State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

April 19, 2018

Meeting Minutes

Members Attending: William Arroyo, M.D., Mental Health Provider Representative; Ellen Beck, M.D., Family Practice Physician Representative; Ron DiLuigi, Business Community Representative; Kenneth Hempstead, M.D., Pediatrician Representative; Marc Lerner, M.D., Education Representative; Bert Lubin, M.D., Licensed Disproportionate Share Hospital Representative; Paul Reggiardo, D.D.S., Licensed Practicing Dentist; Jan Schumann, Subscriber Representative; Diana Vega, Parent Representative.

Members Not Attending: Elizabeth Stanley Salazar, Substance Abuse Provider Representative; Liliya Walsh, Parent Representative.

Members attending by Phone: Karen Lauterbach, Non-Profit Clinic Representative; Pamela Sakamoto, County Public Health Provider Representative; Theresa Stanley, Health Plan Representative.

Attending by Phone: 25 stakeholders called in

DHCS Staff: Jennifer Kent, Javier Portela, Stephanie Conde, Alani Jackson, Adam Weintraub, Morgan Clair, Joanne Peschko.

Others: Hoa Su, Health Net; Amy Turnipseed, Partnership HealthPlan of California; Dharia McGrew, California Dental Association; Kelly Hardy, Children Now; Sean O'Brien, United Healthcare; Miriam Faulkner, United Healthcare; Peggy Rossi, Aetna Better Health of California; Elizabeth Evenson, California Association of Health Plans; Susan McLearan, California Dental Hygienists' Association; Anna Hasselblad, United Ways of California; Jane Blomquist, Aetna Better Health of California; Martha Hanson, Parent.

Opening Remarks and Introductions	Bert Lubin, M.D., MCHAP Chair welcomed members, DHCS staff and the public and facilitated introductions. Ron DiLuigi read the legislative charge for the advisory panel aloud. (See agenda for legislative charge.) http://www.dhcs.ca.gov/services/Documents/MCHAP_agenda_041918.pdf Dr. Lubin called the meeting to order and thanked Dr. Beck for her leadership over the past three years. Minutes from January 31, 2018 were approved. http://www.dhcs.ca.gov/services/Documents/013118_MCHAP_minutes.pdf *Adam Weintraub, DHCS:* Responses to the follow-up list have been posted to the MCHAP web page. *Bert Lubin, M.D.:* Wendy Longwell, one of MCHAP's parent representatives, informed us that she will no longer be able to serve on the Panel. I want to thank her for the work that she has done. I also want to recognize the importance of having committed members serving on the Panel. Any advice on identifying a replacement? *Adam Weintraub, DHCS:* For past vacancies we placed a notice inviting applications on the MCHAP web page and emailed stakeholders about the vacancy. The Director will review the applications and consult with the Chair about candidates. **General Update:** *Jennifer Kent, DHCS:* We're working with the Department of Finance on finalizing the May Revision, which will be released on or around May 15 by the Governor. In January, we worked with stakeholders and the Legislature to make sure the Proposition 56 funding was fully appropriated to add additional services for supplemental payments where appropriate. The funding has not been fully expended in the current year. The AB 340 Trauma Screening Workgroup is having its first meeting on April 20, 2018. This is a 25-member group that will either provide referrals or suggestions on trauma screening tools. The Department of Social Services will also be in attendance given their work around the Continuum of Care Reform. There's a pending draft federal regulation around what would constitute public charge for individuals without satisfactory documentation status. The most concerning thing to the State is

	that it would apply more broadly to children with American citizenship; if their parents are here in the country using any services such as Medicaid, CalWORKs, SNAP, etc., that would constitute as a public charge. It also would include local and state funded programs, even those without federal funding. Broadly, the Administration will work to communicate concerns to the appropriate federal officials at the right time about our beneficiaries and the impact to populations we cover through our state-only programs. Dr. Beck asked us to speak to some of the states that have State Plan Amendment (SPA) 1115 waivers tying Medicaid to work requirements. Some states are requiring certain able-bodied adults to have community engagement, such as working. A number of states have been seeking waivers to hold these requirements to certain types of populations, but California has not. California has several components in its existing waiver. The Dental Transformation Initiative (DTI), which is funded through Designated State Health Program funding, will be ending at the expiration of our current 1115 waiver. Since we negotiated the DTI funding, the federal government has since issued guidance that states will not be allowed to use this funding in future waivers. The other component of the waiver that may not be continued is the Public Hospital Redesign & Incentives in Medi-Cal (PRIME) program, which is tasked with rebuilding or redesigning hospital systems, focusing them more on preventive care and building outpatient capacity, and looking at quality in terms of preventable admissions, infection rates, cultural and linguistic capacity. These funds were previously available within the Delivery System Reform Incentive Payment (DSRIP) program. There have been ten years of funding from the Federal government to help our hospitals do critical infrastructure and quality improvement work, but they may not be willing to fund an additional five years. Medi-Cal's entire managed care program and our new Substance Use Disorder (SUDs) Organized Delivery System are also in the waiver. Lastly, our Whole Person Care (WPC) pilot allows counties to provide comprehensive supportive services to high-cost or particularly challenging or medically complex patients. *Marc Lerner, M.D.:* How can the quality improvement work of these innovative programs be incorporated in efforts of

