DEPARTMENT OF HEALTH CARE SERVICES
STAKEHOLDER ADVISORY COMMITTEE
October 24, 2016
9:30am – 3:30pm

MEETING SUMMARY

Attendance
Members Attending In Person: Kirsten Barlow, County Behavioral Health Directors Association of California; Michelle Cabrera, SEIU; Richard Chinnock, MD, Children’s Specialty Care Coalition; Lisa Davies, Chapa-De Indian Health Program; Anne Donnelly, Project Inform; Bob Freeman, CenCal Health; Michelle Gibbons, County Health Executives Association of CA; Bradley Gilbert, MD, Inland Empire Health Plan; Kristen Golden Testa, The Children’s Partnership/100% Campaign; Carrie Gordon, CA Dental Association; Marilyn Holle, Disability Rights CA; Stephanie Lee, Neighborhood Legal Services of Los Angeles County; Marty Lynch, LifeLong Medical Care and California Primary Care Association; Kim Lewis, National Health Law Program; Sandra Naylor Goodwin, CA Institute for Behavioral Health Solutions; Steve Melody, Anthem Blue Cross; Linda Nguy, Western Center on Law and Poverty; Chris Perrone, California HealthCare Foundation; Brenda Premo, Harris Family Center for Disability & Health Policy; Rusty Selix, CA Council of Community Behavioral Health Agencies; Cathy Senderling, County Welfare Directors Association; Farrah McDaid Ting, California State Association of Counties; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers; Richard Thomason, Blue Shield of California Foundation; Anthony Wright, Health Access California.

Members Attending by Phone: Sarah de Guia, CA Pan-Ethnic Health Network; Erica Murray, CA Association of Public Hospitals and Health Systems; Bill Walker, MD, Contra Costa Health Services.

Members Not Attending: Bill Barcellona, CA Association of Physician Groups; Lishaun Francis, CA Medical Association; Michael Humphrey, Sonoma County IHSS Public Authority; Sherreta Lane, District Hospital Leadership Forum; Gary Passmore, CA Congress of Seniors; Herrmann Spetzler, Open Door Health Centers.

DHCS Attending: Jennifer Kent, Jacey Cooper, Sarah Brooks, Adam Weintraub, Ryan Witz, Rebecca Schupp, Jim Watkins, Karen Baylor and Morgan Knoch.

DSS Guests: Greg Rose

Public in Attendance: 23 members of the public attended.

Welcome, Purpose of SAC and Today’s Meeting
Jennifer Kent, DHCS Director

Director Kent thanked Blue Shield of California Foundation and California HealthCare Foundation for their support to convene the stakeholder meetings. She reported on several events across the state for the Medi-Cal 50th Anniversary. She also welcomed Linda Nguy from Western Center for Law and Poverty to her first meeting, replacing Elizabeth Landsberg.
Follow-Up Issues from Previous Meetings and Updates  
Jennifer Kent, Mari Cantwell and Adam Weintraub, DHCS:  
http://www.dhcs.ca.gov/services/Documents/FollowupItems_081116.pdf

- Follow-Up from Previous SAC Meetings  
- Updates on:  
  - Whole Person Care (WPC)  
  - PRIME and GPP  
  - Health Homes ACA 2703  
  - Substance Use Disorder-Organized Delivery System (SUD-ODS) Waiver Implementation  
  - California Children’s Services (CCS)  
  - DHCS Evaluation Tools  
  - Enrollment and Renewals

Adam Weintraub reported on highlights from the follow-up list of questions raised in the August SAC meeting, which was distributed to members. He provided details about changes to the estate recovery program and said stakeholders will be engaged to review materials soon. He said PRIME materials have been posted to the website as requested. DHCS is still working through the details on the enrollment applications pending longer than 45 days and will have additional information on this early in 2017. Director Kent said there are 1,500 remaining applications to be transitioned from restricted Medi-Cal to full scope under SB75. These applications are being reviewed and cleared out as quickly as possible. Since May, a total of 31,000 new enrollees have been enrolled who were previously unknown to Medi-Cal.

