State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children’s Health Advisory Panel

January 18, 2017

Meeting Minutes

Members Attending*:* Ellen Beck, M.D., Family Practice Physician Representative; Jan Schumann, Subscriber Representative; Karen Lauterbach, Non-Profit Clinic Representative; Paul Reggiardo, D.D.S., Licensed Practicing Dentist; Pamela Sakamoto, County Public Health Provider Representative; Elizabeth Stanley Salazar, Substance Abuse Provider Representative; William Arroyo, M.D., Mental Health Provider Representative; Jeffery Fisch, M.D., Pediatrician Representative; Marc Lerner, M.D., Education Representative; Terrie Stanley, Health Plan Representative; Liliya Walsh, Parent Representative; Wendy Longwell, Parent Representative; Ron DiLuigi, Business Community Representative; Alice Mayall, Parent Representative.

Attending by Phone: Laura Hogan, Pacific Health Consulting Group; Frank Lee, Contra Costa Health Plan; Brenda White, Kaiser Foundation Health Plan; Emma Zirkler, Mills College School of Education; Farid Hassanpour, California Health & Wellness; Elia Gallardo, Alameda Alliance for Health; Amber Kemp, California Hospital Association

Not Attending: Sandra Reilly, Licensed Disproportionate Share Hospital Representative;

DHCS Staff: Jennifer Kent, Adam Weintraub, Morgan Knoch, Liane Winter, Angelica Ruiz

Others: Bobbie Wunsch, Pacific Health Consulting Group; Margaret Kisliuk, Partnership Health Plan; Sonya Rahders, Planned Parenthood Affiliates of California; Kelly Hardy, Children Now, Lynn Thull, California Alliance of Child and Family Services; Dharia McGrew, California Dental Association

Public Attendance: 6 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 Alice Mayall. (See agenda for legislative charge.) http://www.dhcs.ca.gov/services/Documents/011817_MCHAP_Agenda.pdf Dr. Beck announced that it was Dr. Alice Mayall’s last meeting as a panel member and that it was a huge loss for the panel. Dr. Beck

presented a thank you letter and card to Dr. Mayall.

Ellen Beck, M.D.: In the current political climate, the panel should assess what is important for both the state and the country in health care for children and families, access to care, and comprehensive care. We can offer letters in support of improved access to health services. Perhaps we should consider an agenda item for the April meeting on crafting a letter that the panel would write collectively.

Ron DiLuigi: I agree with Dr. Beck. We should explore the most meaningful advocacy, including how to fix the health care system at the federal level. Health care is something that we all need and is not a commodity.

William Arroyo, M.D.: In addition to reaching out to the obvious leaders in our state government, we may want to invite Sen. Pan.

Ellen Beck, M.D.: We have discussed adding a June meeting because of the changing healthcare landscape and the desire to have a response, and to structure the meeting around what the future of health care looks like.

Adam Weintraub, DHCS: We need a decision by the panel to add an additional date to the meeting schedule.

Ellen Beck, M.D.: Are the members comfortable with adding a June date to explore some of the larger issues?

Elizabeth Stanley Salazar: Right now, we don’t have enough information to respond to anything. When we do respond, I want to make sure our recommendations are clear and deliberate and support continued coverage and access for children’s health care services. I agree that we should invite Dr. Pan to gather his insights and perspectives. Our response should be very precise and focused.

Karen Lauterbach: With the shifting political landscape, we should consider writing a strong letter in support of the health programs that help families and children. Once we know the specifics of the changes, we can offer our support or opposition.

Ellen Beck, M.D.: I’m hearing two different things which are overlapping and make sense: one is a general letter of support that we can draft between now and April, and the other is writing very specific recommendations. Also, we should consider inviting Dr. Pan and possibly another leader to share their thoughts.

Elizabeth Stanley Salazar: I agree, I think the positions overlap. We should be able to say, “if you take away part of this program, these are the costs associated”

Ellen Beck, M.D.: If the panel has additional ideas, please email them

	to me. We will draft something to present to you either before or at the next meeting. We will also explore agendas that include inviting Dr. Pan. Liliya Walsh introduced herself. Minutes from November 15, 2016 were approved. http://www.dhcs.ca.gov/services/Documents/111516_MCHAP_Summary.pdf
Meeting Minutes, Follow-Up, Opening Remarks by Director Kent	*Adam Weintraub*, *DHCS*: Dr. Beck asked us to provide information on the Whole Person Care (WPC) pilots. Included in the meeting materials are links to the 18 approved pilots and a link to the application for the second round. In addition, the deadline is later this year for DHCS to create education guidelines under Proposition 64. We'll be happy to provide those guidelines. *Ellen Beck, M.D.:* I'd like to place a June meeting date on the agenda. *Adam Weintraub:* We feel it's important to schedule a meeting after the June 15 legislative deadline. We can send out a poll to the members for meeting dates. *Jennifer Kent, DHCS:* The Governor's budget was released last Tuesday, with both good and bad news from our standpoint. For the current year, we went beyond our estimated spend for Medi-Cal by about $1.5 billion in the General Fund, which equates to about $10 billion in the federal fund. In addition to declining revenue, the Department of Finance (DOF) took a conservative approach and while we didn't see program or population cuts in our budget, it did delay implementation dates and revenues reverted in some cases. We didn't have any significant program changes but it also signals that we aren't adding programs. *Ron DiLuigi*: Is there an extension for the California Children's Services (CCS)? *Jennifer Kent, DHCS:* For the Whole-Child Model under the CCS program, we have suggested delayed implementation, no sooner than July 1, 2018. We forewarned the program that we were planning to push back implementation to January 2018 for all counties due to the compliance of the managed care rule, but given the current budget, we decided to push that back another 6 months. We met with the CCS Advisory Group (AG) last week and shared this information with the stakeholders. This gives us a better opportunity to work with the families through outreach and education. The plans will have more time to gather data on the children. We will have a few follow-up items related to NICU services for the CCS AG, including who billed for what, when, and how.

