ellen Beck, M.D.:* With our remaining time, I would like to hear from some of the children's groups on the areas they think are important for the Panel to address. I also think we should revisit the question Director Kent raised before about practical input related to the 50% no-show rates for dental. We should spend a few minutes as part of our member updates, because it models one of the ways we can move forward as a Panel. I would also like to hear from the panel members about how best to work with this list. Perhaps voting isn't the best way. Maybe the best way to move forward at this point is to try to take some of these ideas and return to the next meeting with a document, or the Panel can review the document and provide feedback on the topics. It sounds like the panel members are ambivalent on voting. I would like to ask for input from the stakeholders. *Diana Vega:* I have a few concerns regarding the low Denti-Cal

	utilization rates. I received a letter of eligibility a few weeks ago saying that I was not using the services. The reason why we are not using the services is because not all providers are accepting Denti-Cal patients. Also, there is a lack of transparency for what Denti-Cal covers or doesn't. There's also a lack of communication between dentists and general practitioners on how dental health impacts overall health. *Ellen Beck, M.D.:* Are you saying parents and doctors sometimes don't recognize the importance of oral health, and it would be good if the doctor told the parent that their child's dental health affects their overall health? *Diana Vega:* Yes. Doctors should say to the families that it's important to go to the dentist. *Ellen Beck, M.D.:* Let's continue for a few more minutes on the objective conversation for topics to explore in 2018, then return to the dental no-show conversation. Do you have thoughts about this list? Are there things we should add? I'd like some guidance on the different things we could do. We could do a draft vote to see where we are, we could take this list with us, or we could do some ranking and send it back to DHCS. *Ken Hempstead, M.D.:* Can I propose that we still suggest our top five choices today to get a screenshot of what's going on, and then provide that information to us via email with the request for additional feedback or comments? With that context in mind, we could either comment on the issues that received the most votes, or voice our disappointment that a certain aspect isn't being addressed. *Ellen Beck, M.D.:* I think that's a valuable activity, but I would like to hear from the Panel. Given the limitations that this document has, let's select the top five topics now. We won't give you the results of the topic selection at this meeting. We'll have to add the topics that were raised from this meeting to the list we have. Let's not weight the topics. *Adam Weintraub, DHCS:* We'll collect the ballots, tabulate the results, and post the results before the next meeting. *Ellen Beck, M.D.:* If you would like to make additional comments on the ballot that would be helpful.
Member Updates	Ellen Beck, M.D.: I'd like to talk about what's contributing to the

	dental no-show rates. From our experience, what is contributing to the 50% no-show rate for dental visits? *Marc Lerner, M.D.:* By having an initial teledentistry visit, that would prevent no-shows. *Ellen Beck, M.D.:* Is that for the dental exams or the screening visits? *Marc Lerner, M.D.:* Screening visits. A dental hygienist can deliver preventive care. *Ellen Beck, M.D.:* I don't think these are the screening visits Director Kent was referring to? *Jennifer Kent, DHCS:* It's preventive visits for any kind of dental visit in the pediatric population. Our understanding is that 50% of the appointments are no-shows, whether for FQHCs, private practice dentists, or dental clinics. *Paul Reggiardo, D.D.S:* Where does that information come from? I have no mechanism for reporting no-shows. There's no incentive or mechanism to report no-shows. *Jennifer Kent, DHCS:* I believe it originated from our dental program. We've surveyed our dental providers and asked a series of questions around Medi-Cal patients, including: how many Medi-Cal beneficiaries are seen, how often do providers see the patients, how many appointments are scheduled, and are appointments only available on certain days? The last survey that we did was a statistically valid population, which reported that 50% no-show rate. We don't have a way in our claim system for reporting no-shows. *Terrie Stanley:* There are high no-show rates for the Medi-Cal population in general. It's something that we hear anecdotally. Some of it goes back to the antiquated way we delivered care in this country. We now have Uber, and Amazon Prime, yet we continually resist change on the medical side. We really need to think about a different way for care delivery. Practice site redesigns help to lower no-show rates. We need to spend some quality time looking at the redesign of the system because that can better accommodate the way people live today. *Ellen Beck, M.D.:* I think there's a lot of fear associated with dentists. What we see in our free clinic population is that

