State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

May 11, 2016

Meeting Minutes

Members Attending: Ellen Beck, M.D., Family Practice Physician Representative; Ron DiLuigi, Business Community Representative; Karen Lauterbach, Non-Profit Clinic Representative; Wendy Longwell, Parent Representative; Alice Mayall, Parent Representative; Paul Reggiardo, D.D.S, Licensed Practicing Dentist; Pamela Sakamoto, County Public Health Provider Representative; Sandra Reilly, Licensed Disproportionate Share Hospital Representative; Jan Schumann, Subscriber Representative; Terrie Stanley, CalOptima – Health Plan Representative; Elizabeth Stanley Salazar, Substance Abuse Provider Representative.

Attending by Phone: Marc Lerner, M.D., Education Representative

Not Attending: Jeffery Fisch, M.D., Pediatrician Representative; William Arroyo, M.D., Mental Health Provider Representative; Liliya Walsh, Parent Representative.

DHCS Staff: Jennifer Kent, Adam Weintraub, Sandra Williams; Alani Jackson; Laurie Weaver

Guests: Rhea Schumann

Others: Bobbie Wunsch and Laura Hogan, Pacific Health Consulting Group (PHCG)

Public Attendance: 15 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_051116.pdf
Meeting Minutes, Follow-Up, Opening Remarks by Director Kent	Minutes from March 16, 2016 were approved with minor amendments. http://www.dhcs.ca.gov/services/Documents/MCHAP%20March%2016%20Meeting%20Summary.pdf Director Kent announced that the May Revise for the state budget will be released May 13th. SB 75 is a significant positive step we will discuss as part of today's meeting. Budget pressures within health were alleviated by passage of the Managed Care Organization (MCO) tax because, although not final, it is expected to be resolved favorably. Implementation of the Medi-Cal 2020 Waiver has been a significant focus for DHCS since the last MCHAP meeting, including the Dental Transformation Initiative (DTI) to be

	discussed today and other initiatives such as the Whole Person Care (WPC) pilots. In addition, CCS Redesign continues. There are amendments to a current legislative bill on CCS Redesign that DHCS is reviewing and will engage with legislators and advocates to discuss. Finally, on May 24th, there is a Medi-Cal 50th Anniversary celebration. Advisory members were invited to the event. There will be speakers and a panel including Anne Schwartz from DC-based Medicaid and CHIP Payment and Access Commission (MACPAC); State Senate President pro Tempore (retired) Darrell Steinberg; State Senator Ed Hernandez; C. Dean Germano, CEO of Shasta Community Health Center, and State Assembly Speaker Emeritus John Pérez; a video featuring beneficiaries, the launch of a new mobile app and a new Beneficiary Identification Card (BIC). A smaller employee party is also being planned. Ellen Beck thanked DHCS for action on the follow-up list from the March 2016 meeting. One topic she recommends to be revisited from the list is the issue raised about inconsistencies between Spanish-language application forms and English language materials subsequently going out to families, which they do not understand. In addition, MCHAP will revisit basic literacy levels for forms and letters. Finally, the dental dashboard being prepared as part of the waiver should be regularly reviewed by MCHAP and this can be discussed as part of today's agenda. *Alice Mayall:* I want to raise the topic of member terms. Healthy Families had three-year terms. Is there a formal guideline for MCHAP? *Adam Weintraub, DHCS*: Current statute does not include term limits. MCHAP can set limits if it wants to set guidelines outside the statute. We are exploring the options for this and can put this on a future agenda for discussion. Currently, members would resign if they wish to leave the Advisory Panel. *Alice Mayall*: I want to mention AB 2007 (McCarty). It is a bill to prevent sport concussions that expands current statute for schools to cover club sports as well. There is huge financial cost to the state and personal cost as well that this bill addresses. I want to ask what the process is for MCHAP to consider signing on to a letter of support for AB 2007. *Jennifer Kent, DHCS:* This is probably in the appropriations committee suspense file due to the financial implications. At the end of each month, bills are released - or not - from the suspense file. There are several options for action. As a group of individuals, you can urge support to the Governor or directly to the legislature. Currently DHCS is not tracking this bill and the internal process for supporting legislation is quite lengthy. We cannot take an official position of support since we are not tracking it. That also means DHCS can't support your process, but MCHAP can send the letter to DHCS, the legislature, or the Governor. Individuals can also send a letter of support. Timing-wise, it will be viable in July when you have your next meeting if you choose to have a discussion of the bill. *Ellen Beck, M.D.*: Yes, the previous Healthy Families Committee supported bills. Perhaps Alice could send information around to members and draft a letter of support.

	Marc Lerner, M.D.: I appreciate Director Kent putting forward the information about the Free Care Rule and I encourage members to review this. This is important because school health services are an important source of care for low-income families and there are a number of questions remaining. This allows the Local Education Agency (LEA) to support Medi-Cal beneficiaries without requiring an Individual Education Plan (IEP) in order to receive health related services. I am not sure where it stands. Is there a commitment that schools may bill for Medi-Cal services provided at school without further action? What will help with more consistent approaches across school districts to implement billing? What is DHCS pursuing related to the recommendations in the SBHA letter? Will DHCS seek to limit services to students with IEPs? *Jennifer Kent, DHCS*: DHCS filed a State Plan Amendment (SPA) consistent with CMS direction. As to the question of whether we are going beyond what is federally requested, I think the answer is no. We are not seeking a waiver. I need to follow up with DHCS staff knowledgeable about LEA/MAA billing. There have been changes to the methodology related to claiming for costs for LEA billing so I prefer this to be informed by staff discussion. *Marc Lerner, M.D.*: A waiver would help overcome substantial barriers. Is there openness to further consideration of this? *Jennifer Kent, DHCS*: A waiver requires the school district to put up the nonfederal share. We can't require schools to do that and the state is not going to put up the nonfederal share. I need to understand this for more discussion. *Ellen Beck, M.D.*: Both of the member items (from Alice Mayall and Marc Lerner) should be put on the follow-up list.
Implementation of SB75 – Coverage for All; Sandra Williams, DHCS	Director Kent introduced Sandra Williams. She joins DHCS from Stanislaus County with extensive county eligibility experience. She is Chief of the Medi-Cal Eligibility Division and oversees staff, policy, technology and legal issues related to eligibility. Sandra Williams presented an update on SB 75. As of May 2016, there will be no child on restricted benefits in California. On March 22, DHCS held a webinar about the eligibility and enrollment plan for SB 75 and the process to transition children currently on restricted scope over to full-scope Medi-Cal. On April 15, letters were sent to existing restricted-scope Medi-Cal beneficiaries and a summary was handed out, available on the SB 75 web page, reporting county-by-county numbers for the outreach notices sent to restricted-scope beneficiaries in 13 threshold languages. In May, DHCS will post a provider bulletin to update them about the expansion and offer information about this new population. Implementation is set for May 16th and we will have the final word soon. System readiness is going well and is being assessed for the final confirmation about the 'go' date. Following the implementation date, there will be a batch system to convert children from restricted to full-scope Medi-Cal based on their application date, and anyone applying after implementation will be given full scope through their 19th