	supporting the Triple Aim? For example, how would teledentistry be supported in the DTI, and what's the path forward? *Jennifer Kent, DHCS:* For dental in particular, there have been significant investments that the state has made recently, including: the ten percent rate restoration in 2015/16, the DTI which had another infusion of funding, Prop. 56 supplemental payments that were directed toward dental, and the Legislature restoring full adult dental benefits. However, given the infusion of cash into the dental program in particular over the last 2-3 years, provider participation hasn't increased in the way we thought it would. At the end of the DTI, we have to do an overall evaluation for each of the domains. Once the evaluation is complete, it starts the conversation of which domains saw the most dramatic results, and would the State be in a position to want to fund in a different way? We could have a discussion with the State Oral Health Director on making silver diamine fluoride (SDF), which is a benefit that is only being provided in the DTI, available for children, or certain populations. *Paul Reggiardo, D.D.S.:* For the SDF, it's a program benefit. We know that it was a benefit in close to 40 of the states. There's legislation that would make SDF a program benefit in California. *Bert Lubin, M.D.:* Phenomenal review of the issues. Is there anything we can do as a Panel to advocate for? *Jennifer Kent, DHCS:* During one of the previous meetings, I had posed a question about one of the vexing issues, which is the high no-show rate in the dental program. We've struggled as a program, and we also look at what happens at the commercial dental plans and they have different mechanisms they can employ. As a component of the DTI, we have committed to increase utilization of dental services by children by ten percentage points over the next five years. How we communicate that the benefit is available to children can always use feedback. We are always looking for opportunities for how other waivers could help highlight the services that are available. *Bert Lubin, M.D.:* We could market this more and do more educational things, but I'm extremely impressed with how First 5 has been putting out content, which encompasses a lot of the things we do. Is there a budget to do something like that related to dental services?

	Ellen Beck, M.D.: As one of my roles as an educator at a medical school, I emphasize with every medical student the importance of integrating dental health. Most medical schools in the state and the country have one hour per year focusing directly on oral health. It could be more than one hour. As the MCHAP, we could send a letter to deans of medical schools to advocate, recommend, collaborate, or learn about how the schools are addressing the important oral health needs. *Bert Lubin, M.D.:* We could function as an organization that goes out into the community. *Paul Reggiardo, D.D.S.:* I wouldn't put very much focus on the no-show rates. That's something that the provider can solve. Offices can address this in certain ways, such as overbook by 25%, decide to have Saturday or evening hours, do more outreach to confirm appointments. The fees that are being paid are not something the provider can control. For the DTI, there are two different areas of Prop. 56 funding – that's something that can be solved within the Department. When you were asking what the Panel can do, we should look at the results of the DTI; which of the programs are the most effective, and then help DHCS in deciding which would be the program they should go forward with once federal funding is received. We can make recommendations or look at DHCS' recommendations for ways to move forward. We would need to look at the very discrete data – which domains work in the counties that have a large number of providers versus a county with only a few providers. The preliminary data indicates in the first year that we're exceeding those expectations of increasing ten percent. The 47 percent utilization is a very low bar and we need to look at getting that up to around 60 percent as the Little Hoover Commission has pointed out before. Lastly, going back to the medical schools and addressing dental issues is futile. I don't think it will make a change in the delivery of dental services to the pediatric population. *Bert Lubin, M.D.:* Almost every medical school covers health equity, and the access to dental care is an example of not having health equity. I think we could advocate as Jennifer suggested. I wanted to ask about what we could do regarding public charge. Public charge will cause loss of services to the many children we see. It will have a dramatic, negative impact of the health for children in Medi-Cal. *William Arroyo, M.D.:* This is a major concern of all the things in

	Director Kent's updates. Is there a federal draft document that we could review? *Jennifer Kent, DHCS:* To the extent that it gets put out as a promulgated regulation, I believe there will be significant comment and/or legal action to prevent it from being implemented. *Bert Lubin, M.D.:* For WPC, are there pilots that are just pediatric oriented, and could there be? *Jennifer Kent, DHCS:* WPC was built based in part on a concept from San Diego county. The top 25 users from their 911 system had SUDs, serious mental illness, they were in jail or ERs, and had a lot of overlap with different public entities. Once we realized that these individuals were in every single program that San Diego operated, they provided comprehensive wraparound services for these individuals in terms of finding housing and helping them with mental health and SUD. These supportive services have lowered the overall costs. That was how the WPC pilot was built. The high-cost users in the Medi-Cal population are not typically children. The WPC pilot is about managing high-cost individuals with avoidable cost and reducing those. Typically, the pediatric population with high medical expenditures are not avoidable because they have significant medical conditions that are extremely expensive and can't be avoided. *Bert Lubin, M.D.:* Are medical homes different than WPC? Is that supported differently in terms of improving care and reducing costs? *Jennifer Kent, DHCS:* Yes. We looking at care coordination as an opportunity for DHCS more broadly. The outcome of that is not necessarily pediatric-focused; we're trying to figure out if there's a better way to coordinate care across the different delivery systems. The pediatric population, especially those with high-cost or medically complex needs, would benefit. *Bert Lubin, M.D.:* Can you give us an update on California Children Services (CCS)? *Jennifer Kent, DHCS:* The Whole-Child Model implementation goes live in several counties on July 1, 2018, followed by Orange County and Partnership HealthPlan in January 2019. At the recent CCS Advisory Group (AG) meeting, we discussed

	network adequacy, health plan readiness reviews, and shared the 90, 60, and 30-day notices with families and beneficiaries. The counties going live in July are CenCal Health (Santa Barbara, San Luis Obispo), Central California Alliance for Health (Merced, Monterey, Santa Cruz), and Health Plan of San Mateo (San Mateo). *Bert Lubin, M.D.:* How can we communicate with the CCS AG? *Jennifer Kent, DHCS:* Ask to be added to the CCS e-mail distribution list at CCSRedesign@dhcs.ca.gov. *Ron DiLuigi:* Has DHCS monitored the other states that make these proposals, particularly in regard to the community engagement charge? How many of those waiver proposals are work-required? *Jennifer Kent, DHCS:* The National Association of Medicaid Directors share the public documents. There are a handful of states that have community engagement requirements. *Ron DiLuigi:* Are they work related? *Jennifer Kent, DHCS:* They have to be either actively searching for work, in a work-related activity, or volunteering at a non-profit. There are broad brushstrokes for what they consider to be community engagement. CMS says 'community engagement' because it's not just work, but work is a component for what they are considering community engagement. *Ron DiLuigi:* How would this impact children's health care? *Jennifer Kent, DHCS:* Each state is very different. What we do in California is very different than what other states may want to do. *Ron DiLuigi:* I'm more concerned about what the negative consequences would be. *Jennifer Kent, DHCS:* If you read some of the documents in the different states, each state has a different perspective on how they want their Medicaid program to operate. California's Medicaid program doesn't look like any other state, and that is what make it a unique contract between each state and the federal government.

