State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

November 15, 2016

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; Jeffery Fisch, M.D., Pediatrician Representative; Marc Lerner, M.D., Education Representative; Terrie Stanley, Health Plan Representative.

Attending by Phone: Alice Mayall

Not Attending: Sandra Reilly, Licensed Disproportionate Share Hospital Representative; Liliya Walsh, Parent Representative; Wendy Longwell, Parent Representative; Ron DiLuigi, Business Community Representative

DHCS Staff: Jennifer Kent, Adam Weintraub, Rick Record, John Mendoza, Norman Williams, Samantha Leos, Morgan Knoch

Others: Bobbie Wunsch, Pacific Health Consulting Group; Alison French, Beacon Health Options; Margaret Kisliuk, Partnership Health Plan; Duane McWaine, M.D, Anthem.

Public Attendance: 25 members of the public attended.

Opening Remarks and Introductions	*Ellen Beck,* M.D., MCHAP Chair welcomed members, DHCS staff and the public and facilitated introductions. The legislative charge for the advisory panel was read aloud by Pam Sakamoto. (See agenda for legislative charge.) http://www.dhcs.ca.gov/services/Documents/MCHAP_Agenda_091316.pdf
Meeting Minutes, Follow-Up, Opening Remarks by Director Kent	Minutes from September 13, 2016 were approved. http://www.dhcs.ca.gov/services/Documents/091316_MCHAPSummary.pdf *Adam Weintraub*, *DHCS*: Most of the items for follow-up that we

	discussed at the September meeting are on the agenda today. Dr. Reggiardo had asked for a written version of the Director's comments in response to the recommendations on dental that the panel made. The responses are available at: http://www.dhcs.ca.gov/services/Documents/DHCSResponse_DentalRecs.pdf There were some questions regarding SB 75. The county-by-county data requested is still being compiled. Additionally, we've been asked if there were any counties reporting barriers to enrollment for newly eligible children. We checked with our partners at The California Endowment (TCE). Richard Figueroa responded that they have not heard of any operational barriers to enrollment; they have heard that some families are concerned with the reporting of personal data to the federal government. In response, TCE has pointed out the federal notice about Medicaid coverage not being counted as public charge, however, there are still some who are hesitant to provide information even with that data. *Ellen Beck, M.D.*: In the current political climate, it's very understandable why parents might be frightened or reluctant to have their children sign up for coverage under SB 75. As leaders around the state, we need to reinforce that SB 75 is a state law rather than a federal law and there is no reason to assume that any change will occur in that law. I would encourage those who are involved in organizations around the state to do whatever they can to reduce fear. Adam Weintraub discussed the report to the legislature, which requires DHCS to report no later than January 1, 2018 on the activities of the MCHAP, including the advisory panel's accomplishments, effectiveness, efficiency, and any recommendations for statutory changes needed to improve the ability of the advisory panel to fulfill its purpose. Panel members and the stakeholders will be receiving the first of at least three surveys from the MCHAP mailbox in December. *Ellen Beck, M.D.*: I assume the report will include each of the areas that we've paid attention to? *Jennifer Kent, DHCS*: Yes. Adam Weintraub provided an update on the membership guide and the proposed changes to the bylaws. DHCS' legal staff determined that some of the proposed changes discussed at the previous meeting would require technical changes to the bill. *Jan Schumann:* Will the panel get a copy of the technical changes before it is presented to the legislature? *Adam Weintraub, DHCS*: Yes. *Ellen Beck, M.D.:* There are some details to be worked out over the

	next period of time. It seemed more practical to us to give DHCS staff more time to explore what would have to happen if any changes were made and bring it back to the panel before any decisions are made. *Jennifer Kent, DHCS*: To follow on Dr. Beck's previous comments on the current political climate, the department cannot speculate as to any potential changes that may occur under a new federal administration. I think it's fair to say that there will be changes given the focus on health care and coverage. We will be happy to engage in those conversations and track changes at the federal level, but until there are changes, we are staying the course. Director Kent discussed ballot propositions that passed in the recent election and impact Medi-Cal: • California Proposition 55 extends personal income tax increases. Theoretically, the revenues from the income tax wouldn't materialize until 2019, and Medi-Cal would only see funding depending on the growth of the state's economy at the time. • California Proposition 56 increases the tobacco tax. Some of those revenues are dedicated to the Medi-Cal program. They are broadly provided to us so there is not specificity on how those supplemental revenues will be spent. • California Proposition 64 legalizes recreational marijuana. DHCS will receive revenues from the legalization and will educate children regarding anti-smoking. This passage will impact the Medi-Cal program and we will be working with the MCHAP members since it involves youth, outreach, and education. • California Proposition 52 puts a hospital provider tax into the constitution and ensures continuation of the fee. This does not change the way it is administered. Director Kent provided general updates, including the ongoing work to finalize the budget for next year. Revenues have dipped somewhat. Director Kent also discussed transitioning over the remaining files for SB 75 enrollment numbers; nearly 150,000 children have come into full-scope Medi-Cal since May 2016. DHCS approved 17 lead entity applicants for the Whole Person Care (WPC) waiver pilot projects targeted to high-cost users. DHCS is accepting a second round of applications, including a consortium of small counties. DHCS sought a technical amendment to the waiver from CMS on one piece of the Dental Transformation Initiative (DTI). The Local Dental Pilot Program (LDPP) applications have been received and are under review. DHCS is working with providers on the Provider Application and