	sometimes an appointment will be made, but that doesn't mean that the patient understands where, when, and how. Are there social determinant issues, transportation issues, etc.? I also support co-location, meaning dentistry, primary care, specialty care, and mental health care are all located in the same area. The patient is going to the same place and see the various providers. I also think there's a place for children to receive preventive services in schools. *Jennifer Kent, DHCS:* Dr. Reggiardo, does your staff call or send mailers to confirm appointments? It sounds like some practices have better staffing around that. Do you make the appointment and tell the patient this is when the appointment is? Is the patient able to select times and dates? *Paul Reggiardo, D.D.S.:* We do confirm appointments. We let the patient select the times within certain parameters. I see younger children in the morning, older children are seen in the afternoon after school. That's the same for the commercial population. We confirm appointments two days in advance. That works for my practice. Other practices might have a high no-show rate, so they double book and don't confirm appointments. Those practices ignore the average 50% no-show rates, which is their strategy, and somehow at the end of the day it all works out. Different practices and practitioners approach the problem differently. I don't know which strategy is best. Contacting the patient used to be simple, but now there are multiple numbers to call, and some patients prefer email or text over calls. *Karen Lauterbach:* The Venice Family Clinic has a Virtual Dental Home program and one of the things we had to do was have a health enrollment staff member present because there is so much misinformation parents had regarding dental benefits, or a real lack of understanding for what was covered, and a fear that they were going to get charged. There are a lot of dental providers that are not community oriented, meaning they try to upsell services and the patients feel pressured to make extra purchases. Beneficiaries then hear stories about how their friend or neighbor received a bill and become wary about accessing dental services. *Jennifer Kent, DHCS:* As of October 1, the Department instructed managed care plans to start providing nonmedical transportation to all beneficiaries, regardless of whether plans are responsible. This is most predominantly impacting CCS, dental, and Specialty Mental Health Services.

	Diana Vega: There's a lack of transparency from the parents' perspective in terms of what the program covers. You rely on the staff to tell you whether or not certain procedures are covered. If there's a handout or a booklet on what exactly is covered for each plan, that would be helpful. There needs to be a navigator or case plan manager we could contact to check on coverage prior to an appointment. *Jennifer Kent, DHCS:* We can provide that for both dental managed care and dental FFS as a follow-up item. *Danielle Cannarozzi, LIBERTY Dental Plan:* I'm happy to contribute to this topic. I'm based in Sacramento working on Geographic Managed Care (GMC) for dental managed care outreach. A lot of the feedback I hear from the community is the missing education piece. Members want to know what their benefits are, or how they go about making an appointment. We provide the members with our contact information to the member services department. A lot of times I hear that the member has a bad experience, so they stop going. We let the patients know that they have benefits and rights to change their provider, and if they had a bad experience, we want to know what happened because we want to fix that. Barbara Aved did a study in Sacramento showing that fear was one of the biggest barriers to dental care. We're also working on educating the dental providers by letting them know they need to send appointment reminders and explain the reasoning behind the treatment plans. *Pamela Sakamoto:* What I've heard from families is that they shouldn't worry about their children's baby teeth, which is coming from people they respect. *Jan Schumann:* I urge DHCS to work with LIBERTY Dental Plan or some of the other providers to do a patient survey instead of a provider survey. Maybe incentivize beneficiaries to complete the survey. *Ellen Beck, M.D.:* To follow what you were saying, the Panel should identify beneficiaries in need of speaking to someone from the Department. We should reach out to include underserved patients or people who only speak Spanish to help them feel more likely to go to the dentist. *Karen Lauterbach:* There are two different issues: one group

	that's not accessing care and another group is making appointments and not showing up. *Jennifer Kent, DHCS:* We started mailing outreach cards to families with children aged 0-3, advising them that they have a dental benefit and encouraging children to be seen for their first dental appointment. We mailed it out to a few hundred thousand families. We've been tracking to see if those families actually make an appointment. I think it was a good rate of participation. However, the issue is advising beneficiaries that there's a benefit for use, how to access it, and once you have an appointment, making sure that the beneficiary gets to the appointment. We're hoping to solve the transportation issue, but if it's also the provider wasn't treating you appropriately or there was a lack of communication about when the appointment was, that could contribute to the high no-show rates. It's a matter of parsing out the biggest barriers, then working your way down. *Paul Reggiardo, D.D.S:* DHCS has a very robust protection for the patients. In order for me to provide a service that's not covered under the Medi-Cal program, I first have to obtain from the Department a written denial saying it is not a covered service for that patient. Then the Department also recommends formally rendering into a written contract prior to providing that service, documenting that the service is not covered, and the patient must understand the cost involved and the treatment that is being provided. These are significant protections for the patient; any dentist or provider would be foolish not to follow those guidelines because then you're entering into Medicaid fraud. *Ellen Beck, M.D.:* I wonder if the additional charges are for products, such as a teeth whitener or a toothbrush, rather than for a service? *Diana Vega:* I heard from my dentist that they wouldn't cover a certain service, but I never received a denial letter. *Ellen Beck, M.D.:* What you're highlighting is the need for education; patients need to have that knowledge when they go in to the office. *Karen Lauterbach:* We've had a few cases that went through the grievance process through the managed care plans because of the way it was handled. All you need is one or two bad experiences, and it can spread throughout the community.

