State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

June 28, 2018

Meeting Minutes

Members Attending: Ellen Beck, M.D., Family Practice Physician Representative; Jan Schumann, Subscriber Representative; Karen Lauterbach, Non-Profit Clinic Representative; Kenneth Hempstead, M.D., Pediatrician Representative; Marc Lerner, M.D., Education Representative; Terrie Stanley, Health Plan Representative; Diana Vega, Parent 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.

Members Not Attending: Liliya Walsh, Parent Representative; Ron DiLuigi, Business Community Representative; Bertram Lubin, M.D., Licensed Disproportionate Share Hospital Representative;

Attending by Phone: 31 stakeholders called in

DHCS Staff: Jennifer Kent, Javier Portela, Adam Weintraub, Morgan Clair

Others: Susan McLearan, California Dental Hygienists' Association; Amber Kemp, California Hospital Association; Sean O'Brien, United Healthcare; Reina Hudson, United Health Care; Kelly Hardy, Children Now; Troy Larsen, Sage Therapeutics; Danielle Cannarozzi, LIBERTY Dental Plan.

Opening Remarks and Introductions	Ken Hempstead, M.D., MCHAP Co-Chair welcomed members, DHCS staff and the public and facilitated introductions. Pam Sakamoto read the legislative charge for the advisory panel aloud. (See agenda for legislative charge.) http://www.dhcs.ca.gov/services/Documents/MCHAP_agenda_062818.pdf Dr. Hempstead called the meeting to order. Dr. Hempstead provided an update on Dr. Lubin's unexpected absence from the committee. Dr. Reggiardo had one minor edit to the April 19, 2018 meeting summary; silver diamine fluoride is a benefit for close to 40 percent of U.S. states. Minutes from April 19, 2018 were approved unanimously as edited. http://www.dhcs.ca.gov/services/Documents/MCHAP_Summary_041918.pdf *Adam Weintraub, DHCS:* Responses to the follow-up list have been posted to the MCHAP web page. *Jennifer Kent, DHCS:* The Governor signed the budget yesterday. DHCS' budget is approximately $107 billion. We estimate approximately 13.3 million beneficiaries will be enrolled in Medi-Cal for the next Fiscal Year (FY). Notable items from the California State Budget include: • General dental anesthesia rates will receive a supplemental payment using Prop 56 funds which will bring them up to parity. • Additional dental supplemental payments include periodontal services and orthodontia codes for former foster youth. • The Legislature approved the Administration's proposal to increase home health rates by 50%, which will improve services for children who are in waiver programs, EPSDT private nursing, or in California Children Services (CCS). • Prop 56 funds will also be provided to pediatric subacute facilities and pediatric day health care centers. DHCS will be working to get federal approval and do supplemental payments for those. • $750,000 for the California Health Interview Survey (CHIS), conducted by the UCLA Center for Health Policy Research, to provide child-specific questions to the survey. • $2 million for whole genome sequencing for children with undiagnosed or rare genetic defects in the CCS program.

	• $1 million was used to close out a pilot program that ended on June 30, “Vision to Learn,” which provided mobile vision services to children. There were unspent funds for the current FY for Proposition 56: $190 million for the physician services, and $30 million for dental services. DHCS will work with the Office of Statewide Health Planning and Development (OSHPD) and external stakeholders to construct a loan repayment program using the funds for dentists and physicians. They must make a multi-year commitment to serve Medi-Cal beneficiaries. The repayment program is not limited to specialists or geographic areas. Other allocations using Proposition 56 include: • Funding for physician services in the next FY is about $500 million. Overall, the supplemental payments for next year will total approximately $1.2 billion. • There were 13 codes with supplemental payments for physicians. Those supplemental payments have been increased to be roughly 85% of the Medicare rate. Ten new preventive health codes have been added, and those supplemental payments are now up to 100% of the Medicare rate in Fee-For-Service (FFS) and Managed Care. • For dental services, there is approximately $210 million which will equal approximately $550 million in supplemental payments for dental providers. The next AB 340 Workgroup meeting is scheduled for late August. On July 1, the Whole Child Model (WCM) goes into effect in two of our County Organized Health Systems (COHS): Central California Alliance for Health (Merced, Monterey, and Santa Cruz counties) and CenCal (San Luis Obispo and Santa Barbara counties). We’ve worked with the health plans and counties, certifying their networks and all the notices and beneficiary outreach. The two remaining COHS, Partnership HealthPlan of California and CalOptima, are slated to go live on January 1, 2019. *Marc Lerner, M.D.:* The loan repayment is just one example of an area where our young workforce has been struggling. There are concerns about the compensation being directed through Managed Care Organizations (MCOs) that may not get to the providers.