	Validation for Enrollment (PAVE) project for a soft launch on November 18. We have a phased approach for how we are rolling out the project and are encouraging providers to use this portal instead of the paper applications. *William Arroyo, M.D.:* Can you please provide an update on the Substance Use Disorders Organized Delivery System (SUD-ODS)? *Jennifer Kent, DHCS:* San Mateo received approval from CMS on their contract and are in the final contracting with providers. Santa Cruz, Santa Clara, Riverside, and Los Angeles are the next counties in queue. We received a total of 10-11 plans including the counties I listed, all in various stages of the process. We received proposals from a few rural counties and opened Phase IV several weeks ago. Phase V will be opened to Tribal Partners in 2018. *Jan Schumann:* Do you have target dates for the Phase II and III of the PAVE rollout? *Jennifer Kent, DHCS:* It's open to new providers or providers that are recertifying. Phase II will likely happen in the spring of 2017, and Phase III is slated for fall of 2017. As part of the federal requirements, we must recertify providers every 3 years. These phased rollouts will help expedite the recertification process. *Ellen Beck, M.D.:* Are there particular constraints with how DHCS can use revenues from the tobacco tax? *Jennifer Kent, DHCS:* The ballot initiative language was broad; the revenues have to be used for the Medi-Cal program, as well as improving access and quality. It's a finite amount of money and will be a diminishing resource. DHCS will have conversations with the stakeholders and Legislature on what the revenues will be used for. *Ellen Beck, M.D.:* Are there any categorical limits? *Jennifer Kent, DHCS:* No. *Ellen Beck, M.D.:* Regarding educating children about not smoking marijuana, I do think there are different models that panel members are involved with across the state and we could provide input. I would like to see the list of counties, both for the WPC and for the DTI. Finally, I would like to reinforce that this is an autonomous panel and as leaders across the state, we need to reduce fear and help families to continue to sign up for health coverage through SB 75. As an independent panel, we are in a position to make statements or write letters in a way that the department is not.
Deep-Dive of Medi-Cal Behavioral Health	Dr. Beck introduced panel member Elizabeth Stanley Salazar to moderate the discussion on behavioral health.

Services: Learnings/Reflections and Recommendations from Health Plans **Alison French, Beacon Health Options** **Margaret Kisliuk, Partnership HealthPlan of California** **Dr. Duane McWaine, Anthem** **Terrie Stanley, MCHAP Panelist, Care1st Health Plan**	Presentation materials available at: http://www.dhcs.ca.gov/services/Documents/Beacon_BehavioralHealth_MCHAP.pdf http://www.dhcs.ca.gov/services/Documents/HealthPlanPerspective_TS_.pdf *Elizabeth Stanley Salazar:* The concept of having these deep-dives was to look at how the managed care plans implement their responsibilities related to mental health for mild to moderate cases. At the last meeting, DHCS gave us a deep-dive on behavioral health and how the counties provide specialty mental health services and some of the funding constructs. Today we're going to look at the mild-to-moderate range and how health plans react to this. Alison French with Beacon Health Options (BHO) provided an overview of the company. BHO manages mental health benefits in conjunction with health plans in California, as well as across the country. The goal of BHO is to provide access to health care with as few barriers as possible. BHO manages mental health services for mild to moderate impairments, which includes: medication management, individual and group therapy, psychological testing, and behavioral health treatment for Autism Spectrum Disorder (ASD). The Medi-Cal managed care mental health benefits began in California on January 1, 2014. BHO partners with federally qualified health centers (FQHCs), Indian Health Clinics, Rural Health Clinics, among others, to create a network for beneficiaries to access services. BHO conducts screenings over the phone and refers beneficiaries to the right level of care. *Access to Care:* There is a lack of psychiatrists in California and the country; 40% of all psychiatrists only accept self-paying patients and 48% of psychiatrists are aged 60 or older. BHO works closely with Primary Care Physicians (PCPs) and utilizes them as much as possible to improve access. BHO uses telehealth to expand access to psychiatrists. *Funding Streams*: County-operated clinics and county-contracted agencies reside under the specialty mental health network, while the FQHCs and the private providers who take public insurance are in the mild to moderate network. *Marc Lerner, M.D.:* I'd be interested in hearing more about the telehealth services, and specifically, any successes or challenges relative to protected communication. Also, is this because you have an at-risk contract that you're able to work in this fashion, as I'm presuming that there is not a Fee-For-Service (FFS) telehealth level of support that you get from Medi-Cal? *Alison French, Beacon Health Options:* Partnership HealthPlan of California (PHC) has a vendor for the medical side of telehealth. The

	vendor partners with FQHCs in the northern counties for services such as endocrinology, diabetes, pain management, etc. We partnered with the vendor to add psychiatry in FFS. We've implemented it within the FQHCs. The other model is to find psychiatrists who prefer to work in their home or have extra time in the clinic and link them with members in FFS. Since 2014, we've had over 20,000 successful visits via telehealth. BHO will pay for the facility fee as well as the transmission fee. Transportation to the clinics can be a barrier to care so we've recently piloted a home-based telehealth program with a subset of members who were identified under the 'mild' category. This is useful for short medication check-in visits. *Marc Lerner, M.D.:* Do you facilitate the medical malpractice of telehealth coverage for your contractors? *Alison French, Beacon Health Options:* We do. The contractors must submit proof of malpractice insurance, sign a contract, and review a member rights form with the member prior to the telehealth visit. *Ellen Beck, M.D.:* What are the wait times for screenings? One of the issues that has come up is the amount of time that a family has to wait. Are there challenges with care coordination between BHO and with the county? And finally, what challenges do you encounter, and where do you see gaps in what you're able to do, and what would you hope for in terms of what could be different? *Alison French, Beacon Health Options:* Initially, there was over-screening but over the last year screening times have decreased. We give that responsibility to the provider as well; if the member wanted to access care, they wouldn't have to call BHO. Instead, they could walk into their local clinic or FQHC and that clinic would have the responsibility to conduct the screening. We also conduct modified screenings, where you ask the five most important questions about suicidality and risk. If we feel like they are not high risk, we will get them to a provider. In terms of counties, we work hard to contract with the counties for existing beneficiaries. The counties have been very forthcoming with providing us information on the members. The easiest way to manage mild to moderate members is to contract with the county to bill BHO for those members. *Ellen Beck, M.D.:* What do you consider some of the biggest challenges? *Alison French, Beacon Health Options:* There are a lot of children that fall under the severe category for a few reasons: either the county contracts with the schools and the children are very severe and they fall under that, or they don't know where else to go so they go to the county. One of the biggest barriers is how we can partner with the schools. The easiest model – other than contracting with the schools – is contracting with the clinician who would go into the school, or getting the school to