	Marc Lerner, M.D.: In reviewing the pediatric dashboard on child immunization status – combination 3, there was a drop of about 4.5 (percentage points) from 2014 to 2016. Immunization rates need to go up, not down. In terms of quality, what are we doing to identify the differences across different health plans, geographic areas, or techniques? What is DHCS doing to move these numbers? *Jennifer Kent, DHCS:* Our Managed Care Quality Monitoring Division is responsible for the monitoring of these kinds of quality metrics. Dr. Amarnath has presented here before. We track the health plan data on specific measures and then post aggregate numbers, including vaccination rates, mammogram screenings, and other metrics. We look at the trends and ask if there are changes that need to be made to improve outcomes. If we have a plan that drops below a minimum performance standard, we contact their Chief Medical Officer and ask about their data, and also ask them to do a Quality Improvement Plan (QIP) to bring up a particular quality score. We also could put the plan under a Corrective Action Plan (CAP). *Marc Lerner, M.D.:* It would be helpful to us as a Panel to have a review of the child-aged focus of CAPs and other interventions that have happened over the last year, and to be aware of DHCS' efforts in those areas. *Jan Schumann:* How could this Panel give guidance or recommendations on the proposed waivers that DHCS will be seeking in 2020? *Jennifer Kent, DHCS:* We will have to post a draft waiver proposal six months before the expiration of the existing waiver, which means we have start engaging in discussions in the fall of 2018/Winter of 2019. Not only is our 1115 waiver up at the end of 2020, we also have a 1915 waiver for Specialty Mental Health Services that's up in August of 2020. *Ellen Beck, M.D.:* In the legislative update document, SB 974 was related to single-payer for undocumented adults. *Jennifer Kent, DHCS:* The Senate has heard proposals to cover all undocumented individuals in California. There's no fiscal analysis related to that yet.
DHCS Communication	DHCS' presentation can be found here: http://www.dhcs.ca.gov/services/Documents/DHCS_comm_ben

with Beneficiaries	eficiaries.pdf *Jan Schumann:* On slide 7, are the forms available online? *Stephanie Conde, DHCS:* Yes, on the Health Care Options (HCO) website. *Javier Portela, DHCS:* I just wanted to highlight for this group, in July 2017, the managed care final rule required DHCS to include a beneficiary support system. We utilized the HCO website to develop that; all materials must be available on the HCO website and the content must be downloadable. This portal is about our non-County Organized Health Systems (COHS) plans. *Bert Lubin, M.D.:* Have you done surveys of beneficiaries on how they feel about the information they receive? Do they understand it? *Javier Portela, DHCS:* We do conduct CAHPS surveys to determine if beneficiaries received the information and did they understand it, and how would they rate their health plan. We also track returned mail, and whether increasing call campaigns is necessary. *Bert Lubin, M.D.:* Did you get positive feedback? *Javier Portela, DHCS:* We generally received positive feedback from the surveys; the beneficiaries received the information and understood it. There are challenges with getting feedback as well. From our experience in surveying beneficiaries, we found that the time of day is important, and you can't call everyone during the 8 a.m. – 5 p.m. hours because most are at work. Some surveys we actually conducted after hours. A great example is when we transitioned the Healthy Families Program to our area – we conducted the calls between 5 – 7 p.m. because we knew beneficiaries would be home. *Marc Lerner, M.D.:* I'm just curious about agents of transition in vulnerable populations. Can you elaborate on efforts for older teens to inform them about the health care system so they can establish routine care as they start to become independent adults? *Javier Portela, DHCS:* I think you're referring more to marketing of Medi-Cal versus what we're talking about now, which is once

	a beneficiary becomes eligible, here are the choices and services. We do use social media as marketing tools. California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) has done a lot of marketing. *Jennifer Kent, DHCS:* CCS has an intentional transition policy because of the significant need of that population or their ongoing need for medical care. We start engaging children at age 14. The guidance given to the counties is that they need to start talking to parents and children earlier. In Medi-Cal, more broadly, to the extent that a child emancipates or they are independent, they would have to seek to come back to the Medi-Cal program. Former foster youth, whom we cover up to age 26, receive a notice saying that their eligibility for Medi-Cal is going to be coming due. We usually give about 3 months' notice. It's not necessarily a transition, it's more of an eligibility issue. The vast majority of children in CCS are also enrolled in Medi-Cal. *Marc Lerner, M.D.:* I think it's just a health literacy challenge broadly for the population of young adults to understand this process of maintaining coverage. *Jennifer Kent, DHCS:* The great thing about Medicaid expansion is that we don't have open enrollment. To the extent that someone has aged out of their parent's coverage, they're still able to qualify. The great thing about Medi-Cal is that we do presumptive eligibility and there's retroactive coverage, and we are open year round, so you don't have to wait for a qualifying event. *Jan Schumann:* If I happened to come across the HCO website and am from a county that isn't part of MCO, I would find it very beneficial to see which counties participate. Are there any goals to include additional languages other than English and Spanish forms on that website? *Javier Portela, DHCS:* The requirement was primarily for MCOs, so we wanted to focus on those first. We are looking into this, just so you are aware. As far as English and Spanish, which are the two threshold languages, we do translate all materials in what is now 16 threshold languages. We have the taglines on our website which direct beneficiaries who don't speak English or Spanish to call us. In the call center, we speak all the languages in person. Beyond the 16 languages, beneficiaries have access to over 100 languages through a language

