State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

September 13, 2016

Meeting Minutes

Members Attending: Jan Schumann, Subscriber 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; Elizabeth Stanley Salazar, Substance Abuse Provider Representative; William Arroyo, M.D., Mental Health Provider Representative; Jeffery Fisch, M.D., Pediatrician Representative.

Attending by Phone: No members attended by phone.

Not Attending: Ellen Beck, M.D., Family Practice Physician Representative; Marc Lerner, M.D., Education Representative; Terrie Stanley, Health Plan Representative; Liliya Walsh, Parent Representative.

DHCS Staff: Jennifer Kent, Adam Weintraub, Sandra Williams; Alani Jackson; Karen Baylor, Erika Cristo, Marlies Perez, Anastasia Dodson, Sean Mulvey, Morgan Knoch

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

Public Attendance: 15 members of the public attended.

Opening Remarks and Introductions	*Jan Schumann,* MCHAP Acting 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 May 11, 2016 were approved. http://www.dhcs.ca.gov/services/Documents/MCHAP_MeetingSummary_051116.pdf *Adam Weintraub*, *DHCS*: The follow-up list was not distributed as everything on the list was being addressed by a presentation at this meeting or at the next meeting with one exception: Wendy Longwell raised some issues about

	inconsistencies between Spanish-language application forms and English language materials subsequently going out to families, which they do not understand. We did not identify any systemic issues on our end. Wendy indicates the problem has been resolved at the county level. Anastasia Dodson provided an overview of the Medi-Cal mobile app, which was launched at the Medi-Cal 50th Anniversary event. Currently, the app includes contact phone numbers for local enrollment, general information and health reminders. As we identify functions that will not duplicate other apps already in use, we will add new functions. Links to the Medi-Cal mobile app: https://play.google.com/store/apps/details?id=gov.ca.dhcs.MediCal&hl=en https://itunes.apple.com/us/app/medi-cal-app/id1097909509?mt=8 *Paul Reggiardo, D.D.S.:* Is there some type of functionality that will allow beneficiary identification for the provider or the office to access in the absence of a physical ID? *Anastasia Dodson:* We don't have anything like that yet and can certainly explore. However, one challenge as we cross that threshold with sending and receiving personal information is a much higher level of security required. When we get to that point, that's the consideration we would need to make.
Implementation of SB75 – Coverage for All; *Sandra* Williams, DHCS	Presentation materials available at: http://www.dhcs.ca.gov/services/Documents/SB75_presentation.pdf Sandra Williams presented an update on SB 75. On May 16, 2016, DHCS rolled out implementation of SB 75, which enrolled restricted scope children under the age of 19 regardless of immigration status into full-scope coverage. As of August 2016, approximately 97% of the estimated number, or 117,436 eligible children, have been transitioned. A deeper dive into the 3% is being conducted. Counties are reporting that many of these children have turned 19 and transitioned back into restricted scope Medi-Cal or were assessed for other coverages. From May through August 2016, approximately 20,000 newly eligible children have been enrolled in full-scope Medi-Cal. It is important to note that these children qualify for managed care and that a plan-choice packet is distributed to them. *Elizabeth Stanley Salazar:* Have you received any reports of barriers for new enrollees or other reports from the counties? *Sandra Williams, DHCS:* I have not, but if you do hear anything, we certainly would look into those barriers. *William Arroyo, M.D.:* To follow up on Elizabeth's question, do we track or calculate how many beneficiaries have been rejected for SB 75 enrollment?

