

Department of Health Care Services

Medi-Cal Children’s Health Advisory Panel

March 16, 2016

Meeting Minutes

Members Attending: Ellen Beck, M.D., Family Practice Physician Representative; Jeffery Fisch, M.D., Pediatrician Representative; Karen Lauterbach, Non-Profit Clinic Representative; Marc Lerner, M.D., Education Representative; Wendy Longwell, Parent Representative; Alice Mayall, Subscriber Representative; Paul Reggiardo, D.D.S, Licensed Practicing Dentist; Pamela Sakamoto, County Public Health Provider Representative; Jan Schumann, Subscriber Representative; Terry Stanley, Cal-Optima – Health Plan Representative; Elizabeth Stanley Salazar, Substance Abuse Provider Representative;

Attending by

Phone: There are no members participating by phone

Not Attending: William Arroyo, M.D., Mental Health Provider Representative; Ron DiLuigi, Business Community Representative; Sandra Reilly, Licensed Disproportionate Share Hospital Representative; Liliya Walsh, Parent Representative

DHCS Staff: Jennifer Kent, Rene Mollow, Adam Weintraub

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

Public Attendance: 29 members of the public attended.

Opening Remarks and Introductions	<i>Ellen Beck, MD</i> , MCHAP Chair welcomed members, DHCS staff and the public and facilitated introductions. She thanked DHCS and PHCG for the preparation and support of meetings. She also thanked Lucille Packard Foundation for Children’s Health for funding support of the meetings.
Meeting Minutes, Follow-Up and Election of Chairperson	<p>The legislative charge for the advisory panel was read aloud by Karen Lauterbach. (see agenda for legislative charge). http://www.dhcs.ca.gov/services/Documents/MCHAP_MeetingAgenda_Marc_h162016.pdf</p> <p>Minutes from January 27, 2016 were reviewed and approved. http://www.dhcs.ca.gov/services/Documents/012716MeetingMinutes.pdf</p> <p>Adam Weintraub, DHCS reported on the follow-up list from the January 2016 meeting. Most items are included in today’s agenda or there was email follow up since the prior meeting. The paper application for Medi-Cal, information about the 1296 Work Group and the SB75 implementation plan were circulated to all members. One item still in process for follow up with Wendy Longwell is the item about letters sent in two different languages.</p>

	<p><i>Ellen Beck, MD:</i> Asked staff to circulate the deep-dive tracking follow up list to members so that the group can ensure they are covering all the subjects.</p> <p><i>Adam Weintraub, DHCS:</i> We will be happy to do that</p> <p><i>Adam Weintraub, DHCS:</i> Introduced the need for a confirming vote of Ellen Beck as the chair due to a technical issue related to notice that occurred at the last meeting where the vote took place.</p> <p>Marc Lerner moved; Pam Sakamoto second to nominate Ellen Beck, MD as the chair of the Medi-Cal Children’s Health Advisory Panel. There was no discussion or other nominations. The vote was unanimous to elect Dr. Beck as chair.</p> <p>Jennifer Kent, DHCS led members through a swearing-in oath of MCHAP membership. There are new members and the existing members were previously sworn in as the Healthy Families Committee, so all MCHAP members present participated. Members repeated the oath verbally and were asked to sign and return the written oath.</p>
<p>Follow-Up on SB75 – Coverage for All; Director’s Update Jennifer Kent</p>	<p>Jennifer Kent offered updates from DHCS. DHCS is working on the May revise for the 2016-17 budget proposal while continuing to discuss the January budget proposal. Staff are finalizing the approved 1115 Waiver terms and conditions, including the dental transformation elements and Public Hospital Redesign & Incentives in Medi-Cal, or PRIME (district and public hospital reform effort), that are of specific interest to MCHAP, as well as all other terms and conditions. The attachments will be over 1500 pages in its final form.</p> <p>The legislature passed and the Governor signed the revised Managed Care Organization (MCO) tax. It will be submitted to CMS next week for approval. Staff have asked CMS for a rapid approval because of its budget implications for the upcoming year. The MCO will provide \$1.2B into the base funding for Medi-Cal. It would be catastrophic if not approved because we would have to cut over \$1B General Fund from the budget.</p> <p>There was a budget subcommittee hearing on the CCS proposal for redesign. The trailer bill language DHCS proposed was rejected and the department will pursue a policy bill.</p> <p>Two senior staff are joining DHCS in April who will interact with this committee. First, Patricia McClelland will oversee Systems of Care (CCS, GHP, CHDP). She comes from Santa Clara Family Health Plan and is the mother of a CCS adult recipient. Also, Jacey Cooper will join DHCS working under Sarah Brooks in Medi-Cal Managed Care. She comes from Kern Medical Center and is relocating her family to Sacramento.</p> <p>Rene Mollow offered an update on SB75 implementation. Members received the planning document that details the efforts to implement SB75. DHCS is providing technical assistance and support to the foundations and organizations working on outreach. Materials are being reviewed for readability and translation through our subcontractor, Maximus. It will be revised to be at 6th-8th grade level. Once readability is set, it will be</p>

translated. The notice will go out 60- days pre-transition. Once the transition is implemented, current beneficiaries will get a notice that coverage has changed from restricted scope to full scope. May 16th is still the go-live date for implementing full scope coverage and for accepting new applications regardless of immigration status. Once enrolled, beneficiaries will be informed about their managed care options. In a County Organized Health System location, beneficiaries will be automatically enrolled in the health plan. For other counties, they will be given information to make a health plan selection.