Sarah Brooks offered an update on WPC. Applications were received in July from 18 counties and have been submitted to CMS for approval. Approval letters will be issued this week. DHCS will not make public announcements of the counties until final approval signatures are received.

Questions and Comments

Steve Melody, Anthem Blue Cross: What is the timeline for readiness and implementation once approved? Will there be a staggered implementation based on readiness?

Sarah Brooks, DHCS: Once approved, counties will begin to hire staff and implement. Payment for services will begin January 2017 and will operate on a calendar year in the waiver. We may see some variation in when beneficiaries receive services.

Anthony Wright, Health Access California: What is the general picture of the number of counties who will participate? Are the resources sufficient for all?

Sarah Brooks, DHCS: I expect the majority will be approved. We have had good conversations with applicant counties and CMS. At this point, we have sufficient resources and will accept a second round of applications, for new counties to apply or existing counties to expand, in March 2017.

Jennifer Kent, DHCS: There is about $40-50 million for a second round. There is an interest among small counties to apply as a regional program.

Michelle Cabrera, SEIU: What is the time frame for second-round implementation?
Sarah Brooks, DHCS: We are working through the timing and will share it publicly when we know.

Anthony Wright, Health Access California: On the Global Payment Program (GPP), are there any additional requirements for counties in this second year? Are the documents public?

Ryan Witz, DHCS: There are specific encounter reporting requirements for year two.

Kim Lewis: We provided comments on behalf of the Health Consumer Alliance on the evaluation elements of the waiver. What is the process for moving forward to get CMS approval?

Sarah Brooks, DHCS: There is a specified timeline for CMS feedback on the evaluation, and following that, we will work to incorporate both CMS and stakeholder feedback to the evaluation. We will resubmit to CMS for final approval.

Jennifer Kent, DHCS: There were comments from you and others on several parts of the waiver -- PRIME, GPP, Dental Transformation. In some areas, we will make changes and if we can’t make the change we will reply with a reason.

Erica Murray, CA Association of Public Hospitals and Health Systems: In response to the PRIME question, on Sept 30th, we were able to submit 2012 data. It took quite a bit of effort to gather the baseline data for the work ahead. We are going through the data to identify commonalities and outliers among the health systems. Going forward, there is a uniform 10% improvement requirement across the board. We are working on an issue brief to offer information about the process to date and we are looking forward as to how best to approach technical assistance for members.

Jennifer Kent, DHCS: On Health Homes 2703, we will be delaying the roll out to July 2017. Other questions?

Marty Lynch, LifeLong Medical Care and California Primary Care Association: When will the rates be out?

Ryan Witz, DHCS: We are working on rates. We are working through data collection and working with the actuarial firm, Mercer. It will not be sooner than April, and perhaps June, before rates are finalized.

Jennifer Kent, DHCS: We had a letter from CMS that San Mateo is approved as the first county to go-live with the SUD-ODS waiver. Santa Cruz, Santa Clara, Los Angeles, Riverside and other counties are in line for approval. We hope other counties will move faster now that San Mateo is approved.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: Last I heard there are 14 plans total with 7 plans approved.

Jennifer Kent, DHCS: Jacey Cooper is lead on the implementation of CCS Whole-Child Model (AB586) and we are moving forward. There was a stakeholder meeting early in October to present the changes.
Jennifer Kent, DHCS: Enrollment numbers for re-determination cases are posted for July/August. There is a normalizing trend now apparent as we have worked with county enrollment systems to clear up the various system glitches and standardize data. We are hovering at 14 million beneficiaries in Medi-Cal.

Chris Perrone, California Health Care Foundation. Do you have a sense of the churn between Medi-Cal and Covered California?

Cathy Senderling, County Welfare Directors Association: We are working right now to determine that information. I don’t have an answer yet, but soon.

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Are the numbers of recertifications flat?