	Jennifer Kent, DHCS: These supplemental payments are structured as directed payments. When we provide the funding for these supplemental payments to the MCPs, they have to ensure that they are directly passing them to the providers who billed those codes, or if they are in a medical group, they have to go to the physician who is billing. *Marc Lerner, M.D.:* That would be an important message for us to get out to the primary care communities. I've been hearing from some of the pediatricians in our community about their sense of where they fall in terms of physician compensation and relative to other specialties. Because this is coming out as increases in specific rates, what does this mean in terms of relative compensation? *Jennifer Kent, DHCS:* We specifically chose codes that all physicians could bill, so it's not geared towards pediatrics or general practice. We were looking at services that would be the most utilized by the largest number of providers. Depending on the type of practice you have in terms of your managed care penetration, you will either see a significant increase because of these codes, or if you have a very limited amount of Medi-Cal patients that you see, you won't see much of a change. The inclusion of the preventive codes was very much a statement on what we would like physicians to be doing, which is bring patients in on a preventive basis. *Marc Lerner, M.D.:* Is there some type of vehicle for communication about these changes? It's hard to get these changes across to the provider community. *Jennifer Kent, DHCS:* We worked closely with the California Medical Association (CMA) on the development of this proposal. We would look to CMA if there's a messaging component. On DHCS' end, we'll include information in the provider bulletins, All Plan Letters (APLs), and through a stakeholder update. We're happy to provide facts: here's when we think the new payments are going to flow, here's what the structure looks like, etc. *William Arroyo, M.D.:* $254 million was returned to counties for repeal of state mandate, which was AB 3632; will this go into the general fund sub account for counties?

	Jennifer Kent, DHCS: It's getting returned however realignment works; I don't know if it's going back into the behavioral health sub account, or into their overall realignment general account. *William Arroyo, M.D.:* Could you speak to the $5 million item to establish a council on health care delivery system, with the legislative intent to establish universal healthcare? *Jennifer Kent, DHCS:* This is funding to support the external evaluation and research on universal coverage. *William Arroyo, M.D.:* My last comment relates to U.S. Attorney General Session's comments on not defending the ACA provision of preexisting conditions. How is California responding? *Jennifer Kent, DHCS:* If this is the Texas case, we along with 13 or 14 other states have already filed an amicus. I signed a declaration about significant harm that would come to the state should the ACA be overturned. *Jan Schumann:* You mentioned there's funding for the children specific questions for CHIS. Can the Panel be involved in this discussion and the development of those questions? *Jennifer Kent, DHCS:* The advocates that sponsored the request can probably better answer this. I'm not sure what questions they wanted to ask; they would have to work with the researchers on what those questions will look like. As a state department, we fund CHIS ourselves. I'm happy to reach out to the groups that sponsored the request and ask. *Ellen Beck, M.D.:* The council that you described, will that be under DHCS' purview, or under the Legislature? *Jennifer Kent, DHCS:* I would have to look at the final budget language; it's not under DHCS. It's either being convened through the Legislature or through the California Health and Human Services Agency. *Ellen Beck, M.D.:* Regarding children who receive SB 75 care, I heard that their parents could be held liable under public charge. It concerned me very much. *Jennifer Kent, DHCS:* That's correct. The concern that states and others have had around that pending draft regulation has

	been just that; whether you are a child that is an American citizen because you are born here, but your parents are undocumented, or if you are here under immigration status that is allowed, that would penalize other family members. *Ellen Beck, M.D.:* Regarding the children that are separated from families, is the state involved in any way in serving those children's health needs? *Jennifer Kent, DHCS:* I have limited knowledge on this. To the extent that a child has been removed because of a deportation or immigration issue, it's my understanding that children are being placed into licensed child care facilities overseen by the California Department of Social Services. To the extent that a child needs health services, either regular or emergent, we would most likely be the program providing those services. *Terrie Stanley:* Would those children be treated as if they were in foster care? *Jennifer Kent, DHCS:* They would. If a child meets income standards, regardless of their documentation status, they're Medi-Cal eligible. Residency in California is legally defined as you are in this state with an intention to reside here. *Ken Hempstead, M.D.:* I'll echo Dr. Lerner's comments about payment increases. If the providers and groups don't have a good awareness, then impact is limited in terms of getting services to beneficiaries. I think we should come back to the idea of what the CMA and DHCS can do to publicize that. With the Proposition 56 funds, it's a double-edge sword; we want people to stop smoking, but on the other hand, do the funds seem fairly steady? *Jennifer Kent, DHCS:* I'd have to refer to the initiative, but I believe it was not only attaching a tax onto tobacco products, but to electronic cigarettes and other types of delivery systems, which explains why the revenues have been steady. There's additional funding for Prop. 56 in the new FY because of the stability of the revenue, which includes the physician and dental loan repayment programs. With Prop. 64 (cannabis), there is funding dedicated to DHCS at the end of a very long line of other buckets that need to be filled. As of this year, there is still no indication from the Department of Finance that we will be provided funding in the next fiscal year. That funding was tagged in the initiative for youth programs on prevention and

	treatment for substance use. Prop 64 is a volatile revenue source.
Communication with Beneficiaries – Recap from April 19, 2018 Meeting	*Ken Hempstead, M.D.:* We have a generous amount of time to recap, have a discussion, and hear thoughts from the Panel on what we have been addressing for a while on the general communication issues with beneficiaries. My intent is to open this up for discussion to figure out what the Panel should do with the information, and what specific actions or recommendations we have. *Elizabeth Stanley Salazar:* I was absent from the last meeting, but the minutes were really good. The regulations are burdensome given the legal aspects and the necessary detail needed to communicate. We're operating on a railroad track that already is unintelligible to the average person looking for information. All of this information must be translated in multiple languages to a beneficiary. That's where we start, and I don't know how we make that accessible from a written point of view. I think some of the best efforts are done by navigators and people on the ground who are in contact with the consumer. In different settings, these individuals have the ability to support the navigation. How do we provide the navigators with this information? Regarding the information on DHCS' Health Care Options website, you can compare different health plans in the same county and the member handbooks are available in different languages. What struck me was the language on the pages that said "specialty plans," but it didn't link to the specialty mental health plan or the specialty substance use disorder plan. That should be all in one place. If you examine L.A. Care for example, their member handbook dives into the specialty mental health and substance use disorder plan numbers and links. We should think about other mechanisms of communication with consumers. I don't know how much more we can do to simplify the mandated communication. *Karen Lauterbach:* We see the beneficiaries receiving multiple notices and they'll get three different letters. I understand that certain things are legally mandated, but do they need to be? Maybe we should focus on how we can move the needle on this issue? If the beneficiaries are receiving three notices in one day with seemingly contradicting information, that doesn't help. *Terrie Stanley:* This is a tough topic because adults process