	contract with a clinic to route all the students to that one particular clinic. *Ellen Beck, M.D.:* Thank you. We're open to hearing about 'on the ground' ways to improve the system. *Alison French, Beacon Health Options:* During a three-month window on penetration rates for children accessing services, there were about 27,000 utilizers for that quarter. The majority of the services provided were for therapy, followed by medical management. *Marc Lerner, M.D.:* What is the denominator? *Alison French, Beacon Health Options:* I will get the denominator for you, but it's about 450,000 to 500,000. *William Arroyo, M.D.:* Does the 3.2% average penetration rate refer to the penetration rate across the lifespan? *Alison French, Beacon Health Options:* It's the total membership. *Jennifer Kent, DHCS:* Alison is only referring to PHC, which has a total enrollment of about 480,000 members in 14 counties. The entire penetration rate across the PHC population is 3.2%. *William Arroyo, M.D.:* Does that include the 25 and over age group? *Jennifer Kent, DHCS:* Yes. *William Arroyo, M.D.:* Is there a benchmark that you have in mind for a reasonable penetration rate for children? Knowing that the penetration rates for children with mental health issues is 20% nationwide, and 8-9% are Substance Use Disorders (SUD), what do you use as a reasonable benchmark? *Alison French, Beacon Health Options:* Previously, we saw about a 15% penetration rate in California for mental health services. With the bifurcation of benefits, we're aiming for 5-6% across the board. We are concerned when we see penetration rates under 5%; for children, this rate is even less. The goal is to match. If we know that 20% are being affected, how can we reach those? One of the barriers we have is that we only get the mild to moderate data; we don't get the county data. The county data is where the SMI, SUD, and school-based service data resides. If we could combine the mild to moderate data with the county-level data, we would get a better picture. *William Arroyo, M.D.:* The county level data is about an 8% penetration rate with 3.2% across the PHC population; together we're hitting about 10%. What are your thoughts? *Alison French, Beacon Health Options:* I would appreciate if you could provide those numbers. It's difficult to get an overall picture. Children are

	difficult to reach under the mild to moderate benefit. Some children fall under the moderate category, so who sees those children? If the PHC is responsible for mild to moderate and the county is responsible for moderate to severe, where do the children fall under the 'moderate' category? We need to do a better job defining what moderate is and especially for children. *Elizabeth Stanley Salazar*: Thank you. Are there questions from the audience? *Margaret Kisliuk, Partnership HealthPlan:* I'd like to add a couple of items from PHC. We are in 14 counties and in some counties, we are the only managed care plan. The counties have invited us. We met with the county staff and tried to work out the process by which children and adults would be identified. One of the challenges as we're moving into the schools is that we're still working with the counties to determine how to get people to move between the systems while also ensuring that we don't put up barriers. Our network is very much focused on the primary care setting, particularly in the rural areas. One of the services that BHO offers in the rural areas is e-consult. *Alison French, Beacon Health Options:* It's also referred to as the 'PCP Decision Support'. We have on-staff psychiatrists for BHO who will conduct curbside consults for medication management. *Margaret Kisliuk, Partnership HealthPlan:* That's especially important when talking about the challenges of accurately prescribing for kids, or even the decision to prescribe. We've also funded some of our PCPs to go through the University of Davis fellowship program, the 'Train New Trainers Primary Care Psychiatry (TNT-PCP) Fellowship', which provides training on mental health support for primary care. Ms. Kisliuk noted that she would prefer if all the county systems would contract with BHO, although very few do. There are many barriers; a common barrier is compliance-related concerns about double-dipping. Providers are concerned with the contracting with both the county and with PHC due to having two separate Medi-Cal rates. Where we've had issues is when someone is accurately in the severe system but wants to see a provider in the BHO system; we've worked through these cases on an 'ad hoc' basis, which may not be the ideal way. We work very closely with BHO to make sure they are encouraging access as much as possible and trying to address issues that may come up during transition. *Elizabeth Stanley Salazar*: As you say, primary care is usually the first gate to a family with children. What type of screening is usually done at that point? I assume that there's been a referral to Beacon either for services or for more assessment? What goes on within your system of care for PCPs and workforce in terms of doing screenings at that point? *Margaret Kisliuk, Partnership HealthPlan:* The only screening we require

	is the health risk assessment (HRA). To refer to BHO, we developed a one-page screening tool that's available to providers. We would certainly encourage them to use any evidence-based screening tool. Some of the PCPs have psychiatrists on staff and have a very standard way of operating while others are 'at sea'. In those cases, we encourage the PCP or family to contact BHO, or we assign staff to visit. *Elizabeth Stanley Salazar*: How do we track PCPs providing mild to moderate or perhaps more complicated mental health support? *Margaret Kisliuk, Partnership HealthPlan:* The best way to track, and while it's not 100% accurate, is through our claims system and through our pharmacy system. Some psychotropics are carved out and billed directly to the state. We are working on bringing that data into our system. Gathering the data around mental health is always a challenge. On top of the challenges that Alison mentioned, FQHCs billing data doesn't necessarily go through the counties. There are a variety of data sets that are collecting different information. Going forward, we will encourage the data to be more integrated through HEDIS, which will be doing depression screenings and some of the key screenings for mild to moderate. *Ellen Beck, M.D.:* We need to train PCPs, particularly in many of the rural counties, by using professional associations and counties to offer programs for CME, as well as residency training programs. I'm wondering if you've reached out to them? *Margaret Kisliuk, Partnership HealthPlan:* We've done that to a limited extent and I appreciate your suggestion. *Ellen Beck, M.D.:* I'd like to see a list of counties as part of the materials that you could share with us afterwards. *Duane McWaine, M.D.:* To dovetail on Dr. Beck's suggestion of reaching out to the counties and local associations, that's a great suggestion and I'm going to take that back. When you talk about family practice, they see behavioral health as part of their mission. It's the internal medicine doctors where we have more of a challenge due to their specialties. I appreciate my colleagues' presentation and I will concentrate on topics specific to Anthem. We have about 1.2 million lives in 29 counties in California. I'm going to talk about things we're doing well and some of the challenges we see, and then maybe a wish list of things that we wish were different or maybe wish the state would help us with. One of the successes is the transition of families from regional centers to managed care when it comes to the Americans with Disabilities Act (ADA) and ASD. That was a big undertaking for the health plans and the state. The families are now getting the care they need and we see that as a success. Anthem views behavioral health and physical health integration as a