Jennifer Kent, DHCS: Across the systems, around 85-90% are continuing coverage so a high number are continuing with coverage. There was a drop in LA that may be due to the transition from LEADER to LRS enrollment systems. Most who received a discontinuance notice came back in quickly.

Linda Nguy, Western Center on Law and Poverty: In LA, it was around 30% discontinued rate. Are county staff indicating that most are back in coverage?

Jennifer Kent, DHCS: There is a lag in the data and these are month-to-month snapshots. We are working with LA to get a clear picture.

Linda Nguy, Western Center on Law and Poverty: When will we be able to see the aging report?

Jennifer Kent, DHCS: We agree it is important. It has been hard to get and match the data accurately because of different technology systems.

Kim Lewis, National Health Law Program: At the last meeting, there was data on the backlog status. Do you have that report ongoing?

Jennifer Kent, DHCS: We are tracking that data but there has not been a recent report. I can follow up on the 45-day pending and send that out.

New CMS Rules Impacting Medi-Cal Program

Mari Cantwell, Sarah Brooks, Rebecca Schupp and Laurie Weaver, DHCS

- Medicaid Managed Care ‘Mega Rule’
- Home and Community Based Services (HCBS)
- Office of Civil Rights

http://www.dhcs.ca.gov/services/Documents/Links_CMS_FinalRule.pdf
http://www.dhcs.ca.gov/services/Documents/Section1557Regulation.pdf
http://www.dhcs.ca.gov/services/Documents/HCBSFinalRule_101816.pdf

Jennifer Kent reported updates on the new federal rules impacting the Medi-Cal Program, including the CMS Medicaid Managed Care “Mega Rule”. In addition, there are recent rules from Home and Community Based Services, Office of Civil Rights, Emergency Preparedness, Mental Health, Access and others. This requires teams across multiple divisions and all delivery systems, as well as legal, rates and other units to understand and identify implementation
changes. It has been a difficult task and there are multiple downstream effects on managed care plans, information to go out to providers, changes to notices, etc.

Sarah Brooks reported on All Plan Letter (APL) updates already released. She highlighted that a letter on changes to grievances and appeals will be out for public comment shortly. In addition, DHCS is working on a contract amendment for managed care plans and a workgroup on handbooks for beneficiaries. It is difficult to accomplish the technical and medical information in lay language. These all have a July 2017 start date.

Jennifer Kent, DHCS: On the Mental Health and Substance Abuse systems, we have worked with legal and technical support to identify the network filings that will change. Dental managed care plans are also working through a set of changes.

Ryan Witz, DHCS: Our focus is on getting prospective rates accomplished by FY 17-18 and the time is short to accomplish this and make up multiple years and rates.

Questions and Comments

Michelle Cabrera, SEIU: What is the timeline on the mental health changes? What about the supplemental payment rules?

Jennifer Kent, DHCS: They are on the same deadlines and timelines; we have to certify their networks and provider certification on the same schedule. There is significant work internally to change language such as tri-annual audits becoming annual audits.

Kim Lewis, National Health Law Program: On grievances and appeals and beneficiary notices, will there be an opportunity through Managed Care Advisory Group (MCAG) or other process to have input or talk through the materials? There are several areas related to grievances and appeals requirements such as requirements to exhaust appeals at the plan level. Will you proceed with an APL? Are there statute changes required?

Sarah Brooks, DHCS: We will engage stakeholders on the beneficiary materials. Some things are straightforward – like a change to 18-point font. There are other requirements that we will want to talk through and we will look to the SAC and the MCAG for feedback. We are working to identify what changes are needed. We will review policy and procedure changes from plans and approve them. We are also reviewing the need for any statute changes. We will update APLs and notices and they will go out for public comment.

Stephanie Lee, Neighborhood Legal Services of Los Angeles County: Has there been coordination about beneficiary grievance and appeals with Department of Social Services (DSS)? For example, if a beneficiary has not exhausted the grievance and appeal process with a plan and filed a hearing, some counties work to instruct them about what to do.