	Sandra Williams, DHCS: Rejected for not having completed the application? *William Arroyo, M.D.:* Whatever the case might be. The Managed Risk Medical Insurance Board (MRMIB) would track those who were rejected and describe the reasons for such rejection for enrollment in the program. Does your unit track rejections? *Sandra Williams, DHCS:* We do track denials on the whole. For example, if someone applies for Medi-Cal and is subsequently denied, those numbers are tracked. For carving out SB 75 children, those numbers are not tracked. *William Arroyo, M.D.:* Do we know how many of those denials would apply under SB 75? *Sandra Williams, DHCS:* We do not track those children specifically. *William Arroyo, M.D.:* We would have a difficult time knowing what the obstacles for enrollment are for those people as opposed to the larger Medi-Cal Program. *Sandra Williams, DHCS:* SB 75 is going to aid any child under 19 regardless of immigration status. *William Arroyo, M.D.:* In theory, there is a population of children who are not citizens and would be eligible for enrollment under SB 75. However, to Elizabeth's original question, it may behoove DHCS to find out what the barriers were for those applicants in terms of enrollment. In terms of how the system is set up, it seems there's no way to get that information. *Sandra Williams, DHCS:* Currently, no. I can say we haven't seen a spike in denials. *Elizabeth Stanley Salazar:* This is a hidden population to a large extent and we all are concerned about health care services for early and well-child services for this population. My thought would be reaching out to the Federally Qualified Health Centers (FQHCs) in communities where those services would be delivered and solicit some feedback from them. *Ron DiLuigi:* Perhaps we could gather enhanced information from the entities funded through The California Endowment. They have the most focused outreach effort and it might be beneficial to plug into what they've observed. *Sandra Williams, DHCS:* We meet with The California Endowment regularly and will reach out to them for any observations. The California Endowment led the SB 75 outreach effort and continue encouraging applications. *Ron DiLuigi:* There have always been hidden pockets that we've had difficulty reaching. That's the caution you would hear from a group like this. *Karen Lauterbach:* As a representative of an FQHC, we have monitored our population and have not seen children turned away. We have our children

	transferred over in the correct way. Our biggest lift now are the families that don't want to apply at all due to concerns that it would cause problems with their immigration status. Overall, we've seen a pretty smooth transition. *Pamela Sakamoto:* The way we might be able to locate children is through the FQHCs that are operating and the clients, as Karen stated, that have chosen not to apply. Has the FQHC seen a decrease in the number of those that they are charging on sliding scales? They probably have that data tabulated locally and that may be one way to see if that number has indeed decreased or if it might be an area where we need to educate further in regard to SB 75 *Sandra Williams, DHCS:* We can see if The California Endowment has looked into it. *Wendy Longwell:* As a board member of a local FQHC, they had closed their doors to new members for a time due to lack of doctors and limited appointments available. They just reopened the doors to new clients. Their 'new' clients were actually the uninsured clientele they had previously, who now are approved for Medi-Cal. It was an interesting trend to see when the doors reopened; of the first 100 new clients, 80 of them were not new. *Alice Mayall:* There's a lack of periodic check-ins with the consumer with their experiences and barriers. *Elizabeth Stanley Salazar:* As a larger consideration for DHCS, we've had this huge increase in enrollment in Medi-Cal. There are many disadvantaged populations such as immigrant children and hidden populations, individuals leaving prison, or first time enrollees in health insurance. Are you tracking the trends in accessibility and the impact on provider accessibility, which I imagine is under enormous stress right now? 'How do we get more providers actively engaged?' is becoming a more critical issue across the state. *Bobbie Wunsch:* Sandra, can you talk more about the Plans' efforts to reach out to the Kaiser program and the Healthy Kids enrollees and the timeline for enrolling these populations in Medi-Cal? *Sandra Williams, DHCS:* I am not equipped to speak to that as I'm not involved in those efforts. *Bobbie Wunsch:* There are about 78,000 children enrolled in the Kaiser Child Health Program for undocumented children and the remaining Healthy Kids Program, who have insured undocumented children since 1998. Those children are starting to move into Medi-Cal in addition to the children already known to the state. Perhaps we could hear from Kaiser's perspective, Jeff? *Jeffery Fisch, M.D.:* From our perspective, it's clear that there is plenty of outreach and as I have said many times, the members are going to continue to come. We will continue see them and guide them into the new system once we've identified that they would fall into that category. *Jan Schumann:* As a panel, we are really concerned with the obstacles to