	core goal and have approached the integration in three ways: 1. Ideologically: Behavioral health and physical health should be integrated to give beneficiaries the most comprehensive care. 2. Functionally: Integrating rounds between behavioral case managers and physical health case managers. We saw a diffusion of skills between integrating these two rounds. 3. Structurally: As the behavioral health benefit has been carved into the managed care plan, the behavioral health staff has been carved into the greater staff of Anthem. The behavioral health staff now report up the same structure that the physical health case managers do. We see this as a success, especially as it begins to be reflected in what we see in our providers. We believe we've done a good job of educating families. As we see families coming into managed care as the first time being insured, they need to know about the services provided, how to access the services, and how to navigate the systems. Our case managers and utilization managers have taken on the educating role and we've seen families do much better in terms of health measures and utilization. Challenges: My colleagues have discussed information exchange and case identification. One of the challenges with having incomplete or sometimes no access to the care that's being provided at the county level is that we have people with serious mental illnesses that we don't know about. It's important to know about these cases because the treatment can have an overall impact on their physical health. Early detection for children's mental health issues has a huge impact on how we would educate that family and how to treat that child. We appreciate that the information we receive from the state regarding the carved-out medications is much more timely. We're working to integrate the information we receive into our system and it sounds like PHC is doing the same thing. The ADA transition has been a challenge. The level of expertise that's necessary in managing ADA services is not something that health plans are used to having and we're not accustomed to this level of training. When it comes to providers doing what they're supposed to do and that our management decisions are well informed, that's a challenge. And I believe the state recognizes that. In-patient psychiatry for children and adults are also a challenge; the number of beds is lower than what we would like to see. SUDs is a challenge in the adult population and especially for children. We've seen very young children who identify for needing SUD treatment, and it almost becomes a case-by-case basis when you're trying to get treatment for those children. Eating disorders can be a grey area and determining who is responsible for the care is a challenge. On a case-by-case basis, when you have the

	right information and relationships, you can get the care for the children that is needed. Additionally, the number of case hours spent on figuring out the best treatment for the child before the child even receives the treatment can be a challenge. Finally, another challenge is determining the appropriate care for children identifying as transgender. Wish list: • Clarity regarding the scope of responsibility for mild to moderate cases. Clarity from the state would be welcomed, however, the state is in a tough position when trying to draw this red line. • Respite care. When you have a child needing a high-level of parental or caregiver attention, we know that the best place for the child is with their family. Figuring out a way to provide respite care to keep the family from getting burned out is something we would want. • The facilitated ability to contract with county and the county-contracted providers, or a full carve-in of behavioral health benefits, would help Anthem address some of the challenges mentioned. What this wouldn't address is the shortage of child psychiatrists. • Overall, a better health information exchange. *Marc Lerner, M.D.:* I wanted to thank Dr. McWaine for raising the issue of the mental health needs of children in hospitals. There have been recent reviews suggesting that there's a 50% to 60% increase over the last 10 years in the utilization rates and health costs associated with stay in children's hospitals. As we move to a whole-child model, I'm very concerned with the attention given in the California Children's Services system to mental health needs. This is an area of opportunity; what are the plans and counties doing in terms of providing this care? How are they going to guarantee that they'll be able to provide services for children, not only in the community, but when they're in the hospital? *Duane McWaine, M.D.:* Let me also say that during my time at Anthem, our partnership relationship with DHCS has improved dramatically. I've heard this from other health plans as well. The ability and willingness to collaborate on solutions to some of these issues has been helpful. *William Arroyo, M.D.:* I wanted to underscore some of the things you said regarding the inpatient services related to kids has only intensified statewide. My opinion is that the business model of hospitals does not align with Medi-Cal reimbursements. Therefore, hospitals don't perceive it as paying to provide such a service. SUDs treatment for children is a priority to the members of this panel. Despite it being an entitlement through Medicaid, we have a very small

	network of services for children. Perhaps the new SUD-ODS initiative would be able to address that to some degree. And perhaps the final mental health parity rule, that has yet to be implemented in California, will take care of some of the issues. The challenges to providing adequate care for young people with eating disorders takes extensive collaboration between the health plans and the county mental health plans. Your mention of respite care has never been mentioned on this panel. I think you are correct on this issue; it happens to be a service in other states. It is not part of our waiver here so Medi-Cal does not pay for respite care. In some counties, the mental health plans will use MHSA to pay for respite while other states use Medicaid. The transgender issues that you mentioned are emerging statewide. In Los Angeles, we are moving forward with this issue and will hopefully do a better job. *Elizabeth Stanley Salazar:* I wanted to applaud the fact that you're doing so much work on the integration of the workforce. You are bringing together disparate workforces that hadn't worked together. Until we change the structural barriers, we're going to continue to see this fragmentation. There are distinct silos; where do we get together and share the data and take an overall picture? *Margaret Kisliuk, Partnership HealthPlan:* Some of the problems are not necessarily related to different organizations providing services. Much of it has to do with the different rules about sharing the information, regarding how you have to keep the records separate and you can't work together. That's probably the largest current barrier. Public Comment: *Emma Zirkler:* How many of you know what a child life specialist does? We're child development experts who provide children and families with coping skills, mostly in hospitals. I look forward to hearing more about the perspectives you have in providing care from the assessments to the actual diagnosis to the long-term care of these children. *Lydia Bourne, AAP and CA School Nurses:* You all have noted there is a lack of psychiatrists. Is there any thought within the managed care plans or the other programs to expand the range of providers who are out there? There are others such as LCSWs and MSWs and they are already in the schools. The school is a different environment and HIPAA is a problem. If children have IEPs, then sharing of information could happen. The biggest issue is the inadequate number of psychiatrists providing these services, but we know that there are others who have that type of expertise who could provide those services for children in the schools.