Sarah Brooks, DHCS: We are working with DMHC as well as DSS with respect to the grievance process on areas that impact other departments.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: Is there any clarification about the language on allowing up to a 15-day limit in a capitated payment for IMDs?
Jennifer Kent, DHCS: We don’t pay any IMD facilities on a capitated basis so it doesn’t apply to California.

Carrie Gordon, CA Dental Association: Will there be one package for comment or will there be separate frameworks for dental and other changes?

Jennifer Kent, DHCS: For each delivery system, they will issue specific guidance to their plans. We will coordinate to ensure there are consistent approaches.

Sarah de Guia, California Pan-Ethnic Health Network: Do you have a sense of how long the comment period will be for each of those?

Jennifer Kent, DHCS: We try for two weeks, but it may be as short as 10 days. APL documents are usually fewer than 10-pages.

Carrie Gordon, CA Dental Association: How will you handle the Medical Loss Ratios (MLR) requirements for dental plans?

Jennifer Kent, DHCS: We will work with rates on that. Dental is not treated any differently.

Anthony Wright, Health Access California: There is significant administrative work to do. Do you have an inventory and time table for any legislative changes that will be required?

Jennifer Kent, DHCS: There will be statutory changes needed and we are working on the list of those. We will put forward information on the compliance changes for DHCS coordinated through the legislative office.

Rebecca Schupp provided an overview of federal HCBS rules and how California will come into compliance. She reviewed slides on HCBS rules, including new requirements for settings and participant involvement. Requirements that apply to all settings include:

- The setting is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.

There are additional requirements put forward for “provider owned/controlled” settings and a list of excluded settings such as hospitals. She also reviewed rules on presumed institutional settings, such as the campus of a hospital, across from a jail or disability-specific settings. The state may apply for “heightened scrutiny” used to certify that the setting does meet the requirements for HCBS. There are 11 programs impacted (see below). The departments that manage these programs are working together to weave together monitoring tools:

- Multipurpose Senior Services Program (MSSP) Waiver
- HIV/AIDS Waiver
- Persons with Developmental Disabilities (DD) Waiver
- Assisted Living Waiver
- NF/AH Waiver
• In-Home Operations (IHO) Waiver
• San Francisco Community Living Support Benefit (SFCLSB) Waiver
• Pediatric Palliative Care (PPC) Waiver
• Community-Based Adult Services (CBAS)
• 1915i DD SPA
• 1915k Community First Choice

Rebecca Schupp, DHCS: There are 300,000 participants and 175 provider types impacted by the rules. We believe that California has met the person-centered philosophy and is mostly in compliance. The state submitted a transition plan to CMS in August 2015 and received a response in November 2015. Public comment has been received and we are incorporating that input to resubmit to CMS and meet full compliance by March 2019. The transition plan is posted on the DHCS website.

Questions and Comments

Marty Lynch, LifeLong Medical Care and California Primary Care Association: Is there any interaction with subsidized senior or disabled housing where programs such as CBAS or PACE are providing services?

Rebecca Schupp, DHCS: All settings, including private residences, must comply with the characteristics on the slides. We are assuming private residences are in compliance and will assess compliance, for example through home visits.

Anne Donnelly, Project Inform: The HIV waiver sets rates at lower levels than other waivers. With the aging HIV population increasing, we are concerned about maintaining HIV expertise in home and community-based settings. We look forward to continuing conversation about this with DHCS.

Chris Perrone, California Health Care Foundation: Is there anything that stands out as a leap for a subset of providers?

Rebecca Schupp, DHCS: The biggest impact will be for the developmentally disabled population. Settings such as sheltered workshops will need to change the way they are providing supported employment. We are focusing on settings that may need to remediate the physical setting or the way they provide services.

Brenda Premo, Harris Family Center for Disability and Health Policy: I agree that one of the biggest challenges will be developmental disability populations, including autism. They may be high- or low-functioning. We have multiple agencies trying to coordinate services and we need to look at this population differently than we traditionally have. We are working on medical homes and training for providers to care for developmental disabilities. The diversity of folks, with unique needs – some medical, some not; some independent, some not. Most managed care plans don’t know how to work with this population.