	birthday. We will continue to monitor the restricted aid codes until we shut down those aid codes for children. *Ellen Beck, M.D.*: Welcome. MCHAP had an extensive meeting agenda on SB 75 with outside presenters. Many of the issues raised over the discussion included potential fears from parents about applying for Medi-Cal such as reporting specifics about their income and expenses, Social Security numbers and other issues. Can you review the steps taken to overcome these fears? Also, given that enthusiasm can vary from county to county, is there outreach to counties and follow up to monitor how counties are progressing in enrolling all children? *Sandra Williams, DHCS*: I am not sure I can speak to all of your questions. On public charge, we have been doing work with the private foundations on messaging. The language is that Medi-Cal will not and never has used information submitted to us for anything other than determining eligibility for Medi-Cal. We understand fears remain and we are working hard to publicize this. There are posters in eligibility offices and a wide net of outreach to publicize the messages. On the application itself, I am not aware we have the ability to change the application. There has never been anything to indicate we share the information beyond Medi-Cal. *Jennifer Kent, DHCS*: Correct, we don't do customized applications. If someone doesn't fill in Social Security number, their eligibility is processed based on that. If you don't fill in an address, we process the application as homeless. We have electronic matching methods to verify status so we don't need to ask for follow up information. The application has not been modified; the system has been modified. *Ellen Beck, M.D.*: I understood guidance would be given to counties on what we just talked about. *Sandra Williams, DHCS*: Yes, there is a county workgroup on SB 75 and this information is also included in the monthly calls with all 58 counties. There is an immigration workgroup that has discussed messaging and other issues related to SB 75. There is no change related to public charge, however we are more proactive in getting the message out. In my experience, counties are generally excited about this opportunity. It is rewarding for eligibility workers to offer full-scope coverage to all children. *Jan Schumann*: We just went through annual eligibility renewal process as we were part of the transition from Healthy Families. We always withhold Social Security numbers to protect our children's identity and there has not been a problem. You mentioned information going out to providers to ensure children get into care and receive preventive care. What steps is DHCS taking to reach out and improve preventive care? *Sandra Williams, DHCS*: There is a notice going out to children who transitioned, with information about full-scope benefits and managed care. There will then be a 3rd notice in late May to beneficiaries about health plan enrollment along with a packet for choosing a plan. For non-COHS counties, they will have a packet of information about preventive care, how to pick a primary care physician and all the benefits they are eligible for under full

	scope. *Ellen Beck, M.D.*: In my experience, families have likely been getting preventive care through CHDP. What was missing was ongoing primary and specialty care and continuity of care. We should not make the assumption undocumented families are not receiving preventive care. *Jan Schumann*: I would like a report back to MCHAP on the number of transitioned children who do actually receive primary care and dental visits within one month. *Jennifer Kent, DHCS*: That will be difficult as there is such a lag in the information. Providers have a year to bill under fee-for-service (FFS). In managed care, the plans may be capitating the provider for primary care and not submitting claims. It may take some time. *Jan Schumann*: My interest is monitoring that they have true access not just a card. *Jennifer Kent, DHCS*: Yes, I understand and we will provide follow up. *Wendy Longwell*: I run a coalition in Shasta, Trinity and Siskiyou Counties, the Rural Health Coalition. There is confusion around SB 75. There are various organizations around the table who work with families, such as the FQHCs and Head Start. No one felt they knew how to answer questions for families or deal with problems. Families will be reaching out through schools, IHSS, Head Start, etc. How can we be sure the information trickles out? It concerned me because these are front line workers and they didn't know who to reach out to for answers. *Sandra Williams, DHCS*: March 22 was the eligibility plan roll-out webinar on eligibility criteria for county eligibility workers. There were teacher associations, foundations, and many others – about 1,000 participants. The plan is on the web site that will walk a person through how to apply, how they will be affected, what they are eligible for and all the information needed for front line workers. *Marc Lerner, M.D.*: What is going on through you or your partners related to public service announcements on this change? This is a pathway into coverage for mental health services for low-income children and I have not seen any coordinated activity using trusted voices such as First 5 or Mental Health Services Act in Orange County. *Jennifer Kent, DHCS*: The California Endowment (TCE) is spending millions on paid and free sources of media and outreach. We have worked with them and they are working with communication firms to develop outdoor ads on buses and through the ethnic media. *Ellen Beck, M.D.*: In San Diego, I have seen ads. *Karen Lauterbach:* In LA, we see this everywhere. I recommend the Health 4 All materials. TCE has a booklet that is free for download with good information and messages.