	Elizabeth Stanley Salazar: Do I hear in that comment that we should be looking at scope of practice as we develop strategic responses to the workforce? *Alicia Kauk, The Children's Partnership:* I'm wondering if the plans that just spoke could speak to the assurances of transportation for all of our children that are in rural counties. These children shouldn't be receiving a lower level of care simply because of that fact, although I do understand it's extremely challenging for the plans. *Duane McWaine, M.D., Anthem:* There are situations where providing transportation doesn't solve the problem. If the provider is 120 miles away, you're still talking about 6-8 hours of transportation. So at some point that becomes impractical. I can speak for Anthem that we take very seriously our responsibility for transportation. *Alicia Kauk, The Children's Partnership:* Is your plan very similar to what BHO provided, which was increasing the use of telehealth? *Duane McWaine, M.D.:* Telehealth has been a challenge to us. One of the things we've been working on, and I was glad to hear similar stories from my colleagues, is home-based telehealth. The home-based option will be helpful to some of our most geographically challenged members. *Marika Collins, Casa Pacifica Centers for Children & Families*: I would highly recommend the use of psychiatric child nurse practitioners in your set of recommendations as a solution. The concept of waiting 20 years to regenerate child psychiatrists is not a realistic solution. To Dr. McWaine's comments earlier: I was very heartened to hear about respite services. I was hopeful to see that part of your recommendations going forward is the inclusion of respite services, as well as home-based services, especially in the schools. *Marc Lerner, M.D.:* With your work in schools, do you track any of that information? Do you have any type of effort to approach licensed providers in schools? Home-based services are another opportunity for children and families to access care while maintaining resources of a family. Do you have outreach to school mental health providers to essentially be on your network or a mechanism to track those efforts so that we can see if we are growing in another area of caregiving, which may not involve medication? How are you tracking that care on school sites? What's the data source for that? *Alison French:* The only tracking is the rendering service on the claim and whether it's done in the homes, or in schools, or in the office. *Ellen Beck, M.D.:* You spoke to barriers and patient consents. As an example, I directed a program where we had 8 to 10 organizations trying to provide care to individuals. We have a consent that was approved by the Medical Board of California that says that we are all working for that patient and that we have permission to talk to each other around the

	care of the patient. The patient must sign a regular consent form and group consent form. So it's a barrier, but I don't think we should see it as insurmountable. *Terrie Stanley:* The benefits went into effect in January 2014 and behavioral health today focuses on the level of impairment. Does this level of impairment stay with the health plans or the county? This has been one of our biggest challenges. Another issue for us are the screenings because we must train practitioners and providers. The referral of beneficiaries to a provider is difficult to do at the health plan level but there are examples such as Inland Empire Health Plan that manage benefits internally. Additionally, it was difficult to create a mutually agreed upon assessment tool with a mental health plan. Specialty mental health services on the outpatient side vary immensely from county to county. There aren't many day treatment and crisis residential services offered for children. It has been difficult to identify services following an inpatient stay that meet needs. Children are also eligible for EPSDT services and this means that health plans tend to take responsibility for needs when there is a doubt. In terms of transportation, the state has sent out APLs regarding transportation and EPSDT services. There are services from County Alcohol and Other Drug Programs but trying to find those services specifically for children is not an easy task. The whole issue of prescription drugs is huge and what physicians can and can't do around prescribing. The state has issued guidance related to MOUs between counties and health plans. They vary between counties but are in place everywhere now. Barriers: • Early identification • The state has issued plan guidance around behavioral health assessment tools. The health plans all have this and we do track completion. • Chart reviews can be a very time consuming and labor intensive process • The complexity of the health care system in general • There is a lack of professionals who speak more than one language • Barriers related to siloes such as regional centers, schools, etc. • Social stigma We are providing support to providers around the tools that they'll need, educating them about resources, and working with schools. We are providing information to parents and to youth, although this remains a challenge in terms of disseminating the information and making it

	relatable. Also, it can be a challenge to treat when we can't treat the parent or caregiver. Many health plans have embraced the interdisciplinary care teams model by bringing in social workers and Marriage and Family Therapists. *Ellen Beck, M.D.:* I want to reinforce the treatment of the child in the context of the family. There's an opportunity for PCPs to address the needs of the parents and children. There are models for additional reimbursement when you have patients with very complex diseases. *William Arroyo, M.D.:* Is it your understanding that mental health plans are responsible for providing all EPSDT mental health services? *Terrie Stanley:* For the Specialty Mental Health, it's my understanding that it is the counties' responsibility. *Paul Reggiardo, D.D.S:* To a lay person, how do you define the significant impairment and who makes that determination? *Terrie Stanley:* This is a big issue for use on the plan side. For example, with eating disorders, there are significant impairments yet we tend to have significant discussions about who is responsible for providing services. *Duane McWaine, M.D.:* At the end of the day, it's the county who decides. With 58 counties in California, there certainly are different definitions for mild to moderate versus moderate to severe. *Jeff Fisch, M.D.:* My perspective after hearing this discussion and my experience in working in the field for 16 years is that there are a lot of steps required for integration. In Kaiser, integrated service delivery means I identify a problem and know they will be seen within our system. The mild to moderate versus the moderate to severe categories can be a barrier at times because there's a disruption in the continuity of care. It's a problem of not knowing where they can get their care and to what degree. One of the other advantages of having an integrated system is not dealing with silos. We've found a way to leverage the shortage of providers by educating the pediatricians and family practitioners. We've incorporated the use of e-consulting to help with the lack of child psychiatrists.
Discussion of Schools and Mental Health, Dr. Marc Lerner	Presentation materials available at: http://www.dhcs.ca.gov/services/Documents/Schools_MentalHealth.pdf *Marc Lerner, M.D.:* As many as 1 in 5 children have a significant or impairing mental health related concern. There is a significant increase in the utilization of mental health for adolescents, indicating high needs. I wanted to address the issue of where children receive mental health

