State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

September 10, 2015

Meeting Minutes

Members in attendance: Ellen Beck, M.D., Family Practice Physician Representative; Karen Lauterbach, Non-Profit Clinic Representative; Jan Schumann, Subscriber Representative; Marc Lerner, M.D., Education Representative; Jeffery Fisch, M.D., Pediatrician Representative; William Arroyo, M.D., Mental Health Provider Representative; Ron DiLuigi, Business Community Representative; Pamela Sakamoto, County Public Health Provider Representative; Alice Mayall, Subscriber Representative; Wendy Longwell, Parent Representative; Sandra Reilly, Licensed Disproportionate Share Hospital Representative

Members not in attendance: Elizabeth Stanley-Salazar, Substance Abuse Provider Representative; Paul Reggiardo, D.D.S, Licensed Practicing Dentist

Attending by Phone: There are no members participating by phone

DCHS Staff in attendance: Jennifer Kent, Director; Rene Mollow, Jim Watkins, Adam Weintraub, Norman Williams.

Public Attendance: Nine members of public attending.

Opening Remarks and Introductions	*Ellen Beck*, MD, chair welcomed members and the public and facilitated introductions. The agenda order was modified to accommodate Director Kent's schedule.
New subcommittees: schedule, plans, timelines	Three subcommittees were created at the previous meeting (in addition to the Pediatric Dashboard Subcommittee): Dental; Network Adequacy; Mental Health And Substance Abuse. The chair of each subcommittee offered a short update on their work to date. There will be additional meetings over the next several months. Draft recommendations from all subcommittees will be the focus of the January MCHAP agenda. Subcommittees will be considered work groups and have less than a quorum of MCHAP members so their meetings are not subject to the Brown act. Dental: Subcommittee has not met. Mental Health And Substance Abuse: Karen Lauterbach reported three priority areas of focus for the group: 1) understand changes in Drug Medi-Cal and how they will impact children; 2) review access and utilization data to

understand adequacy; 3) understand the degree of integration/seamless communication between primary care and mental health providers. There will be two additional meetings prior to November.

Member Questions/Comments

Marc Lerner: We agreed our continuous focus is both mental health and substance abuse. In addition, we want to include a broad data review and look at how data emerging under the waiver can contribute to our work. Also, we want to think through how to include mental health and substance abuse indicators in the dashboard. We will move issues related to mental health and substance abuse adequacy to the network adequacy subcommittee.

Ron DiLuigi: Are the Mental Health and Substance Use waivers one in the same?

Jennifer Kent: There are two waivers approved. One is the specialty mental health services 1915b waiver; the other is a substance use disorder services/Drug Medi-Cal amendment to the 1115 Waiver. The 1915 waiver allows county mental health plans to provide services to seriously mental ill patients. The Drug Medi-Cal amendment is to allow counties to provide substance use disorder services via a voluntary opt-in to the waiver. We expect that most, probably 54 of 58, counties are likely to opt in to the Drug Medi-Cal waiver.

Network Adequacy: Sandy Reilly reported that the subcommittee discussed how to narrow the scope of the network adequacy discussion because it is a large topic. Focus will be on three areas: 1) prompt and efficient determination of eligibility and enrollment; 2) reviewing network adequacy with a definition of “right care at the right time;” is it close, timely, meeting the need of the child?; and, 3) adequate oversight and accountability will also be a focus. This is part of the already active discussion of adequacy occurring for Medi-Cal managed care and commercial populations.

Wendy Longwell: I want to share an example. My son had hip pain that was keeping him in bed. He was referred to an orthopedic clinic. His original appointment was in June and the orthopedic appointment was set for November. Waiting from June to November with constant pain shows that “right care at the right time” is not happening.

Ron DiLuigi: On eligibility determination, the current process is cumbersome and takes a long time. This is essential for adequate care -- we need to get people into coverage and get them into networks quickly.

Jeffery Fisch: The other point on eligibility is that we need to understand who is in the system in order to address the needs for an adequate network. Knowing who the population is will help with the other questions we want to address.

Ellen Beck: As a member of the group, we want to understand the current mechanism of accountability for the health plans and providers. We need to understand the accountability because there seems to be a major discrepancy between the reports and the experience of beneficiaries. What can be done to address the gaps?