	information differently. As an adult learner, are you a visual or audio learner? I think we need to make sure there are multiple ways that information is available. If it's a requirement that the notice be mailed, which it usually is, a notice should be posted on the website at the same time. Most health plans have messages on hold, so perhaps something could be added to an on hold message for individuals who call in. Health plans are doing things around texting, but there are some concerns around privacy. I don't believe DHCS is collecting email addresses, but health plans have discussed doing this. Surveys used to indicate that beneficiaries received their health information from their primary care physicians. Now we're seeing more responses saying they're receiving their information from the health plan websites. The outcomes data is the piece that we should focus on. What is the response rate for members? This would help us determine if the message was getting through. Seeing if there's anything we can do to augment those messages would be helpful. *Ken Hempstead, M.D.:* This conversation should center on specific examples, such as the member getting three notices in one day. We would have to dig a little deeper to determine why that's happening, and is there a particularly pattern for why a member would get three contradictory notices? *Karen Lauterbach:* My understanding is that there's all these things that people have to be notified on. For instance, a child might be enrolled in Medi-Cal under a particular aid code, and then they change. To the parent, the benefits don't change; they are still enrolled in Medi-Cal. They are told they are being disenrolled in one notice, then they'll get a separate notice that they're being enrolled into another program. The notices will contain names of programs that don't mean anything to the beneficiaries. That's what we've seen, and the answer that we're always given is that the notices have to go out. It's a bureaucratic issue that can be very confusing. You have to hire a whole team of people to explain what these letters mean. *Ellen Beck, M.D.:* I often have patients coming to me who are terrified after receiving a government letter. The level of literacy is so complex, partially due to the legal language contained in the letter. As a Panel, we should try to be as specific as we can in terms of recommendations. To me, we should focus on literacy levels of letters being too high. I know the Consumer-Focused Stakeholder Workgroup focuses on this. I'm thinking about the dental help line number; is there an equivalent Medi-

	Cal phone number that patients can call? Is this number in large font at the top of the letters that are sent out? Perhaps the notices could include, “If you do not understand something in this letter, here is the Medi-Cal help line.” And it could be in the preferred language as indicated by the beneficiary. Promotoras are phenomenal at building a relationship. As you’re finding funding to reimburse certain codes, maybe there’s a code about physician or health provider communication on taking the time to explain the changes. The first step is looking at these examples, reduce fear, increase literacy, and is there anything we can do on a statewide basis, even if it’s including the Medi-Cal help line phone number. *Adam Weintraub, DHCS:* I had a clarifying question because Karen and Dr. Beck have both raised issues about multiple letters and alarming letters. It sounds like those are more in line with eligibility letters rather than the kinds of communication we discussed at the last meeting, which was communication from the managed care program. Is that accurate? *Karen Lauterbach:* Yes. *Ellen Beck, M.D.:* It aligns more with the eligibility department rather an education program. *Ken Hempstead, M.D.:* Despite the mandatory language that needs to be there for regulation, when a member gets these letters, is there a fairly obvious phone number or a website to visit with questions? *Jennifer Kent, DHCS:* If it’s coming from the county, then it does. We have mailings that are specific to court cases. When you see the data from Javier’s presentation, there’s data provided at the end of the PowerPoint presentation that indicates what happens when beneficiaries receive notices, which is the number of transfers over to the counties. The Ombudsman’s line is really intended for managed care issues, but many beneficiaries will call when they need something else. The Ombudsman’s Office will do warm transfers. We try really hard to communicate the best way we can within the limitations that we have. *Diana Vega:* There usually is an eligibility worker that works with families. Why doesn’t the eligibility worker have access to the

	letters so they can act as a point of contact? This could alleviate a lot of stress for families and providers. We can't expect the providers to fully understand the letters and try to determine where to direct the beneficiary. *Jennifer Kent, DHCS:* The eligibility worker can tell you who to call, but they can't solve all of the beneficiary's issues or concerns. Eligibility workers are not allowed to do plan enrollment, they can only do eligibility. Within any large call center or within the counties, there's an entire group of people spending their days trying to help people navigate. *Diana Vega:* What I'm talking about is explaining the content of the letters. *Terrie Stanley:* The big challenge is that the health plans don't make those determinations of eligibility. There are calls that come in from the plans on beneficiaries not understanding what their coverage is. We help connect them back to the county. And likewise, I'm sure the county or the physician will review letters that the plan sends. For the determination of coverage, health plans are required to send this not just to the members but also to the requesting provider. So the requesting provider does get a copy of that notice, so they should have it available to see what the determination was from the health plan. If there are issues around eligibility, those are not decisions that are made by the health plans, which is very different from how it works with commercial coverage. That's another big factor that plays into the confusion sometimes. If any major things are happening, health plans will send out information to their entire provider network. The concern is whether this information gets past the front desk to the provider. If there's a better way that the offices want health plans to communicate with them, I urge you to get with your provider network folks to determine who that contact should be. *William Arroyo, M.D.:* The complexity of the health system is so daunting. For a person with very limited health system literacy, it's very difficult for them to navigate. With the Los Angeles County Department of Mental Health, we have dedicated money to train health navigators for people who have mental health problems, and to help them get through the health care system because it is so daunting and threatening in some ways. I'm wondering if there are certain people who are supposed to be assisting on the health plan side that have a similar role, because it is really needed.