	enrollment. We should reach out to these organizations assisting these populations to determine what these obstacles are. The follow ups items may include education, access to providers, and consumer follow up. *Sandra Williams, DHCS:* Speaking to enrollment, we currently have 13.5 million beneficiaries enrolled in Medi-Cal as of February 2016 with about 10.5 million enrolled in the managed care realm. *William Arroyo, M.D.:* Do those numbers reflect those under the age of 21? *Sandra Williams, DHCS:* It reflects the total. *Jeffery Fisch, M.D:* What is the percentage of enrolled under the age of 21? *Sandra Williams:* We have about 5.7 million age 0-20 enrolled. In regard to Medi-Cal enrollee applications pending 45 days or more, we've had quite an improvement. Approximately 1% of our applications are pending at any given time. *Elizabeth Stanley Salazar:* When an individual falls into the Medi-Cal pending eligibility status category, how do they receive their health care? *Jan Schumann:* Just to clarify, the 4,657 children pending enrollment are still able to receive care currently? *Sandra Williams, DHCS*: The majority, if not all, 4,657 children pending eligibility are cases of duplication. These are instances where the county Statewide Automated Welfare System (SAWS) and CalHEERs systems need to sync up to adjudicate the case and close out the pending application. *William Arroyo, M.D.:* If an adult applicant has a pending application, can they receive services from a Medi-Cal provider while their application is pending? Can a child receive services while their application is pending? *Sandra Williams, DHCS:* An adult cannot. A child will not be pending; they will be determined eligible or conditionally eligible in the accelerated enrollment program and can receive services. *Pamela Sakamoto:* Are you referring to the CHDP Gateway Program? When they go into the clinic to be seen, they are put into the system that shows they are pending and receive full-scope Medi-Cal for a period of 60 days. *Sandra Williams, DHCS:* Systematically, that is what happens. *Karen Lauterbach:* If someone comes into an FQHC, they're required to put the beneficiary on a sliding fee; if they're under 100% of the federal poverty level, they will slide to 0. This places more burden on clinics. Usually the patients will get the care they need but there's a financial burden to the clinic.

	Sandra Williams, DHCS: They still can access care, but for all intents and purposes, it will not be Medi-Cal or showing in the Medi-Cal eligibility system as eligible. For the Medi-Cal March renewals data, of the 500,000 renewals due in March, approximately 88% were processed either prior to or in the month due. Roughly 78% continued on as Medi-Cal eligible. During the month of April, there were 400,000 renewals due, with 87% of those being processed either prior to or during the renewal month. Roughly 76% continued on as Medi-Cal eligible. For both percentages, 76% and 78%, the remaining 20% could represent those who discontinued, going on to Covered California, or were enrolled in some other coverage. *Karen Lauterbach:* For those not processed, what does that mean? *Sandra Williams, DHCS:* When you're talking about renewals from an eligibility perspective, there are cases that automatically go to the federal verification hub and the renewal is automatic for the next year. For cases with incompatible information, the customer is contacted and a packet is distributed for them to complete. This process could take several months; if the customer continues to make a good faith effort, we don't just discontinue the case, we continue to work with them. *Karen Lauterbach:* It seems like there's a big difference between the different systems: Leader Replacement System (LRS), C-IV, and CalWIN. Is there a reason for that? *Sandra Williams, DHCS:*
Update on Dental Transformation Initiative	Alani Jackson provided updates to the Dental Transformation Initiative (DTI) including specifics for each domain. She discussed the stakeholder engagement process for the DTI, including holding three webinars since May and continuous updates to the frequently asked questions on the web page. Domain 1 is statewide and aims to increase utilization of preventive services for children by 10 percentage points over five years. A waiver amendment was submitted to CMS on 8/15/16 and includes two changes, adding authority to provide partial incentive payments to provider service office locations that partially meet annual increase targets as well as revising the methodology used to determine the baseline metrics for incentive payments to new and existing service office locations. A Tribal Notice was posted on 7/14/16 for 30 days and no comments were received. We will send letters to provider offices with the baseline numbers for 2014 and the benchmark to receive an incentive payment. Domain 2 covers the Caries Risk Assessment (CRA) and disease management. The Domain 2 fact sheet was recently posted to the website as well as the CRA costing and county rankings. There are 11 pilot counties selected but dentists will opt-in within the county to participate and part of this opt-in process will be completion of a CRA training developed specific to this domain. The CRA tool was piloted by 11 dentists and will be finalized soon; the training will be developed for January 2017.