	Jennifer Kent, DHCS: There is no money in the state budget for outreach. We are working through our county partners. TCE and BSCF are doing the actual advertising outreach in partnership with the state. *Marc Lerner, M.D.*: Is there a web site with materials to answer those questions such as the issue raised about questions in rural counties? *Ellen Beck, M.D.*: I want to mention another organization, "All In", that is doing a great job with schools on this. *Sandra Reilly*: My question is about the aid code for SB 75 children – will there be a new aid code? *Sandra Williams, DHCS*: On the web page, there is information about aid codes. There was early discussion about coming up with a new aid code but we decided not to use any distinctions for the expansion. They will look like any other child (who is) eligible. Children will transition from a restricted aid code to a full-scope aid code. *Sandra Reilly*: For those who do not choose a primary care provider in a managed care county, 75% of the children will be defaulted into the county. We are in Pomona and are geographically distant from county facilities. It will be difficult for them and I want to be prepared to answer questions about why they are assigned to a provider 35 miles away. *Paul Reggiardo, D.D.S.*: My understanding is that this will add 175,000 children to the Denti-Cal delivery system. About 120,000 will move from restricted to full scope and about 50,000 will be new to Medi-Cal. *Ron DiLuigi*: Coming back to Marc's point, the issue of outreach comes up a lot everywhere - not just in rural areas. It is a major issue in urban areas as well. This is an exciting time. I think many here will remain friendly skeptics for some time. There is no way to over-tout the importance of outreach and enrollment. There has been a lot of finger pointing about who has responsibility for the lack of access. MCHAP will be watching closely to ensure success. *Jennifer Kent, DHCS*: Over the history with Medi-Cal, we have never had a true outreach and enrollment effort and 13 million are enrolled. One big difference between Covered CA and Healthy Families is that people have to be convinced to enroll in a program with cost-sharing. There is a big difference in needing to talk someone into premium-based programs compared to Medi-Cal. Here, people will be covered without doing anything. We understand the barriers related to immigration but many people will be covered with no negative consequences and we hope that disseminates out into the community. *Elizabeth Stanley Salazar*: It is disappointing to hear some counties may not be stepping in as a full partner to enroll all kids. Where they are all-in, let's celebrate. This doesn't succeed from saying 'do it.' It comes through some method of accountability. On a different topic, what have you run into related to issues or confusion about court-ordered placements, such as foster youth

	and probation? Have you run into problems; have counties raised issues; have you worked through this to ensure seamless access for kids in court-ordered placements? *Sandra Williams, DHCS*: Separate from SB 75, we are working to make this more seamless. Jail staff and probation are reaching out to families with information about eligibility and enrollment and it relies on parents to respond. For foster youth in placements, we are working on systematic instructions to counties to improve the system. *Elizabeth Stanley Salazar*: There is complication because they are detached from parents. There is more work to do. *Pamela Sakamoto*: In Solano County, county agencies are working to get the word out – perhaps elsewhere than eligibility workers. Public health and others within the county are excited and working hard to get the word out through clinics, schools and others. *Ellen Beck, M.D.*: We also want to get an update on Kaiser and what is or is not going to happen related to Kaiser in the transition. Also, what will happen when children they turn 19? *Sandra Williams, DHCS*: They will receive a letter, a notice of action, explaining the reduction in scope of benefits. Up to age 21, they will be eligible under the old Medi-Cal rules. *Ellen Beck, M.D.*: I think this needs more exploration – what will happen at age 19? Will they have to respond? What will the transition be? *Sandra Williams, DHCS*: They only respond if there happens to be an annual redetermination. That is a separate renewal process and requires them to respond. Otherwise, no. They will be notified they are eligible for restricted scope of benefits. Enrollment Updates 13.3 million beneficiaries as of December 2015 in Medi-Cal. Approximately 10.3 million are enrolled in Medi-Cal managed care and 5.6 million are children under 19. There is a handout report on applications pending adjudication that is over the threshold of 45 days. We send notices to counties and recently reached out for calls to understand more about the high levels of pending/over 45 day applications. We learned that many of these are duplicate applications and many of the children are already on Medi-Cal. We also learned that many were pending for a reason - and that the county is actively working with the family to determine eligibility. *Karen Lauterbach*: Did you see trends in particular counties? In LA, we are migrating to a new enrollment system and we have had issues with applications that just seem to disappear. Are those included? *Sandra Williams, DHCS*: There will be some applications that don't show up in this report. Only about 3,000 of the pending applications were due to system issues. Most of those have to do with denials showing up differently in CalHEERS vs the county system. We are offering technical assistance

	and we are seeing the numbers drop from over 30,000 to about 23,000 in one month. Counties are getting to about 80% of renewals. *Karen Lauterbach*: On renewals, LA is at only 8%. Why would that be? *Jennifer Kent, DHCS*: We are working on that. This report is only February numbers. There are differences in the eligibility systems for how counties work on cases and how they are counted across the different systems. For example, SAWS is going back into their system to see how they are capturing the data to make sure it is accurate. It is an example of how just publishing the data has generated action on the issue. *Alice Mayall*: I want to note that this is a good report and appreciate getting the data. Is there a way to show kids as part of this report? *Jennifer Kent, DHCS*: These are cases and may include kids. We can tell you how many kids are impacted, but parents are driving the redetermination so it may not be useful. *Ron DiLuigi*: What is the sense of why people drop off? Are there trends you watch? *Jennifer Kent, DHCS*: There is some information in CalHEERS. Some transition to Covered CA and we have information on that. Others move, choose not to continue, or get employer coverage that we don't know about. On trends, we do take note of differences between the county eligibility systems and are trying to work through those differences. On Kaiser, there is no specific update. DHCS wants all beneficiaries to be treated the same. The Endowment's message has been that all children should apply for Medi-Cal so they have restricted benefits and can transition on day one to full-scope benefits. To the extent Kaiser wants to continue subsidies for children for continuity purposes so they can stay in Kaiser while they go through the choice process, they may do that. DHCS wants all children to apply and go through the choice process for a plan and primary care provider. **Public Comment** *Janis Connallon, Children's Defense Fund*: As participants in the children's health coverage coalition, we are excited about SB 75 and DHCS implementation. It has exceeded our expectations. We are working with TCE to develop information for community organizations. The website is Health 4 All and it links to DHCS web site FAQs in English and Spanish. We conducted a recent webinar with 700 participants with detailed information about issues that might trip local communities. We are interested in what is happening with Kaiser and advocates would like to be helpful. *Terrie Stanley, CalOptima*: Kaiser is in our plan and in a number of other plans. We have had discussions on this issue as well. Kaiser is doing proactive outreach to ensure that all Kaiser Kids families know they have the choice to stay in Kaiser or go to another provider. This is an issue with FQHCs as well. The Medi-Cal plan cannot do that outreach, but if a family wants to stay with their provider, we are supporting that. Members have