	Terrie Stanley: Every health plan is different. Most plans have a first line, the member services department, and there are different levels of member services representatives at each plan to help beneficiaries navigate. Within the medical divisions of plans, we have either care navigators or care coordinators to help and assist members navigate. When we get calls from members saying they have difficulties scheduling appointments with a practitioner, we'll help. On a clinical side, it's really more about navigating the medical system. *Elizabeth Stanley Salazar:* I wanted reiterate these concepts. 'In writing' is the chosen methodology. We also agreed that a lot of the communication is done by voice messaging. I love the fact that the word "threatening" was used. These are serious matters that are threatening to your well-being if you can't get what you need. With complex medical health issues, navigation has to occur. We may need to start infusing into the culture a realization that customer service need to occur at every level so that the consumer has access to a single point who can connect all of the dots for them. We can always improve literacy levels, and there are committees dedicated to this, but there's a cultural change that we may want to support. *William Arroyo, M.D.:* If your child has a severe substance use problem, where do you go? It's bewildering. *Ellen Beck, M.D.:* In San Diego, there's a service called 211 that people can call 24 hours a day. You can call with any housing or health issue. Does this exist in other places in the state? Is this something we want to support? With the letters that are sent out, perhaps we could have a line that says, "If you're having problems understanding this letter, here are some options." Referring to what Terrie mentioned, the whole teach back thing is not just about listening to the information, but somebody actually hears that you understood it. I was thinking about the presenter from Health Net's educational system; they have that kind of system in place. But because of the nature of our country, each plan and structure is different. We should communicate something similar to the dental line slider from a medical point of view. *Jennifer Kent, DHCS:* If we did 211 officially as a state, all 211 would do is direct you to the county if you had a question on county eligibility. We also don't want to frustrate people by

	putting them through 9 different handoffs. We will pull sample documents of what the notices say; here's what a standard notice on eligibility looks like. When they come out of our system or the county eligibility system, there are things in them that say, "If you have a question or think your eligibility is being wrongly terminated, this is what you do. Sometimes the notices will say "do not contact your county eligibility worker," because it's not a county eligibility letter, it's a health plan letter. The feedback we received from the Coordinated Care Initiative and Cal MediConnect is that we sent out too many notices. That's also an issue we're dealing with; we crossed a fine line of over noticing beneficiaries. We sent out three notices (90, 60, and 30 day) for the Whole Child Model. *Ellen Beck, M.D.:* In terms of 211's current practices, I'm very pleased that when a person calls, they're opening a file and gathering information and following up. It takes that level of navigation, but it works when it's countywide. *Ken Hempstead, M.D.:* Did we have an answer on whether other counties have a 211 system? *Jennifer Kent, DHCS:* We do in Sacramento. It's operated by United Way. *Terrie Stanley:* Many of the counties do. They're operated differently. I know for a fact that the one in San Diego is a fantastic one. *Ellen Beck, M.D.:* If the Panel is interested in this, it might be a place for the 211's to learn from each other. There are some practices in terms of health care and following up and networking across different resources so that one person has a file that they can connect electronically. This may be relevant in terms of what we've been discussing. *Jan Schumann:* You mentioned with Amy Turnipseed that the plans submit the information to DHCS for approval. In those approvals, is DHCS limited in the way that information is sent out, or can the plans send this information by email? *Jennifer Kent, DHCS:* It depends on what they want to send. In some cases, we'll deny the health plans request to communicate in a specific way. They will provide either a proposed template or a proposal of how they want to communicate with beneficiaries and we'll either approve it for electronic submission, but we'll put

	parameters around it. We have approved in limited formats the plans' ability for texting for appointment reminders, vaccination reminders. The health plan has to come to DHCS and tell us what they want to do and then we either approve, deny, or modify it. *Jan Schumann:* Our family received a very specific letter, DHCS 9060, which is also known as a 'yellow letter.' My wife panicked when she opened it. The language included, "your estate is subject to forfeiture or repayment for recovery of any payments for you." What wasn't included was exemptions for estates under the 50% market value as defined under SB 833. The back side of the letter was completely blank; the notice did not mention anything regarding the exemptions, and there was no email address or toll free number. *Ken Hempstead, M.D.:* That's a specific example, so that might be something we could address. Going back to 211, what are thoughts about whether we should address further or write a letter to the counties to suggest increased cooperative sharing and best practices? *Marc Lerner, M.D.:* Having a discussion would be useful. San Diego has the strongest 211 and I'm not sure if there's universal coverage. I would agree that if the best thing that is accomplished is another handoff requirement, that we really haven't aided the families. I was on the 211 board for Orange County and saw the nature of these calls and I don't remember this being a big aspect of their caseload. We can talk to someone who manages their call centers if we wanted to get some initial feedback; they'll let us know whether this is an area we can work on or not. *Elizabeth Stanley Salazar:* I have some concerns about that. Because it's a local issue, I would not sit here and presume that other counties aren't doing good jobs at it. Some key elements are missing on the Office of the Ombudsman webpage. If you added one link or if you added this one statement more to a website, you might get a better product. If the eligibility contact number was in a little box on the side that said, "if you're having eligibility problems with your plan, click here." There are simple electronic solutions, but it's more about the components and whether they are rich enough to provide information. Maybe we look at this more closely and provide suggestions for rich content for the website. Many of the counties have problematic sites and are trying to improve them.