Questions:

Terrie Stanley: Will the beneficiaries come to health plans in the same aid codes as other children already in managed care?

Rene Mollow, DHCS: Yes

Jennifer Kent, DHCS: There will be a flag that there is no immigration information in the file but otherwise they will have the same aid codes and will have the same benefits.

Rene Mollow, DHCS: The managed care division is working to coordinate notice to the plans of those who are transitioned from restricted to full scope coverage. The beneficiary also will be given a health plan choice. This is being handled the same way as enrollees who are currently in restricted benefits.

Ellen Beck, MD: Has there been any solution or change with Kaiser? Have you noticed any uptick in applications for restricted Medi-Cal? Have you offered guidance to counties about making this as easy as possible?

Rene Mollow, DHCS: On Kaiser, we are working with them but everyone will be given choice of a health plan. We will not automatically place them in a health plan. On notices to counties, everything in the application process remains the same; everyone is to be treated the same. There will be a letter to counties, a Medi-Cal Informational Letter, to inform counties. We also meet monthly with counties and are talking about this transition. We will make sure they understand the changes to allow everyone full-scope coverage regardless of immigration status.

Jennifer Kent, DHCS: We are not able to see swings in the number of applications unless it is very large. We have 100,000 applications every month so even big efforts within this population probably wouldn't likely show up. We have not noticed any macro-level changes.

Marc Lerner, M.D.: Thanks for the sequence of readability and translation process. Do you have data on whether the 6th-8th grade level work will well for the families coming into the program under SB75?

Rene Mollow, DHCS: This is the standard reading level we use. We don't have any data to indicate this is a problem.

Marc Lerner, M.D.: I appreciate this is the current practice and the need for consistency. In the spirit of the advisory role we play, I think it is worth an

exploration and review of the literature about whether this will work for this population.

Jeffery Fisch, M.D: I think the population you seek to reach out to has a lower education level and this would hinder their application.

Ellen Beck, MD: Many of us have data to document the average education level of the parents of undocumented children. I have data on 2,000 parents of the target population and the education level is lower than 6th-8th grade. I am concerned that 8th grade is too high.

Rene Mollow, DHCS: One challenge we have on notices is that there are certain things we must tell people and they don't translate well or respond to readability. We try to balance readability with issues advocates and others want to have included in technical terms. We are at the point of letters being translated so it's unlikely that we can modify them at this stage.

Ellen Beck, MD: I understand. You can start with an introductory paragraph that is simple language to tell them that their children now have Medi-Cal and that they can get help understanding the information in the letter.

Wendy Longwell: I support that the readability seems high. School systems document education level and that might be available.

Jennifer Kent, DHCS: We have been working with advocates and foundations who are doing their own outreach. They are more nimble and capable of messaging this program in different ways, with simple messages. We can get sued if we don't include very specific words and language. The point is well taken in this conversation. We can impress upon the foundations and community organizations how important it will be to use low reading levels.

Rene Mollow, DHCS: It is an important point. We have been reaching out to the foundations to help with making the information more reader-friendly. It is a huge undertaking to change the notices; the last time we looked at notices, we ended up with a policy letter that was 150 pages long. All the letters also have to be loaded into the county information systems.

Wendy Longwell: On the notice, can you add information about how they can get help, who they can contact if they have questions about the notice? It is important they can speak to an actual person.

Rene Mollow, DHCS: On notices, we do include a phone line about a number to call that sends them to the counties. We can't include individual community organizations. In addition, the letter has information about appeals; how they can contact legal aid. That is the only external group we reference.

Jennifer Kent, DHCS: Our challenge is that the program is 13M people. DHCS and counties are not able to guarantee a live person. Programming notices comes through three different eligibility systems. This is done for each of the county software systems. Each county has referral information that is local and is used to support applicants.