	care. It's estimated that roughly 70% of children with mental health services for their conditions receive care from their school. However, many of these children may not have a diagnosis, so they have undiagnosed mental health conditions and have impairments that are often regarded as behavioral problems. There are also issues with disparity, including issues regarding language barriers, poverty, and geography. These children are less likely to receive care. It's also difficult to make referrals and we discussed co-location as one potential response, but funding for mental health services for children is primarily in the schools. Our system of care is inadequately represented there. When we try to refer children out to clinics, we see high no-show rates. The ability to engage with families and to sustain treatment over time is substantially higher if the services are engaged with schools onsite. This doesn't mean that schools are a complete panacea. There's still a high degree of stigma about mental health related concerns from school personnel. There are many models for mental health care within schools, which includes school-based mental health centers, consultation models, and community agency partnerships with school districts, to name a few. There are 243 school-based health centers (SBHCs) in the state. About 30% of the SBHCs provide primary care but no mental health services. Even when SBHCs are associated with the campus, they don't necessarily provide mental health services. We need to know more about these barriers. About 70% of SBHCs work in association with FQHCs or county health departments. Roughly 30% of SBHCs employ school personnel to do this care. We've heard that it's the responsibility of the county health plans to manage aspects of crisis intervention. It's important to recognize how many children are having crises related to mental health in schools. Dr. Lerner surveyed 27 school administrators in Orange County. A little over 50% of school administrators said they need mental health support in their schools. When asked what services they were providing, all said they had counselors and most had referrals, but they had much more limited services to direct clinical services on campuses. There are multiple silos that trap the students in schools who have significant mental health related issues. In the same survey, when asked who the school administrators partner or refer with to provide services, 55% responded that they have no resources nor an integrated process. Dr. Lerner provided an example of an integrated program between a community service provider and school district. The school district had to address issues including data collection and data entry concerns. The district conducted collaborative interviews to support optimal hiring for

	the school environment and provided special badges to all the mental health staff so that they were integrated with the team and could move around. They began to integrate the mental health staff in a co-located fashion. They found that this created a significant reduction in violence and disruptive incidents. They did this with a tiered system of care. They found more attendance, a reduction in principal office referrals, and teachers reported that they had more time to teach. Multi-Tiered Systems of Supports (MTSS) integration ties prevention work with the treatment resources. Dr. Lerner discussed the tiered mental health system: • Tier 1: Mental health screenings for all students; suicide prevention plan across school districts and addressing substance use and bullying • Tier 2: Social skills and trauma groups. • Tier 3: Individual therapy and/or medication, crisis teams, and special education services and the counseling. Dr. Lerner discussed the differences between school counselors and social workers. Counselors are generally only available to a degree and are primarily focused on the students' trajectory. As a result, they are not as engaged in children's mental health needs. Dr. Lerner asked if DHCS noticed a change in prescribing patterns across the transition from AB 3632 to AB 114 There's also the question that has come up with the Free Care Rule as it relates to the provision of services in school-related settings, and whether it's possible for licensed personnel to be able to engage in billing through the school districts to Medi-Cal for students who are not covered by an Individualized Education Program (IEP) or an Individual Family Service Plan (IFSP). I think it would be worthwhile to have some discussion about this. This speaks to the potential areas of compensation to school districts and LEAs. In general, it's my sense that DHCS has taken the view that counseling related services in schools are not billable. Schools need to be recognized as integral partners in the provision of mental health services to all Medi-Cal children in need and not just for the students in special education. To do this, the counties, schools, and health plans need to partner to ensure that there's a continuum of mental health services present. Schools should also be supported as the site of care to provide these services. That is the goal I'd like to put forward and we can discuss the specific problems, suggestions, and solutions. *William Arroyo, M.D.:* I just want to remind everyone about an audit report concerning how funding for special education mental health services provided to students through IEPs was being used. Paraphrasing the conclusion: there was absolutely no tracking of how the $400 million was being used. Senator Beall passed a bill to hold Department of Education

	(CDE) more accountable for tracking funding that previously funded services through county mental health programs. That bill morphed into something that wasn't as comprehensive and is not going to fulfill the original intent. At some point, we need a fuller idea of the entire funding landscape for mental health services used in schools. I know of at least six different funding streams that could provide mental health services. It's a complex matrix of funding streams that could support mental health services in schools and it's going to be a challenge to streamline the funding streams. *Elizabeth Stanley Salazar:* This subject is complicated. It seems to me that there is a lot of duplication, fragmentation, and massive gaps. There are wonderful innovative projects that come up, but we can't migrate these projects into systems of care. We also have funding mechanisms that have changed dramatically but we haven't aligned the resources to the funding streams. It's not just about putting multi-tiered systems in every school district. *William Arroyo, M.D.:* Because we don't have a handle on the dollars that are supporting whatever services that are taking place in the schools, it's hard to come up with a cogent recommendation on what amount of money should be used. There are other funding streams – whether it's 504, LEA Medi-Cal, MHP Medi-Cal, or MCPs. It's a hodgepodge of providers and funding streams. Without looking at this more comprehensively, it's difficult to come up with what the best model for education should be. *Marc Lerner, M.D.*: Making the determination between mild to moderate versus severe is a challenge. However, the counties shouldn't sort this out; we have the DHCS and CDE at the state level to address this issue. I would encourage DHCS meet with CDE, as well as have input from appropriate consumer groups to try and come up with mutually agreed upon guidelines of financial responsibility for different types of mental health services delivered at schools. For example, the school district will have their programs, but how does it relate to the integrated systems framework, particularly for the tier 3 and tier 2 services? There are example MOUs, which would allow for an agreement on service flows between schools, managed care plans, and the county mental health. Having legally agreed upon language would be helpful, which would then be utilized with guidance from CDE and the California School Board Association. *Ellen Beck, M.D.*: I would like us to move into recommendations. As a panel, we should use the information from the last two meetings and identify what is important and what our recommendations should be. *Terrie Stanley*: Another challenge is segmenting the service delivery points; it's a disruption to the continuity of care and is detrimental to children. My recommendation is having guidance and criteria sets around continuity of care, and to the delivery of services across other delivery sites. We're seeing that with ADA; there are some services that