	Ken Hempstead, M.D.: There may already be doing work around improving their website. Is there something specific or actionable that we're seeing that we worry is not being seen? *Adam Weintraub, DHCS:* One thing I would note to help frame this discussion is that the charge of this Panel is to provide advice to DHCS. If your advice is going to 58 counties and organizations that run independent 211's, then maybe you're exceeding your charge. There may be a channel that could provide more robust information than what we provide, and it's useful to do outreach to them, but when we're talking about 211 as a primary source for this kind of information, you run into issues of protected health information (PHI). To the extent that you see value in forging connections with 211 associations to make sure they are directing those individuals to DHCS' number that can handle those calls, there might be value there. It's been nice to hear specific examples being raised, but not many are on the managed care issues we discussed at the last meeting. There are basically three areas that the Panel identified as possibly needing their attention: 1) managed care plans' direct communication with beneficiaries, 2) eligibility problems was another topic we can bring to the next meeting (what the notices require, suggestions for improving the website, etc.), and 3) provider to provider communication about an individual case. I'm not hearing a lot of questions and thoughts pertaining to the first topic. *Elizabeth Stanley Salazar:* I visited the Health Care Options (HCO) website, and there are a couple of improvements that could be made. When you select the health plan options, you can choose the county to see the health plan materials. There are multiple places on this website that ask if you want to enroll, and if you are a Medi-Cal beneficiary. You can put these buttons or banners on the top of these same pages. Once a person is in a page, this page assumes that an individual is already enrolled and now they are going to choose their plan. I would also recommend including the specialty mental health plan and the specialty substance use disorder links as well. *Ken Hempstead, M.D.:* Dr. Arroyo, would that help address your concern that you raised earlier about where parents or family members can go for mental health assistance? *William Arroyo, M.D.:* To some degree. I wanted to follow up to what Adam said. Given the charge of this Panel and regarding the Cal Mediconnect survey that Jennifer mentioned, can the health plans serve as proxies for the effectiveness of

	communication? *Jennifer Kent, DHCS:* There are Consumer Assessment of Health Plans Survey (CAHPS). It's a national survey. It's asking consumers what their perceived attitude is towards their quality of health services. There are limitations to the CAHPS in that it's only in English and Spanish. *William Arroyo, M.D.:* If it's effective communication that we're most interested in, then testing some proxy or measurements might be worth consideration. *Ellen Beck, M.D.:* The reason I raised 211 was simply as a system that seems to work; it's not necessarily that we should reach out to them or have them attend a meeting. I just visited the DHCS website and there are two things that I would change. The way now the banner says, "Need help finding a Medi-Cal dentist?" I think there should be a banner that includes the Medi-Cal help line. The language choice on the website should be made larger, possibly as another banner option. The "help" link on the right hand corner of the website is actually for help to navigate the website and for computer literacy, and not for medical help. If one of our promotoras is with a patient and they're looking to ask a question, then that information should be much more visible on the website. *Jan Schumann:* I noticed that some websites use live chat, where someone can click on the link and type in the question they have. Initially, a bunch of resources would pop suggesting other links to try, and if you need more assistance, click here and a live chat person would come on from a customer call center. On the notices, I would like to see at least three forms of contact information to reach DHCS, including local resources such as 211 if applicable. *Ken Hempstead, M.D.:* This goes back to Terrie's point about having multiple ways to contact DHCS. I think we learned that some of the communications already have that but not as thoroughly as we would like, including the yellow letter. *Karen Lauterbach:* We should have a vision for what we're trying to accomplish. *Ken Hempstead, M.D.:* I agree. I'm optimistic that what I hear from this conversation. Most of the action items were website-based and fairly specific and inexpensive. Creating a more robust 211

	system or creating a live chat are good ideas but would take a lot more time and resources to put together as opposed to the recommendation with all three forms of communication on all notices, or the banner issues. *Elizabeth Stanley Salazar:* I wanted to return to what Terrie said which is critical to this Panel; our focus should be on outcomes. If we're talking about communication, how do we know if we changed the outcome for beneficiaries? What can we learn from access data? We previously discussed incentivizing plans; they'll be innovative. They'll hire navigators and care coordinators. *Ken Hempstead, M.D.:* Maybe we should have a refresher for the Panel for what's already in place, or at least some element of tracking customer service, communication, member satisfaction, etc. *Pam Sakamoto:* While there are many navigators and case managers in multiple programs in the county I work in, it has not gotten rid of the churning Medi-Cal population. The health plans should be enticed to track data on the member churn. I've dealt with Medi-Cal clients for over 35 years and their plan coverage is better than a lot of private insurance plans that I've also dealt with in the CCS program, and I do believe they are satisfied with the services. There's a small population that has difficulty in access or remaining and keeping their access. *Jennifer Kent, DHCS:* We let the health plans reach out to beneficiaries. When the enrollment file gets sent to the plans, they can see when the redetermination date is. The MCPs reach out to the beneficiaries prior to their redetermination to see if they need any help. We've been doing that since 2014. That has helped cut down on the churn slightly. We have put in some efforts that allow MCPs to do limited outreach to this population. *Ellen Beck, M.D.:* Do you have any suggestions for the Panel? *Jennifer Kent, DHCS:* From a homework perspective, I would ask the Panel navigate the DHCS website. Pretend you're a beneficiary who needs mental health services; try to navigate through out website to see if you can find those services. We will pull a sample of our most common notices. We'll ask the Panel if there's anything we can do to improve. There are a couple of different ideas that I have on ways to pursue