	assistance line. *Jan Schumann:* Are the call centers from the beneficiary's local areas, or are they out of state? *Javier Portela:* Our call centers are located in Rancho Cordova and a temporary location in Folsom, CA. All the calls come out of our local area. The caller ID shows "Health Care Options." *Ellen Beck, M.D.:* I'm referencing the example of the beneficiary confirmation letter we received as part of our materials. With the issue of languages, how do the beneficiaries receive this letter? *Javier Portela, DHCS:* The beneficiaries receive the letter based on the language selected in their eligibility profile, and they can request it in any other languages they would like. *Ellen Beck, M.D.:* We looked at a number of these letters, and there has been some concern with this group over the last year about the level of literacy. One part of the letter, "The State of California must seek repayment of Medi-Cal benefits from the estate of a deceased Medi-Cal beneficiary for services received," is the type of language that can be frightening to some beneficiaries. Yet, I realize by law that DHCS may be required to include this language. I'm wondering if there's a way to make this paragraph a little less frightening. *Jennifer Kent, DHCS:* The Consumer Focused Stakeholder Workgroup (CSFW) includes legal aid advocates and county representatives. All of our notices are both translated and we have professionals put it into a sixth grade reading level, which is required by statute. I think the problem is that the legal advocates want the beneficiaries to know all of the legal options that are available to them, while also striving to make the notices easily understandable. Notices in particular are very complicated in that you have to convey important information, and you have to try to do it in a clear and appropriate literacy level as possible. *William Arroyo, M.D.:* For my personal health care plan, each year I have about six plans that are available to me, and I receive a copy of every benefit offered by each plan. I'm wondering if enrollees have asked you to do anything similar, especially for those in counties with two health plans, and if they have a side-by-side with all the benefits?

	Stephanie Conde, DHCS: We do have a comparison chart available, which is also on paper. *Javier Portela, DHCS:* It's called a consumer guide, which focuses on what hospitals are in our network. Our benefit structure doesn't differ across health plans. Our focus is more on which providers/hospitals are available. The Consumer Guide is also distributed on an annual basis. The HCO website also uses star ratings, to help enrollees compare the quality of care for services between health plans. *Bill Arroyo, M.D.:* To what extent do you inform enrollees about pharmacy benefit managers and what the formularies are like? *Javier Portela, DHCS:* The formularies are available to the members via the HCO website. *Jennifer Kent, DHCS:* On the commercial side, formularies are driven by cost-sharing, which is not the case for Medi-Cal. *Jan Schumann:* On the forms that in are foreign languages, are the representatives able to type in the form fields? *Javier Portela, DHCS:* Our forms are completed by eligibility workers. They are operated in a single enrollment system. Part of our requirement is that you must speak both English and the language you're certified in. Our system is in English, and only the employees can view the English system. *Jan Schumann:* There's no free-form area on these forms, or anything that a social or call worker can type in or have the option of typing in? *Javier Portela, DHCS:* There is no free-form area. *Jennifer Kent, DHCS:* On the eligibility side, if you have family that applies for services in the county welfare office, they also have a lot of staff that are dual or trilingual. The system and application is all English. *Jan Schumann:* I went into a social worker's office last week due to a lapse in coverage. One of the social worker's concerns was her inability to type in a native language in a free-form area that goes out to beneficiaries. Is DHCS looking at integrating anything that would allow the social workers to speak in a foreign language on paper?

	Jennifer Kent, DHCS: No. The information technology systems that are running these processes are vast in terms of the automation and the way the system is programmed. The forms are not meant to be easily customizable. *Javier Portela, DHCS:* Having the free-form area becomes a quality concern and potentially creates room for error or misleading information. DHCS needs to have standard messages that are clear and precise. *Diana Vega:* On the beneficiary confirmation letter, I don't understand why the social worker doesn't have access to this letter, especially for the families who don't speak English. On the bottom of the letter, it says not to call your eligibility worker. *Jennifer Kent, DHCS:* This is the letter that you get once your eligibility has been determined and you're being enrolled in a health plan. Eligibility workers have nothing to do with your health plan selection or choice; this is just saying that you have been made eligible and you're being enrolled into this plan. *Diana Vega:* Why isn't the eligibility worker able to view this letter? *Jennifer Kent, DHCS:* The eligibility worker can't put them into a different plan, ever. The Office of the Ombudsman will be able to help you. This notice is also about channeling the members to the right place.
Health Plan Communication with Beneficiaries Amy Turnipseed, Senior Director of External and Regulatory Affairs, Partnership HealthPlan of California	Amy Turnipseed, Senior Director of External and Regulatory Affairs, Partnership HealthPlan of California The presentation for the Partnership HealthPlan of California can be found here: http://www.dhcs.ca.gov/services/Documents/PHC_BeneficiaryComms.pdf PHC is a County Organized Health Systems (COHS) Plan, which means PHC is the single Medi-Cal health plan for this area. PHC serves 14 counties in Northern California. PHC notifies members through 90, 60, and 30- day notices, as well as call campaigns. Outside of the mandatory communications, we pride ourselves on doing direct member mailing campaigns on key issues. In 2016, we had the mental