	<p><i>Ellen Beck, MD:</i> Even though there are urgent timelines for this notice and that it is unlikely to be changed, a longer term review of literacy and readability to make them more accessible is something there is consensus for around the table. We respect the difficulties although this is huge issue. I would offer an additional recommendation to review this, look at the data on reading level of the population and improve the literacy levels and the information about getting help.</p> <p><i>Jennifer Kent, DHCS:</i> I think that Karen Lauterbach is participating in the Immigrant Workgroup and they reviewed the notices. Those are some of the comments we received from the workgroup – ways to drop down the reading level.</p> <p><i>Rene Mollow, DHCS:</i> I encourage your participation in our consumer work group – there is a sub-workgroup that deals specifically with notices.</p> <p><i>Elizabeth Stanley Salazar:</i> There are limitations to the notices you send out. I don't think we want more research – the information is out there and is common knowledge. Perhaps looking at some of the newer ways to communicate with consumers is a way to make this better. Your commitment to engaging with stakeholders is critically important and the outreach and navigation funding from foundations is very important to this issue. Social media and technology should be providing some answers. Research demonstrates this population uses social media and these solutions should be considered in the future.</p>
<p>Proposed Dental Recommendations and Discussion</p>	<p>Dental Sub-Committee http://www.dhcs.ca.gov/services/Pages/031616MeetingMaterials.aspx</p> <p>Paul Reggiardo presented the Dental Sub-Committee recommendations that were first passed out at the January MCHAP meeting. Dr. Reggiardo reviewed the charge of the committee: to identify issues impeding optimal delivery of dental services and develop recommendations to DHCS. There are nine recommendations coming from the sub-committee. They are not all-inclusive but represent a solid set of recommendations from the small group assembled here. This is the beginning of a dialog with DHCS offered in the spirit of collaboration. These recommendations are offered in the spirit of our charge and to work with DHCS to improve services. Denti-Cal is only 1.4% of the overall Medi-Cal program but very important to overall health. DHCS is under many constraints. The waiver provides \$750M but otherwise, we understand it is a zero-sum game.</p> <p><i>Elizabeth Stanley Salazar:</i> What was the basis for being able to prepare such detailed recommendations? Was the audit a foundation for the starting place of these recommendations?</p> <p><i>Paul Reggiardo, D.D.S:</i> No. Since we developed these recommendations, the Office of the Inspector General reported in January 2016 that over two years, only 20% of children received all the services required by EPSDT.</p> <p><i>Ellen Beck, MD:</i> There is a good basis for the recommendations. A series of reports were shared with the committee that offer information from state</p>

studies and national studies.

Increase provider reimbursement by targeted changes in the Schedule of Maximum Allowances (SMA) in the fee-for-service program to incentivize provider participation and retention in the Denti-Cal program:

Rates have not actually increased for more than ten years. Even with the increases in last year's budget, that brought rates to 1% below the level they were in 2000. The state auditor reports and DHCS review indicates that rates are an issue in having enough providers across the state for all kids. It is not just the total number of providers but where they are and whether they will see all Medi-Cal kids. Rural counties like Shasta or children with special needs are factors. We must discuss rates to ensure the Medi-Cal program works. The recommendation takes into consideration that targeting reimbursement increases will be more effective than general increases.

Ellen Beck, MD: I support this recommendation. We can offer recommendations even if we can't guarantee it is funded. The data put forward here is compelling that we are paid at 30% of other areas in the country. This demonstrates that other states have been able to raise rates. And, it is only 30% of commercial reimbursement?

Paul Reggiardo, D.D.S: Medi-Cal reimbursement is about one-third of commercial rates.

Ellen Beck, MD: In some places, there are not enough dentists; in other places there are enough providers overall but they choose not to see Medi-Cal.

Karen Lauterbach: I support this recommendation. We see many dentists using the low rates to charge families or not participate in the program. What do you mean by targeted changes in reimbursement?

Paul Reggiardo, D.D.S: For example, if we want to reduce disease burden, we need to target early ages. This is a similar concept to the way the waiver incentives work. Targeted could be an increased fee for seeing children under age 3. Or, in rural counties, we could pay providers higher rates than in urban areas; or pay more for special needs children.

Jennifer Kent, DHCS: We are not supportive of across the board increases – it is like trying to boil the ocean. In 2000, the optometrists requested that their entire rate increase be applied to only two aid codes because they thought that would have the most impact.

Ellen Beck, MD: Is there anyone who is not supportive for this recommendation? We have consensus on recommendation one.

Simplify and streamline the Denti-Cal provider enrollment application and recertification process to more closely mirror that of commercial benefit carrier provider contracting.

This recommendation has been included in other reports and DHCS is working on it, but it is important to include to keep it on the table. The issue is that the process for provider applications to Medi-Cal is not specific to dental. I went through a re-enrollment recently and it took several months even though I knew how to get help. It was very time consuming. We need a new process. Although DHCS is working on this, keeping this recommendation allows us to track progress and follow up to understand if the new process is an improvement.

Jennifer Kent, DHCS: The Provider Application and Validation for Enrollment (PAVE) is an automated enrollment application process going live by the end of July for Medi-Cal provider enrollment. It is web-based and will guide the applicant through what is required (the license, lease, etc.). This is a big leap for us because currently we are all paper. We are looking to reduce the length of the dental application and not collect duplicative information.

Ellen Beck, MD: Is it possible for a preview of the PAVE application? Could Dr. Reggiardo review this?

Rene Mollow, DHCS: Dental is part of PAVE, but is not the first phase to roll out. Each phase of the roll-out will come out for review prior to going live.