	Domain 3 will be implemented in 17 counties and aims to improve the continuity of care between a child beneficiary and their dental provider. The baseline year for data will be 2015 and we have collected this data for fee for service (FFS) and dental managed care (DMC); FFS provider baseline letters were sent out on 9/8/16. We continue to work on baseline data collection for FQHCs/SNCs. Domain 4, the Local Dental Pilot Project (LDPP), received 25 nonbinding letters of intent in May. Applications are due September 30th. Once the final selection is done, programs will begin February 15, 2017. *Paul Reggiardo, D.D.S:* When will the decisions be made as to which of those applicants will be granted the funding? *Alani Jackson, DHCS:* Decisions will be made in December or January. We're conscious of making a decision with enough time to include advanced funding. Update: LDPP applicants will be notified of DHCS' final decision on 12/6 with formal acceptance to DHCS by 1/15/17; LDPP programs will commence on 2/15/17. (see timeline: http://www.dhcs.ca.gov/provgovpart/Documents/LDPPApplicationTimeline07.28.16.pdf)
AB 2007: Concussion Bill Discussion	*Jan Schumann:* Next on our agenda is a discussion on the concussion bill AB 2007, led by Panel Member Alice Mayall. Alice Mayall discussed AB 2007, an addition of concussion prevention measures that would be extended to recreational leagues. This is currently in place for all schools. She asked the group to review the draft letter and respond as to whether the group would want to sign on to support the bill. Beyond this measure, she asked whether the group would want to consider other bills before the Legislature that relate to children's health. *Adam Weintraub, DHCS:* This legislation is sitting on the Governor's desk. Unless we provided notice on the agenda, a motion from the panel would not be appropriate because it would indicate the action as a whole. *Jan Schumann:* This will be circulated to the members to act independently and separately from the panel as a whole. This does lead to the discussion for what Alice suggested: what steps do we want to take as a panel in terms of addressing future legislative bills? *Adam Weintraub, DHCS:* This question came up previously in some of the agenda preparation discussions with Dr. Beck. There has been a question about resources at the Legislative and Governmental Affairs (LGA) section of DHCS and whether they have the resources to provide a separate tracking list for this body. We also could ask the Chair to reach out to some advocacy groups that track issues of interest to children and children's health and ask them to identify watch bills they feel are worthy of the panel's attention. I'm

	hoping to gather more information and present what we find at the November meeting to the panel. *Ron DiLuigi:* While I certainly think you should be sensitive to resources, DHCS does not track legislation? *Adam Weintraub, DHCS:* We track significant legislation. The Administration doesn't generally comment on legislation until we are actually asked to present those arguments before the legislature. *Ron DiLuigi:* Since the Panel is under your umbrella, are you concerned about taking positions that would be in violation of the policy approach you're referring to? *Adam Weintraub, DHCS:* This is an independent body and frequently you bring to our attention issues from a perspective that was perhaps not fully represented in earlier discussions. This is how we try to make policy better. We just want to find the best answer for the panel. *Ron DiLuigi:* I appreciate that. I would want to hear DHCS' perspective on significant proposed legislation or policy changes. I think we would also like to hear from the advocacy groups. If we could just have benefit of assessment on some of these things absent recommending a position. *Adam Weintraub, DHCS*: We're at early stages of these discussions. Much of the legislative analysis is done in-house, so we need to ensure that the people who have expertise in those areas are assessing the bills. We're trying to find a solution that has low impact on existing resources as possible and still gets you what you need. I should know quite a bit more ahead of the next meeting. *Bobbie Wunsch*: The panel would probably benefit from hearing DHCS' position but also having the children's advocacy groups research these issues and have in-depth expertise and perhaps a different perspective. We should look at both options going forward. *Jan Schumann:* It is our Panel's position that we are to advise DHCS and that should include legislative matters. *William Arroyo:* I would strongly endorse Bobbie's last statement. **Public Comment** *Ben Rubin, Children Now:* To the extent that the panel does look for outside resources, Children Now would be happy to provide those resources. We track legislation impacting children in Medi-Cal regularly. *Elizabeth Stanley Salazar:* Would it be possible to include panel members on the distribution list? *Ben Rubin, Children Now:* Yes.

