State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

January 30, 2020

Meeting Minutes

Members Attending: Ken Hempstead, M.D., Pediatrician Representative; Jan Schumann, Subscriber Representative; William Arroyo, M.D., Mental Health Provider Representative; Katrina Eagilen, D.D.S., Licensed Practicing Dentist; Ellen Beck, M.D., Family Practice Physician Representative; Diana Vega, Parent Representative; Ron DiLuigi, Business Community Representative; Nancy Netherland, Parent Representative; Jovan Salama Jacobs, Ed.D., Education Representative; Alison Beier, Parent Representative; Pamela Sakamoto, County Public Health Provider Representative; Elizabeth Stanley Salazar, Substance Abuse Provider Representative; Karen Lauterbach, Non-Profit Clinic Representative; Terrie Stanley, Health Plan Representative.

Members Not Attending: Bertram Lubin, M.D., Licensed Disproportionate Share Hospital Representative

Attending by Phone: 37 stakeholders called in

DHCS Staff: Richard Figueroa, Jacey Cooper, Norman Williams, Morgan Clair, Carol Sloan

Others: Betsy Ha, CalOptima; Susan McLearan, California Dental Hygienists' Association; Paul Reggiardo, California Society of Pediatric Dentistry; Rebecca Boyd Anderson, Partnership Health Plan; Jennifer Alley, California Association of Marriage and Family Therapists; Hannah Awai, California Children's Services; Kelly Hardy, Children Now; Ellesse Flores, California Association of Health Plans; Jessica Moran, The Children's Partnership; Rachel Velcoff Hults, The National Center for Youth Law.

Opening Remarks and Introductions

Ken Hempstead, M.D., MCHAP Chair, welcomed those in attendance.

Karen Lauterbach read the legislative charge for the advisory panel aloud. (See agenda for legislative charge.)

Dr. Hempstead introduced Acting Director Richard Figueroa, Alison Beier, and Dr. Jovan Jacobs.

Figueroa swore in two new members, Dr. Jovan Jacobs, education representative, and Alison Beier, parent representative. He then swore in Karen Lauterbach, Jan Schumann, and Pam Sakamoto to terms ending Dec. 31, 2022.

Meeting minutes from September 25, 2019, were approved.

Norman Williams, DHCS: Responses to the follow-up list have been posted to the MCHAP web page.

Opening Remarks from Richard Figueroa, Acting Director

Richard Figueroa, DHCS: The Governor's proposed budget was released on January 10, 2020, and DHCS' budget highlights are available on the DHCS website. You'll hear an in-depth presentation on one of the major elements, California Advancing and Innovating Medi-Cal (CalAIM). Proposed items that directly affect the Department include:

- **Expansion of full-scope Medi-Cal to undocumented older adults:** As of January 1, 2020, low-income young adults ages 19-26 were added to Medi-Cal, regardless of immigration status. This budget proposal requests that otherwise eligible individuals age 65 and older be added to Medi-Cal, regardless of documentation status.
- **Medi-Cal Rx:** Transitions pharmacy coverage from managed care plans (MCPs) to fee-for-service (FFS). Currently, those covered by private health insurance are getting a "one size fits all" rate based on age and location that covers a wide array of services, including prescriptions. Medi-Cal has done the same thing on the managed care side for members, but has proposed pulling the drug cost out of the monthly rate that the MCP would normally receive and transitioning it to the state on a FFS basis. The transition of the Medi-Cal pharmacy benefit to the FFS delivery system will be effective on January 1, 2021.
    - A **Medi-Cal Rx Advisory Workgroup** has been established to work through continuity-of-care issues and ensure that there are no service disruptions from this transition.
    - **340B**: Certain providers can participate in this program by purchasing prescription drugs at a federally prescribed cost. Clinics, hospitals, counties, etc., use this mechanism to purchase drugs at a low rate and have traditionally provided reduced-price prescriptions to individuals with limited means. Over the years, more of those individuals are in Medi-Cal managed care. In that environment, those provider entities were purchasing prescription drugs at the federally reduced price, then seeking reimbursements from MCPs at the higher, normal reimbursement rate that plans pay any other provider. This has resulted in a large difference between what the clinic paid for the drug and what the MCP was

reimbursing. Over time, that spread became larger as more sliding fee scale members were moved to Medi-Cal managed care. When you move the members back to FFS, that spread is now gone since you can only bill at the 340B price. The state wasn't aware of the scale of the spread because every clinic was doing its own thing. The spread, per the results of our clinic survey, was about $105 million, which were dollars the counties and clinics were using to otherwise put into the safety net. As part of this conversation, the Governor proposes investing $105 million back into the safety net as part of the budget