The approved Local Dental Pilot Programs (LDPPs) projects will be released soon. We received 23 applications for 15 slots.

We are in the final approval process for releasing a network adequacy proposal, which is tied to the Medicaid and CHIP Managed Care Final Rule. The proposed standards apply to Medi-Cal managed care, County Mental Health, Drug Medi-Cal Organized Delivery System, and Dental Managed Care plans. We had to set a network adequacy standard according to the federal rule for both the adult and pediatric populations, and in some cases, they've required us to set it for both primary care and identified certain specialties: pharmacy, LTSS, etc. It's a significant document that we're hoping to release by the end of the month for comment and public feedback.

Paul Reggiardo, D.D.S: Under Domain 4 of the DTI, what are the expectations for awarding the grants and notifying the applicants?

Jennifer Kent, DHCS: We're looking at a February award date.

Jennifer Kent, DHCS: This panel is well aware of the importance of the Children's Health Insurance Program (CHIP) and its financial impact. As authorized by the ACA, there will be an 88% enhanced bump under the CHIP program through 2019. The problem is that CHIP needs to be reauthorized next year. We think this program will be reauthorized, but at what level? We're looking to strike a middle balance; we don't think it will be reauthorized at 88% and we also don't think it should drop to 50/50%, so we thought it should go back to its original 65/35% split, which is reflected in the budget. Obviously if it drops from 88% to 65%, it's a $530 million hit on an annualized basis.

From our standpoint, we need to determine who to talk to and at what level we need to advocate to have CHIP reauthorized. We would like to stay at 88%. If you, as an advisory panel or at your individual organizations, want to chime in on the importance of the CHIP reauthorization, we have sent letters in the past when it has been up and we will work with the Governor's Office to send the state letter.

Ellen Beck, M.D.: Sounds reasonable.

Jennifer Kent: We will share our prior CHIP letters with the panel.

William Arroyo, M.D.: What is the difference between the 88% and 65%?

Jennifer Kent, DHCS: In the budget, its $536 million to reflect the assumption, effective October 1, 2017. From a general fund perspective, it's a quarter off and at least $800 million per year.

Ellen Beck, M.D.: Is there anything else from this point of view when thinking about state responses to possible federal changes?

Jennifer Kent, DHCS: Since the last time we met, we're still in the 'wait and see' approach; there's a lot of activity happening at the federal level but nothing from my assessment that we need to act on. There was a letter sent by Congressman McCarthy to all of the Governors in December regarding the ACA repeal. Both Gov. Brown and Insurance Commissioner Dave Jones responded saying careful action should be taken since many rely on coverage. In our budget, the numbers reflected a half-year cost because the Medicaid expansion shifts from 100% federal funds down to 95%. The half-year costs for the state is about $800 million, or $1.6 billion per year to cover the 5%. The expansion then shifts down to 10% in 2020, so it will be about several billion dollars to cover the 10% of the share.

Ron DiLuigi: Do you have a sense of how the federal government feels about Medicaid expansion?

Jennifer Kent, DHCS: From a vulnerability standpoint, you look at the multiple billions of dollars that you can appreciably shift when you change that percentage. It's such a large expansion that if we covered it on a 50/50 basis, it's a big deal.

William Arroyo, M.D.: It appears as though the Governor will use the Proposition 56 funding as part of the general fund, which is a bit of a disappointment on some level. Do you have anything to add?

Jennifer Kent, DHCS: Nothing more than the Governor's budget. There has been, and continues to be, substantial growth in the program. The initiative contemplates helping to sustain either growth in the program or other allowances. The funds from Proposition 56 are supplemental to, not supplanting, general funds.

Jan Schumann: While on the Healthy Families Board, we had budget cuts and had to stop enrollment. I think it's critical for this panel to put forth a recommendation for DHCS to move forward with advocating to help protect children enrolled in the program. I want the state to have a letter from us that they can then attach to their letter that goes on to the federal government saying that any cuts to the program affects the children of California.

Ellen Beck, M.D.: Is this something that we should be doing now, or proposing that we look at something between now and the next meeting?

Jennifer Kent, DHCS: I think the CHIP reauthorization is something that this group could weigh in on in the next three months.

Ellen Beck, M.D.: I'd like to have a vote of support at this moment with the intention to develop a letter. Would anyone like to make a motion?