Update on CCS RSAB Process and DHCS Proposal for CCS	Jennifer Kent provided an update on CCS. We have engaged many stakeholders over the past few months. DHCS had released a proposal in June to move CCS children into managed care in 5 of 6 County Organized Health Systems (COHS) counties no earlier than January 2017. This is dependent on meeting all of the network adequacy and other readiness issues prior to launch. DHCS has refined the proposal and offered statutory language reflecting input and stakeholder concerns about other counties. I have spoken to some of you on realignment issues related to financing of CCS. Based on this, we offered a number of amendments -- to make any carve-in contingent on evaluation of COHS experience; delaying Orange County to 2017 based on its large size; requiring each health plan to create a CCS clinical advisory panel based on provider concerns about authorizations and medical decisions. The bill is on the governor's desk without these amendments and we are now in an administrative process where we do not share recommendations on the bill. However, the continuation of the carve-out does not change the timeline. We are working with plans on implementation and improvements that need to be made -- managed care or not, such as eligibility determinations; standardized care plans for CCS children across spectrum of services; and, how to do a better job of behavioral health services for CCS children. <u>Member Questions/Comments</u> *Jan Schumann*: I want to encourage DHCS to include/require subscribers on the health plan advisory panels. *Jennifer Kent*: Thank you. That is a requirement. We are working on contract amendments with plans and will be sharing the boilerplate contract amendment for CCS populations. We are requiring COHS plans to have a family/subscriber panel for feedback. *Marc Lerner*: Care coordination is also a concern. Contracts between county mental health and primary care don't require tracking of mental health communication across the providers. In terms of contract amendments, it would be useful to include a request for some tracking across mental health and primary care. *Wendy Longwell*: One of my concerns as a parent is the timeliness of Medi-Cal vs CCS. My son has multiple coverages. When I deal with CCS, getting authorization for equipment to go home from a hospital stay is fast. Medi-Cal requires a treatment authorization request (TAR) and it takes a long time. This can mean he may stay in the hospital longer or need to go to the ED. I hope you are looking at this, the quick determination, as an issue. *Jennifer Kent*: This is a good point and an example of what we are trying to solve. Currently, when you go to a Medi-Cal plan for authorization, and it is not within their scope, the plan must send the denial to CCS. There is gray area that can cause a ping-pong about who has responsibility. We are trying to clarify who is authorizing and who is paying so families don't experience that delay. *Wendy Longwell*: I know what is Medi-Cal and what is a CCS responsibility and I still have these problems. Often, it is not an issue of Medi-Cal vs CCS because even when it is straight Medi-Cal, there are problems. It is more complicated to get approvals in Medi-Cal.

	Ellen Beck: The issue Jan raised is that subscriber members should be incorporated into the advisory group – not structured as a separate group. Also, I think the areas we identified for subcommittees are good topics for ongoing attention, not just related to CCS but also for Medi-Cal, because the issues are problematic and the solutions identified here might hold promise beyond CCS. Public Comment *Bert Lubin, UCSF Benioff Children's Hospital*: I am concerned there are inadequate numbers of mental health and dental providers across the state. Do you have an assessment of the number of providers? Should we look at alternate ways to get mental health services to kids? *Jennifer Kent*: On dental, I will defer to Rene Mollow who is here today. On the mental health side, we work closely with county mental health plans and have a survey out now on this topic to identify services available. We have heard about mobile vans and other extensions of networks. There is a focus on foster care youth and there is concern about psychotropic drugs. In some counties, there are no psychiatrists. That is where telemedicine and e-consult come in to address this. We are adding monitoring and new adequacy requirements on mental health. This has not been done in the past and we will work with counties to implement.
Review and Approval of July 16, 2015	The chair returned to the original order of the agenda. The legislative charge for the advisory panel was read aloud by member Marc Lerner (see agenda for legislative charge). http://www.dhcs.ca.gov/services/Pages/091015MeetingMaterials.aspx
Update on Timeline, Planning Process and Progress Toward Implementation of SB 75 (Coverage For all Children) and Discussion	Rene Mollow, Deputy Director for Health Care Benefits and Eligibility, DHCS, provided an update on SB 75. SB 75 affords full scope Medi-Cal for children, under age 19, otherwise eligible for Medi-Cal except for immigration status. The implementation focus of SB 75 is on eligibility and enrollment. There are 170,000 eligible children statewide and we are currently covering 120,000 of them through restricted scope Medi-Cal. Therefore, there are two populations to bring into full scope Medi-Cal: those currently receiving restricted scope Medi-Cal and those individuals who will be newly enrolled. The systems must be in place by May 2016 or when the Director makes a declaration that CalHEERS, the eligibility and enrollment system, is ready for SB 75 implementation. We are looking at system changes to enroll new children and to transition those in restricted Medi-Cal into full scope without additional steps. Our efforts also include working with stakeholders. We have had a process of working with stakeholders on eligibility and enrollment through AB1296 and there is a subcommittee on immigration. We will work with this group for SB75 as well. Foundations have approached DHCS about additional outreach that can be accomplished to families who may have children eligible under SB 75. The SB 75 enrollees will be mandatorily enrolled in managed care, just as are other children in Medi-Cal. We are working through the details of moving restricted-scope children who are currently in Fee For Service (FFS) Medi-Cal but with this change will be enrolled in managed care. Member Questions/Comments *Ron DiLuigi*: To clarify, in the new program all children will be in managed care? *Rene Mollow*: Yes. For those newly enrolled, they will be treated the same as all other children enrolled in Medi-Cal. What we are working through now is