- **Dental Managed Care Transition:** DHCS is proposing to transition dental benefits to the FFS delivery system. There are two counties (Sacramento and Los Angeles) where dental services are through managed care. The CalAIM proposal intends to make everything consistent across the state.
- **Non-Medi-Cal program for hearing aids and related services to children:** The budget proposes a non-Medi-Cal program for children under age 18 who are at or below 600 percent of the federal poverty level, have no coverage for hearing aids, and need them. The effective date would be no sooner than July 1, 2021.

Elizabeth Stanley Salazar: For the specialty use delivery system, we are doing a massive rollout for access to Medication Assisted Treatment (MAT) for opioids. There are significant barriers for accessing those medications in the current funding structures and rates in a way that rolls out at the local level. Are the medications – Naloxone, Buprenorphine, etc. – being integrated into Medi-Cal Rx?

Richard Figueroa, DHCS: Jacey Cooper will provide an update on the CalAIM initiative, so I would defer to her since there is a relationship between that and the initiative.

Terrie Stanley: From a health plan perspective, the readiness and availability of having at your fingertips thorough knowledge of where the member is at, what the compliance ratios are, etc., is a fundamental piece of medical management at the health plan level. One of the biggest concerns is that information could come extremely late or is not conclusive; it's difficult to navigate. I strongly request that the task force you created address that.

Richard Figueroa, DHCS: We've heard that loud and clear. There's a broader stakeholder group and a smaller group of just health plans that are working through the plan issues they may have.

William Arroyo, M.D.: Will the $100 million fund the safety net?

Richard Figueroa, DHCS: The data we collected was from primary care entities, not the counties. We have to work on our methodology to get that money back out to the same clinics that were doing the billing. It won't be 1:1; the payment has to be redirected to the broader clinic group. Now we're working with the California Primary Care

Association (CPCA) and others to revisit the methodology to get the money back out, or as close to the way it came in.

Ron DiLuigi: For Medi-Cal Rx, what has the state communicated to the health plans?

Richard Figueroa, DHCS: There's no difference in alignment or philosophy in ensuring that care coordination and case management occur in a consistent and efficient manner. We're handling the pharmacy transaction part; the health plans will continue to have the case management and care coordination function.

Ellen Beck, M.D.: I'm thrilled about the coverage for undocumented older adults.

Richard Figueroa, DHCS: The California Endowment was very active in funding the health care for all initiative for a long time. The group that Deferred Action for Childhood Arrivals (DACA) wanted to cover next was their grandparents. This was a grassroots movement to get comprehensive health care coverage for older adults.

Ellen Beck, M.D.: In my experience, many of the American citizen grandchildren of this state are cared for by undocumented grandparents, so caring for them leads to caring for the children. What age is being considered for this coverage?

Richard Figueroa, DHCS: 65 and older.

Ellen Beck, M.D.: Regarding 340B, there are free clinics around the state that are affiliated with larger institutions. Those clinics are serving exactly the population that 340B is supposed to cover, but don't have access to 340B because they are a group within an institution (not separately licensed). Could there be an exception for those clinics? Regarding Medi-Cal Rx, I assume the intention is to renegotiate hard-to-get, unaffordable mediations?

Richard Figueroa, DHCS: Some of the Governor's budget proposals don't have a direct budget impact, but they're part of a larger affordability construct to try to make prescription drugs more affordable to people generally. There's a proposal that California will seek manufacturing partners to do a private label; is California big enough that we can do our own private label, and not just for Medi-Cal beneficiaries? Can we do a better job at negotiating a rate than what we currently have? The federal government gets rebates through Medi-Cal; the state can get supplemental rebates on top of the federal rebates. By law, we can only approach a manufacturer for a rebate based on the lowest price in the U.S. We are proposing to change the law to allow us to negotiate a rebate based upon the lowest price in the world. It's part of a larger set of tools that the state can save taxpayer money.