	more discussion. I would also ask the California Welfare Directors Association or representatives from the counties to come in to talk about how their portals work. Each of the counties have put into place portals for beneficiaries to access the county system, not only for Medi-Cal benefits, but for SNAP, CalWORKs, etc. Having the counties discuss what they do to help beneficiaries navigate the system is an important piece. I would have a consumer advocate perspective. Consumers Union, National Center on Law and Elder Rights, Western Center for Law and Poverty, Health Access, and the California Pan-Ethnic Health Network (CPHEN) have their own mechanisms by which they help beneficiaries navigate the system. This is an important perspective for you to have in terms of communication and consumer issues. *Diana Vega:* After navigating the website, the issue is if you click on the county, it opens an outside website. Each county navigates differently; how can we make a uniform system? *Jennifer Kent, DHCS:* Some of these aren't going to change if we're directing the links to the specific health agencies within the county. The counties themselves will be consolidating into a single eligibility system by 2023. *Marc Lerner, M.D.:* We were struggling with our website for one of our professional societies. It's common when you go to a webpage, there's a popup that says, "were you able to find what you were looking for on this webpage?" The actual users should be able to provide some feedback to the website managers. *William Arroyo, M.D.:* The various IT departments of Los Angeles county met because the LA County Department of Mental Health had a major problem with identifying racial and ethnic backgrounds. What was being reported to us from DHCS did not match our own internal data. We discovered, meeting with the IT folks from five different departments, that every department had different codes for the same group of people. Somehow it impacted the MEDS system as well. We learned that the last person to input data is the one that sticks in the system. The controls are all but absent. When I hear there's going to be one system, will the data be any more meaningful when that transpires? *Ellen Beck, M.D.:* If we identify suggestions related to DHCS' website, but also to communication issues we see in the particular county websites, we're still in a position to make recommendations. We have to take the responsibility to look

	through various county websites and come back and say it was reasonable, or had no idea where to begin. *Ken Hempstead, M.D.:* It sounds like there's continued interest in this. It sounds like there's additional homework on both ends. Ultimately, part of our goal for today is figuring out next steps, including determining content for that meeting. *William Arroyo, M.D.:* Is the CHCF dataset a reasonable thing to also look at? *Jennifer Kent, DHCS:* The dataset around the poll is aggregated data; it's a few pages, I can find it. The Blue Shield Foundation of California was the main funder. *Ellen Beck, M.D.:* We should look at suggestions that came out of this meeting, and then next steps for further learning. We should also bring examples, such as a frightening letter to a beneficiary, for further examples. *Ken Hempstead, M.D.:* We should decide if we want to invite consumer advocates or the counties to present. We're agreeing and recognizing that those are voices we have not heard, but how useful of a voice will that be? *Jennifer Kent, DHCS:* It will be similar to how the health plans came in and gave their presentations. This Panel hasn't talked much about managed care communications since then. The counties should present what they do so the Panel can have more understanding about what your recommendation is based on. The same for the consumer advocates because if what you're saying and what I hear you saying is communications are overly legalistic, long, unwieldy, etc., then I think that's an interesting perspective for them to hear. It's an important voice for the Panel to hear as you make informed and concrete recommendations.
Office of the Ombudsman Update	Link to presentation: http://www.dhcs.ca.gov/services/Documents/Ombudsman_Update.pdf Javier Portela provided an overview of the Medi-Cal Managed Care Ombudsman program. The Office of the Ombudsman's main objective is to serve as an objective resource to resolved issues between Medi-Cal managed care members and MCPs. Javier talked about the new Voice Over Internet Protocol (VOIP) system. The previous system only allowed for a maximum of 14

	lines to be in use; the new system allows for 80 lines. *Marc Lerner, M.D.:* Regarding the self-service menu options, if you're looking to speak to someone about Medi-Cal FFS, would you push 3? *Javier Portela, DHCS:* All of this is telephonic. *Marc Lerner, M.D.:* So this is a series of button pushes that would move you into the self-service menu? *Javier Portela, DHCS:* Correct. *Marc Lerner, M.D.:* Do you begin with a language option? *Javier Portela, DHCS:* We do begin with a language option. Our office is staffed with English and Spanish speakers, and there is an "other" languages option, which uses a third party line to help the beneficiary. *Ellen Beck, M.D.:* You use an intermediary service to help with all other languages? *Javier Portela, DHCS:* We use a language help line, which has 120+ languages. Many will call with that person on the line already, or we can engage that person if we need to. *William Arroyo, M.D.:* Are there other standards in other states to which you compare yourself? *Javier Portela, DHCS:* We don't compare ourselves to other states; we consider ourselves to be a help center. *William Arroyo, M.D.:* The Centers for Medicare & Medicaid Services doesn't have any metrics for this? *Javier Portela, DHCS:* No. We do have metrics in other call centers that are performance based that we have for contractors, but this is a state-staffed office. We're essentially there to help beneficiaries get what they need. No matter how long or short that call is. *Jan Schumann:* Regarding the abandonment rate of calls, do you have any matrix on those calls, such as who called and those calling back for assistance?