	Jennifer Kent, DHCS: DHCS wants to hear about complaints on individual providers. Sometimes it helps us analyze what's happening with that particular provider, but also helps us look a little more broadly. It helps us to understand if there is one provider who is utilizing a code a certain way. You cannot legally charge a Medicaid beneficiary for a covered service. We want to know about providers who are charging for covered services. *Ellen Beck, M.D.:* We need to encourage physicians and other health care providers to be more knowledgeable about the importance of oral health care, and encouraging patients and families to see a dentist. *Ellen Beck, M.D.:* There's an Early Intervention and SUD Treatment Summit on November 8 and 9. *Adam Weintraub, DHCS:* We distributed an invitation to the Panel members in October. *Ellen Beck, M.D.:* For the two items that Dr. Reggiardo referred to, perhaps at the next meeting, you could present those to the Panel? Please note the upcoming meetings: • January 31, 2018 • April 19, 2018 • June 28, 2018 • October 18, 2018 At the next meeting, we will select a new chair. *Adam Weintraub, DHCS:* The statute that authorized MCHAP said no chair could serve longer than three years. We'll choose the chair at the January meeting. We're asking for any panel members interested in serving as Chair to submit a statement of interest and vision to the Panel. We'll send an email to all the Panel members in the next several weeks that includes details for that process and invites nominations. This material will be presented to the Panel in advance of the January meeting. Additionally, with the changes included in SB 220, the positions on the MCHAP now are three-year appointments. They will be staggered, which means we'll be drawing lots at the January meeting. Some of the members will be assigned to an additional year in their term before their term is renewed, some members

	will receive two additional years, and some members will receive three additional years. *Ron DiLuigi:* Will these be added to the existing term? *Adam Weintraub, DHCS:* Exactly. No one will phase out in January because of the legislation; at the very least, every Panel member will have membership through 2018. Please send any questions to the MCHAP@dhcs.ca.gov mailbox. *Ron DiLuigi:* So effective January 1, everyone would get at least 1 year to our existing terms? *Adam Weintraub, DHCS:* There are no lengths to existing terms. There was a technical correction. There was no guidance given to whether you were nominated for life, or whether you remained eligible if you changed jobs. *Ellen Beck, M.D.:* If anyone wants to reach out by email or text about the role of the Chair and my perspectives, feel free to do so. *Jan Schumann:* I just want to reemphasize that we have a lot of topics that came up today that need to be discussed in 2018. We have a huge gap between June and October so I would like to suggest we have a meeting during the first week of September. *Adam Weintraub, DHCS:* Because you raised that at the last meeting, we have been exploring some available dates. We identified a couple of possible dates in late August that might work. We'll provide more information to the Panel once we determine what is available. Ellen Beck, M.D.: The practicality of having five dates allows us the flexibility in terms of things that come up.
Public Comment	*Kristen Golden Testa, The Children's Partnership:* We are focusing on some of the topics like the SB 75 eligibility through age 26 and social determinants of health. However, I want to add immigration as a social determinant to health. We should focus on breaking down the barriers in oral and dental health. We would appreciate the Panel's support in a comprehensive examination of Medi-Cal children's access in managed care. We see the data on an aggregate level but not a drill-down on kids specifically beyond the dashboard.

	Ellen Beck, M.D.: Can you speak to that last issue a little more? How would this occur? Learning about what happens to one child and using examples? *Kristen Golden Testa, The Children's Partnership:* What we've seen so far is the Medi-Cal population overall in managed care, but not a breakdown for just children, and specifically looking at children's access in managed care. *Ellen Beck, M.D.:* So you'd like to add to the list the word immigration to the social determinants of health care, dental barriers, SB 75 enrollment through age 26, and the audit of children's access to care in Medi-Cal managed care? *Kristen Golden Testa, The Children's Partnership:* Yes. *Kelly Hardy, Children Now:* In addition to what Kristen Golden Testa mentioned, I just wanted to add the family engagement piece. I would add "customer service" to topic S, "Parent/Guardian/Family Communication with providers and DHCS". We need to make sure that what's being sent to families is understandable, and creating a dialogue about how to best serve children and families in a customer service way and retain the families. If the families are enrolled and are retained in care, then there could be more attention to utilization. Include the dialogue around customer service to make sure that families feel engaged and important. I also wanted to second the comment on the deep-dive issues. At times, these discussions can lead the Panel off course. I agree with Director Kent's comment about needing practical input from the Panel. I really like that idea of DHCS bringing their problems for the MCHAP to solve. That would be very useful. *Dharia McGrew, California Dental Association:* There's big opportunity for this Panel to make concrete suggestions on applicable items to advise the Department. I would urge the Panel to focus on items that aren't necessarily a "deep-dive" into a topic of minutiae, but to ask questions where the Panel can provide policy guidance to the Department, whether it's the dental suggestions from Dr. Reggiardo, or the other suggestions on the list. *Ellen Beck, M.D.:* So specific areas that could lead to policy changes?

	Dharia McGrew, California Dental Association: Yes. Topics that are actionable by the Department.