Alison Beier: When they did the study to determine the spread was $105 million, did they look at numbers over the years to see if there was inflation?

Richard Figueroa, DHCS: The survey was a point in time, which I believe was based on 2018 data. The community clinics asked if there would be an opportunity for it to grow over time as a reimbursement from the health plans. It's hard to know how the health plan reimbursement would have changed over time, but it is based on a point of time. The data is from the clinics for a full year. They will want to see that the $105 million increases over time, but I don't know if it will.

Alison Beier: About reimbursing the nonprofits, it seems like they're looking at block funding. Are you looking at individual user density?

Richard Figueroa, DHCS: It will be some sort of directed payment. The methodology will need to be determined. It will go through the pharmacy reimbursement system since that's how the money was derived. It probably wouldn't be a directed payment to physicians; it would be directed toward pharmacies.

Alison Beier: Some pharmacies are a little busier than others.

Richard Figueroa, DHCS: I don't know if it would be volume-based.

Jacey Cooper, DHCS: The funds in the budget proposal are for the non-hospital 340B clinics. There is a narrow pool. We would do it through a supplemental payment so we could draw down federal funds for those services. We are thinking about it being utilization driven, so based on the number of prescriptions. We're still in the early stages and engaging with CPCA and others on that.

Alison Beier: For the Medi-Cal Rx FFS proposal, are there any consumer representatives on panels that are making decisions? Some nuances include children switching over from G2 medicines, from oral solutions to pills. This change may require a prior authorization, which may not be covered even though it's the same dosage.

Jacey Cooper, DHCS: We recently launched an advisory committee that is going to be providing guidance and feedback on the process. I don't believe there's an actual beneficiary on the workgroup, but we do have a number of supporters calling for consumer advocates. I will talk to my team, Rene Mollow of Health Care Benefits & Eligibility, about whether we can identify a beneficiary who can sit on that workgroup.

Karen Lauterbach: I applaud the Governor on expanding coverage to different groups. Now that the injunction on public charge has been lifted, do we have clarification on whether these expansions fall under public charge?

Richard Figueroa, DHCS: This is a tricky issue. What we've been saying generally is that the chilling effect of the public charge rule is much broader than the actual number affected by the regulation. This is driving up the general fear in the community about accessing services, even if the specific circumstances that the family is in don't trigger public charge. The state has put up a significant amount of dollars to fund legal services for individuals. Our best suggestion is for people to seek legal counsel to see if they do

fit in a category of the public charge rule. The state is not in a situation where it can give broad-based legal advice.

Ellen Beck, M.D.: Legal aid services were unable to provide services to the undocumented because of their funding sources. I'm assuming that the lists you're creating online have free legal clinics that are able to serve? I'd like there to be resources available to those who are undocumented.

Richard Figueroa, DHCS: I will send the link. The California Department of Social Services has compiled a list of the paid legal services that the state can provide. I don't know if there are other sources on there that are free.

Ken Hempstead, M.D.: We have about 90 percent coverage on the managed care side, so the transition from managed care to FFS presents interesting curiosities about how continued work in that direction wouldn't somehow improve with the utilization in dental managed care. It sounds like people are giving up.

Richard Figueroa, DHCS: Just through data and audits, there have been a number of issues raised in managed care counties compared to FFS. Over time, the Legislature and DHCS have given it significant attention. It hasn't changed substantially enough that, in the larger context of making things more consistent across counties, we want to continue in those two counties. The CalAIM proposal is about standardizing the health care system across counties, so when people are moving from county to county, they're not experiencing big changes in the way they receive care.

Terrie Stanley: One of the single biggest issues with this is the different models we have across the state. Is that something that the state is looking at? The thought process was looking at the different models across the state, evaluate, and determine which worked best for California, yet that hasn't happened.

Jacey Cooper, DHCS: Through the managed care procurement, we're looking at the options and flexibilities for that process to ensure that it gets us the best quality of care statewide, which is where we're focusing our efforts.