	health benefit that was brought on to the health plans. After noticing a low utilization of that benefit, we sent mailings to our members with the mental health services offered in their community. We noticed after the mailing went out we saw a significant increase in mental health care service utilization in our service area. We also conducted call campaigns if we have a lower metric in our service area to increase utilization of services, such as immunizations or pap smears. Our newsletters include information about new benefits coming into the health plan, as well as changes to PHC. We recently redid our website to be more user friendly. Part of our review process to update the website was through our consumer advisory group. If English is not their primary language, they can click on the threshold languages on the blue tabs, which include information on how to contact PHC to receive materials in languages that are best for them. We have a robust Consumer Advisory Committee, which is another way we communicate with members. In our four regional offices, we have quarterly consumer advisory group meetings. We use this forum to get feedback on member mailings, and to hear what is important to them and their community. We also communicate with providers and community partners. We found that the best way to reach our members is through their primary care providers. The members can get a mailer, but they will take it to their physician and ask what it means and what they should do. Most of these campaigns are based on Healthcare Effectiveness Data and Information Set (HEDIS) scores that we received. One of the larger initiatives that we're working on is the Whole Child Model (WCM). We are one of the health plans that are transitioning from CCS to WCM. We are transitioning January 2019. Part of this transition will include a robust communication plan; we want to communicate with the members, family, and the provider community on how we implement this transition. We've dedicated a webpage to the WCM transition, so if any families or providers have any questions, they can use the webpage. In late 2016 we developed focus groups with CCS families to ask what they like about the CCS program and what could be done better. We are also hosting four stakeholder meetings to the community, which are open to everyone to get

	feedback on the transition. We're also working with the associations to bring training to parents. Looking forward, PHC is always looking for ways to inform members. We working on developing a member portal, and are looking at going live at the end of 2018. We're also looking into text messaging in a way that meets regulatory requirements. *Karen Lauterbach:* In Los Angeles, members receive both voluntary/mandatory packages and it is very hard to tell the difference. Could these packages be made slightly different so beneficiaries know what is mandatory or voluntary? Are there plans that are carved out of the whole Health Care Options process? *Jennifer Kent, DHCS:* When someone is made eligible for Medi-Cal, they get notices. The notice includes that they have 60 days to review their health plans and make a choice. If they don't make a choice within that 60 day period, they are defaulted into a plan, and there's an algorithm for how they get defaulted if they don't select anything on their own. I can go back and see if there are specific forms around letting people know that they have a choice versus when they have not affirmatively made a choice. In Los Angeles, there are two plans: LA Care and Health Net and both of those plans subcontract with other plans in the Los Angeles area. *Karen Lauterbach:* One of my children is adopted out of the foster care system. We get a plan choice every year. I know what it is, but we get zero explanation with it. It makes me wonder how many people receive this package but don't understand it. *Bert Lubin, M.D.:* How many children are in your plan? *Amy Turnipseed.* Our total enrollment is 560,000. *Bert Lubin, M.D.:* You're the primary Medi-Cal provider? *Amy Turnipseed:* We're the only Medi-Cal provider in the 14 service areas, so probably 45-50 percent of our membership is children. *Marc Lerner, M.D.:* I was curious about the material you developed for specific initiatives, like mental health. Will the

	MCPs around the state have an opportunity to see the materials for input on communication? *Amy Turnipseed:* We are happy to share copies of what we have done. We pick certain interventions like mental health or cervical cancer screenings based on HEDIS scores or regional needs. *Bert Lubin, M.D.:* Do you have all of the educational materials that you can share? *Amy Turnipseed:* We turn over all the materials to the state for review. *Jennifer Kent, DHCS:* A plan is not able to communicate with members unless they receive approval from DHCS first. *Marc Lerner, M.D.:* So for example, we might want to review materials around HPV. *Hoa Su, Health Net:* We have been participating with DHCS in a linguistic workgroup. The intent of that workgroup is to share best practices and resources with the health plans. The health plans know what the other health plans are doing, they reach out to collaboratively share their content. *Ellen Beck, M.D.:* What's the biggest challenge the plan faces with communication? If you had the option of improving a certain aspect, what would you like to see happen? What are the kinds of problems you encounter with patients who have the lowest levels of literacy? *Amy Turnipseed:* When it comes to larger initiatives, and I'm thinking of the WCM 90, 60, and 30 day notices, there's a lot of information that needs to be synthesized, and needs to be clearly reviewed and articulated. Sometimes the language is difficult to understand. In terms of your literacy question, we try to build the relationship with the provider, which is the best way to reach that population. Some may not receive our mailings, or they have an inaccurate address. If the provider is aware that we're trying to target this population for a health immunization, the best way to reach a member is through collaboration with the provider. *Hoa Su:* In addition to working with providers, we use plain language standards. Materials must be easy to understand at

	the lowest common denominator. We have a rigorous review process and we make sure that all of our communications go through that process. Hoa Su, Manager, Health Education, Health Net Presentation can be found at: http://www.dhcs.ca.gov/services/Documents/HealthNet_MemberComms.pdf Recently, Health Net and California Health and Wellness merged together under Centene Corp. In total, there are 12 counties covered by Health Net, and 19 counties covered by California Health and Wellness, both rural and urban counties. We're required by DHCS to implement a Group Needs Assessment every five years. We surveyed Los Angeles County in 2016 and asked the members of their preferred method of communication, which was by mail, then by phone, and finally by website. During this survey, we asked members if they would be interested in getting text messages or emails in our attempt to have them opt-in, but only ten percent of members are interested right now. We also hold quarterly Community Advisory Committee meetings, engaging community members to understand what their concerns are, share resources, and share feedback with them. We also conduct focus groups to make sure that our interventions are effective. Member-informing materials provide essential information to our members regarding access and usage of health plan benefits and services; newsletters can be member-informing. These are available in the members' preferred language. The member-informing materials go through DHCS approval. Health education materials are meant to educate members about maintaining a healthy lifestyle. There are no requirements for us to translate the materials into special languages, but we made a decision to pre-translate them into English and Spanish. For the 22 health education topics that are required by DHCS, we do translate those into all threshold languages. We also allow our members to request any of our communications be translated in an alternative format, such as Braille, audio, PDF, etc. Health education materials do not require DHCS approval since we have a qualified health educator with a Master's in public health who can use a checklist to review the content for accuracy and comprehension. The Language Assistance Program is available 24/7 to help