General Updates	Director Kent provided general updates, including the work ongoing to finalize budget preparation for next year. Director Kent also provided updates to 1115 Waiver programs, including DTI and the Whole Person Care (WPC) pilot program. The WPC program allots $300 million per year to counties to collaborate with other county entities or community-based organizations to support Medi-Cal beneficiaries identified as high-cost users. We're hoping to announce the first round of applications and grants sometime in October. Director Kent provided an update about the federal managed care regulations that were released in May. The Department is continuing to review six regulations from the federal government: Managed Care regulations, Mental Health Parity, Home and Community Based Services (HCBS), Program of All-Inclusive Care for the Elderly (PACE), Emergency Preparedness, and Office of Civil Rights. DHCS is determining the impact of each of these regulations but also acknowledging the work or changes that each provider, plan, or county must comply with. Both the Mental Health Parity and managed care regulations dovetail because multiple systems within the Department must come in compliance with both. *Ron DiLuigi:* For the regulations, is it one regulation or are they varied in individual regulations? *Jennifer Kent, DHCS:* The managed care regulation, is one regulation that is 500 pages. The rest are each separate regulation packages: PACE, Home and Community Based, Mental Health Parity, Emergency Preparedness, and Office of Civil Rights. *Ron DiLuigi:* There may be some conflicting aspects of the regulation that isn't consistent, perhaps with some intent. I'm sure you're pointing those inconsistencies out? *Elizabeth Stanley Salazar:* Will implementing any of these regulations require legislation? *Jennifer Kent, DHCS:* Some may. There will be a discussion with our Department of Managed Health Care colleagues about where we set standards and what that means for commercial health plans. *Elizabeth Stanley Salazar:* Realistically, what do you see as the timeframe for rolling out to implementation? *Jennifer Kent, DHCS:* Each piece has a different timeframe; some pieces of the rule were effective 60 days after. The big changes to the network standards are effective in 2017; some of the rate changes go into effect in 2017-18; quality ratings and quality process improvement won't go into effect until 2020. Depending on the part of the rule, it has a different time standard. *Elizabeth Stanley Salazar:* Can you provide an update to the progress on Provider Application and Validation for Enrollment (PAVE)?

	Jennifer Kent, DHCS: We're in user acceptance testing (UAT) right now through October 12th or 13th. We have 90 physicians or providers that are doing UATs. We're looking to go live with our first set of providers later in October or the beginning of November. Providers will be documenting every step and logging any defects by completing the UAT. The PAVE providers are slated for the 1st phase, dental providers are slated for the 2nd phase, and the Drug Medi-Cal providers are 3rd phase.
MCHAP Dental Recommendations to DHCS	**Dental recommendation letter is available at:** http://www.dhcs.ca.gov/services/Documents/MCHAP_Final_Dental_Recs_091316.pdf Director Kent addressed recommendations 1 through 6 and agreed to provide a handout summarizing her responses prior tothe November 15 MCHAP meeting.
MCHAP Membership Guideline	Adam Weintraub outlined the proposed language on revised panel vacancy guidelines for discussion at the November meeting. The statute that created MCHAP doesn't address term length or when a vacancy occurs. The proposed language was adapted from other similar bodies. This could be one of several changes to the language. A representative from the Office of Legal Services will be at the November meeting in case any members have questions or would like to make recommendations. *Ron DiLuigi:* Is this simply a general review of our bylaws or is this something specific: do we have a vacancy? *Adam Weintraub, DHCS:* We noticed that there were certain gaps in the statute that weren't addressed and there are also some very specific provisions of the statute where circumstances have changed and they no longer apply. For example, one position is vacant on this panel that we can't fill. The statute says the member must be a parent with a child from a particular program and that program no longer exists. *William Arroyo, M.D.:* In reference to the handout provided to the members regarding the amendment to the bylaws, is (a)6 standard from some other document that DHCS uses for other bodies? There's a whole array of issues that the panel deals with and although at times there may be a perceived conflict of interest with one issue, there are enough other issues where there are absolutely no other conflicts. *Adam Weintraub, DHCS:* This was language from our legal services division from similar bodies, also created by statute and also intended to be advisory. Someone from legal services will be here at the next meeting and I'll flag that as an issue you'd like clarification on. *William Arroyo, M.D.:* Wherever there may be a conflict of interest, I would hope that the member of the panel would recuse him or herself from discussing or voting on such an issue.