	Jan Schumann motioned for the panel to draft a letter supporting reauthorized CHIP funding. All panel members voted in favor. *Adam Weintraub, DHCS:* One more follow-up item is the panel's request for a legislative update. Children Now provided the panel with legislative watch lists, which we distributed before the meeting. *Ellen Beck, M.D.:* I was excited to see this list. I would like everyone to review the legislative watch list with particular attention to SB 18, which declares the intent of the legislature to expand the Bill of Rights for Children and Youth of California to establish a comprehensive framework that governs the rights of all children and youth in California. This is consistent with the conversations we've been having here. *Marc Lerner, M.D.:* As Dr. Pan is the author, and we're talking about inviting him, obviously that could be part of the conversation.
Behavioral Health Recommendations and Discussion	Dr. Beck introduced the topic of behavioral health recommendations. Presentation materials available at: http://www.dhcs.ca.gov/services/Documents/DRAFT_MCHAP_BHrecommendations.pdf *Ellen Beck, M.D.:* This behavioral health recommendation letter to DHCS was based on our conversations, review of previous meetings, and background information on data demanding that we address mental health services. Serious barriers to mental health care, coupled with the complexity of funding sources and programmatic laws, make it difficult to provide seamless, high quality care to one child at a time across the state. **Recommendation 1: Collaborate with California Department of Education (CDE) to develop guidelines for mental health services and clarify reimbursement and financial responsibilities.** *Marc Lerner, M.D.:* On recommendation 1c regarding the required MOU between CDE and DHCS to facilitate services, we talked about model MOUs that might be used by individual school districts; is the required MOU the same topic? *Ellen Beck, M.D.:* Our takeaway was that this was at the state-level. Were we waiting on something to be signed? *Bobbie Wunsch, Pacific Health Consulting Group:* That's what we understood. *Elizabeth Stanley Salazar:* What is the requirement governed by? Maybe you would want to reference that. *Ellen Beck, M.D.:* I'm not sure. It was mentioned at a previous meeting where we were discussing recommendations and that there was an

MOU between the CDE and DHCS that was in process to facilitate. There was one at the level of the state; it wasn’t a model MOU for each Local Educational Agency (LEA).

Marc Lerner, M.D.: I think we had proposed a consideration of a legal review for an acceptable MOU that would allow districts to engage.

Ellen Beck, M.D.: So provide model MOU examples?

Marc Lerner, M.D.: Examples, or a legally vetted MOU.

Ellen Beck, M.D.: That’s an additional task between LEAs and health care service entities?

Marc Lerner, M.D.: Individualized Education Programs (IEPs).

William Arroyo, M.D.: In recommendation 1, should we identify all Medi-Cal programs? It seems to me like they are addressed as a single program, but there are at least two that I can think of that are separate and have different mechanisms for drawing down federal money. There’s the LEA Medi-Cal, which is different from EPSDT Medi-Cal. It’s a little beyond our purview, and it was in part invoked by our discussion on IHSS, but the responsibility of the school systems vis a vis federal programs would hurt children. One that came to mind when hearing the IHSS discussions this morning was Individuals with Disabilities Education Act (IDEA), and the extent to which that supports the children benefiting from IHSS. In perusing the education budget, IDEA is projected to bring in $1.3 billion, which is 13 categories for special education. Given the law, we’re restricted to the Medi-Cal program. There are other services in which the same children we’re concerned with in the Medi-Cal program have entitlements for. It’s hard for me to look at the array of services in a vacuum because the landscape is broader.

Ellen Beck, M.D.: What would you suggest adding, that we encourage exploration of other funding sources?

William Arroyo, M.D.: The federal programs that assist the same children warrant significant coordination and collaboration among the state agencies.

Wendy Longwell: We usually receive children with IEPs under the Emotional Disturbance (ED) category or the Otherwise Health Impaired (OHI) category, which is a doctor diagnosis as affecting the child’s education. Dr. Arroyo is suggesting placing this item under recommendation 3 because it’s addressing county programs, schools, and Medi-Cal managed care plans. We need to include all three because mental health issues happen at schools, home, and in the community. They all need to work together to make sure that there are full-scope reports for these children. I thought number 3 was the right place to put that.

Ellen Beck, M.D.: Maybe we should include in recommendation 1. It’s recognizing and increasing awareness, and establishes relationships so that these programs are fully utilized.

Wendy Longwell: Now, if I go to an IEP for a child having mental health issues, the county representative or the counsel that has been assigned may not show up because they consider it a conflict of interest since they aren’t employed by the school. If we do get a representative to the school, they refuse to sign that they were even there.

William Arroyo, M.D.: In addition to the federal entitlement IDEA, there’s another federal entitlement supporting the same children, which is Section 504, The Rehabilitation Act

Bobbie Wunsch, Pacific Health Consulting Group: I just wanted to add that the legislative reference under 1c is SB 123.

Ellen Beck, M.D.: Dr. Lerner’s recommendation was added to 1b because it will deliver and strengthen services, and one of the ways is to include model MOUs.