	choice and this is no different than other transitions that have occurred. On the other hand, we also have continuity of care requirements, so if they want to move to a new provider and they have care needs, we will meet those as well. *Ellen Beck, M.D.*: It is difficult that there are families who don't know about this opportunity. We all have a role to play in getting the word out. DHCS has made a great effort. *Ellen Beck, M.D.*: Director Kent will take a few moments to swear in new members.
Proposed Dental Recommendations and Discussion	**Dental Sub-Committee** Presentation materials available at: http://www.dhcs.ca.gov/services/Documents/MCHAP_PedDentiCal_051116.pdf *Ellen Beck, M.D.*: We will turn to our discussion of recommendations to improve access to dental care. A memo was sent after the last meeting with some recommendations and today, we will discuss additional recommendations. Dr. Reggiardo offered an overview of the Dental Subcommittee and reviewed the five recommendations discussed at the January 2016 meeting. He noted that recommendation #4 (below) does not specify DHCS should set a benchmark target, however, that was the intent of the recommendation. Recommendation 4: Assess and report on actual network capacity and set beneficiary utilization goals. *Bobbie Wunsch, PHCG*: We can add information about setting a target to recommendation #4. Do you or other panel members have thoughts about what the target should be? *Paul Reggiardo, D.D.S:* I think this is a good conversation for us to have. *Ron DiLuigi*: Is there good rationale to adopt the Little Hoover Commission (recommendation) of 66%? *Alani Jackson, DHCS*: We set a target of increase of 10 percentage points over 5 years as part of the 1115 waiver Dental Transformation Initiative. We are currently at 50.9%. *Jennifer Kent, DHCS*: We are aiming to increase our utilization by 10 percentage points as part of the five-year waiver. There would be $10 million at risk in the waiver if we don't meet this target. *Alani Jackson, DHCS*: Each year over the five years, we are expected to hit a target of 2% increased utilization. There is $10 million total that can be earned. We are hoping the incentives will move the needle much faster than in the past. *Ellen Beck, M.D.*: This is a target that has been set through 2020?

	Jennifer Kent, DHCS: Yes, it is part of the waiver terms and conditions. I am happy to have targets so we know where we are and where we are going. I think the utilization is understated right now because it is only fee for service; it does not include FQHCs (Federally Qualified Health Centers). We want to work with clinics to better capture that data. *Marc Lerner, M.D.*: I am comfortable with the federal target number. I would like it to be reported on the dashboard. In addition, I hope the increase is not just capturing data for those already in care but also represents a real increase in the number receiving care. *Ron DiLuigi*: From the department's point of view, is it important to be consistent with 1115 waiver? Use the Little Hoover rate of 66%? *Jennifer Kent, DHCS*: It is up to the panel to determine their recommendation if you want to shoot for a higher target. The waiver can't change, so that target is 60%. I am not sure how the 66% target was established. I think we are all talking about the same ballpark. *Paul Reggiardo, D.D.S*: In the initial discussions, we didn't have any target so it is great to have a target and be able to monitor. In addition, part of this is to define the data so we are comparing the same information. Kids enrolled in a calendar year, 90 days, 180 days continuous enrollment? *Alani Jackson, DHCS*: Our reporting for the 10% increase target is tied to how we report continuous eligibility. *Ellen Beck, M.D.*: I think we should add to the recommendation to capture the data for FQHCs as well as health plans. *Elizabeth Stanley Salazar*: I think it is important to align to the waiver. The question is, 'can MCHAP support the waiver target?' and I hear that we do. *Laurie Weaver, DHCS*: The STCs (special terms and conditions) in the waiver do include data from all visits: FFS, health plans and FQHC. *Alani Jackson, DHCS*: Just to clarify, the 50.9% is based on "11 of 12 months", not the 180 days continuous enrollment. *Ellen Beck, M.D.*: I would like the group to review all the recommendations provided to date in the memo – 1 through 5 – and offer any comments or revisions to those so we can sign off on these recommendations before we move to additional recommendations. *Elizabeth Stanley Salazar*: In recommendation #1, the language of "targeted changes" is confusing although it becomes clear as you read the narrative. It is really about using targeted methods/targeted populations. *Paul Reggiardo, D.D.S*: The recommendations do accurately reflect the discussion and decisions of the January MCHAP. *Jan Schumann*: Can we set a goal on recommendation #4 for utilization that