Jennifer Kent, DHCS: We are doing user-acceptance testing now, with providers doing dummy applications to find bugs and glitches. I think dental is part of phase two at the end of the year.

Public comment

Gayle Mathe, California Dental Association: The list of providers was released for phase one and in reviewing it, I noticed dentists were not listed at all.

Rene Mollow, DHCS: Dentists go through provider enrollment at Delta Dental. Once it is built, we will leverage what is developed on the medical side for dental. You won't appear on those lists from Medi-Cal.

Bobbie Wunsch, Pacific Health Consulting Group: Given that the department is working on this, perhaps the recommendation could read: "support DHCS efforts to streamline and automate ..." in order to acknowledge the efforts and continue to keep it as a recommendation for tracking purposes.

Rene Mollow, DHCS: Just to build on Bobbie's comment, it would be good to have language that acknowledges that we are working on some of the recommendations and that you know we are working on it.

Paul Reggiardo, D.D.S: I am not sure how to accomplish the wording but it is fine.

Jan Schumann: I do support the efforts of the department. These will be formal recommendations to DHCS and there may be additional recommendations in the future. We can use the language of "support" now and if we find it is not adequate, we can offer other recommendations.

Alice Mayall: I am not familiar with PAVE. I am familiar with a system already in place where I can put my license in every year and that is all I need to do. As a managed care provider, there is very little I need to do each year. Why isn't DHCS using the same system as the health plan?

Jennifer Kent, DHCS: This is for Fee for Service (FFS) Medi-Cal enrollment. We are paying FFS providers directly. In the case of managed care, the health plans credential providers. PAVE is not part of that managed care system.

Terrie Stanley: As a health plan, we credential providers at the plan. For some vendors, like DME, we look for certification or affiliation with Medicare or others. What happens at DHCS is an actual registration process.

Rene Mollow, DHCS: DHCS goes deeper than credentialing. We are responsible for the payment of state and federal dollars so there are federal and state requirements we follow because we are paying the provider. It means we have validated that you have the right credentials to bill the state for a service.

Terrie Stanley: Health plans re-credential every three years. It follows NCQA and is defined in our state contracts. We have a separate credential committee. If any event triggers a quality investigation, it is sent back through credentialing for action. We have clear definition of this in our provider contracts.

Alice Mayall: It is all done through one centralized application.

Terry Stanley: There is universal application so it looks the same, but each plan has to validate the information and credential each provider at each plan level.

Ellen Beck, MD: In summary, I didn't hear any disagreement that this is a good recommendation and we will revise the language to use "support and monitor".

Reduce unnecessary administrative claim payment and treatment authorization requirements so that the Medi-Cal dental program more closely resembles that of commercial benefit carriers.

Paul Reggiardo, D.D.S: This will make Medi-Cal as similar as possible to the other payers. Currently, the universal claim form used by all other companies is not used by Medi-Cal. This will make it easier for providers to treat the Medi-Cal population and this will encourage providers.

Elizabeth Stanley Salazar: The 3rd leg of the stool is managed care plans. I imagine there are separate reporting requirements?

Terrie Stanley: Dental is not a health plan benefit. The state manages it directly. There are a few things that cross over into a medical service, like anesthesia, those items are included in the medical managed care plan.

Rene Mollow, DHCS: Dental is FFS in 57 counties with only two counties in managed care. The form mentioned is a proprietary form from Delta Dental.

Terrie Stanley: In dental, I want to point out that there are huge differences between commercial HMO and PPO plans. We shouldn't confuse the two (PPO vs HMO). The PPO has huge out-of-pocket. The majority of dentists do not participate in commercial HMOs, only PPO.

Jennifer Kent, DHCS: I appreciate the recommendations for #2 and #3. The providers do say the administrative process is difficult. It is not possible for us to align to commercial. The main determination on commercial is the benefit limitations. The dentist bills the insurance and when the maximum benefit is reached, the dentist bills the patient for the full cost of other services. In our system, we are responsible for the full benefit. We did remove a Treatment Authorization Request (TAR) that no longer makes sense. We have noted abuse in a different area and added a TAR in that instance. We monitor the data. The norm for dentists is to see 10-12 patients; we just pulled data on a dentist with over 99 patients per day. We don't want to be a burden, but we put these constraints into our system for a reason.

Elizabeth Stanley Salazar: If we reimburse at a reasonable level, the administrative issues would fall into place. They are secondary to low reimbursement that mean we don't sustain providers over time.

Ellen Beck, MD: Dr. Reggiardo, what would a process be to identify the most onerous rules? This recommendation is general. Should we add specifics or a mechanism to look at this? Is there a particular team working on these?

Jennifer Kent, DHCS: There are a variety of places for input. We did put a representative from the Dental Association to the overall Stakeholder Advisory Committee. We are beginning discussions related to the waiver dental incentives. Rene is part of a Sacramento dental managed care advisory group. We respond to individual requests for meetings all the time.