Recommendation 2: Issue guidance to clarify definitions of mild, moderate and severely mentally ill as well as roles, responsibilities and anticipated actions among local managed care entities and programs, especially as they affect children and youth.

Ellen Beck, M.D.: It’s hard for me to read some of these because we should rethink thoroughly seamless and effective care. Even though we’ve had the carve outs for so long, and even hearing about what Wendy just said, it’s difficult for me to move on to recommendation number 3. I had a discussion regarding the vision of our future with limited funds and what would we really want from mental health care for our children. We’re trying to make recommendations for incremental change relating to what exists, but for those of us on the Healthy Families Panel, this has been an ongoing 12-year conversation about the carve outs.

Pam Sakamoto: When you have to issue guidance to clarify definitions, you can have 6 entities clarify a definition and still have different definitions. A definition should be established and applied across all of the plans to level the playing field from the beginning.

Alice Mayall: Just a minor point, but under recommendation 2, letters a, b, and c aren’t phrased as actions. Regarding the carve outs, there is an arbitrary categorization of children into mild to moderate. You can’t have complete continuity of care because someone will need outpatient or inpatient services or day services and care will vary depending on location and providers. It seems like these categories should be based on the level of care that you need.

	Ellen Beck, M.D.: That's a good point that it should be based on the level of care. For instance, if a child needs hospitalized, it won't be based on a,b,or c, but rather that child needs to be hospitalized. Saying the child meets the following 15 definition criteria, which can change, is confusing. It should be based on the level of care needed. *Alice Mayall:* A child will need differing levels of care depending on how they are doing. *Ellen Beck, M.D.:* I feel like we have two different levels of discussion here. One is to look at these definitions in the short term. I think it demands us to revisit seamless care. If we want mental health coverage for children in this state, what will it take? These recommendations try to get there, but within the current structure. *Terrie Stanley:* There has to be coordination at two levels: the first is in the treatment plan and the next piece is in the care plan. I view these as being different because the treatment plan is more provider-specific, whereas the care plan is how all of the entities communicate, coordinate, organize, and deliver services to that member. We need to take into consideration those two levels. DHCS sent the health plans a questionnaire regarding mental health parity. It strikes me as curious because in a plan where you have behavioral health as a carve out, parity shouldn't be discussed at the plan level. Both the counties and the plans need to understand the definition of parity, as well as anyone else who is delivering behavioral health-related services. *Elizabeth Stanley Salazar:* I agree. As I look at recommendation 2, there aren't clear actions; just statements about problems that exist. I'm not sure if mild-to-moderate versus severe is the problem here. The problem is that we don't mention EPSDT at all in this document, and that really strikes me as problematic given the level of coverage and services it provides. We need to examine carve outs further and the coverage needed. *Liliya Walsh:* One way to address recommendations is to list the issue then clarify with the recommendation. There could also be a recommendation with more than one solution. Also, an objective should be listed. *Ellen Beck, M.D.:* Are you suggesting a structure that lists the issue, recommendation, and the goal? *Liliya Walsh:* Yes, or maybe the issue, goal, and then recommendations. *Wendy Longwell:* When discussing mild to moderate and severe in recommendation 2, you would want to remove the silos. The issue that was mentioned was when parents are told their child isn't severe enough to be at the county level. Meanwhile, when they go to the

	managed care plan, their child spirals out of control and are told that their child is now severe and that they need to go back to the county. Parents are given these excuses for why their child cannot be helped. We need to establish definitions, and ensure that the plans or counties are helping the child. It’s frustrating for parents to call five different entities and then they still don’t receive care for their child. *Ellen Beck, M.D.:* I think there are two steps involved: we’ll continue to look at these recommendations, but we also need to revisit the issues that have been raised during this meeting. We’ll need to either have another meeting, or provide additional recommendations from this panel. **Recommendation 3: Improve care coordination by clarifying legal requirements for information exchange and requiring data exchange between county programs, schools and Medi-Cal managed care plans.** *Wendy Longwell:* The main issue is the release of information; everyone is concerned about Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) and everyone has their own release form. This convolutes the process. I know other counties are working on universal release to collaborate on a child’s case for ultimate care. *Jeff Fisch, M.D.:* In my county, community organizations show up at the IEPs and are happy to coordinate. We do need a clear definition. *Marc Lerner, M.D.:* For recommendations 3 and 4: in recommendation 3 you have “of mental health and substance use services at school sites through an All Plan Letter”. I sent language to Dr. Beck and Bobbie to incorporate licensed school mental health providers onto panels of county contracted mental health systems of care, as well as tracking service site data regarding mental health visits done at school LEAs. It’s the issue that we have a system of care which generally tends to turn to community-based providers rather than licensed school providers. As a result, we’re never really able to build our school workforce because there’s not adequate support. **Recommendation 4: Expand benefits and services to improve access, quality and outcomes for children and youth.** *Ellen Beck, M.D.:* This recommendation was intended to recommend cases where expansion was needed. *Elizabeth Stanley Salazar:* The use of the word ‘expand’ is a little bit enticing. To my understanding, respite care and residential crisis services are federal benefits. We’re not expanding federal benefits, we’re aligning California benefits within the current structure. *Ellen Beck, M.D.:* To the extent that we can, we should include

achievable recommendations but every so often, we should include a recommendation we strongly believe in.