	is higher than CMS? *Ellen Beck, M.D.*: We can set a recommendation to aim higher although we want to take care about the financial consequences. Is there consensus? *Paul Reggiardo, D.D.S*: I think the recommendation should include language of "no lower than CMS goal." Recommendation 6: Revisit the Medi-Cal Department of Health Care Services All Plan Letter 15-012 (Revised 8/21/15) and the Denti-Cal Provider Bulletin Vol 31, No 12 (August 2015) regarding modified General Anesthesia and IV Sedation policies. *Paul Reggiardo, D.D.S*: The original recommendation language was changed to "revisit" not retract. Subsequent to our discussion, the Little Hoover Commission issued its report with a recommendation that reads: The DHCS Care should overhaul the process of Treatment Authorization Requests. Dr. Reggiardo offered additional information and rationale for including a recommendation on this topic, including inconsistent authorization criteria by medical managed care plans, inappropriate denials and unnecessary appeals and delayed treatment. He offered actual examples of denials that resulted in delays of care and he indicated the All Plan Letter did not resolve the issues related to denials. *Ron DiLuigi*: A question for the department: is there a process you use to revisit letters? *Jennifer Kent, DHCS*: We issue All Plan Letters as guidance. If we agreed to change the policy guidance or wanted to clarify, we would retract the letter and re-issue a new letter. *Elizabeth Stanley Salazar*: I think this is a reasonable request. The field is asking for a deeper dive on this area to achieve more consistency. *Laurie Weaver, DHCS*: I want to mention that since the policy was issued, we have developed some clarification to the guidance. At the last meeting, Rene Mollow mentioned that we distributed technical assistance and training in early January to clarify this policy. The plans covering the vast majority do look at the data and are looking at the reasons for denials. We would like to go through that data to make a determination of trends or differences among the plans to offer an evidence-based recommendation about this. Thus far, we are seeing some patterns and we are working with those individual plans related to misinterpretation of the policy. We would appreciate allowing us to continue that process and return to you with information before revisiting the policy. While it appears there is standard language going out in the denials, there are instances where providers are not following the policy and not submitting the correct information. With clarification, they are moving through the process more quickly. *Paul Reggiardo, D.D.S*: I am delighted to hear that. I am not saying revise the letter. I am asking to revisit the issue. All I have is anecdotal information, not data. It would be enormously helpful to have DHCS review data and identify whether there is a problem, whether we need a fix.

	Laurie Weaver, DHCS: We would like to come back with more information. *Ellen Beck, M.D.*: I think using the language of "revisit and report back", rather than retract makes this recommendation something widely supported. *Alice Mayall*: I want to put this in context; is this part of a reaction to fraud? *Jennifer Kent, DHCS*: No this is different. When we changed the policy, we began tracking the data of denials, reasons and medical necessity from plans in different parts of the state. There are different billing patterns in different parts of the state. We see patterns on both sides – plans that were approving 100%; others with patterns of denials. We have a responsibility to children with developmental disabilities or other problems who need general anesthesia. We also need to walk a careful line to protect children as there have also been issues in other states of children dying from general anesthesia. We are happy to come back to you with data. *Ellen Beck, M.D.*: As the Healthy Families Advisory Panel, we struggled with the right balance on this issue and had concerns with the balance of access to services, but also that children were not unnecessarily being submitted to anesthesia. *Wendy Longwell*: This topic also was brought up during the rural coalition discussion. Our Medi-Cal plan has been looking for providers to do anesthesia and a place to conduct the service. We might find dentists willing but no place they can do it. It's not a denial – it's just that the space is never made available. Can MCHAP help with this? *Jennifer Kent, DHCS*: This is not isolated to you. Sutter closed a facility here in Sacramento that was a key access point. We acknowledge this is specialized and scarce and we are thinking about how we can help. We are also aware of this as we move consumers from Developmental Centers into the community. *Pamela Sakamoto*: Perhaps we can look at training sites for additional access such as the University of Pacific clinic in San Francisco or LaClinica facility in Alameda? *Jennifer Kent, DHCS*: Before leaving, Director Kent offered background and introductions of Alani Jackson as head of the Dental Services Division and Laurie Weaver as Deputy Director for the Eligibility Division, who will remain at the meeting to offer input. Recommendation 7: Establish and utilize the expertise of an independent Medi-Cal Dental Program Evidence-Based Policy Advisory Committee, the purpose of which would be to assess and make recommendations to the DHCS regarding the delivery of Denti-Cal services *Paul Reggiardo, D.D.S*: This recommendation was discussed preliminarily at last meeting. Subsequent to our meeting, the Little Hoover Commission included a very similar recommendation. In addition, a bill, SB 1098, was introduced that also calls for an advisory body. I suggest we leave this

	recommendation in the letter and modify it to add that it should be coordinated with the State Dental Director, California Department of Public Health and any advisory body established under SB 1098. *Elizabeth Stanley Salazar*: DHCS can and does have stakeholder groups but I think legislation is where action is needed to establish an advisory body. Perhaps we want to say we support legislation to develop such a body. Legislation might help by making an appropriation. *Ellen Beck, M.D.*: There are multiple considerations and we don't want to micromanage. One advantage of this Advisory Panel is consumer members and varied experience. We should think through the composition of the panel to include consumers and primary care participation on the body as well as dentists. *Elizabeth Stanley Salazar*: We should review the legislation introduced to see if we want to support it. I don't think support of the legislation goes into this memo. *Ellen Beck, M.D.*: Perhaps the recommendation should indicate we will review legislation and relevant opportunities. I want to add that I had a good conversation with the public health dental director. There is a new plan for public health and prevention developed. Primarily, our recommendations include access to services and network adequacy. Clearly, Medi-Cal also includes prevention activities. I think at some point we might want to include recommendations to support prevention activities. *Adam Weintraub, DHCS*: I want to add the information that, as written, the legislation SB 1098 includes one consumer member out of 15 members and all others are dental representatives. *Ellen Beck, M.D.*: We might want to consider recommending additional consumer members – perhaps a parent and adult – as well as suggesting non-dental provider such as a physician. *Alani Jackson, DHCS*: I want to add that the managed care dental advisory group for Sacramento includes plans, providers, consumers, parents, and advocates. In Los Angeles, for both FFS and managed care it is similar. There is also the state public health oral health advisory committee. . *Paul Reggiardo, D.D.S*: I think it is important that we not get into the weeds and we don't want to recommend a parallel group. We want to support what happens with legislation and the Little Hoover recommendations. Recommendation 8: Explore increased case management services to Denti-Cal beneficiaries and their families to overcome obstacles of limited oral health literacy, cultural attitudes and beliefs, transportation challenges, appointment compliance, follow-through with professional recommendations, and other barriers to good oral health *Paul Reggiardo, D.D.S*: The structure for this recommendation already exists inside CHDP. Many programs already have staff for case management or care coordination. The point is to tie eligibility to actual care and remove