	the schools provide, some services that plans are responsible for, and some that regional centers still provide. We should look at who is providing the continuity of care and who is delivering those services and what can or can't be done in terms of credentialing practices and the ability to license providers. We need to add some additional clarity in that area. *Ellen Beck, M.D.*: Adding clarity to the continuity of care across the providers and services, the services locations, and organizations including the counties. *Jan Schumann*: It sounds like there is no state language in providing definitions for mild to moderate or severe; it's decided by each individual county leading to 58 different definitions throughout the state. I would urge that this panel recommend to DHCS that they define the language at the state level and include language that is also at the discretion of the PCP. I also recommend that DHCS urge the counties to increase the availability of psychiatric beds. I also urge DHCS to remove barriers of intake of referral, especially when it comes directly from the PCP so that the individual doesn't need to go through a second interview with a less trained medical doctor. Finally, I would like to see a cost analysis related to respite care coverage versus the relapse of these children going back for more inpatient care throughout their lives. This is like an IHSS service that we could provide to these families to allow them to get the tools that they need. *Karen Lauterbach*: It seems very clear that streamlining and creating fewer barriers is very important. While we're doing that, we need to think about how are we going to communicate that message to our patients. The whole MC system is difficult to navigate, and then they're going into mental health areas that are very new to them. As we're streamlining, how are we communicating to them so they understand? *Paul Reggiardo, D.D.S*: There is a lack of resources to treat the family. I can't treat the disease unless I'm treating the family. Where can the resources be made, how can they be made available, should they be available, what can be done to provide some level of service to the family and not just to the child? *William Arroyo, M.D.*: There is a certain portion of students who have private health care insurance. They need to be brought into the fold. I think for us to assume that all students can only receive mental health services through schools through Medi-Cal does not hold the obligated provider to its contractual responsibility. *Elizabeth Stanley Salazar*: We talked about integration, WPC, and the grants for WPC. I think that everyone supports the principles and values of that approach to care. I want to see messaging or some clarity that this is where we're going. This is our mission and value. I think we have that already; if you look at DHCS' mission statement you see it, but it's not widely known or adhered to. I think DHCS should convene strategic

	discussions on how to remove financial barriers or come up with alternate payment methods that might be necessary for respite care, residential crisis services to children, or whatever continuum is needed. Looking at innovations that support integration and movement would be ideal. We also need to have some principles and mechanisms of care coordination with different models. We also need to educate everyone in the sharing of information. *Alison French, Beacon Health Options*: In treating the family, the county and the SMI can bill for things like case management, family therapy, and collateral. If the mild to moderate cases in a managed care plan were also able to bill for case management, family therapy, and collateral, we'd be able to treat a lot more children. *Ellen Beck, M.D.:* I've talked about wanting to have family therapy and case management supported. *Alison French, Beacon Health Options*: Partnership HealthPlan has agreed to add family therapy in the next year, so we are adding that to our network, but we could still benefit from collateral and case management. I know the other health plans have not taken that route. *Marc Lerner, M.D.*: I think family services is particularly important in therapeutic parenting related work, which is done for disruptive behavior disorders. There's no system of care yet the parents have to be engaged through parent interaction therapy or other treatments. I want to push for getting the data in this area. Dr. Arroyo mentioned data around expenditures, but I think that on the billing encounter form, like on an APL, we need something to promote the completion and tracking of school-cited services to see if the programs are improving over time. Schools and LEAs that bill DHCS often feel that they're harmed by the process of retrospective auditing. It's an effective mechanism for inhibiting their desire to move into the school-sited provision of services. Mental health therapy needed by schools should be billed through a mechanism, perhaps by direct billing of Medi-Cal. *Pamela Sakamoto*: Integration versus communication is a big topic and I know that there are agencies such as the regional centers who have developed multi-agency relation forms for release of information. These have not bothered HIPAA. I think if the state were to take a leading role and develop the forms informing all the local county councils that this was indeed acceptable to improve the outcome of the treatment and continuity of care, it would improve communication. *Jeff Fisch, M.D.*: We need to look at ways to screen children to identify problems. We should recognize that children are a captive audience in schools as Dr. Lerner has identified, and we need to realize that it's an amazing opportunity for screenings. Then we can decide the best way to communicate where that care can be best delivered. If you look at programs designed in the past for identifying vision and hearing problems and scoliosis screenings, they are done in schools. On one