Ken Hempstead, M.D.: Has the California Dental Association (CDA) had any particular stance on the FFS shift?

Katrina Eagilen, D.D.S.: I can't speak on behalf of the CDA, but I know in general, most dentists would be very happy about the fact that we'll be moving dental to a 100 percent FFS model, because most weren't very satisfied with the managed care model. What is the effective date of the transition?

Jacey Cooper, DHCS: January 1, 2021.

Ken Hempstead, M.D.: We all applaud the expansion of care to the 65 and older population for a number of reasons, even though our charter is focused on children. I

was surprised to see how little cost was associated with the expansion – $58 million growing over a few years. Can you comment on the projections?

Jacey Cooper, DHCS: All of the physical health services would be provided through MCPs. Then you have the additional In-Home Supportive Services (IHSS), which is above and beyond our estimate. We've done a number of expansions, so we do have a good methodology of identifying individuals in our system that would switch over to full-scope. We feel comfortable with the estimate, and we don't think it would distract from our other programs.

Richard Figueroa, DHCS: This estimate is also for half of the fiscal year. Implementation would be in January 2020, so it would be halfway through the state's fiscal year. It will also take some time for individuals to be aware of the expansion. IHSS is also very substantial for this population.

William Arroyo, M.D.: Which document are you referring to related to budget items?

Richard Figueroa, DHCS: The link to the Governor's 2021-21 Budget Proposal is available on the DHCS website.

Election of Chairperson for 2020

Dr. Hempstead was the only member to express interest in the position, and he provided highlights from his vision statement.

Katrina Eaglien, D.D.S.: We appreciate the leadership that you've given us over the past year. I'd like to make the motion to reappoint Dr. Hempstead as the Chair of MCHAP.

Dr. Beck seconded the motion.

Jan Schumann: Just wanted to mention that I'd like for you to carry on the tradition of selecting a Co-Chair.

The panel approved Dr. Hempstead as Chair, 14 – 0.

CalAIM Update

Slides are available at: https://www.dhcs.ca.gov/services/Documents/Medi-Cal-Healthier-CA-4-All.pdf

Jacey Cooper, Chief Deputy Director for Health Care Programs and State Medicaid Director, provided an overview of DHCS' CalAIM initiative.

Starting in 2018, state staff traveled throughout California to speak to MCPs, providers, counties, and community-based organizations on what DHCS is doing well, opportunities, and best practices to improve care coordination. Based on the

conversations, we started developing a roadmap for changes to the Medi-Cal program over the next five to 10 years. The CalAIM proposal, which was issued in October 2019, touches upon all of our delivery systems.

Our key focus is on individuals who are very vulnerable, with initiatives to address homelessness and increase behavioral health access.

The initiative has three primary goals:

1. Identify and manage member risk and need through Whole Person Care approaches and addressing social determinants of health.
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
3. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.

Identify and Manage Member Risk and Need

The following proposals fall under this goal as well as incorporate the third goal of improved quality outcomes:

- Population Health Management
- Enhanced Care Management
- Mandatory Medi-Cal Application & Behavioral Health Coordination
- In Lieu of Services and Incentives
- Mental Health Institution for Mental Disease (IMD) Waiver, Serious Mental Illness/Severe Emotional Disturbance (SMI/SED)
- Full Integration Plans
- Long-Term Plan for Foster Care

We didn't have exact proposals on the IMD waiver, full integration plans, or the long-term plan for foster care, which was intentional. We wanted to engage with stakeholders first before drafting the proposals. The feedback we heard on the full integration plans included a single entity that would be responsible for all services: physical health, mental health, and dental services under one contract. We currently have this marked for going live in 2024. We just announced that DHCS is working directly with CDSS in order to convene a foster care workgroup; members will be selected in March 2020, and the group will start meeting in April.

Ron DiLuigi: Much of what you discussed seems dependent on the approval of the federal government. Can you speak to the State's confidence level in achieving all of those proposals?