	barriers. The barriers might be enrolling providers, increasing health literacy, removing transportation barriers, changing behavior – all the options for increasing case management and care coordination. *Laurie Weaver, DHCS*: The vast majority of children are enrolled in Medi-Cal managed care organizations because as part of ACA implementation, California expanded managed care to all counties. There is a mandate for all full-scope children to be in managed care. Plans are compensated for case management. For example, if there are issues with transportation, follow through or compliance, the plan should be managing this. We are discussing the DTI and domain 4 with CMS and including in local pilot programs some of the innovations you are discussing today of case management, education and other interventions that focus on domains 1-3 (preventive services, caries risk management, continuity of care). We will share examples, such as the ones you have discussed, with CMS and discuss with them what they see as being reimbursable. *Elizabeth Stanley Salazar*: This is a relatively new concept: integrated care and care management as part of managed care. What is currently expected in contracts related to care management? How is it incentivized? Are there best practices? Are dental services included? *Laurie Weaver, DHCS*: Care coordination/case management is a contract requirement. The plans must follow the American Academy of Pediatrics Bright Futures periodicity schedule which includes oral health, preventive exams and referral to a dental home. *Elizabeth Stanley Salazar*: This needs to be strengthened. We are requiring best practices but we need to support the plans in doing more with providers and strengthen compliance. *Laurie Weaver, DHCS:* The local dental pilots will allow us to test innovations and expand upon their success. We will measure performance measures and monitor overall performance to ensure the pilot is achieving success, then expand statewide what works. *Ellen Beck, M.D.*: I agree with a change in the language; instead of "explore" I would use strengthen, overcome obstacles to social determinants of health (SDOH), such as the examples listed. In addition, I don't want to lose the recommendation in the examples. You mention that case management is expected. How do we track whether, and how, a plan is doing on case management? *Laurie Weaver, DHCS:* We now have a quality monitoring division within Medi-Cal with responsibility to look at contract compliance and how plans are doing. This care coordination function is something they monitor. *Terrie Stanley*: From the plan perspective, all plans use medical management systems with integrated utilization management. One caution here is that plans do not have responsibility to pay for dental. Therefore, the concept of having plans monitor and report for kids in dental is not possible. We look at the whole child, however, if you are looking at dental specifically, we don't do that. I can tell you kids in case management, kids by risk level.

	We do health risk assessments for populations that require an HRA – now Seniors and Persons with Disabilities (SPD) and we want to expand to CCS kids who are not SPD. When you try to marry multiple specific activities, I can't report that unless we have claims data. *Ellen Beck, M.D.*: There are needs across the board; a child needs transportation to receive care whether it for an x-ray or dental. The purpose is to ensure that all kids get the care they need. *Terrie Stanley*: Yes, if we want to report on kids who are in case management and the services they are getting, I can do that. The issue is that we can't report on kids who receive the specific service types like dental or specialty mental health because they are carve outs. *Pamela Sakamoto*: There is a quandary here. We can explore/strengthen care management and coordination. It may not get the child into care. Many entities provide coordination and we have worked on this locally but have not seen improvement. We need a metric -- what is needed to address the problem -- and then monitor. We need to look at what we can measure first. *Ron DiLuigi*: Part of this discussion is influenced by current parameters in the system. However, we are moving in new directions and we aren't going to have carve-outs in the future. We need a broad perspective and we should not be impeded by existing parameters since we don't know where case management is going and how dental might be folded in. *Paul Reggiardo, D.D.S*: In terms of trying to increase dental services provided, this proposal is to have specific dental case management. There is a description of scope of responsibilities and services for someone in that capacity described. It is not the responsibility of the managed care plan to accomplish those duties. They are not charged with bringing kids into the system. This is a proposal to explore having a person responsible for case management at the local level as part of the existing EPSDT mandate that is not funded or implemented currently. *Kelly Hardy, Children Now*: The Los Angeles Medical Dental pilot involves working with plans to share the names of kids who have not utilized dental services with their primary care physicians so that they can write a prescription to see the dentist and help connect them to services. We would like to see that included in this or in another recommendation. *Alani Jackson, DHCS:* In addition, there is current legislation, AB 2207, that reiterates the role of case management for plans for both medical and dental. *Ellen Beck, M.D.*: We should see where that is in the process and look at that. *Elizabeth Stanley Salazar*: Everything is changing quickly and some recommendations were written several months ago now. We should be consistent with what is moving forward. We don't know that care management will make the difference. To use an old structure may not accomplish what we want. We should see what is innovative, such as the pilot Kelly described, and support that.

	Paul Reggiardo, D.D.S: These are new billing codes for dental case management for January 2017. There is a difference between billable and reimbursable. It is important because they are starting to define case management, coded and potentially reimbursed. The point now is to build data about what is being done. If we have a position at county level, they can look at these items moving forward. *Ellen Beck, M.D.*: It is excellent these are coming into play as a way to measure what is being done even if they are not reimbursed. My confusion is why we would want the case management person to be in CHDP. Even though historically that is where the staff were located, wouldn't we want them to be part of Medi-Cal? It would seem we would want someone to look widely – not just at CHDP. *Elizabeth Stanley Salazar*: We want to advance good practice yet the vehicle to pay for these things in the current system is not available. We have a conflict between the transactional/FFS world we are in now as opposed to the case rate/managed care world we are moving to. I am uncomfortable recommending adding transactional items. *Alani Jackson, DHCS*: I want to add that in domain 2, part of the incentive payment is about dental caries risk management and treatment plan. That may give us information on best practice and outcome data that might inform recommendations. *Paul Reggiardo, D.D.S*: We can increase fees to convince dentists to participate or change the scope of services, but that doesn't bring a child into care. This recommendation is to address those other barriers. *Ellen Beck, M.D.*: I hear consensus on the overall recommendation. It is the examples of how to implement that are a concern. Perhaps we can add, "identify existing best practices" rather than include the examples. *Marc Lerner, M.D.*: A lot of the work toward tele-dentistry and virtual home are important and support for those models will accomplish this recommendation. *Ron DiLuigi*: Of course, legislation is enabling; If we are talking about something that is restricting improvement, I think that is where MCHAP should be looking. We would hope that it advances both the policy direction and the financing. I would like to hear from DHCS on legislation such as AB 2207 - is DHCS taking a position? *Laurie Weaver, DHCS*: We do take positions and advise the administration although not all positions are made public. *Ellen Beck, M.D.*: Do you know if you are involved in this bill – AB 2207? *Alani Jackson, DHCS*: Yes, we have offered technical assistance. AB 2207 is currently in appropriations. *Jan Schumann*: I would like to move forward with this recommendation. We