Elizabeth Stanley Salazar: We need to modify the language; it may be better to suggest ‘align with best practices’ instead.

Ellen Beck, M.D.: Or even the word ‘parity’, which isn’t mentioned.

Elizabeth Stanley Salazar: Perhaps we should include what parity is or the services provided.

William Arroyo, M.D.: Thank you for ensuring that we always are keeping with the legislative intent of this group. If we believe a certain service is necessary, we should make that recommendation.

Wendy Longwell: This came to my mind when we were discussing recommendation 4, but I’m not sure if this fits under the recommendation: when we are talking about the counties, schools, and plans, we must also consider the hospitals. When your local hospital says that they are unable to help your child, what does the parent do? When children are denied coverage at hospitals, we end up sending the children out of state for care. We need to include local and state hospitals as part of this group.

Marc Lerner, M.D.: In 4b, for the “improve access to screening and assessment” line, I would also add “and treatment”. It would not only be by primary care providers, so I would say, “and other school-based clinic providers” which would include the mental health provider role.

Ellen Beck, M.D.: So for 4b, it would read: “primary care providers AND school-based clinic providers” rather than using the language “including school-based clinic providers”?

Marc Lerner, M.D.: Correct.

Jan Schumann: For 4a, I think it’s critical that we also address the stigma within health care that might be present among the parents. So on 4a, it should read, “mandate/reimburse school-based screening and parental education resources for the early intervention of mental health”.

Ellen Beck, M.D.: I think that’s essential. If we added additional terms, it would be using promotoras or other ways to address stigmas.

Recommendation 5: Improve timely and efficient service delivery by removing barriers to innovative service delivery options and supporting training.

Terrie Stanley: I would include a line about the importance of evidence-based programs. When I see the word “efficient”, to me that doesn’t necessarily mean that you’re effective.

Ellen Beck, M.D.: So maybe we should say, “timely, efficient, and effective” and include evidence-based.

Recommendation 6: Raise awareness about services and reduce stigma through provider and public education.

Ellen Beck, M.D.: For 6c, we should also include “and mental health providers” because sometimes there are new approaches and new evidence-based approaches.

Terrie Stanley: I wouldn’t limit it just to primary care because you may have specialiststreating these individuals.

Ellen Beck, M.D.: That’s a good point. Often, children are being seen by specialists. In addition to mental health issues, they will be seen on an ongoing basis by a specialist. The primary care physician may not be involved at all. The specialists need to be aware of the resources.

Liliya Walsh: I don’t see much on the issue of consent competency. It’s important to identify specific criteria for guidance for commitments. We need to make sure that area is in compliance and aligns with constitutional law and due process.

Ellen Beck, M.D.: There are two areas that have come up as we have gone through this. One of the issues for the team that put this together were certain items that did not come up during the last two meetings but are coming up now, such as the issues of consent and commitment. I think we should place some of these items in this letter, and then having a second letter.

Bobbie Wunsch, Pacific Health Consulting Group: Can you speak more about issues of commitment?

Liliya Walsh: Commitment, meaning involuntary hospitalization.

Bobbie Wunsch, Pacific Health Consulting Group: To reinforce what Dr. Beck said, we didn’t include everything in the letter because the panel didn’t mention the items during previous meetings. We should add to future agendas any issues the panel wants to include.

Ellen Beck, M.D.: Is the panel comfortable with the letter as it is and the edits suggested? We may want to have an additional letter or addendum. We will send the panel a version to review, addressing the issues that have come up during this meeting.

Karen Lauterbach: Can you clarify what the additional items are?

Ellen Beck, M.D.: I would like us to explore the commitment issue raised by Liliya. The other two I would like to see us discuss is the carve-out conversation on how to truly achieve seamless mental health care, what we envision for this care, and whether we return to the issue of maintaining the carve outs. The second issue is an email we received from Ed Schor about treatment of mothers with postpartum depression. CMS issued guidance about maternal depression screening. It's important to realize the link to children's health.

William Arroyo, M.D.: We may want to revisit what Liliya alluded to, which in part dovetails with what Wendy had stated on children receiving care from hospitals out of state. What's not clear, and it seems we have a consensus on this, is providing community-based care in the least restrictive setting. If the panel wants to endorse these issues, I would recommend putting them in the introduction.

Ellen Beck, M.D.: I've discovered that this has led institutions to feel that they did not have responsibility in care at the level of the community and there were inadequate resources to provide the continuum of care needed. I'm concerned with the actual definitions of those terms. From my experience, I've seen this in action and the communities haven't stepped up sufficiently.

Wendy Longwell: As a parent, I dislike hearing that the parent is the payer of last resort. It's everyone's excuse why they can't help my child. Most parents don't know this but when you start out with one provider that maxes out, you have to find another provider. This disrupts the continuity of care. The barriers to care need to go away, regardless if care is full-scope or private.

Alice Mayall: For the concept of school-based health centers, how do reimburse those providers? It seems like a basic issue and I realize these recommendations are aspirational, but given that each county has at least two different programs children can be in, each provider would have to be an employee or contracted with those different entities.