Laurie Weaver reported on the final regulations related to Section 1557 of the ACA on non-discrimination. She reviewed slides on the new civil rights protections that build on past non-discrimination. Compliance is required by all who receive federal financing for a health program or activity, such as managed care plans, county eligibility departments, DSS and others. The rule also requires a compliance coordinator and grievance procedure; it requires taglines in 15
languages (plus Laotian, a California threshold language not included in the federal rule) for a total of 16 languages. Currently, DHCS is working with advocates, stakeholders and other departments to identify the forms and notices that require translation and input on language in notices and taglines. She provided contact information for the compliance coordinator, Michelle Villados.

Questions and Comments

Michelle Gibbons, County Health Executives Association of CA: Is guidance going out to counties and entities that are impacted by the changes?

Laurie Weaver, DHCS: We are working with counties and the associations to notify them about various changes like the tag line requirement.

Jennifer Kent, DHCS: The rules say the tag line requirement covers any significant communication with the public so we are first determining what documents fall into that category. We will not translate notices going directly to plans or counties but there are hundreds of forms that are used in county eligibility offices, call centers, fee-for-service (FFS) materials and health plan external-facing materials. We are creating a plan for the roll-out of translation and a timeline for the technical changes to software to have the languages available through the various technology systems. We are letting provider offices know about their responsibilities.

Laurie Weaver, DHCS: Some examples of external-facing materials include marketing materials, ad hoc enrollee information, explanation of benefits (EOB), evidence of coverage, pharmacy directories, enrollment forms and grievance and appeals notices. This impacts DHCS, plans, counties and providers.

Kim Lewis, National Health Law Program: We have provided comments and want to highlight that this rule covers not only language access but includes access for various disabilities that require alternative methods of communication. How will this impact the state consumer assistance centers such as the ombudsman offices? Sometimes, a beneficiary comes through an ombudsman line and is transferred to a county, so how will the rules apply to these situations?

Jennifer Kent, DHCS: That is something we are figuring out relative to the rule. The state has the responsibility to implement our own changes as well as notify counties and our partners about their responsibilities.

Kim Lewis, National Health Law Program: We want to ensure seamlessness so that someone who is passed along between entities does not have to argue for language or other communication access.

Brenda Premo, Harris Family Center for Disability and Health Policy: Everything said is important. Part of the secret is not only saying we need to do it, but also involving the population to be sure it works as it should. Technology makes this possible and we need to ensure that all providers hear about their responsibilities. This is a small but potentially expensive population and some of the agencies are mom & pop operations that require support.

Anthony Wright, Health Access California: Another part of Section 1557 is the LGBT population. Are there any exceptions being contemplated, such as religious providers? How will you apply the sexual orientation non-discrimination requirements for Catholic or religious providers?
Laurie Weaver, DHCS: For transgender populations, we have policies in place to ensure health and well-being. For providers, we are still discussing the issues.

Jennifer Kent, DHCS: We just issued an updated APL related to gender reassignment surgery. If individuals are refused service because of religious affiliation, the health plan should have alternate arrangements to provide the service. On the FFS side, we would similarly work to ameliorate the situation. It has not come up to date. The letter on gender reassignment surgery was recently issued and we can make it available.

The Aging Population: A Medi-Cal Perspective
Jim Watkins, DHCS
http://www.dhcs.ca.gov/services/Documents/AgingMediCalPop.pdf

Jim Watkins and Jennifer Kent recently made a presentation to Medicine X at Stanford that may be of interest to the advisory committee. Jim Watkins offered a general overview of Medi-Cal and the aging population. Medi-Cal covers 1 in 3 Californians overall, 6 of every 10 children, half of the births annually and 65% of long-term care services. State financing of Medi-Cal is significant; however, it has declined as a percentage of overall General Fund financing. Medi-Cal is about 14.5% of overall General Fund spending, which is lower than past years. About 34% of federal deficits are made up of health programs that include mandatory spending. Federal contributions have increased sharply, and now account for 65% of Medi-Cal’s budget. Changes in federal policy in response to budgetary pressures or economic downturns may introduce complex and difficult funding decisions in the future.