	Adam Weintraub, DHCS: If it's the sentiment of the panel that it's better to strike that and handle on a case by case basis at the discretion of the chair, that is an amendment we can make at the November meeting. *Alice Mayall:* On the vacancy issue, missing three meetings is half of a year, so I'm wondering if it would make sense to change it to two meetings. In this case, unexcused means the panel member hasn't even contacted anyone. *Adam Weintraub, DHCS:* In our discussions with Dr. Beck, she expressed some interest in moving to a quarterly meeting schedule with the ability to add a fifth meeting if the panel's business required that. We could say two consecutive meetings; we could say six months, or whatever the panel feels is appropriate *Alice Mayall:* We should also address tenure during that meeting. *Pamela Sakamoto:* I am in agreement that unexcused vacancies should be limited to two meetings. We're representing the state and we want the positions from the members who are representing the state heard. If they are not here, there's a big void. *Jan Schumann:* As Adam said, we'll make these amendments, suggestions, and anything else at the November meeting.
Overview of Medi-Cal Behavioral Health Services	**Mental Health Overview** Presentation materials available here: http://www.dhcs.ca.gov/services/Documents/MHSUD_MCHAP_091316.pdf Elizabeth Stanley Salazar introduced Karen Baylor, Marlies Perez, and Erika Cristo from DHCS. The presentation included a global overview of how the behavioral health system has changed over time. Karen Baylor provided the history of the Specialty Mental Health Services (SMHS) and an overview of the Substance Use Disorder Services (SUDS). In 2012 through 2013, California transferred the former Mental Health and the Alcohol and Drug Programs Departments to DHCS. Ms. Baylor covered the timeline for the 1991 Realignment, Early and Periodic Screening Diagnosis and Treatment (EPSDT), 1915(b) SMHS Waiver, and the 2011 Realignment. Centers for Medicare & Medicaid (CMS) approved the 1115 Waiver for the Drug Medi-Cal Organized Delivery System (DMC-ODS) in 2015 for a period of 5 years. Ms. Baylor continued with an overview of how SUDS and MHSA are funded. Funding for SUDS can be provided by Drug Medi-Cal, the Substance Use Prevention and Treatment Block Grant, and State General Funds. Mental Health Services funding mechanisms include: Medi-Cal, Substance Abuse and Mental Health Services Administration (SAMHSA) Grants, 1991 Realignment, Mental Health Services Act, the 2011 Realignment, and

	County General Funds. **Substance Use Disorder (SUD) Services** Marlies Perez presented on the SUD Medicaid system, which is operated by State Plan services and also under the MediCal 2020 waiver known as the Drug MediCal-Organized Delivery System (DMC-ODS). Ms. Perez noted that SUDS are primarily carved out of the managed care system except for Screening, Brief Interventions, and Referral to Treatment (SBIRT) services. The DMC-ODS Waiver is for both adults and the youth populations, and does not override any EPSDT benefits for youth. Counties are looking to increase services to both the youth and adult populations. This is a significant redesign of services for providers, counties and the state level. An important distinction to note is that the waiver only applies to beneficiaries that reside in a county that opts in to the waiver. For Medi-Cal beneficiaries who live in a county that hasn't opted in, they will continue to receive the state plan services. 53 of 58 counties expressed an interest to opt-in; however, counties must submit an implementation plan for review and approval by DHCS and CMS. Ms. Perez discussed other elements of the DMC-ODS Waiver, which include utilization of American Society of Addiction Medicine (ASAM) criteria, new service modalities, care coordination, an integration plan, program integrity safeguards, state annual reviews, external quality review organization, complying with federal 438 requirements, an evaluation by the University of California of Los Angeles, and reporting of quality measures. **Specialty Mental Health Services (SMHS)** Erika Cristo presented on the 1915(b) SMHS Waiver, which has been in place since 1995.The Waiver allows for SMHS to be delivered through a managed care delivery system. There are 56 Mental Health Plans (MHPs) in California with two plans uniting in a joint partnership agreement, Sutter and Yuba, and Placer County acts as the MHP for Sierra County. DHCS conducts MHP triennial compliance reviews that include system reviews, and outpatient and inpatient chart reviews. Following the reviews, the plans receive a very detailed report of the findings. When areas of non-compliance are identified, the counties are required to submit a plan of correction identifying how they will come into compliance with those requirements. Ms. Cristo explained that MHPs and MCPs use memoranda of understanding (MOU) to ensure the coordination of mental health services to meet the needs of beneficiaries. Ms. Cristo provided an overview of the Continuum of Care Reform (CCR), which draws together a series of existing and new reforms to child welfare services. They are designed to be the statutory and policy framework to