	hand, these programs are duplicating our efforts in what we do in the healthcare world as physicians, but on the other hand, we know that so many children do not regularly see a physician. And again, we need to think about how we would communicate to providers or health plans to say that we've identified a patient, now we need to decide how are we going to care for them. *Elizabeth Stanley Salazar*: As we move forward, especially at the screening level and the early intervention opportunities, the screening efforts need to also include substance use and tobacco. *Jeff Fisch, M.D.*: Of course, that's the opportunity. *William Arroyo, M.D.*: Recommendations related to mental health services and schools should include a public awareness campaign for parents that informs them of their parental rights. There are entitlements in education that relate to mental health services that most parents don't know about. Secondly, to dovetail some of the recent comments, there should be a systematic screening instrument. No one here has mentioned the pediatric symptom checklist, which is one of the best instruments for identifying emotional and behavioral problems in children. This should be administered at every primary care entry point for a new enrollee to a plan. Insofar as the high school population is concerned, I think just as we require certain health screenings for this group, a depression screening in high school is overdue. *Ellen Beck, M.D.*: I want everyone to feel comfortable with the recommendations. Someone in the group mentioned evidence-based non-medication treatments. We should promote those, especially with children, and educate the community and professionals. The more we can do in schools, both for the children and the families, is a wonderful way to achieve access. We talked about stigmas and education and people who speak other languages and cultural bridges, we could benefit by training people as mental health promoters and youth health promoters. We could also benefit from a statewide system to support primary care physicians. If there are resources that are available through e-consult and mental health services across the state that any clinician could contact, I think that would help. Including psychiatric nurse practitioners could help. I agree with the respite care services mentioned. I think we need better integration of care. Perhaps we could also have a meeting on schools in general and discussing some of the issues that have been brought up. *Bobbie Wunsch:* We've received specific feedback from Alice Mayall. Many of her comments duplicate the comments that the panel members have made. *Ellen Beck, M.D.:* I think her experiences as a parent and a mental health professional have informed this panel. *Marc Lerner, M.D.*: It would be helpful if DHCS would reconsider the

	use of telehealth approaches to allow medical home participation and care coordination at the schools. At this point, we're hearing that this makes sense enough to invest in it. We would like to see that there is encouragement. *Pamela Sakamoto*: In regards to claims, we've talked about multiple funding streams, who is paying for what, and whether there is duplication. It would be nice to take a baseline of each of the funding sources at this point and what they've coded for these charges so that when they implement some changes, there's a way to compare whether there has been an improvement in the receipt of services or a decrease in cost of services by changing the focus of where the treatment occurred, perhaps by putting more into the whole family instead of just into the client. *Ellen Beck, M.D.:* There is an additional reimbursement when you're serving complex pediatric clients, as well as considering the social determinants of health and case management.
Public Comment	*Kim Flores, Senate Office of Research:* If this panel is going to have another meeting specifically on schools, I'd suggest maybe bringing in the auditor. There are two audits that have been done on this issue. The problem is trying to get Medi-Cal to fund these services in the schools. There are two different programs: School Based Medi-Cal Administrative Activities (SMAA) and LEA. There are a lot of issues around how these programs are administered. Sen. Liu had a bill that was vetoed; one of the pieces in the legislation was trying to get the CDE and DHCS to have an MOU. In the discussions around the bill, the MOU is supposed to be in place but DHCS does not have one. There are a lot of issues around this coordination. *Lisa Eisenberg, California School-Based Health Alliance:* I want to commend you all for taking on this topic. I want to reiterate the understanding of the education system. For schools, understanding the Medi-Cal system and how county health plans work and how managed care plans work is a whole separate system that they also don't understand. I think that the knitting together of these silos, the education system and the Medi-Cal system, is important and difficult. I think a lot of the negotiations must happen at the local level between county health plans, managed care plans, county offices of education, and schools. *Ellen Beck, M.D.*: My experience has been that health care in this country is county by county, and each county has a different health care system. And each education system differs. Here we are trying to make it work, and it's difficult. *Alicia Kauk, The Children's Partnership:* First, we can move forward by leaps and bounds by having telehealth in the schools. Second, we have a lot of energy and ideas going for things that we will continue to implement and down the road, but for the here and now, I would

	encourage the panel to have the Department do secret shoppers of managed care plans and access to mental health professionals. We want to make sure that the access is there now. Third, it would be wonderful if DHCS could issue a statement similar to the one that Covered California released reminding families of immigrants not be fearful in enrolling their children. *Michael Brodsky, Molina Healthcare*: I wanted to echo one of the comments we heard regarding the success we've seen at the regional centers in terms of establishing the ability to exchange information between service entities. When we think about topics such as respite care and interdisciplinary care teams, the regional centers have done a good job of coordinating services across many domains in the spectrum. So whether the regional center model could be adapted for schools, or whether a more specialty-based site like a regional center would make more sense to address children's mental health needs is an open question. The regional center provides a useful model. *Kelly Hardy*, *Children Now*: Two points I wanted to make for questions. We heard that there is not really a way to identify school-based services other than on the claim, and I'm wondering if DHCS has a way to identify a portion of services provided that are school-based services? My other question, to what extent is DHCS working with DOE on these cross-sector issues, and what can the panel/stakeholders be doing to help with that? *Marika Collins, Casa Pacifica Centers for Children & Families*: I want to briefly echo Dr. Arroyo's comments. We obviously have large tasks ahead of us with all of the things we've discussed – systems issues, silos, and payer systems. In the here and now, there are parents in schools trying to get services for their children and they don't know where to go. There should be a public campaign for parents and a task force should be put together to get this process started.
Member Updates	*Jan Schumann*: I think it's appropriate to make a motion that comments presented here by the panel should be presented in a bullet format for us to take a formal action in January. *Ellen Beck, M.D.:* We will work on looking at the language and creating a draft of the bulleted points. Are the panel members comfortable with that suggestion? The panel approved. *Terrie Stanley*: Looming is the reauthorization of Children's Health Insurance Program (CHIP) funding. At some point, we do need to address that. *Ellen Beck, M.D.*: Everything we can do to support the reauthorization of CHIP funding, so thank you for bringing that up. Please reinforce the message to our SB 75 clients.

	William Arroyo, M.D.: To that end, I'm chagrined we didn't bring up the CHIP reauthorization much up earlier. I move that this body write a recommendation to the administration to do everything in its power to ensure that CHIP is reauthorized. *Ellen Beck, M.D.*: It's not on the agenda, but for January, we'll put it on the agenda. *Kelly Hardy, Children Now*: Children Now and other children's groups are happy to provide the materials that we get on CHIP reauthorization, if that would be helpful? *Ellen Beck, M.D.*: I want to thank everyone who has not only presented but has worked on these issues. This is very challenging, but so very important.
Upcoming MCHAP Meetings/ Next Steps	Meeting Dates for 2017: • January 18, 2017 • April 18, 2017 • September 12, 2017 • November 1, 2017