	how to inform those in the FFS environment to be sure the transition is smooth. We have now made many transitions similar to this and that helps us with this implementation. One of the notices will be helping them enroll in a managed care plan. *Sandy Reilly:* Will this be like the Medi-Cal Adult Expansion (MCE)? Will this be part of a default if they don't choose a primary care provider? Will they be defaulted into a county system? *Rene Mollow*: Yes, they will have aid codes under the current program. Now, they are under PRUCOL. Under SB 75, they will be notified that they have full scope Medi-Cal. Then, they will have a choice to enroll in a health plan and, in some counties, dental. If they do not make a selection, they will be defaulted into a health plan. Everyone in Medi-Cal is identified by aid codes and we are not creating new aid codes. We will match them to the aid code most appropriate. *Marc Lerner*: Can you distinguish between restricted and full scope care services? *Rene Mollow*: Restricted aid codes provide pregnancy and emergency services. *Marc Lerner*: So other than income documentation, I assume all children under age 19 should have access available? Who will remain uncovered? *Rene Mollow*: They could remain uncovered if they don't apply. When they apply, we will ask for information and they need to let us know if they are a citizen so we can put them into the right category. Some will be covered by state general funds and some by federal funds. Where we can, pregnancy and emergency services will be claimed (to draw down federal funds.) *Marc Lerner*: There is a requirement that schools be involved in notifying families about health coverage options. Will there be resources for nurses or administrators to speak to this new coverage and how this could impact their ability to obtain legal status? *Rene Mollow*: That is part of what we will look to stakeholders to help us with – how to identify where and how to do outreach. *Marc Lerner*: I think this is part of our charge and this panel would want to be part of this, in addition to other stakeholders. *Ellen Beck*: Do the stakeholders include potential subscribers and undocumented parents? *Rene Mollow*: We are still working through this. We have not solidified the process but are looking to how foundations can help with outreach to families. DHCS (is not looking to take on the role of) doing outreach. We will work through stakeholders to identify families to work with us. *Ellen Beck*: The information is available in English and Spanish, correct? *Rene Mollow:* Yes, it is the regular system currently available. *Ellen Beck*: Will the parent be required to give a Social Security number? We worked on this in our clinic and the consistent reason for not enrolling children was fear of immigration. We need to address this fear. A simple way to remove a barrier is to not require the Social Security number.

	Rene Mollow: The system has to be re-programmed based on this new policy. A Social Security number is required as part of the program - although someone can receive temporary coverage while they secure a Social Security number. If they do not respond or respond they do not have the Social Security number, they will be (placed in the appropriate coverage group for) their citizenship status. *Ellen Beck*: This is a deterrent for parents, a barrier, because the system bounces back at the parent. The other piece is using church, school and other places where people already feel safe. Finally, I am wondering whether there will be a system to roll children covered under Kaiser Care for Kids into Medi-Cal? *Rene Mollow*: Those are good points. Irrespective of SB 75, we have been working on some changes related to Social Security numbers to remove this barrier. Messaging is part of what we are working on. The Kaiser program children will represent new children because they are not known to our system. One question we have been asked is how we can work with local programs to transition children who have county-based programs. For example, would they have to use Kaiser? No, they always have an option of where to enroll. The county programs may also include children above the Medi-Cal income limits. The application information to the state is only for our use – not for any other purpose. *Karen Lauterbach*: Will this expansion impact how they get gateway Medi-Cal? *Rene Mollow*: Through the gateway programs, children are getting full scope Medi-Cal for 60 days. *Karen Lauterbach:* There are some who were previously known to Medi-Cal and they get restricted Medi-Cal. *Rene Mollow*: The rules wouldn't change but the way we use the gateway programs will change. It is self-attested and not verified. CHDP and gateway programs do not connect to CalHEERS, the online eligibility and enrollment program. If you are aware of cases that are incorrect and can provide us a sample, we can work on that. <u>Public Comment</u> *Wesley Samms, California Coverage and Health Initiatives*: We are a statewide network working to get folks into coverage and we manage several of the local programs. I want to clarify that immigration status is going to be verified as part of the process? Also, you said Social Security numbers are required and you are making this not required? *Rene Mollow*: Today, we ask for immigration status and depending on how they respond determines the next step. Part of getting ready is the programming behind this. Currently, a parent's Social Security number is requested as well as the child's. We are changing the system to not ask for the parent's number (if they are not applying for coverage). It will not stop eligibility if the child does not have Social Security number. *Marc Lerner*: Will the individual pages in the application system let the applicant know, 'your application will continue even though you do not a social security number'? *Ellen Beck*: This is on our agenda for the November meeting. However, if we have consensus now that this information about not having a Social Security