	Javier Portela, DHCS: We don't track caller ID numbers in our office. It could be someone calling in many times. *Marc Lerner, M.D.:* Do you let people know the average wait times? *Javier Portela, DHCS:* We don't have that ability. Those methodologies are things that our current contractors have not deployed for us yet. *Jan Schumann:* What is the top 90-100% of wait times? *Javier Portela, DHCS:* I'm not sure. Some beneficiaries may have a long wait, but our average hold time is 6 minutes. *Marc Lerner, M.D.:* What percentage of your clients have an understanding of what "ombudsman" means? There's a minority of the general population that could define ombudsman, and it would rarely come up as the place you would call for help. It's a critical number, and I'm wondering if the phone line might be relabeled. *Javier Portela, DHCS:* We are described in every managed care material that goes out. *William Arroyo, M.D.:* Do you see upticks in the number of calls, such as in January? *Javier Portela, DHCS:* We usually do see a lot of calls in January because folks are going through open enrollment. Our phone numbers are widely advertised. Also during school season when children need vaccinations. *Jan Schumann:* Do you bring in additional temporary support for the 31% increase in call volume from December to January? *Javier Portela, DHCS:* No. *Diana Vega:* What kind of services are covered under the self-services? *Javier Portela, DHCS:* The self-service is just a referral service. *Diana Vega:* Is there a percentage based on the language selected, or is it just by the number of callers regardless of the language they speak?

	Javier Portela, DHCS: We do track our English and Spanish calls, but once they select the "other" option, we can't track those languages. *Karen Lauterbach:* Do you have the breakdown of English and Spanish? *Javier Portela, DHCS:* It's posted on our website and we can share that with you. *Ellen Beck, M.D.:* I'm interested in your follow up mechanism. Does staff check in with the beneficiary a week later? *Javier Portela, DHCS:* We're not a resolution center. We do tend to close all of our cases on the phone. We will follow up with some just to make sure things were resolved, but this is case-by-case. We do refer cases to the Department of Managed Health Care (DMHC), which is a resolution center. If there are grievances against a provider or the benefits of the plans, they can log a formal complaint there and have it researched and resolved. We will also refer cases over to our contract management office, and we will follow up with the plan and member. We're not typically an outbound calling system, generally just inbound. The majority of our calls are about the eligibility and enrollment system, and how to get into the right delivery system. *William Arroyo, M.D.:* There's no coverage on the weekends? Has this been a problem for enrollees? *Javier Portela, DHCS:* We're not open on weekends or state holidays. This has not been a problem; most provider offices aren't open on weekends or state holidays. *Jan Schumann:* What is the email address? *Javier Portela, DHCS:* It's on our website: MMCDOmbudsmanOffice@dhcs.ca.gov *Jan Schumann:* Is there a fillable form for beneficiaries to fill out online? *Javier Portela, DHCS:* No. Only County staff can use the fillable form. The fillable form is only for changing your plan from one to another. It's not a contact point.

	Ellen Beck, M.D.: Do you have any concerns or areas that could be improved? *Javier Portela, DHCS:* Our largest volume of discussion is about enrollment and disenrollment. The DMHC seems to fulfill the complaints very well. *Ken Hempstead, M.D.:* Going back to the Ombudsman title and lack of literacy, how does the beneficiary know about this division and know of your existence? *Javier Portela, DHCS:* We are posted on every Medi-Cal publication, and we've been around for two decades. Word of mouth is also another big factor for us. *Ken Hempstead, M.D.:* Most of focus is on recognizing that there are robust resources, yet it doesn't always trickle down to the beneficiary. Even though it sounds simplistic, somehow beneficiaries' needs aren't getting met. We're trying to explore how to make it even easier and simple for the beneficiary to get where they need to go. If this was so seamless, we wouldn't be having these discussions. *Marc Lerner, M.D.:* Some of these systems will allow a one question feedback about the experience to the people who use the system. Do you have that capacity, and as part of your self-evaluation, are you gathering this feedback? *Javier Portela, DHCS:* There is a feedback option that we have not taken advantage of, and it's possible that we might explore it at a later time. *Marc Lerner, M.D.:* I tend to think that ombudsmen are typically involved in dispute resolutions. *William Arroyo, M.D.:* You mentioned that you refer plan complaints to DMHC. Is that a special unit at DMHC? Can you describe the common problems that you refer to them? *Javier Portela, DHCS:* They're the licensing entity for many plans. If you want to file a formal complaint with the plans' licensing entity, DMHC has a call center for that. They actually log them and try to make a resolution determination, and may work in additional fines.