Rene Mollow, DHCS: We do take comments and input seriously. For example, we had a requirement to submit x-rays with a TAR and now we just ask for them to be on file for onsite reviews. We have staff within the program and our fiscal intermediary at Delta Dental who are looking at practices; DHCS audits/investigations look at this all the time. It is a challenge and we want to have checks and balances but we don't want to have prior authorization on all services. We have feedback from Sacramento and Los Angeles managed care that are helping us streamline and reduce administrative burdens.

Paul Reggiardo, D.D.S: These are purposefully broad. I think looking at a more granular level to identify what should change would come after the recommendation is forwarded. In Michigan, they use Delta for their Healthy Kids program and submit claims on a regular commercial claim form.

Ellen Beck, MD: I agree with the recommendation.

Elizabeth Stanley Salazar: We should always look for opportunities already occurring within DHCS and ensure that there are mechanisms for input such

as including members of this group in other advisory groups where we can do the more detailed work.

Alice Mayall: it seems we can lift these two recommendations and add them to our Mental Health subcommittee recommendations. There are similar agency/system issues. DHCS creates unique systems that are not consistent with what providers are using for other payers.

Elizabeth Stanley Salazar: I am in favor of the PAVE. I don't think DHCS is creating a duplicate system. It is enormous improvement in an already archaic system. We don't have enough information to make a judgment about that because some providers participating in the testing of the systems say it is a good thing to put this in place.

Alice Mayall: I was commenting on billing issues. How can we identify specifics? It feels similar to our discussion of beneficiary enrollment experience. We need a system to give DHCS more information on what providers experience.

Ellen Beck, MD: Are we comfortable with this recommendation? Yes.

Assess and report on actual network capacity and set beneficiary utilization goals:

Paul Reggiardo, D.D.S.: This recommendation is also broad and has two parts: to assess and report on network capacity and set actual utilization goals. How do we track our progress if we don't know where we are going? There are different ways to determine utilization goals and DHCS is working to standardize reporting under AB2207. I listed some types of goals that should be reasonable. For example, Connecticut and Texas have 60-65% annual utilization rate goals. Across the country, the Medicaid utilization is about 50%. Commercial plans have rates of about 60-65%. California is below all of these examples.

Jennifer Kent, DHCS: This recommendation is consistent with our efforts. We have been benchmarking and publicly sharing a dashboard. We are happy to share the measures we are using but yes, there are different ways to look at utilization. We agree we can't know if it's right unless we measure. There will be metrics in the waiver initiative because CMS will require that we accomplish some progress with the incentive funding. We agree we can't know if we have made progress without having a target.

Marc Lerner, M.D.: I am excited about that effort. Establishing a target and having the targets publicly available are different. Are those metrics on our dashboard?

Rene Mollow, DHCS: There is a benchmark in the CMS-416 report in actual utilization. We need to develop a benchmark year and take utilization up by 10% over the benchmark year. If we get to 15%, there is additional federal funding. We are working to finalize the metrics for each initiative under the waiver. We have had extensive stakeholder engagement on this. Part of the recommendation from the California State Auditor (CSA) report was to look at provider participation and beneficiary utilization. We can make input from

those workgroup efforts available related to provider participation standards. We don't have ratios in FFS. We do have these for managed care. We have looked across data points such as enrolled beneficiaries served, provider participation, beneficiary utilization are some metrics based on the input.

Ellen Beck, MD: Are you looking at network capacity? What is the existing capacity of the provider network we have?

Jennifer Kent, DHCS: In managed care, by contract, we require plans to contract with a set number of providers to meet a ratio of 1 provider to 2,000 patients. We don't have this standard in dental and in any case, it would not be enforceable in FFS. There is no contract in FFS, so I can't tell a provider they must serve a set number of beneficiaries. There is no contracted network.

Rene Mollow, DHCS: Another CSA recommendation is to target areas with low provider participation. We have been working with Delta Dental on their required outreach plans to target specific areas with low utilization and low provider participation rates.

Paul Reggiardo, D.D.S: We have talked too long about dentist-to-patient ratios in the past and that isn't going to tell us what we need. What DHCS is beginning to do is to report out on results – beneficiary utilization; percentage of kids getting sealants; percentage getting preventive services. We want to support that effort and get the data we need.

Ellen Beck, MD: What are your thoughts about how to assess network capacity?

Paul Reggiardo, D.D.S: Part of it may be through a survey similar to what DHCS did in the past. It was too small a sample in the past to be representative, but something like that that may be an option.

Ellen Beck, MD: Having providers report on their capacity through a survey seems like a good idea.

Wendy Longwell: I am hearing about network capacity at the local level as it relates to access. A mom recently called for help and she was given a list of dentists. Dentists on the list said they weren't taking patients or didn't do that procedure. The only provider available to do the procedure was in Southern California. It was going to take 3-5 visits with overnight stays, transportation and \$3,000 of other expenses for services not billable to Medi-Cal. Eventually, her adult teeth were pulled because the family couldn't get the procedure done. So, looking at network capacity from a list doesn't do any good. The list of providers is not doing any good if they are listed and not available.