	number for the family be available in real time, we can make that recommendation. *Rene Mollow*: We can get screen shots for each area of the application to help explain how this will work. Currently, people apply and can get covered without a Social Security number. We are making changes and improvements based on SB 75 and we are looking for input to these changes. *Hellan Dowden, California Teachers for Healthy Kids*: One thing we learned through our work with school districts for more than 15 years, is that many times the addresses are wrong. Many (addresses for) restricted scope Medi-Cal are in the system for a very long time and are not accurate. We are concerned you will reach out to families through these inaccurate addresses. Schools do have the address; they know who the kids are through school applications We have discussed with some large districts about how we might run school data against Medi-Cal data to find and enroll the children efficiently. It will require some privacy considerations. We look forward to working with you on this. *Rene Mollow*: Of the 120,000, we are looking at current, active enrollment so we think those addresses are accurate. *Ellen Beck*: I want to ensure that these practical suggestions are sent to DHCS and to this committee. *Rene Mollow*: We have set up an email inbox for input. Please send input and I encourage it to be practical and feasible. The effective date is May 2016, however this is an iterative process. An initial push on outreach won't be the only effort. We know it takes multiple touches in trusted locations and entities to successfully enroll. Sb75eligibilityandenrollment@dhcs.ca.gov *Kelly Hardy, Children Now*: Thank you. I know you don't hear that often. We are thrilled to be working on this with you. When will there be a timeline for the implementation steps? Also, is the most streamlined way to offer input through the AB1296 workgroup and the website? *Rene Mollow*: Yes, the workgroup and website are the best. As to implementation timeline, it will be out around early October, but this is not a firm timeline. *Jan Schumann*: When we did Healthy Families to Medi-Cal, one of our concerns was Social Security numbers. They still don't require Social Security numbers for those children and that system is in place to not require Social Security numbers. *Alice Mayall:* As a reminder, our family ran into a glitch in the transition of Healthy Families to Medi-Cal at the county enrollment level due to difficulty with computer systems at the county. I hope this has been addressed. In my case, I had twins and one got dropped during the Healthy Families transition due to this computer problem. *Rene Mollow*: We learned a lot from that transition and will be working from the lessons learned. *Ellen Beck*: Thank you. We are happy to be part of this process.
Meeting Minutes	Minutes were distributed, reviewed and approved.

	http://www.dhcs.ca.gov/services/Documents/071615MeetingMinutes.pdf A clarification was made the minutes by the chair that *members* were invited to state a short or long term takeaway. Also, a suggestion was made to include action items as part of the meeting format.
Deep Dive Topic: Data on Pediatric Populations Within Medi-Cal	Jim Watkins, Chief, Research and Analytics Division of DHCS Slides for this presentation can be found at: http://www.dhcs.ca.gov/services/Documents/Childrens_Statistics_201505_ADA.pdf AND http://www.dhcs.ca.gov/services/Documents/Child_Pop_Presentation_2015-09-04-1414.pdf We are the official statistics bureau within DHCS. We take the data sets from multiple sources and make it manageable so DHCS and groups like yours can understand what is occurring and make informed decisions. Today's presentation is a panoramic view and includes 2011 data for children 1-18. Newborns will be out soon on the website and are not included here. Mr. Watkins presented enrollment data since 1966, outlining major expansions on a timeline documenting the number of children enrolled. He reviewed the data sets included in the presentation statistics, such as Medi-Cal eligibility and claims/utilization data, Short-Doyle and Mental Health data, Office of Statewide Health Planning and Development (OSHPD), the California Health Information Survey (CHIS) and Agency for Healthcare Research and Quality (AHRQ). Focus of the data presented is children in FFS (17%), FFS/managed care within the same year (19%) and children in managed care for the full year (65%). He reviewed a number of break-downs of beneficiaries such as geographic region, language, ethnicity, spending ($9.9B total), PMPM costs (average $240 PMPM) and a range of conditions among the population subcategories. <u>Member Questions/Comments</u>: *Bill Arroyo*: Can you speak to coding problems related to ethnic/racial groups? In LA, we see a large disparity between the way LA categorizes the data and the way DHCS codes race/ethnicity. *Jim Watkins:* We do see differences among different data sources and we like to have more discussion of the subpopulations to make it more useful. *Ellen Beck:* Can you review the eligible population that is undocumented? It seems higher than Rene Mollow mentioned. *Jim Watkins*: The number we are presenting is different. We are using the number of eligible children who touched the system for even one month in a year. *Marc Lerner*: Will we be able to track actual expenditures going forward? *Jim Watkins*: We have ideas about how to identify expenditures even though the state payment is a capitation amount. *Kelly Hardy, Children Now*: Where is the PMPM generated from? *Jim Watkins*: It is from DHCS data. We capture FFS and capitated payments as well as the expenditures for services such as Short Doyle, not included in the capitation. *Bill Arroyo*: For the foster care population, what is included in the non-