The aging population is growing and especially those over 85. Because they are covered by both Medi-Cal and Medicare, the programs need to work together to accomplish the needed care. The aged population in Medi-Cal is 9% and accounts for 35% of spending. The number of eligible seniors is growing and spending on this population may reach 50% of all spending in the next period. The costliest one percent of the aged population generated 11.4% of combined spending and had a per-member-per-month (PMPM) cost of $26,962.

Questions and Comments

Marty Lynch, LifeLong Medical Care and California Primary Care Association: You combined Medicare and Medicaid spending in the presentation. We are doing great work with high cost users with Health Homes, WPC and individual health plan projects. The big barrier is that those only include Medi-Cal dollars. How do we combine the Medicare dollars in these initiatives?

Jennifer Kent, DHCS: There are several initiatives looking at addressing that issue. The Coordinated Care Initiative (CCI) does have Medicare dollars and we hope to see flat or reduced costs. In some cases, such as the costs related to institutional and pharmacy costs, we can’t coordinate our way out. We are going to see increased enrollment of populations that have high costs. We may drop the costs somewhat but not enough to flatten the curve.

Bradley Gilbert, MD, Inland Empire Health Plan: The ability to take care of someone with only the Medi-Cal dollar, someone who is institutionalized, is limited. With both Medi-Cal and Medicare, we can manage the care much better.
**Linda Nguy, Western Center on Law and Poverty:** In terms of the over age 65 population, many don't qualify for free Medicare Part A benefits because they haven't worked in the US long enough. There is a Qualified Medicare Beneficiary (QMB) program that pays the premium for Part A and it is underutilized. Would you consider sending a notice out about the program as they turn 65? This could shift costs to Medicare and would increase the eligible population for Cal MediConnect. I would also recommend that California consider entering a Part A buy-in agreement like the existing Part B agreement.

**Jim Watkins, DHCS:** The Medicare Savings Program data are not included in the presentation.

**Marilyn Holle, Disability Rights CA:** Another issue is the lack of information given to those on Medicare about gap coverage. It is a shock to people what the rules are on gap coverage. People need the information to purchase private coverage and it may keep some from going on Medi-Cal.

**Bill Walker, MD, Contra Costa Health Services:** On slide 54 on clinical conditions, the socio-economic (SES) issues and mental health substance use issues are big drivers. Is there data on this?

**Jim Watkins, DHCS:** Yes, we have this data but didn't show it here. We can drill down on mental illness and substance use. We don't have good data on SES or homelessness.

**Jennifer Kent, DHCS:** In the high cost user presentation, several months ago, this group did get mental health information.

**Rusty Selix, CA Council of Community Behavioral Health Agencies:** One study documented that those with mental illness in Medicaid live 25 years less. Do you have data to validate this?

**Jim Watkins, DHCS:** We looked at death records in California and have started a project on this. We see in the Medi-Cal data set, many dying in their 40s and 50s have mental illness. There are also geographic differences. We are looking at mental health data and including medical data to understand themes.

**Michelle Cabrera, SEIU:** We do need to expand SES data. I want to mention the new Secure Choice Retirement legislation that requires employers with five employees or more to offer a retirement savings option.

**Anthony Wright, Health Access California:** Slide 22 speaks to combined Medi-Cal and Medicare spending for aged population. Can you explain?

**Jim Watkins, DHCS:** We spent $63B for care. There are dollars for administration or other matched dollars not going into care included here. These are actual expenditures for federal year 13-14.

**Anthony Wright, Health Access California:** On slide 41 related to costly conditions, was there analysis on the types of conditions that are age-related vs those that are not?