Jacey Cooper, DHCS: Our current construct is a very large 1115 waiver, which includes initiatives like Whole Person Care, the Dental Transformation Initiative, Public Hospital Redesign and Incentives in Medi-Cal (PRIME), and other programs with other delivery systems. The Centers for Medicare & Medicaid Services (CMS) issued guidance in

2018 that made it very clear that there would be different ways of looking at budget neutrality, which doesn't allow California to move forward with having another large 1115 waiver. Our current Specialty Mental Health Services waiver is a 1915b waiver. We plan on moving everything (physical health, mental health, and substance use disorder services) to one consolidated 1915b waiver. There are a few provisions that will need to remain in an 1115 waiver: the IMD expenditure for the SUD (federal funding expenditure), out-of-state former-foster care, and the Global Payment Program. Within the 1915b template, it's an easier submission and approval process for CMS. In our proposal, there are certain items that would go to the 1915b waiver, some to the State Plan Amendment, and some would remain as contractual requirements (population health management, In Lieu of Services (ILOS)).

Ron DiLuigi: Which initiatives do we believe are the most uncertain at this point?

Jacey Cooper, DHCS: We don't have any that we're really concerned about. There may be some pieces within the 1115 waiver that may be more at risk; we must demonstrate the cost effectiveness of those programs.

Richard Figueroa, DHCS: There's an attempt to move things from the waiver's time-limited status to something that's more permanently part of the Medi-Cal program. The Governor's Administration charged us with looking at how to incorporate these broader changes into the Medi-Cal program.

Ron DiLuigi: For in lieu of services, will that give California a good level of autonomy and control?

Jacey Cooper, DHCS: The federal requirements for ILOS is broad. You must show that it's cost effective. CMS will need to approve the list of 13 services. We have been working on "guard rails" that protect against fraud, abuse, and waste.

Ron DiLuigi: If in six months we come up with an innovative approach that's not part of your current list of 13, can it be added?

Jacey Cooper, DHCS: We do have that option, and we would need to amend the MCP contract. We can also remove items from the list if they are not cost-effective or beneficial.

Elizabeth Stanley Salazar: For capacity building a lot must be delegated to partners. My concern is about losing the diversity of on-the-ground local service providers that have been the backbone to many of the services to the Medicaid population. How do we build capacity in technology and workforce? How do we incentivize the MCPs or the county administrations to do something more?

Jacey Cooper, DHCS: In the budget proposal, about $45 million was allocated for behavioral health quality improvement payments. This funding is targeted to providing funding for county behavioral health departments to improve IT systems to get better data and to focus on outcome-based, quality-based metrics. The other opportunity is the

incentive dollars in the budget proposal. That is funding that we're hoping to move the needle on capacity for providers and also for some workforce incentives (clinical and non-clinical teams), competency, and trainings. We are encouraging regional contracting with our behavioral health areas and looking at opportunities for partnership.

Elizabeth Stanley Salazar: Could we somehow incentivize the purchaser, plan, or administrative body that's coordinating the provider list to use innovative ideas for network adequacy?

Jacey Cooper, DHCS: There are a lot of people interested in the specialty mental health and SUD/IMD waiver. We need to evaluate what our capacity is to ensure that there are adequate services available first.

Elizabeth Stanley Salazar: For Medi-Cal Rx, are you going to pull in Buprenorphine, Naloxone, and Vivitrol, or will those stay in a carve-out for a while?

Jacey Cooper, DHCS: Effective January 1, 2021, all prescriptions billed on a pharmacy claim would be through the Medi-Cal Rx process. This is for all delivery systems.

Elizabeth Stanley Salazar: A lot of consumers and providers are finding that many pharmacies don't have adequate supplies. Serious gaps in the community in that regard, so this may be something to address that.

Ellen Beck, M.D.: There are some models around social determinants of health (SDOH) that have been able to demonstrate that if you provide patients at their medical visits with food to take home, it reduces their food insecurity and improves their diabetes. For people leaving incarceration, you should focus on the warm handoff; the assigned case worker who is in contact with the individual should remain involved in their care six months afterward to avoid a break in trust. For the homeless, I would encourage that the police aren't involved, but rather a formerly homeless guide who works with a team to encounter the person on the street and then start to build a relationship. You've referred to the patient-centered model; I would encourage consider using "person-centered" terminology, which means respect, self-awareness. How are we going to work with providers? Dental care will require a great deal of oversight, and I hope an orthodontic benefit is considered. Finally, we need to do something around meaning and purpose for the elderly population, and I'm glad that something is being done for the home care hours.