	ensure services and supports are tailored toward the ultimate goal of maintaining a stable permanent family. Reliance on congregate care should be limited to short-term, therapeutic interventions that are just one part of a continuum of care available for children, youth and young adults Also provided was an overview of crisis services for children and youth: • Crisis Residential Treatment Service • Crisis Intervention • Crisis Stabilization • Psychiatric Health Facility • Psychiatric Inpatient Hospital • Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) *Jan Schumann:* To close out this topic, I'd like to ask for learnings and recommendations from County Behavioral Health Directors and Health Plans, Kim Suderman and Dr. Bill Arroyo. William Arroyo, M.D. provided comments about Los Angeles County. Slides are available: http://www.dhcs.ca.gov/services/Documents/LACounty_Mental_Health_MCHAP.pdf Dr. Arroyo offered an overview of services at the county level that are funded through a number of disparate resources from the state. He reviewed the services offered through the health plans, including care for mild-to-moderate impairment, and services provided through the county SMHS. Populations with non-serious mental health issues are served by primary care, Medi-Cal MCP providers, or FFS mental health providers. SMHS pursuant to California law are provided to Medi-Cal beneficiaries of each county through a county MHP contract with DHCS. Dr. Arroyo presented data on children receiving SMHS through the county: 92,860 or 5.3% of eligible total, were served and almost 60% of those served were Latino. He offered background on the MHSA and how it is used in Los Angeles. Every county has a local planning/stakeholder group that refines priorities for funding under MHSA. MHSA is about 1/3 of the mental health budget and has improved the prevention/early intervention services available. Slides included detailed service and outcome information for the Full Service Partnership and Transition Age Youth (TAY). Overall, there were positive changes in reducing homelessness, reduction in juvenile hall and hospitalizations. Specific to TAY, there are more days living independently and increases in employment. A major change over the twelve year MHSA history is that we no longer have beds in state hospitals filled by youth; they are now served in community settings. Dr. Arroyo spoke about the wide array of services available such as Katie A services, wrap around services, crisis stabilization, foster youth services and

	specialized services like home visitation. Kim Suderman, retired Yolo County Behavioral Health Director, provided comments about how services are provided. She reiterated that with mild-to-moderate services being provided by managed care plans, county MHPs now focused on severe/acute emotionally disturbed youth. Partnership is essential. Beyond managed care plans and private providers, counties partner with juvenile justice, probation, child welfare, schools, regional centers and pediatricians. There are many contracts with local community organizations to provide services beyond that offered by county staff in order to form the full continuum that is needed. Today, counties are working on CCR and a large part of that is reducing congregate care, preferably in the patient's own home, but if not, then placement with a family. This can require out of county placements that necessitates coordination. These are significant changes to how counties function and serve children. *Wendy Longwell*: I am from the far north. I hear about county mental health services not meshing well with school mental health services. There is too much leeway in what services are available and how they are provided while families fall apart. Preschoolers being told to go home because of behavior and expelled in kindergarten because they aren't receiving services. There are no inpatient pediatric beds and hospitals reject cases – leaving people in the ER. Programs that say if you don't have language, you won't benefit from our program. How can we address these challenges from a statewide perspective? *William Arroyo, M.D.:* You remind us that mental health services are not only within managed care, FFS and counties. There is an entitlement through education that was transferred to county mental health 25 years ago, but more recently went back to schools. The entitlement remains intact to ensure an evaluation through the school district. *Bobbie Wunsch:* The next MCHAP meeting will include a presentation by Dr. Lerner on school mental health services. *Jan Schumann*: My question is for DHCS on Mental Health Plan compliance related to Quality Assurance Monitoring of 24/7 Test Calls; is there a maximum wait time on calls? *Erika Cristo, DHCS:* There is not a specified number of rings or wait time although we do look at whether someone can get directly to a person to talk to when we monitor. *Elizabeth Stanley-Salazar*: I recognize that the system is moving forward in ways that are significant. I applaud that. The substance use world is just coming to a point of becoming a more comprehensive system. What has been the impact of having separate systems for substance use disorders and mental health for services, payments and everything? *William Arroyo, M.D.:* CDC data says 5% of all youth have a substance use