**Jim Watkins, DHCS:** We are doing papers on that, however it is hard to separate. For example, Alzheimer patients have costs related to falls and costs for high blood pressure. There are multiple co-morbidities in some sub-populations.
Anthony Wright, Health Access California: We are looking at interventions such as smoking cessation. Some say that will just mean people live longer and cost more. Is there analysis that explains if that is true?

Jim Watkins, DHCS: The literature shows that we live longer at higher quality. There is increased cognitive decline in aging populations and those populations are rising. These are the issues for the future.

Kim Lewis, National Health Law Program: Is anyone not included in the data?

Jim Watkins, DHCS: Everyone is included. Share of cost individuals are included only for months when they met the share of cost.

Michelle Cabrera, SEIU: Are you looking at California’s changing demographics and the prevalence of diseases in those populations to recommend prevention to lower costs in the future? For example, Latinos are increasing and have a high risk of diabetes.

Jim Watkins, DHCS: Yes, we have analysis directly for that.

Jennifer Kent, DHCS: It informs our quality improvement projects.

Michelle Cabrera, SEIU: It would be great to have a follow up presentation on that cross-walk.

Brenda Premo, Harris Family Center for Disability and Health Policy: It will cost more no matter what we do. People are living healthier and longer. We should not think about lowering costs; we should think about how to use the money we have, for people to live as well as they can. It is odd to separate age and disability – separate programs, access to benefits. The experiences of aging and disability have many similarities. One way to save money is to integrate the common things people need.

Bradley Gilbert, MD, Inland Empire Health Plan: To clarify Anthony’s question, we all get older but we decrease the disease burden if we live healthier lives and it lowers the overall cost.

Continuum of Care Reform (CCR) in Mental Health
Karen Baylor, DHCS and Greg Rose, DSS

The Child Welfare Continuum of Care Reform (CCR) has brought DHCS into close relationship with DSS. Greg Rose from DSS provided background and reviewed highlights of the CCR. The rate of foster youth in group homes, congregant care, increased significantly over time. The CCR addresses this and changes the focus of foster care to prioritize placement of youth in families, because they do better when placed in family settings. Services and supports should be individualized and coordinated across systems and children shouldn’t need to change placements to get services. It is not possible to completely avoid congregant care; however, it should be considered an intervention and not a long-term placement. He reviewed key strategies for case planning and mentioned that some of the Katie A lawsuit strategies are included in the reforms.

As of January 2017, Group Homes will become Short-term Residential Therapeutic Centers. Counties will implement Child and Family Teams (CFTs) to drive case planning, placement
decisions and care coordination. There is a process for local collaboration involving Child Welfare, Mental Health, Probation and Education. The rate structure is revised.

Karen Baylor presented information on mental health workgroup meetings across the state that have included topics of medical necessity, child and family teams, relationship to Family Teams and mild to moderate definitions and care. DHCS is combining Medi-Cal certification with the Mental Health Program approvals, eliminating duplication in licensing and creating Therapeutic Foster Care (to become Therapeutic Family Care). Finally, DHCS is providing Mental Health 101 training.

Questions and Comments

Michelle Cabrera, SEIU: I want to hear more about psychotropic medications. The decision points are spread across different systems including the courts. Since the children are on Medi-Cal, what agency has oversight for appropriate prescribing of psychotropic drugs?

Jennifer Kent, DHCS: This is a shared responsibility across DHCS, DSS and courts. There certainly are children who need psychotropic medications and anti-psychotic drugs – and these are different kinds of medications. There are concerns in the increased incidence of overlapping psychotropic and anti-psychotic medication prescribing. There are authorization requirements and new edits in the claims systems to identify this. For example, Prozac is approved for certain conditions and if it is prescribed for other uses, the provider will need to give a justification. There have been concerns about provider prescribing patterns, but it is important to know that some providers primarily see children in foster care or other high risk populations. Also, for children with trauma and some other conditions, providing therapeutic services will decrease medications and improve outcomes. We are working on what specialty mental health services are available. It is DSS that is coordinating the placement for the child and the court ultimately signs off on the medication.