Jacey Cooper, DHCS: For the incarceration piece, there is an opportunity in the SUPPORT for Patients and Communities Act in which CMS has been tasked with coming up with guidance that would allow us to do a 30-day inreach into incarceration and still be able to get potential federal funds. New York has submitted a waiver to that effect, but I have not seen it get approved. California will be looking toward that. For homeless outreach, in WPC, we've seen a lot of peer-driven enhanced care management teams (clinical and nonclinical) working with peers. We are exploring those options as well.

Ellen Beck, M.D.: It really can make a difference if you include SDOH, and for providers to ask SDOH history with a plan for addressing them. I also like the idea of the nurse-led shelters like what Boston has.

Karen Lauterbach: For the standard managed care enrollment, there are populations that it doesn't really work for, or they get left out: people experiencing homelessness or people going into emergency and domestic violence shelters. People without addresses lead to huge barriers for providers to provide adequate care without a huge delay. Is that being considered?

Jacey Cooper, DHCS: For the homelessness piece, we have heard in only certain parts of the state that it's a problem because of neighboring counties. We have heard the eligibility piece is a challenge. We're not changing our eligibility pieces. When it comes to being enrolled in managed care, one of the things we're struggling with on the FFS side is not having adequate coordination functions that can be reimbursed. If you do this through managed care, you can pay for enhanced care management (ECM) or different pieces to reimburse the people who are working closely with the homeless population. There are restrictions for what we have available within that space, especially when it comes to self-guided care in FFS versus someone we can pay to ensure they are getting services across the delivery system.

Karen Lauterbach: I just want to emphasize that we get many beneficiaries in emergency-type situations who need health care. Sometimes that switch to a new MCP can be a month and a half. Is DHCS also looking at the four walls regulations (providing medical services outside a brick and mortar site)?

Jacey Cooper, DHCS: DHCS will be thinking of that policy, and there will be future guidance.

Karen Lauterbach: Homelessness is a huge crisis in Los Angeles. We have multiple street medicine teams that go out to different encampments. It's the only way that we're going to be able to reach them, but it all has to be privately funded. We think that it's part of the solution, and we encourage engagement on that.

Alison Beier: It seems like you want to encompass everyone, but I don't see any specific notation to just children. Historically, when things happen, children tend to fall off the radar. I was wondering where children fit in to all of this.

Jacey Cooper, DHCS: When it comes to the population health management plan, plans will need to submit specific targeted pieces on children, separate from adults. Risk stratification would be different for a child to account for family pieces. For ECM, complex children is a targeted priority population, and all MCPs will have an option for children with complex conditions. For the ILOS side, it does focus on the foster care transition, housing services, as well as the respite benefit for caregivers of children with complex medical conditions.

Alison Beier: In the five CalAIM workgroups, do they include varying ages, professionals and caregivers, and users?

Jacey Cooper, DHCS: We solicited those workgroups in September 2019. The rosters are posted on the DHCS website, and we tried to make sure there was different representation: county, health plan, advocates, etc. We did not get many consumers requesting to be on the workgroups. At a minimum, we require advocates of consumers to be there in the hope that they are working directly with consumers to embed feedback. It's a point well taken to ensure that we encourage beneficiaries to be at the table.

Alison Beier: If you want a sustainable model, you have to ensure that everyone has a seat at the table. Is the Home- and Community-Based Services (HCBS) waiver on the table?

Jacey Cooper, DHCS: In California, we have seven or eight different HCBS waivers. We're trying to determine how to build more state-wideness of those waivers. We're wanting to use some of the ILOS to build a larger infrastructure statewide for HCBS in addition to what we have in our 1915c waivers.

Alison Beier: May I specifically advocate for the medically fragile population? With the HCBS, under the Lanterman Act, children with intellectual disabilities are fully covered under a waiver. But children who are medically complex must have a nurse in order to receive waiver eligibility if they are outside that financial capacity. Parents and family members have been pulled off if they were IHSS providers. There are parents who have stopped being an IHSS provider to bring in a nurse so that they can keep the waiver for their child.