Seleda Williams, DHCS: My question is for Dr. Reggiardo. Did you have discussion of registered dental hygienists and RDHAPs or other ancillary support staff in terms of increasing access to oral screening?

Paul Reggiardo, D.D.S: We did not discuss that directly.

Ellen Beck, MD: As we get through our list of current recommendations, we will ask for other topics to look at in the future.

Marc Lerner, M.D.: For example, we talked about the role of hygienists, tele-dentistry and the emerging role of technology. We are all excited about those opportunities.

Rene Mollow, DHCS: Based on AB1174, we put forward a State Plan Amendment for additional tele-dentistry (store/forward) and added allied dental providers to join Medi-Cal.

Ellen Beck, MD: I think we are all supportive of this recommendation.

Engage within the Department of Health Care Services transparency and opportunities for stakeholder participation in the planning and implementation of the Dental Transformation Initiative within the Medi-Cal 2020 CMS Federal Section 1115 Continuation Waiver:

Paul Reggiardo, D.D.S.: This recommendation is to make the 1115 Waiver process as transparent as possible and include stakeholders – which I think DHCS is doing.

Ellen Beck, MD: The more groups that know about this and that it is well communicated, the better.

Bobbie Wunsch, Pacific Health Consulting Group: Do we want to add to this recommendation that whatever the dental transformation stakeholder process is, it include a represent a liaison to MCHAP so there is a direct line of information back and forth.

Rene Mollow, DHCS: We are planning to have a small stakeholder workgroup and we plan to invite Dr. Reggiardo.

Ellen Beck, MD: I think we all support this one.

Retract the Medi-Cal Department of Health Care Services All Plan Letter 15-012 (Revised 8/21/15) and the Denti-Cal Provider Bulletin Vol 31, No 12 (August 2015) regarding modified General Anesthesia and IV Sedation policies.

Paul Reggiardo, D.D.S.: The intent of the policy is to see that general anesthesia and IV sedation are appropriately administered and to curb abuses, but the current situation is an imperfect solution and should be re-looked at. This recommendation is to revisit this. It has caused difficulty in getting appropriate authorizations.

Ellen Beck, MD: Is the intent to revisit? I am not sure about the language of retracting letters. In the past, Healthy Family spent a very long time looking at sedation and had a hard time making progress.

Jennifer Kent, DHCS: This is an issue that seems small but takes up a lot of our attention. We do have providers who are abusing a billing loophole on general anesthesia so we are not going to retract the letter. We look at data

across the state showing these practices and we are happy to share that.

Marc Lerner, M.D.: I would ask that you should take a look at the other tail of the curve. There should be more in some places – so the data from places that are not doing many procedures may be a problem as well.

Jennifer Kent, DHCS: We are willing to look at both sides.

Paul Reggiardo, D.D.S.: As the author, I would suggest we change the recommendation to “revisit” not retract. The issue is that the way the letter is written; some commercial plans will not provide authorization without certain steps being taken. It is just prolonging the process and leading to many appeals. There are problems with the letter and the mechanism that are resulting in some inadvertent consequences.

Rene Mollow, DHCS: We have had extensive engagement with dental providers, managed care plans and dental plans. The change in the letter was on the dental side – where we were not requiring authorization, when we were requiring it on the medical side and managed care side. The policy is to align the FFS dental side and managed care on the medical side. We are coming out with additional documentation and guidance to clarify the situation.

Elizabeth Stanley Salazar: Where does quality assurance lie and whose responsibility is it within this structure?

Rene Mollow, DHCS: It varies based on delivery system the child is in. There are quality requirements on managed care plans, dental plans and FFS dental.

Jennifer Kent, DHCS: The least amount of control from a quality perspective is in FFS.

Rene Mollow, DHCS: The confusion is that we have children with FFS on the dental side and managed care on the medical side.

Ellen Beck, M.D.: Based on time, we should move ahead and revisit this recommendation later.

Establish and utilize the expertise of an independent *Medi-Cal Dental Program Evidence-Based Policy Advisory Committee*, the purpose of which would be to assess and make recommendations to the DHCS regarding the delivery of Denti-Cal services:

Paul Reggiardo, D.D.S.: This would create an independent policy advisory group to make recommendations to DHCS. For example, DHCS must make decisions about new covered services, what to reimburse, limitations on the frequency and the population to receive the service. Currently, DHCS relies on the program administrator, Delta Dental, to make a recommendation followed by stakeholder review. I think there is value in having an independent body to offer evidence-based information to DHCS on which to base their decisions. This would be an assistance to DHCS to make outcome decisions, beyond financial and internal information.

Ellen Beck, MD: How does this work now?

Jennifer Kent, DHCS: There are a few ways. We have clinical consultants at Delta Dental we rely on for some expertise; we have clinician staff within DHCS; we have a State Dental Director we share with the Department of Public Health; there is a stakeholder advisory committee; and, an advisory committee in GMC Sacramento and Los Angeles. I look to our dental staff and the State Dental Director to know when we need external advice. He is our lead.