	disorder and 4% of all youth have alcohol disorder. We need to do a much better job. The longer their condition persists, the poorer the outcomes. The new waiver will help and we are waiting anxiously to see this happen. DHCS has taken leadership but we have a long way to go. The mandate exists in EPSDT but it will require restructuring of the current system. *Karen Baylor, DHCS*: We hope this has been a good overview and we look forward to providing more in-depth information as needed.
Member Updates	*Jan Schumann*: What are the next steps on our presentation today? *Bobbie Wunsch*: The next meeting will go in-depth into school services and we have invited managed care health plans to speak to mild-moderate services and coordinating with Mental Health Plans. *Elizabeth Stanley-Salazar*: Today's discussion was a good start. We have a baseline understanding of the structure and financing. There are so many partners – schools, managed care plans, mental health plans – and it is good to hear from them. We also need to hear from the state associations. I want to hear from various representatives including advocacy groups about what is happening on the ground and what are the best practices. *Karen Lauterbach:* That would be good. *Wendy Longwell*: I would expand the invitation on MCPs to be sure that Beacon is represented since they are the contractor for managed care plans like Partnership Health Plan. We need to be sure the right people are here. *William Arroyo, M.D.*: Given the discussion on early childhood, we may need to have a discussion on schools and early childhood including the entitlement in Part C. *Wendy Longwell*: I think that is a good idea. My understanding is that each county (SELPA) chooses how to implement. That makes it difficult to discuss because it will differ across the state. In the six counties I work in, each is different. *William Arroyo, M.D.*: There are federal timeframes for getting the evaluations that don't vary and getting that information would at least provide a basic overview. Becoming more familiar with the entitlements for young children would be useful. *Wendy Longwell*: That is correct. The differences are in how the county conducts the evaluation and how access to services work varies. *William Arroyo, M.D.:* What has occurred in some jurisdictions, legal advocates or attorneys have intervened to ensure that parents are fully informed. Perhaps an attorney would be helpful to the group. *Jan Schumann*: Thank you for the recommendations for moving this forward.

Public Comment	*Lynn Thull: CA Alliance for Child and Family Services:* Two main points I want to emphasize. 1) Medical necessity criteria and entitlement has been discussed today from the adult point of view. EPSDT specialty mental health entitlement is under 183210 – a different section. There is nothing that specifies mild, moderate or severe. If there is an impairment, it needs to be treated and improved. The guidance from CMS also says that EPSDT covers physical health, substance use and mental health regardless of whether it is covered under the state mental health plan. EPSDT is up to age 21. The services are result of litigation and we need to do what is required without the cycle of litigation. 2) I am glad that DHCS is correcting the slides to include Crisis Residential Service. It is included in the state plan but the licensing only applies to age 18 and over. There is a bill on the Governor's desk to correct the licensing gap. We hope DHCS will encourage signature of the bill I will provide my other comments in writing. *Linda Nguy, Western Center on Law and Poverty*: I have a related question to Wendy's comments on education. Is this advisory body monitoring the quality of collaboration between schools and county mental health services? Are there recommendations? *Lisa Eisenberg, CA School Based Health Alliance*: I am happy that school-based mental health services were raised here. I want to encourage you go beyond the educational mental health and special education mental health services discussed here, but also to provide the medically necessary mental health services in a school setting. There is a unique opportunity to partner between schools, County Mental Health Plans and managed care plans to provide care in school settings. It is a challenge and a tricky conversation but I encourage this group to take on this topic. *Janis Connallon, Children's Defense Fund*: I have heard that parents are afraid to take their children to the ER for psychiatric conditions because they will not be able to stay with them during inpatient care? Is that a problem and how widespread is this? What standards do we have on pediatric specific inpatient care?
Public Comment Items not on the Agenda	*Lynn Thull: CA Alliance for Child and Family Services*: A bill, SB833, creates funding for children's crisis stabilization, residential and respite services. Funding will be available soon. Please communicate with your counties to look for this funding opportunity.
Upcoming MCHAP Meetings/ Next Steps	Next Meeting: November 15, 2016 Meeting Dates for 2017: • January 18, 2017

	• April 18, 2017 • September 12, 2017 • November 1, 2017