	are only asking DHCS to explore options for the 40% (2.3 million children) not accessing dental services. *Ellen Beck, M.D.*: There is consensus for the language of the recommendation and to identify/explore new initiatives. We should delete the examples in order to keep it more global. *Paul Reggiardo, D.D.S*: The examples are only for explanation. *Laurie Weaver, DHCS*: I think this is consistent with DTI domain 4. We will be releasing a draft of the application for public comment and holding a webinar. Following that, we will release the final version. I think that it will fit nicely with this recommendation. *Adam Weintraub, DHCS*: AB 2207 is currently listed in appropriations. It is scheduled for hearing today but generally, the process would be to move it to the Suspense File until it can be weighed with a view of the big picture. *Ellen Beck, M.D.*: It sounds like this might be a good moment for us to review this legislation and consider a letter of support. *Elizabeth Stanley Salazar*: It is also important for us to distribute to other stakeholders and constituents. There may be a limit to what we do and others may care to weigh in. **Recommendation 9.** Eliminate or redesign the current managed dental care model in Sacramento and Los Angeles counties. *Paul Reggiardo, D.D.S*: If we go back and look at this pilot program over 20 years, it has had lower utilization rates, especially for kids under age 5, longer wait times for appointments, lower provider-to-patient ratios. There are reports that the utilization rate has doubled over the last four years. The program has failed providers and beneficiaries. With due respect to plans, if the program has changed, I would like to see that from DHCS. There are good models of managed care in other parts of the country. I think we should include the recommendation and have DHCS respond. *Ellen Beck, M.D.*: This is a huge recommendation and seems beyond our ability to address. I think the language goes too far. I hear a need for more information and I don't want to table dental recommendations overall to wait for more input. *Terrie Stanley*: One way we have been able to get improvement has been through mandatory public reporting. As you mention, the data has not been publicly available and shared. Rather than go with the recommendation as written, I think we could recommend routine mechanisms to share data publicly -- something like the star rating Medicare uses -- and begin to benchmark to allow consumers and advocates see true performance. *Ellen Beck, M.D.*: Can DHCS weigh in? Is the information Terrie and Paul are referencing available? Reportable? *Alani Jackson, DHCS*: DHCS recognizes the value of dental managed care

	plans. Publicly, there is a dental managed care report card annually to the legislature that includes information on utilization, providers and improvement projects. On the DHCS website, there are reports on performance benchmarks. Also, there is a Beneficiary Dental Exception (BDE) line that reports on requests to be transferred out of dental managed care to FFS. We have not had any requests. Also, DMHC does audits on medical loss ratio. *Elizabeth Stanley Salazar*: This recommendation as constructed expands our scope and role. This crosses from system oversight into contract compliance. I don't know the role of DHCS in compliance now. The way this is presented is outside of our scope as it is worded. I like the idea Terrie Stanley raises on getting a report card or dashboard. *Bobbie Wunsch, PHCG*: I suggest a meeting to learn about all the reports we heard about here that are currently being produced and learn about the state dental plan. I suggest we leave this recommendation out of the memo at this time. Once we know more, we may have a recommendation about the dental carve-out overall, or other items. We can then offer a second memo on dental. *Paul Reggiardo, D.D.S*: I agree that we move forward with the other eight recommendations and then follow up to look at this issue separately. *Ellen Beck, M.D.*: I like this idea. *Marc Lerner, M.D.*: I agree with this direction. If we want to accomplish the conditions in the waiver, we need DHCS to work with DMHC on a separate waiver progress report from the two managed care plans to monitor if they are making progress toward the conditions of the waiver. *Jan Schumann*: I move the memo, as modified and updated during this meeting, with recommendations 1-8 (deleting recommendation 9) be signed by the chair acting on behalf of the Medi-Cal Children's Health Advisory Panel and forwarded to DHCS Director Kent and that we continue the Dental Health Subcommittee to monitor and report back ongoing recommendations related to legislation and other items that are tabled. Panel members voted to move the memo forward. Dr. Beck thanked DHCS staff for their support.
Behavioral Health/Network Adequacy member reports	Elizabeth Stanley Salazar reported on progress of the Behavioral Health Subcommittee. She solicited input on what questions the panel would like to submit to DHCS to be addressed by a deep dive session. A consensus document was handed out at the last meeting including a format for DHCS to use for the deep dive: overview of the topic, DHCS vision/goals/related activities, best practices regarding data collection or reporting; current data being collected or leveraged, obstacles to achieving the vision and goals, and DHCS efforts to overcome barriers/updates to overcoming barriers. The topics of Mental Health systems of care and the Substance Use Disorders Services are unique and at different levels of development so they