Elizabeth Stanley Salazar: It sounds like there is a lot going on in clinical advisory process already. I think the recommendation should be revised to become a dialog with the State Dental Director. We should not create something new.

Paul Reggiardo, D.D.S: I think we could coordinate this with the State Dental Director and DHCS. This could be worked out to ensure that people participating in oversight have the expertise to provide information to make good decisions. Currently, it is fragmented and there is no rhyme or reason as to why certain things are covered. This discourages provider participation. There is something wrong with the system where we have this inconsistency.

Marc Lerner, M.D.: The question is whether the portal is available for practicing dentists to come to the State Dental Director to address issues, to make a petition about their concerns.

Ellen Beck, MD: We could add language to the recommendation to create a mechanism to offer evidence-based information “to the state dental director and DHCS” and not necessarily start a separate group. This would create a conduit for communicating.

Jennifer Kent, DHCS: We will always take a meeting if we get a call about an issue. We don’t need an advisory committee to take input. We coordinate closely and communicate often with the State Dental Director.

Alice Mayall: I am not in agreement and would like to continue this discussion at a future meeting.

Ellen Beck, MD: There is not consensus on this yet so we will continue this in our next meeting.

Paul Reggiardo, D.D.S: I can take out the “advisory body/committee”. I know DHCS is open to input but I am offering a body to advise DHCS about whether it is a good input/a good idea or not.

Jennifer Kent, DHCS: If someone wants to add a product or procedure, I would go to the State Dental Director. He talks to academics, clinicians or convenes people, as he did on general anesthesia. I don’t feel we need a formal body to advise him or to have a different group than the State Dental Director.

Ellen Beck, MD: We can synthesize the work on recommendations 1-6 up to

	<p>this point we have discussed. We will revisit this last recommendation (#7) along with #8 and #9 that we have not discussed at the next meeting.</p> <p>Public Comment</p> <p><i>Kathryn Dresslar, The Children’s Partnership:</i> Harkening back to recommendation #4 on capacity of the system, The Children’s Partnership encourages MCHAP to consider as part of the recommendation the proven programs that serve kids where they are every day: schools, Head Start and pre-school. The virtual dental home is a tried and true program. There is a six-year work force demonstration project the state engaged in. The AB1174 payment system Renee was referencing allows for Medi-Cal reimbursement for this type of program. You could focus on the places with the highest Medi-Cal population and most in need. In addition, under the direction of the dental director, you could focus on dental varnish programs in schools as a way to increase the preventive services.</p> <p><i>Ellen Beck, MD:</i> At our next meeting, we will bring forward additional ideas or recommendations for consideration. I agree that one of the most important topics is to consider as much of the care that can occur in the schools is ideal.</p> <p><i>Gayle Mathe, California Dental Association:</i> I want to acknowledge the good points and great discussion. We appreciate and work with DHCS on a regular basis. In the discussion of the mechanism for how issues come through, often those issues surfacing from practicing dentists come through CDA. Many of these are pretty overarching recommendations. I appreciate Director Kent’s comments about the role of Dr. Kumar and I am pleased he is the source for information on DHCS decisions. We appreciate the need and look forward to working on the details under the overarching issues in the recommendations.</p> <p><i>Eileen Espejo, Children Now:</i> I applaud the work from the subcommittee and Dr. Reggiardo. We want to explore adding additional ideas. In particular, Children Now has been leading a medical-dental pilot in Los Angeles County where DHCS managed care and dental divisions shared dental claims for children age 0-6 to identify children lacking dental exams for the well-child provider to educate and offer follow up. We have had partnership from managed care plans, dental managed care, DHCS and others to implement and we see this as a model that can be scaled statewide.</p> <p><i>Ellen Beck, MD:</i> That is on my list as well. I think looking at primary care and dental care collaboration is essential.</p>
<p>Member Updates and Follow-Up</p> <p>Behavioral Health Sub-Committee</p> <p>Network Adequacy Sub-Committee</p> <p>Enrollment and</p>	<p>Behavioral Health Sub-Committee</p> <p>Elizabeth Stanley Salazar referred to a consensus document for review by the full committee. It includes recommendations to the MCHAP to embark on a series of deep dives as the approach to develop the Behavioral Health recommendations. We should give lead time to DHCS and external organizations to prepare data and offer questions. Based on the deep dive series, we will develop recommendations.</p> <p>The rationale for this approach is that, while there is a Mental Health system;</p>