	members access health care in the language of their choice. We offer both telephone and in-person interpreters, and can translate materials into alternative formats, and we notify members upon our communication with them that they can have any communication translated into 17 different languages. For translation review, once the content is approved, we send the material on to our certified translation vendor. We do not use any bilingual staff within Health Net to translate materials. Once the translated piece is concluded, it's sent back to the health plan, we have qualified bilingual staff that would review the content to make sure that it's understandable. Once we approve the reviewed translated communication, it's sent to the members. *William Arroyo, M.D.:* In terms of the review process for the health education materials, a person with a Master's in public health can review the content and do not need DHCS to review? Is that a California or Medicaid rule? *Jennifer Kent, DHCS:* I think it's a practice that we have set, and it's only for the health education materials. *William Arroyo, M.D.* I'd like to see the list of the 22 health topics. Do those education materials provide any guidance? *Hoa Su, Health Net:* We have preventive health screening guidelines that provide our recommendations on these services by age and gender. *Bert Lubin, M.D.:* What percentage of children are in your program? *Hoa Su:* At least 50 percent of our members are children. *Bert Lubin, M.D.:* Are these educational materials for parents? Of the health education materials, how many are related to children's health? *Hoa Su, Health Net:* We cover the topics as required by the state. A lot we geared towards adult chronic conditions, but we do have immunization, well-child, dental, asthma, pre-diabetes, nutrition, healthy eating and weight management materials. *Marc Lerner, M.D.:* The resources on kidshealth.org has portals for children as well as for adults. I'm curious about the overall

	effectiveness of the format – receiving education from a trusted voice or educator versus the content that's distributed via the health education materials. What do you do to raise health literacy, directly around specific conditions? *Hoa Su:* The health education materials are meant more for the providers to distribute out to the patients that they see in the clinics. A lot of the providers have the ability to identify approved educational resources. *Ellen Beck, M.D.:* What are some of the challenges you face? We've also addressed reaching adolescents about healthcare and prevention. I was just wondering about some innovative areas where you're working on that. And simultaneously, the role of health promoters or promotoras in your education and also access work. Our experience with some of the clinics that I run, is that they're valuable, and a trusted voice in the community is the resource that succeeds. *Hoa Su:* Thanks for bringing that up because we have both of those resources. We partnered with UCLA Field School of Public Health as part of the National Institutes of Health (NIH) grant on adolescent health literacy. From that grant, we were able to develop a social media website to engage teens in understanding health education and health promotion, how to access managed care, and how to go to the doctor. Through that platform, we were able to engage teens nationwide. *Ellen Beck, M.D.:* Your data showed that it was utilized? *Hoa Su, Health Net:* Yes, it showed that teens were using it. This website was available for teens 13 years and above. In terms of your second question, we do have two programs, one in east L.A. and Madera, where we have trained promotoras on how to be trusted community health workers, to be an advocate of the community, and helping members understand how to access the services. *Ellen Beck, M.D.:* How would a patient access a promotora? *Hoa Su, Health Net:* Right now we're exploring the possibility of embedding a promotora with a targeted provider so that they can be the community ambassador. Most of our promotoras are out in the community drumming up attention to get members to come into the doctor's office.

	Jan Schumann: Providers should have some of these materials as part of the beneficiary package. DHCS should have a central depository of all these templates that we talked about today, including the health education material that have been approved. This gives beneficiaries a chance to review and research any materials that might have been discarded. *Bert Lubin, M.D.:* Do you use group treatment, such as patients with diabetes or who are obese? *Amy Turnipseed, Partnership Health Plan:* We piloted a Weight Watchers-type program for members who were interested. *Bert Lubin, M.D.:* What about anything related to children's health, like asthma management? Did you find that by having a number of families together, you have a larger impact from an educational standpoint? *Hoa Su, Health Net:* We do offer classes in the community for support topics, asthma, diabetes, dental, etc. The challenge is trying to get members to the classes. Transportation is an issue, and people have busy lives. *William Arroyo, M.D.:* How can I get access to the health education materials? *Hoa Su, Health Net:* Right now, all of our health education materials are for members only. *William Arroyo, M.D.:* So I can't view them even though I might be a Medi-Cal provider? *Hoa Su, Health Net:* Yes. *Marc Lerner, M.D.:* We've had a lot of discussions about text4baby and other public health related messages that attempt to be timely relative to age, family circumstance, etc. I'm wondering if you've had experience with those, across different cultures and languages to see if they work. *Hoa Su, Health Net:* We have implemented and tested a similar program, but the uptake is not as impressive as we'd like it to be. A lot of the pregnant women might not have known about it until later in the pregnancy, or after delivery. It might be due to the fact that we didn't identify pregnant women early enough. The program was only available in English and Spanish.