Terrie Stanley: Not necessarily. I think DHCS has done a good job defining continuity of care requirements.

Alice Mayall: I was told the only way I could arrange continuity of care was if my child was in the middle of cancer treatment.

Terrie Stanley: DHCS needs to identify the categories that qualify for continuity of care. What are county requirements around continuity of care? One frustration we hear from parents is that continuity of care should cross more than just health plan lines.

William Arroyo, M.D.: The intent of the MOU is to require the managed care plans and the county mental health plans to have a workable mechanism in order to ensure that the child receives benefits.

Jennifer Kent, DHCS: There is not a continuity of care mandate on

	county mental health plans to contract with anyone who doesn't want to contract with them. The panel should put forward recommendations and we'll work with you to understand what is possible, practical, and what is not moveable at this point in time. *Pamela Sakamoto:* I agree with Jennifer. We do not have universal coverage that's going to give everyone exactly what they want. I would like to place timeframes on some of the recommendations. If we're working on definitions and enacting them, then we should consider placing a timeframe such as within 12 months. *Ellen Beck, M.D.:* Do you have any other timeframes you would like to recommend? *Wendy Longwell:* We should review SB123 to see specifically what it says. There may be some timeframes that have been overlooked. *Ellen Beck, M.D.:* With your permission, when we do the final draft, we will look for possible timeframes. *Liliya Walsh:* We may need to do more than a second letter. The initial letter should indicate what we are currently working on while the follow up letter will be more detailed. *Ellen Beck, M.D.:* My preference would be to take the letter we've already created and add timeframes and edits that we've heard. In the letter we'll say that there will be follow up with additional items. *Karen Lauterbach:* It seems there are so many issues with care being siloed, we should see how others have broken down some of the barriers. In Los Angeles, we have a lot of coordination with DMH, county mental health providers, and getting consents. *William Arroyo, M.D.:* There needs to be a coordination service that assists families in navigating. *Jan Schumann:* I would like to make a final recommendation for paragraph 3 on page 1; we should add today's date to the discussions. There should be a comma in the final paragraph, second line to read, "These recommendations are forwarded,". I'd like to move that this be made into a final draft for action at our next meeting. The panel approved the motion. *Jennifer Kent, DHCS:* I would like to say that you have come a long way as an advisory body with the Department. This is a very complicated area and extremely fragmented. There is a lot of money in different buckets, and no one is willing to put their money in one big bucket. I appreciate the panel's thought, intent, and dedication.
Framework for Discussion on	Presentation materials available at: http://www.dhcs.ca.gov/services/Documents/AccesstoCare_051116.p

Access to Care, Dr. Jeffrey Fisch	df Dr. Fisch introduced the topic of access to care and noted that the network adequacy subcommittee discussed similar topics in 2015, leading to a letter presented by subcommittee members Ron DiLuigi, Wendy Longwell, Sandra Reilly, Pam Sakamoto and Dr. Fisch at the May 2016 MCHAP meeting. *Jeffery Fisch, M.D.:* Network adequacy has statutory and regulatory connotations, so the discussion today will focus on access to care. Also, there is an Access Assessment Advisory Committee for the 1115 waiver, so I'm sure that subcommittee is tackling many of these ideas. When we met as a subcommittee, we stepped back and looked at this from the standpoint of a beneficiary. As a subcommittee, it was really insightful for the committee members to break it apart. As a provider, I recognize that telemedicine and other innovative technologies are great ways to expand access to care and provide quality care, which increases member satisfaction. I also oversee about 80 pediatric physicians and about 110,000 pediatric members in Northern California. I'm always told that I have great people working under me building these wonderful IT systems. I find the value of direct testing is important to ensure that you're providing quality care to members and until I actually test it directly, I really don't know what the experiences are. As a utilizer, do I have the same quality and timely access to health care that I really need? Only through direct testing will we ultimately get that question answered. *Ron DiLuigi:* We reviewed this as a basis for which you entered the deep-dive. After we get the benefit of the deep-dive, we'll be able to pick up on our discussion. *Pamela Sakamoto:* About telemedicine, we've made great strides in technological advances, but the reimbursement has not kept up. It's one thing to have the client communicate via an iPad, but sometimes the specialist is needed. Many of our CCS specialists are not scattered heavily throughout the state; they are at the tertiary children's hospitals. For a client in Eureka to get to the doctor is very difficult. They can, however, get to their Federally Qualified Health Center (FQHC) or their private health office where that physician and the client can all be in communication, or even visual communication. *Jeffery Fisch, M.D.:* I'm going to add on to this because we chose a specialist that was located a few hours away for my child. We decided to use telecommunication; sometimes we would do it from our primary care physician's office or from our home. *Ellen Beck, M.D.:* While working in very remote areas as a physician and using specialists over 1,000 miles away while still being able to benefit from their knowledge and guidance was helpful.