<p>Renewals (Report Available) - DHCS</p>	<p>there is no system of Substance Abuse. It is a loose configuration of services at the county level. Mental Health came from the same roots but with the Mental Health Services Act, has developed a system of care. We have a playbook for a grant run system of care and are moving to a realigned, locally controlled system with managed care.</p> <p>We should inform ourselves so we can make good recommendations. What is the opioid epidemic? What is good screening? Because of the array and fragmentation, there is no good source of data linked together to ensure data-informed recommendations. The changes in Drug Medi-Cal and expansion of services is an historic change. The roll-out of network adequacy related to this is a great area of interest. There are additional areas that we can prioritize.</p> <p>We recommend four deep dives and offer ideas about how to structure the discussion: 1) Access, Utilization and Customer Service; 2) Screening; 3) Use of psychotropic medications in children; 4) Overview of the opioid epidemic.</p> <p>Although this is a local, realigned system, we see an important role for DHCS in developing and monitoring standards, providing guidance during uncertainty and offering oversight. Also, there is no data across the systems. The waiver will not immediately create a system. This change will take a while and is a heavy lift to accomplish. We want to plan a way for involvement of others as well. We should invite to the table the County Behavioral Health Directors Association and the California Institute for Behavioral Health Solutions to have a discussion about how the new waiver is being rolled out.</p> <p>We invite a discussion of priorities and how we should move forward.</p> <p><i>Ellen Beck, MD:</i> The May 11th agenda includes a deep dive for Behavioral Health on the agenda and if that timeframe is realistic, what topic should we prioritize to begin with?</p> <p><i>Bobbie Wunsch, Pacific Health Consulting Group:</i> We should be cautious about May 11th. For that meeting, we still have dental recommendations to discuss and it will be close to the implementation of SB75. You may want to defer this to a later date.</p> <p><i>Jennifer Kent, DHCS:</i> I appreciate the acknowledgement of the starting place of these systems. From a topic point of view, wanting to talk about Mental Health and Substance Abuse is huge. We are releasing data on psychotropic medications in foster care that may form a concrete and relevant topic for this group. Also, we may need to break out Specialty Mental Health-EPSTD from Substance Use.</p> <p><i>Elizabeth Stanley Salazar:</i> Yes, the Mental Health system is farther along and Substance Use system is in infancy. There is an opportunity to learn from the Mental Health system about billing competency and other topics. We can still look at the issues separately. I think starting with psychotropic medications is a great starting place.</p>
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Ellen Beck, MD: Are there other comments? We can talk offline about how to move forward.

Public Comment

Wesley Sheffield, Young Minds Advocacy: I want to comment on the issue of psychotropic medications. I caution that you not consider this issue in a vacuum. Children’s advocates see this as a symptom of a larger issue related to the system. In large part, it reflects the fact that psychotropic medications are easier to access through primary care while other services are more difficult to obtain. We recommend that this be considered along with questions of, how are psychotropic medications being coordinated with other services? What is the context of psychotropic medication within other services? Are there quality concerns to be addressed?

Ellen Beck, MD: I think you will find support on the panel for the fact that they are often overutilized and for the full context even though the topic is called psychotropic medications.

Marc Lerner, M.D.: I appreciate the framing. It is an appropriate tool when used in the context of a full plan. Much of our work with DHCS is to focus and accomplish a multidisciplinary approach to address your concern.

Wesley Sheffield, Young Minds Advocacy: Services known as “Katie A” are now available to all Medi-Cal children. This is an important expansion and there is a lot of work to roll this out.

Ellen Beck, MD: We will take up the topic of psychotropic medications first, in context, and will follow up with the group to identify the right date for that discussion.

Pamela Sakamoto: In relation to the agenda, perhaps we should increase the meeting by one hour with specific timeframes and succinct in presenting materials.

Jeffery Fisch, M.D.: Our committee will also take this approach to suggest a series of deep dives. I think that sending materials out sooner will allow for input from constituents.

Elizabeth Stanley Salazar: This is part of our evolving in our role to identify how we can add value. This is a collaboration with DHCS. The deep dive process is a good one. The format we used for SB75 was a good one and we should continue to use that. I would like to find areas where there is common ground and opportunity to work on with DHCS.

Ellen Beck, MD: I want to suggest that we not continue with subcommittees and start our meeting earlier instead to make time for the deep dive discussions.

Pamela Sakamoto: I was going to make that suggestion. We can start at 10. If there are other stakeholder groups working on a similar topic, we should have that ahead of time.

Jennifer Kent, DHCS: Depending on the area of expertise, we will try to link

	<p>you to other stakeholder groups working on these issues so you can benefit from the technical discussion and expertise that is being shared with others.</p>
<p>Public Comment</p>	<p><i>Alisha Hightower, Access Dental Plan:</i> I want to comment on recommendation 9 to repeal the GMC Program. There are a number of entities working on this – the Little Hoover Commission and groups in Los Angeles. I encourage you to go back to those groups to gather input. We have made strides and I don't agree with information in the recommendation. We don't hear the tone reflected in the recommendation.</p> <p><i>Ellen Beck, MD:</i> I encourage you to send specific input to DHCS and MCHAP.</p> <p>There was no public comment from the phone.</p>
<p>Upcoming MCHAP Meetings/ Next Steps</p>	<p>May 11, 2016 July 12, 2016 September 13, 2016 November 15, 2016</p>