	Paul Reggiardo, D.D.S.: In terms of the two health plan member handbook examples provided to us, L.A. Care Health Plan and Inland Empire Health Plan, the two were a world of difference in terms of dental mentions. *Jennifer Kent, DHCS:* There's been a strong march towards standardizing information but each plan may have different areas of focus. Each plan is reflective of the areas that they're more focused on. *Paul Reggiardo, D.D.S:* Some beneficiaries are receiving much different information. *Bert Lubin, M.D.:* The materials that we've discussed during this Panel, can they be distributed to the health care plans so that they can hear what we're concerned about? Not that we have authority, but this came up in a discussion, and they can respond in a way that is consistent with their compliance regulations. *Jennifer Kent, DHCS:* It would be in the purview of this committee. If you wanted to, you could send something to me in writing saying this is what the Panel found to be an area of interest or greater concern. I would share it with Javier and his team as well.
Dental Transformation Initiative Update	Alani Jackson provided updates on the Dental Transformation Initiative (DTI). The presentation can be viewed here: http://www.dhcs.ca.gov/services/Documents/DTI_Update.pdf For Domain 1 Program Year (PY) 1, we not only reached the 2 percentage point goal for the first year, but it increased by 6.64 percentage points, earning an additional $2 million dollars for the first year. *Bert Lubin, M.D.:* Does that count as federal resources? *Alani Jackson, DHCS:* Yes, it's federal. It's part of the waiver performance benefit. If we exceed the additional threshold, then we have the ability to earn an additional $2 million. CMS confirmed that they support our findings. Preliminary data from PY 2 is indicating that we will also meet the threshold for the additional $2 million. We needed to increase by 6 percentage points and so far it's looking like we've increased by 7.36 percentage points.

	The number of Medi-Cal dentists providing preventive dental services to at least ten children increased by 6.07 percent from calendar year 2014 to 2015. For Domain 2, which is Caries Risk Assessments (CRA), there are 11 pilots. As of April 2018, DHCS has spent roughly $2 million on this domain. Because we have not seen the level of participation that we had hoped for this domain, DHCS is actively pursuing additional outreach efforts to providers within the 11 counties to garner participation. Domain 3 is continuity of care, where the beneficiary returns to the provider each year over the duration of the DTI. The providers would earn a flat rate incentive payment each year, and they can enter this domain at any point. This pilot is in 17 counties. Across the 17 pilot counties from CY 2015 to CY 2016, the percentage of children receiving continuity of care from the same service office location increased by 2.6 percentage points. From CY 2014 to CY 2016, utilization of preventive dental services increased 7.46 percent in Domain 3 counties, and 3.74 percent in non-Domain 3 counties. Domain 4, the Local Dental Pilot Program (LDPP) started in PY 2 (2017). The executed Pilots began implementation in 2017. Looking back at MCHAP's recommendations from June 2016, one of the recommendations talked about rates. Proposition 56, coupled with the DTI, will increase provider participation. There were also some recommendations on streamlining dental provider applications. Since we last met, we implemented a streamlined specific dental application (DHCS form 5300). It reduced the general application from 40 pages down to 15 pages. As of October 2017, the average days for a new provider to enroll is 14 days, and the average day for revalidation is 41. The number of new applications we received in the same time period went from 34 to 78. When the dental provider specific application was created, we consulted with the Provider Enrollment Division (PED) to make sure that the form could easily translate into the Provider Application and Validation for Enrollment (PAVE). There was also some conversations and recommendations on the Treatment Authorization Request (TAR) processing timeline. The fiscal intermediary is required to turn around the TARs

	within five business days. As of December 2017, the average TAR processing times for dental managed care (DMC) and fee-for-service (FFS) improved. There was also a recommendation to have an MCHAP representative on DTI. We did establish a DTI small stakeholder workgroup, where Dr. Reggiardo was a representative. For care coordination, Denti-Cal on the FFS side has a service center that offers care coordination for all beneficiaries who call in for assistance with locating a provider or help with transportation. *Ken Hempstead, M.D.:* Where can one find the Denti-Cal telephone service number? *Alani Jackson, DHCS:* They would call the regular beneficiary services line (800-541-5555). Once they call the line, they get a warm transfer to the care coordination specialist within the Administrative Services Organization (ASO). *Ken Hempstead, M.D.:* It's difficult for the average family to navigate this, and as simple as you make it sound, it can be more difficult. It's just a matter of the beneficiaries not knowing that they can call the regular number for their dental questions. *Alani Jackson, DHCS:* It's the beneficiary direct support line. This added feature is a requirement of the new ASO contract. When we start our new beneficiary handbook, the number will be included. *Ken Hempstead, M.D.:* I think the Panel would support any additional education to the beneficiaries about that. The bigger focus of our previous discussion was being able to find a provider, especially one that's able to take special needs children. I think additional work needs to be done so that the beneficiaries are really aware of where to go for their questions. *Diana Vega:* How do you increase county involvement for Domain 3? *Alani Jackson, DHCS:* In Domain 3 for the 17 counties, we're offering incentives for the providers who see the same beneficiaries repeatedly. For care coordination, any beneficiary who is enrolled in Medi-Cal can call the toll free beneficiary services support line and seek assistance either in finding a

	dental provider in their area, or within the network adequacy standards to help them get an appointment within the required timeframes. If they have multiple issues that need to be addressed, they would be transferred to the care coordination team. That applies to everyone; you don't need to be in one of the 17 counties to call the toll free number. *Diana Vega:* What about the dental providers who are outside of the 17 counties? It's really difficult to find a dental provider that accepts Medi-Cal. Is it because the providers are not receiving incentives? *Alani Jackson, DHCS:* We have network adequacy standards with providers for Dental Managed Care and FFS. If anyone is having difficulties finding a provider who will accept new Medi-Cal beneficiaries, then they should call the beneficiary services line. *Ellen Beck, M.D.:* The ASO is an organization that helps with care coordination. When the client calls, does the child have to have a certain level of diagnosis or complexity in order to receive those services, or can a client call with simple questions? *Alani Jackson, DHCS:* The telephone service representative can do some care coordination on their own, but I think for the more complex issues, they can go to their Care and Coordination team. Also, this team accepts referrals. So a Medi-Cal provider can reach out to ASO, and work with them to get the dental services the patient needs. *Ellen Beck, M.D.:* I support what Dr. Hempstead said about the need for this information to be available, not only to the clients, but also to the providers and primary care physicians. The larger issue is the need for additional dentists throughout the state. *Alani Jackson, DHCS:* We have a pretty extensive provider outreach education plan that is done annually as well as a beneficiary outreach education plan. Providing communication on what is offered in 2018 is part of that plan. The goal from the beneficiary perspective is to increase awareness and utilization, know where to get services and how to access them, knowing what the benefits are and knowing that Denti-Cal is Medi-Cal. *Marc Lerner, M.D.:* On the slide with the top five services, there seems to be great variability between the client services. The