	capitation? *Jim Watkins*: The Short Doyle Mental Health service is a big part of the non-capitated cost. *Bill Arroyo*: There are medication costs included in some categories, are those depicted? *Jim Watkins*: Yes, they are captured in the cost data slides outside of capitation. *Bill Arroyo*: Can you conjecture from the data that northern California has such poor access to care, they depend more on emergency departments? *Jim Watkins*: The ED rates can tell you something about access but there are a host of reasons for ED utilization. For example, if my employer does not offer time off, I may use the ED after hours. Also, there are fewer providers overall. The ED rates for commercial plans in the far north are also higher and are not much different than these for Medi-Cal. *Sandra Reilly:* When you are presenting data on utilization by condition, are you using the primary diagnosis? *Jim Watkins*: We combine a number of utilization visits and diagnoses related to each visit and subpopulation, so it is more complex than compiling a single, primary diagnosis for each visit. *Jeffery Fisch*: Have you looked at differences by region and health system to identify where we have better practice or not? Do you make that analysis available to contrast and compare between health systems? *Jim Watkins*: There are a host of breakdowns we can drill down on including health delivery system. We could create this information for you to react to. For example, as we looked at ED rates today by geography and health system in LA, we can see census tract and even down to a building level. We don't recommend or make policy - we make the analysis available to you for comment. *Ellen Beck*: We have a pediatric dashboard subcommittee and want to make recommendations based on data. I want the work group to have access to data and query data to see how we are doing across the state, in different ages, conditions, etc. We want to work with your unit on some of these questions to understand the available data. *Marc Lerner*: We do have questions from the subcommittee to ask today. What data are you planning to collect related to Substance Abuse/Mental Health services and the waiver? *Jim Watkins*: We analyze data but don't decide what data is collected. *Ellen Beck*: Is there current mental health data you are analyzing? *Jim Watkins*: Yes, and there are pieces of substance abuse service analyzed. We are looking at the medical home project on medical services and mental health. *Marc Lerner*: What data do you track about primary care and mental health provider communication? *Jim Watkins*: There are a host of pediatric measures. We just completed a report on undocumented children's use of services. As you know, getting the

	data without having some knowledge is difficult so we need an exchange to understand what you need. *Marc Lerner*: We are concerned about data only available at the county level. We want to be sure that data flows up to you via contract language. *Ellen Beck*: We also had a meeting on access and network adequacy trying to understand what access is, how many providers are in a given geography. Is that data available? *Jim Watkins*: There is no single definition of access. We have looked at what is available and what can be used to determine access. There are a number of challenges. *Alice Mayall:* There is a lag in the data timing. Can you run real time data? If we ask for real time data, can it be provided? *Jim Watkins*: There is the opportunity to do quarterly data review for some data. In some cases, it is not as useful because recent data is not accurate. There are lag factors we use as an estimate to improve the data. *Pam Sakamoto*: Is it all paid claims data and impacted by those not billing promptly? *Jim Watkins*: Some data sets are claims – paid and pending; others are from surveys (CHIS); others are administrative data (OSHPD). *Ellen Beck*: Thank you so much. This is a great benefit to us to learn what data is available. We would like to invite you back for a future meeting.
Member Updates and Follow-Up Pediatric Dashboard Sub-Committee