	William Arroyo, M.D.: Do the plans have Ombudsman's Offices? *Javier Portela, DHCS:* They're not called the Office of the Ombudsman, they're called customer service centers, call centers, or member services. *William Arroyo, M.D.:* Do you refer any calls to them? *Javier Portela, DHCS:* We collaborate directly with them. Most of the time, it's a three-way call with that office. Most of our points of contact are their actual member services offices. *Karen Lauterbach:* If a beneficiary has an incorrect health insurance attributed to their case, does the Ombudsman's Office take that other insurance off of their case? *Javier Portela, DHCS:* We're not the processing office, but we can help them get that assistance. There's actually an online form for that now, so we will either help them fill out the form or get them to the form. *Karen Lauterbach:* Do you track certain trends? *Javier Portela, DHCS:* Our tracking is mostly what we see in our call center each day. As we enhance our system more, we hope to have more indicators to help us see additional trends. *Karen Lauterbach:* Do you think the in-person calls could have been handled by the automatic system? *Javier Portela, DHCS:* Before we had the automated system, we did find a majority of the calls were for tracking down other phone numbers. Once we got our self-service option, we saw those trends go down. *Paul Reggiardo, D.D.S.:* You mentioned that you get about 2,000 calls per year that you handle regarding Denti-Cal. What type of resolutions do you provide? *Javier Portela, DHCS:* If someone calls and is not a managed care enrollee, we will direct them to the FFS or Denti-Cal area. *Paul Reggiardo, D.D.S:* If a patient is enrolled in Sacramento Geographic Managed Care (GMC), and they feel they have a problem, do you work with the dental managed care (DMC)

	plans to resolve those issues? *Javier Portela, DHCS:* No, it's just for our medical MCPs. *Jennifer Kent, DHCS:* Both GMC and DMC are handled by Denti-Cal. *Paul Reggiardo, D.D.S.:* For those 2,000 calls, do you give them another number to call to resolve it? *Javier Portela, DHCS:* I think that number is the self-service number, and the beneficiary will push a button to be transferred over. *Paul Reggiardo, D.D.S.*: On the Denti-Cal side, FFS and DMC, I know there's a beneficiary ID number and you can request to access a provider. Are there any other services that DHCS provides that are similar to what the ombudsman does for the medical MCPs? *Jennifer Kent, DHCS:* Javier has the mental health ombudsman responsibilities as well as the Medi-Cal managed care side. The Denti-Cal Administrative Support Organization, which is Delta Dental, is responsible for running member services for beneficiaries that call in and need dental services. They handle both DMC and FFS. We have a FFS call center through Conduent, our fiscal intermediary. If you are a provider or beneficiary with a FFS issue, they will help navigate. *Javier Portela, DHCS:* We have a beneficiary support system which we house on our HCO website. The goal is to have one place where beneficiaries can go to find all these pieces we're talking about. We started that in July 2017. *Ellen Beck, M.D.:* Is there a backup call center? *Javier Portela, DHCS:* That website can give you places to call. Our HCO call center is also open. *Ellen Beck, M.D.:* It might be a useful thing to share or to have that available to beneficiaries. *Jennifer Kent, DHCS:* We can send the link to the page. *Ellen Beck, M.D.:* You mentioned mental health. If someone called in with a problem with mental health services, would they

	go through the Ombudsman's Office? *Javier Portela, DHCS:* We do handle the physical and mental health needs of the beneficiary and help them to navigate both systems. *Ellen Beck, M.D.:* When someone calls in, do you take the person's name and information, or do you only track when necessary? *Javier Portela, DHCS:* We track all of our calls at a beneficiary level assuming they have Medi-Cal. It's in a very old system, which is why it's hard to derive information from it. Until our new system is in place, we can't do much. *Ellen Beck, M.D.:* That would be the area I would like to come back to on the idea of outcomes and following up with the beneficiaries. It would help us see if the goals are being achieved. *Javier Portela, DHCS:* I'll share the information to the Managed Care Advisory Group, where we report out the quarterly statistics for those calls and the types of calls.
Member Updates and Follow-Up	The Panel decided to hold a meeting on August 22, 2018. Ken Hempstead announced that Julie McReynolds is the newest parent representative. Liliya Walsh has been absent from most MCHAP meetings. Dr. Hempstead talked about next steps for potentially reaching out to her.
Public Comment	*Kelly Hardy, Children Now:* Regarding the Prop. 56 payments, do we know when the funding would start flowing, and do we have any idea about the percentage of funding being directed towards pediatricians? *Jennifer Kent, DHCS:* We continued the existing 2017-18 funding, so the supplemental payments that were approved last year are going to continue past July 1. Those supplemental payments will continue to flow. We will be posting the public notices for the rate increases soon. We're tracking some programming changes through our claims system on the FFS side that we're hoping will happen in the Fall, so by October or November is when we think the retroactive supplemental payments will be calculated back to July 1. The directed payments for the MCPs started in May for the 2017-18 directed

	payments. The MCPs are catching supplemental payments all the way back to July with their May capitation payments. The new increases will likely be seen in the first quarter in 2019, which will be retroactive back to July. On the dental side, the 17-18 continue untouched and the new changes are being programmed in to the system by the vendor. Those are on track to be done in the fall. *Kelly Hardy, Children Now:* I certainly heard the will around some of the MCHAP members about making sure the providers are aware of these changes, and I can circle back to some of our provider partner organizations about that. *Kristine Marck, California Medical Association:* It would be great to have more opportunities for those on the phone to join in on the conversation. My feedback on the ombudsman report is that it would be great to have the type of grievances that the ombudsman gets on the dashboard so that we can see those complaints, and whether they come in from the health plans through the Telephone Service Center, or the ombudsman. Regarding the Prop. 56 funding, I heard retroactive was to start in October. For the prospective changes in 2018-19, when do you foresee those changes being reflected in payments going forward? *Jennifer Kent, DHCS:* The 2017-18 payments are continuing unchanged starting now and into the next fiscal year. We are saying that the 2018-19 payments that were just approved by the Legislature are retroactive to July 1, 2018. It's effective on a supplemental payment basis on a fiscal year. Those 2018-19 payments will hopefully be running by October or November, and they'll retroactively be calculated back to July 1.