	Wendy Longwell: When we went over this, one of the biggest issues was access to care with the changes that have happened. I really feel like we need to be looking at this. *Elizabeth Stanley Salazar:* Is this change regarding the Medi-Cal expansion? *Wendy Longwell:* It's very frustrating when you have extended wait times for a child with special care needs. How are we going to make sure that our children have access to care? *Ellen Beck, M.D.:* People in this room tend to be advocates. What if you were in that situation and you don't have the ability to navigate the system? Does your child go to the ER? We need to address both the needs of the services so there doesn't need to be advocacy, but also when there does need to be advocacy, how does that occur? *Elizabeth Stanley Salazar:* It's not referenced in this letter, but I would want to explore the External Quality Review Organizations (EQRO) process and what the requirements are from the federal regulation perspective. Also, how we are doing in those reviews? *Ron DiLuigi:* We discussed this when we talked about benchmarks. *Ellen Beck, M.D.:* I wanted you to give us an overview of where we were with the network adequacy letter. We should also plan where we want to focus and who to invite to the next meeting. *Jeffery Fisch, M.D.:* We need to narrow our focus while realizing that everything intertwines. Perhaps we should look at how health plans view access to care, and how this works with Medi-Cal beneficiaries. *Elizabeth Stanley Salazar:* After the rules are set, eligibility lies within the domain of the counties and the county DSS. We could spend months digging around eligibility, however, I think we should move into bullet 2, which is once you are eligible, what does access look like? *Wendy Longwell:* As with our discussion on mental health, are there timelines and definitions? *Jeffery Fisch, M.D.:* There can be standards, but what is the reality? *Ellen Beck, M.D.:* We're trying to address the gap between the current standards and the goal, and what's being achieved or not achieved. *Ron DiLuigi:* There are 58 different systems which lack the uniformity we would like to see. These are silos that add to access issues. *Ellen Beck, M.D.:* You are absolutely right. Health care is county by county and the solutions we suggest must be cognizant of this issue.

	Pamela Sakamoto: If there are different set standards for health plans, our first step should be identifying those standards by using the Medi-Cal dashboard data. *Karen Lauterbach:* From an FQHC perspective, we examine a lot of data and determine if we're meeting certain standards. We almost never meet the standards because demand is so high. The other problem is lack of providers. FQHCs do not pay as well and you have to be invested in providing quality care, and sometimes that doesn't pay the student loans. Most clinics are overwhelmed due to capacity issues. FQHCs are aware of the regulations and want to comply. *Ron DiLuigi:* Is there value in knowing what the particular standards are and how far off they are? *Karen Lauterbach:* We're constantly monitoring these numbers in addition to a variety of interventions which look at how many are canceling appointments at the last minute and whether we need to overbook. There is value in knowing the data. I don't think standards should be eliminated, but I think we should look at other solutions. *Terrie Stanley:* We need to reevaluate how we deliver care and who delivers that care. There's been heavy investment by the medical community around what requires or doesn't require a physician visit. Lastly, we need to expand care for beneficiaries outside the Monday – Friday, 9 am – 5 pm structure. Transportation has been an issue for beneficiaries as well. Our discussion should center on innovations. *Pam Sakamoto:* Perhaps Kaiser should share their best practices with other health plans. *Jeffery Fisch, M.D.:* I agree with sharing best practices with plans. *Marc Lerner, M.D.:* I agree with the best practices concept. We hear conversations about FQHCs not being able to keep physicians because they are heading to Kaiser; routinely we hear that about compensations, but it also might be about the system of care. *Ellen Beck, M.D.:* FQHCs are coming up with innovative models. What I'm hearing today is that we should focus on the second bullet of the three with a need to look at what the measures and parameters are within the dashboard. We need to also look at what the expectations are, where are we falling short or succeeding with the health plans, and what innovative models are addressing the care needs. *Marc Lerner, M.D.:* Relative to the regulations, sometimes there are barriers for being able to bill. Telehealth will add to the coordination of care. With health grades, there should be survey options to collect ongoing data to determine what the different challenges are.

Elizabeth Stanley Salazar: Organizations are doing innovation, although I'm not sure what's in it for them other than their mission statement. I don't see incentives being restructured and coming from the state level; you have to take the mechanics, financing and the structural regulations into consideration. Agencies are trapped in complying with over-regulations on multiple levels such as the county and state. We don't incentivize the care coordination or care plans. When you look at agencies with innovative models, they emphasize leadership and the mechanism for use of incentives.

Jeffery Fisch, M.D.: If you look at our document, we did ask what the incentive was and we recognize that drives innovation. If you produce quality outcomes, you should be rewarded.

Ellen Beck, M.D.: I would like to see suggestions about what we should discuss during the deep-dive and guests to invite.

Ron DiLuigi: From a practical standpoint, Kaiser is a five-star plan in Medicare and have great accolades in Medicaid.

Ellen Beck, M.D.: I'm hearing that we should invite Kaiser?

Ron DiLuigi: Yes. They have a lot that we could learn from.

Jan Schumann: I think our concern is with care delivery issues and post enrollment. This letter was written by the subcommittee as more of an inquiry for us to get data back to the panel. Would it be possible for DHCS to give us a presentation at the April meeting to cover those topics?