Greg Rose, DSS: The value of a child and family team is that it allows for the discussion of their goals and creates a place to identify and pay for therapeutic services as alternatives to medications. Also, some youth have profound needs for these medications. We are helping young people and their caregivers to be advocates for what they need.

Rusty Selix, CA Council of Community Behavioral Health Agencies: On mild to moderate, are you saying there is no managed care population for foster youth?

Karen Baylor, DHCS: They are not auto-enrolled into managed care. A small number of foster youth are in managed care; most are in FFS or specialty mental health.

Rusty Selix, CA Council of Community Behavioral Health Agencies: Some have understood this to mean specialty mental health covers all needs of foster youth.

Jennifer Kent, DHCS: For children with behavioral health needs in managed care who exhibit a behavioral health issue, the provider can refer to a behavioral health provider within the plan and assess and provide services if mild-to-moderate. If the assessment indicates a more serious conditions or other services are needed, the child is referred to county specialty mental health services. Mild to moderate is a different door but it does not remove, preclude or change specialty mental health.
Rusty Selix, CA Council of Community Behavioral Health Agencies: If the child shows up in specialty mental health at the county system, can they refer to the managed care plan for mild-to-moderate services?

Jennifer Kent, DHCS: That is correct. A county can assess and say the child doesn’t need specialty mental health. They may provide service or refer to another provider.

Rusty Selix, CA Council of Community Behavioral Health Agencies: Whichever system they show up in can assess and serve the child with the appropriate service.

Anthony Wright, Health Access California: How will you attend to the disparities in the population, such as ethnic groups and LGBT youth?

Greg Rose, DSS: We are building on long term work of DSS dealing with disparities. With respect to LGBT, we are doing training, issuing policy and implementing better ways to surface issues so that placement includes consideration of sexual identity.

Kim Lewis, National Health Law Program: Beyond the child welfare population, 40% of kids are in managed care. There is distrust about managed care which is part of why the level in managed care is low. Kids are eligible for services regardless of the language separating them into mild to moderate and specialty mental health. Their needs change every day and the coordination must be much better for all kids – not just foster kids. There is a lot of ping-pong where people are told no at the front door and basically are being denied medically necessary services. On CCR, this is an important change. It is critical to raise the bar on mental health at the same time so they can be successful and mental health services are essential to their success. The specialty mental health service coordination is the way they can stay out of the revolving door of court systems.

Greg Rose, DSS: We have, over the years, acknowledged that healing from trauma requires mental health services. There is room to be much more coordinated. The structural pieces and the way both systems are looking at oversight roles acknowledges the need for the systems to finely tune and close the gaps. There is still work to be done.

Brenda Premo, Harris Family Center for Disability and Health Policy: We are talking about kids like they are widgets. I was taken from my mother because she was a single mom and I was in foster care for two years with families who didn’t know anything about my needs. Some kids have mental health needs when they enter foster care and some kids may develop mental health problems in relation to the system. We need to think about kids with disabilities and train caregivers about their needs. We need to think about implementation on the level of the person, including role models and caregivers who are like them.

Greg Rose, DSS: One thing we are attempting to do is address the trauma the system inflicts on children. We think the child and family team will put a legitimate youth voice into the process, into placement and services. We are talking about quality parenting in foster care and we do need to do a better job finding foster parents. Finally, we need to identify youth 14 or older who can receive rehab services to help them become independent. You touched on many important topics.

Cathy Senderling, County Welfare Directors Association: We are working hard on this and it is a good partnership. The mental health services are critical.
Kirsten Barlow, County Behavioral Health Directors Association of California: I would offer that the mild to moderate category of services has produced anxiety but we also need to celebrate this benefit expansion for all low-income kids. Until 2014, kids were very disabled before they received services.

Public Comment
There was no public comment.

Next Steps and Next Meetings 2017
Jennifer Kent, DHCS

February 16, 2017
May 17, 2017
July 19, 2017
October 11, 2017