	should be discussed in separate deep dive sessions. We want to solicit additional questions from advisory members and stakeholders through the web site. List of Questions to Inform 1. There are two systems of mental health care for Medi-Cal beneficiaries. Which data are available in regard to utilization of the mental health benefits in Medi-Cal managed care plans? In county specialty mental health system? Data from each system should include age, diagnosis, race/ethnicity, number of visits, number of in-patient stays 2. What is the current and past utilization of EPSDT Mental Health and Substance Use? What will be done to allow billing for SUDS under the existing EPSDT umbrella? 3. How has implementation of legislation and regulation of psychotropic drugs for children impacted utilization of these drugs? What standards of care have been established for these drugs? What type of education has been provided to primary care physicians? 4. How is network adequacy determined and verified for the mental health benefit in Medi-Cal managed care plans? For county systems? 5. What screening is in place in primary care for children's behavioral health services within managed care plans? What is planned for the future? What mental health conditions are being screened for in primary care? By whom and in what settings? 6. How is DHCS using the children's core data set and what are its plans for future use? 7. How will the mental health benefit be provided within SB 75? Will it mirror the bifurcated system currently in place? What guidance is being given to beneficiaries about how to seek mental health services? 8. In the new Continuum of Care Reform Initiative (AB 403) for foster children, therapeutic foster care services will be provided by foster parents hired by a foster care agency and reimbursed through EPSDT. What are the specific services? The dual relationship as therapist and parent may have ethical implications for the parent and supervising clinician. What are the guidelines and guidance DHCS will provide related to these regulations? 9. Therapeutic services are available to all full-scope Medi-Cal children, regardless of whether the child is in foster care. What populations might benefit from such a service? Are there guidelines in place for this service? How will the population be determined for services? What are the specific services that will be allowed? What other guidelines will be in place? *Ellen Beck, M.D.*: You will send this around to members and you are requesting that members suggest additional questions now and over next days. *Elizabeth Stanley Salazar*: Questions should be sent to DHCS MCHAP. This is meant as a general guide to DHCS for the deep dive. *Wendy Longwell*: One additional topic has to do with the split between the school and Medi-Cal. There is confusion about how this should function.

	There should be more guidance about how/when to access each system. *Elizabeth Stanley Salazar*: Perhaps the question is to clarify school-based mental health services and funding streams. *Wendy Longwell*: An additional issue is access to interpreter services for both field and clinic-based behavioral health services – both for language (Spanish) and for deaf (DHH). Often there is an interpreter in the clinic but not available for the home. *Elizabeth Stanley Salazar*: Is this a lack of providers, reimbursement or an issue with the system? *Ellen Beck, M.D.*: Some additional questions: 1) What specific mental health conditions are being screened for? 2) What are the trends in use of psychotropic medications? The risk? What programs or information is DHCS providing about alternatives? What is the incidence of poor outcomes related to psychotropic drugs? 3) How are adolescents reached? Are there targeted outreach services to identify and bring them into care? 4) What are the pros and cons of the mental health carve out? *Alice Mayall*: The data you are requesting on utilization may be difficult given new procedures to list as many diagnoses as possible. *Bobbie Wunsch, PHCG*: I don't think workforce for children's mental health was included. What are the strategies to ensure an adequate work force, psychiatrists and beyond? *Wendy Longwell*: How is the state moving forward on telehealth? *Wendy Longwell*: I would like to include more information and emphasis on hospital services for children based on a recent episode. A child came to the ED as 5150 and there was no placement anywhere that would take the child. He remained in the ED for 3 weeks until they decided he was stable and sent him home. There were no placements available for him. *Ellen Beck, M.D.*: At some point, we may want to invite the ombudsmen to present to us to discuss gaps in services or other trends. *Pamela Sakamoto*: I have the Network Adequacy subcommittee written report for how to approach a deep dive conversation. I will send the full report and list. The list of topics includes: Pre enrollment/pre-care issues to ensure a network is in place for the beneficiaries enrolled; After enrollment/care delivery issues; Post care and continuity of care issues. *Ron DiLuigi*: I think we should use the same methodology as the Behavioral Health subcommittee to solicit input to the deep dive.
Public Comment	*Wesley Sheffield, Young Minds Advocacy*: Our organization focuses on the mental health of children and I would like to offer questions for consideration. 1) On data, what types of services do children receive? We notice that

	children are more likely to receive low-intensity services (office-based therapy or medication management) and there is a gap in the more intensive services, such as crisis services, home services that are important as well. 2) On the issue of the relationship between the county and health plan systems, what is the overlap in eligibility criteria for the two systems? The health plan covers mild to moderate but the county system is defined by whether you need a service that is not available by a private provider. The mild to moderate is an adult framework and is causing difficulty, especially for those considered "moderate." 3. You might include a look at geographic disparities, especially in rural counties. 4. Finally, the issue of the relationship between special education and Medi-Cal. The State Auditor issued a report on this topic with recommendations that may be helpful to this topic. *Janis Connallon, Children's Defense Fund*: A few additional items for consideration: 1) Where do children go for crisis services and are they being treated in adult facilities? 2) Expanding on the relationship between schools and Medi-Cal Managed Care, there is supposed to be a referral loop between the systems. Is that happening? What are the arrangements between the systems? 3) There is confusion among families about how to qualify for EPSDT mental health services. What can be done to clarify the benefit and ensure network adequacy on EPSDT mental health service needs? 4) As you look at mental health services broadly, it would be good to include the topic of trauma-informed care in your inquiry. 5) The Western Center on Law and Poverty released recommendations based on the State Auditor report that might be helpful. *Arlene Ferrer, Inland Empire Health Plan*: Regarding a recent call with DHCS, there was a report on EPSDT partial hospitalization and short term clinical services. It was determined that the managed care plan would be responsible for hospital services and the county responsible for specialty mental health services. The question we have: How would DHCS recommend we approach facilities that do not accept Medi-Cal rates? *Elizabeth Stanley Salazar*: Are they providing partial hospitalization for non-Medi-Cal? *Arlene Ferrer, Inland Empire Health Plan*: Yes, but they have patients under 21 yet they are not accepting our patients. *Elizabeth Stanley Salazar*: We will explore that. *Adam Weintraub, DHCS*: Please send the details of the situation you are speaking about to the MCHAP mailbox. We will follow up sooner than the next meeting.
Upcoming MCHAP Meetings/ Next Steps	July 12, 2016 September 13, 2016 November 15, 2016