Ellen Beck, M.D.: Your recommendation is to look at the second bullet and the actual questions and then see to what extent we need to do adjust those questions for the deep-dive?

Jan Schumann: Yes.

Ron DiLuigi: Jan is asking for DHCS' best judgment, which is helpful.

Jennifer Kent, DHCS: Before this letter was written, there were technical changes within our Department to address the new Final Rule around network adequacy. I will ask Sarah Brooks and her team from the Managed Care Quality Monitoring Division to present on process and data that we receive from the health plans. We will also have the network adequacy proposal that will be released by the end of January that will feed into some of this discussion.

Jeffery Fisch, M.D.: Could you elaborate on the 2015 Advisory Committee?

Jennifer Kent, DHCS: It's managed care access only; it's not fee-for-service (FFS). At the April meeting, the Department's managed care

	staff will talk about network adequacy and managed care. FFS is not impacted; there's not a network standard for CCS because it's a FFS system. That group is working with our EQRO to develop work plans. I don't think we mind duplicating either the knowledge or the expertise. The network adequacy proposal that we're sharing at the end of this month is not a product of that group, it's a product of our internal work as it pertains to the managed care rules. That network adequacy document is across managed care: dental, SUD, and mental health. *Bobbie Wunsch, Pacific Health Consulting Group:* I think the issue of managed care system is very relevant. *Jennifer Kent, DHCS:* Once we do a grounding at the Department level in terms of the technical data from the health plans and network standards, we also need to talk about what DMHC does. At times, we have complementary or supplementary roles because DMHC regulates Knox-Keene plans. Having a selection of health plans come in and discuss what they do on a local basis would be helpful, but you may need to break it up into two meetings or fully focus on one item. *Ellen Beck, M.D.:* Thank you. I agree about breaking up the managed care meetings, as we did with the discussion on behavioral health.
Public Comment	*Kelly Hardy, Children Now:* I wanted to thank you all for your transparency. Sometimes the standards that are laid out are not always met and it's important to recognize that. On the legislation list, I wanted to note that Children Now is pleased to provide you with information on current bills. Children Now doesn't necessarily support or oppose or take any position on those bills. We welcome feedback; these are bills we thought would be interesting to the panel. *Ellen Beck, M.D.:* Thank you. We really appreciate Children Now providing us with this document. *Lynn Thull, California Alliance of Child and Family Services:* There were a couple of items from the budget which Director Kent didn't have time to go over. One item was from last year. Under SB 833, $30 million that was created to fund the startup costs for the crisis continuum of care and specifically for children and youth. This is much like SB 82 from years ago that provided $143 million for adults. We were disappointed that the children received less funding than the adult population, but overall happy that something was provided to the children. However, $17 million of the $30 million is expected to be cut from the Governor's budget, which concerns me. Most of the programs that will be started are geared at helping California come into compliance with federal guidelines around crisis services for kids, so it's not just discretionary programs. Also, one thing that keeps getting overlooked with all the shortfalls is that there are still significant growth funds in the behavioral health fund account; it's projected to be just over $73 million this year just in growth funds to go to the entitlements, which are EPSDT Specialty Mental Health (SMH) for kids, and Drug Medi-Cal EPSDT SMH. Next year's fund is projected to be $96 million.

	Those are in the budget and are opportunities to go forward. You had an action item today about your proposed letter, so I'm requesting for future meetings that there's time for public comment before the panel votes. There are significant comments that I would like to make about those items in writing. *Ellen Beck, M.D.:* We would appreciate if you would put it in writing. Also, if you could provide us with more information on the two items you mentioned. Not everyone on the panel knows of those items, so a little education plus your suggestions would be welcome.
Member Updates	*Alice Mayall:* As a parent trying to navigate the systems, it would be wonderful if there was some system in place to gather feedback from parents. It's very intimidating and formal. It's very unclear who to give feedback to when a problem arises. This can be linked to what Dr. Fisch was presenting regarding how to get information from parents. *Ellen Beck, M.D.:* That's an excellent recommendation. At some point, we should invite the ombudsman to speak to us about the types of cases that come forth and what the process is. This is a subset of what you're describing. We also received a letter about school nurses and all of us feel very strongly about the value of school care. At some point, we should return our discussion to look at the issues of care within schools. *Jan Schumann:* Lynn, I do apologize for the action we did take, but I do want to note that we are moving forward to make a final draft and would really appreciate your public input on that item. *Adam Weintraub, DHCS:* I wanted to remind the members that you have received a survey from DHCS. It's part of the preparations for a mandated report to the Legislature on MCHAP. There will be one more survey before the report is due at the end of 2017. We will be in The California Endowment (TCE) space starting for the April meeting. It's possible that the additional meeting we've discussed could be here or at TCE. *William Arroyo, M.D.:* I would like to suggest that we put on our agenda an item discussing foster care, which is not in the managed care system. This is a vulnerable population with at least 80,000 in the state. If there isn't a managed care plan, they go to whatever physician accepts Medi-Cal. We really should look at this.
Upcoming MCHAP Meetings/ Next Steps	Meeting Dates for 2017: • April 18, 2017 • June 28, 2017 • September 12, 2017 • November 1, 2017