	ratios don't seem whole. How many children are represented? *Alani Jackson, DHCS:* These are services, not beneficiaries; they're not unduplicated by beneficiary. *Jennifer Kent, DHCS:* Are you saying FFS for use of the prophylaxis looks incorrect because the FFS, DMC, and safety net clinic numbers look off? *Marc Lerner, M.D.:* Yes. For example, the sealant per tooth is triple in the FFS category. *Jennifer Kent, DHCS:* There are only two counties that have DMC – Sacramento and Los Angeles – and Los Angeles is voluntary, so it's actually a very small percentage of the population that's in DMC. *Marc Lerner, M.D.:* Are you comfortable with these ratios? *Jennifer Kent, DHCS:* FFS is the largest component, covering 80-90 percent of the entire population in Denti-Cal. The numbers don't look off given the small percentage enrolled in DMC. Safety Net Clinics are billed differently. *Paul Reggiardo, D.D.S:* When you say the top five services, does it mean the most common preventive services? *Alani Jackson, DHCS:* These are the most common preventive services based on the 11 that are authorized under the DTI. These are only for the DTI, not across the board. Also, for the Safety Net Clinics, the data is only for participating in the DTI and not reflective of statewide data. *Bert Lubin, M.D.:* It almost seems to me that pay for performance has a role in some of the things we're trying to address. I'm wondering if you could get a health care expenditures estimate with the preventive measures in place. Is there a way to measure dental preventive care and what the impact of that is? *Alani Jackson, DHCS:* From the DTI perspective, the terms and conditions do require an independent evaluator to do some analysis, and depending on the domain, the measurements of impact are different. Across a few of the domains, independent evaluators are assessing the impact of emergency room usage.

	Jennifer Kent, DHCS: It's hard to capture. You would have to confirm multi-year data analysis. I think it would be difficult and not within the scope of what the DTI is about. *Bert Lubin, M.D.* Dental prevention starting in school-based programs, is that part of the scope? *Alani Jackson, DHCS:* It is part of the LDPP. For Domain 4, counties or applicants could propose alternatives or solutions by which to meet the first three goals of the DTI. I believe 8 of the 14 LDPPs are doing virtual dental home or teledentistry. *Bert Lubin, M.D.:* You don't have data on that yet? *Alani Jackson, DHCS:* Not yet. For Domain 4, we're looking at putting together a template based on the metrics and performance measures they identified within their application. The independent evaluator would also be reviewing them. *Susan McLearan, California Dental Hygienists' Association:* Based on the goals for Domains 1 and 2, do you have any plans to fold alternative practice hygienists into your system to increase the number of services and the number of billable providers? *Alani Jackson, DHCS:* Domain 1 is inclusive of all enrolled Medi-Cal dental professionals, which is dentists and allied dental professionals. *Susan McLearan, California Dental Hygienists' Association:* I don't think you're including them as billable providers. *Alani Jackson, DHCS:* SPA 15-005 allowed allied dental professionals to independently enroll in Denti-Cal. For Domain 2, allied dental professionals can perform pieces of the CRA, but it's billed by the primary dental provider.
Public Comment	*Kelly Hardy, Children Now:* On the health plans and DHCS' communications with consumers, what are communication opportunities for consumers? I just wanted to learn more about that process, and see if MCHAP could be a good body for going forward with those requests. On the communications with members, a colleague of mine had a question about what DHCS and health plans are doing to promote Early and Periodic Screening, Diagnosis, & Treatment

	preventive services to ensure that the children are receiving the well-child visits and Bright Futures services on time. *Jennifer Kent, DHCS:* It's part of the beneficiary notice. *Dharia McGrew, California Dental Association:* Jennifer addressed the federal rule change that would allow states the ability to apply work waivers. Is DHCS analyzing that? *Jennifer Kent, DHCS:* Our Medicaid program is run through accommodation of waivers as well as our state plan. So it's a contract between DHCS and the federal government. It's a two-party contract. There's not a legal basis, unless the law was changed affirmatively by Congress. You would need Congressional action to change that. *Dharia McGrew, California Dental Association:* On the HCO website, there's confusion on the part of beneficiaries about dental services in managed care plans (MCPs), but they're not understanding that the dental is still FFS. I was looking at the HCO website, and it's directed towards MCPs, but it still seems very confusing. There's a gap in helping beneficiaries find a provider.
Member Updates and Follow-Up	*Ellen Beck, M.D.:* The topic of communication is very important. We also talked about the possibility of having the Office of the Ombudsman present. There's also the nuance of people having problems with communication. I think we have an excellent baseline of understanding communication, but I think it might be valuable to find examples. It also might be time for us to make recommendations around communication. It seems that part of the next meeting should be devoted to next steps, the Panel's recommendations about what's still needed, how do we adapt, and what do we propose? *William Arroyo, M.D.:* At one point we considered having the focus on some of the more vulnerable populations, like the foster care population. *Jan Schumann:* We should have a discussion on the waivers that are coming due in 2020.