Jacey Cooper, DHCS: I'm not sure of that exact scenario, but please send additional information on what you're talking about. It is complicated with 1915c waivers because children who are otherwise eligible for Medi-Cal would be getting most of those services through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, which are outside the waivers. There are ways of deeming a child with complex medical conditions who otherwise wouldn't be eligible for Medi-Cal to get into those 1915c waivers to get access to private duty nursing or clinical services. Once you are in, you get access to waiver personal care services, which are services above and beyond what the IHSS offers. I would need to know about your exact example to know how that interacts with what we're doing. Feel free to email the CalAIM@dhcs.ca.gov inbox.

Alison Beier: When you do benefits, alimony is taken off the table and doesn't affect financial qualification of benefits. However, if you have a child and there is a divorced couple and there is child support that comes in, the child is pulled off of the waiver so they don't need to be matched financially to their family, and they have their own income which is $0. When that child starts to receive child support that counts as their income and their families that are afraid to have child support or go through anything because they don't want their child to lose the waiver because financially they may not qualify anymore. It's a difficult thing for many families who go through divorce.

Jacey Cooper, DHCS: I can't speak to those requirements, so we'll need to flag this for our Health Care and Eligibility team.

Alison Beier: We talked about ILOS, but I didn't hear any mention of durable medical equipment (DMEs). DMEs are significant in the medically fragile community. Is this being addressed?

Jacey Cooper, DHCS: Since DME is an actual Medi-Cal benefit available to children and adults through both managed care and FFS, it wouldn't be offered as ILOS since it's a state plan benefit. ILOS are in lieu of state plan benefits. If you wanted to send in specific areas of concern on the DME side, we'd be happy to look at them.

Diana Vega: I saw a lot of emphasis on behavioral health care, but I didn't hear about a plan to keep and hire providers. Are you increasing the payments? You did mention investments to improve behavioral health, but is that only on the IT side?

Jacey Cooper, DHCS: Those funds were for initiatives around payment reform and changes to medical necessity. CMS put us on notice in regard to getting better quality and outcomes out of our behavioral health space. Those dollars are to make sure that the counties do have systems in place to do that. On the network adequacy side for behavioral health, DHCS has made a large number of efforts in the last few years that start looking at network adequacy for mental health and SUD. To a certain degree, we've been looking at network adequacy on the physical health/managed care side. There have been standards in place for a long time, but they are new on the mental health/SUD side. We are having conversations with our BH partners and counties to ensure that we understand where those gaps are and building access to services. We have issued corrective action plans with our counties.

Diana Vega: Are you planning to increase the reimbursement payments for physicians so you can keep them in the Medi-Cal network?

Jacey Cooper, DHCS: Right now, we have a cost-based reimbursement methodology which means that even with additional revenues coming in, it gets offset within this cost-based reimbursement. It's difficult for counties to get additional revenue and invest that revenue to increase their rates and/or do more innovative payment methodologies. By moving to BH payment reform cost-based reimbursement, it allows us to have a fee schedule that we would be able to evaluate annually on the BH-side for adequacy. The rates would vary by different providers. It would allow them to be paid above cost. At the provider level, they reconcile the cost so that the minimum costs are being reimbursed. Through payment reform, we would have a fee schedule that would allow not only counties but their providers to be paid on the fee schedule which could be above cost. Counties would be able to get additional revenue if they contract with MCPs for things like ECM and ILOS. Those are additional revenues that could then be accessed in BH services. That payment reform piece is critical in order for us to get to the place that you're talking about where we would be able to increase reimbursement.

Diana Vega: When families are referred to BH services, they are on a wait list for more than six months. Children are without services for a very long time. Who is responsible for providing developmental screening? $29 for each screening seems like a very low rate. Is that the reason why physicians aren't motivated enough to work with Medi-Cal?

Jacey Cooper, DHCS: Physicians will get paid for the actual visit, which is separate from the screening. The $29 is an add-on. Developmental screening has been in Medi-Cal for a while, but in order to incentivize to do them, we're paying them in addition to what they receive for the visit. Same for the trauma screening. Those just went live, and we're seeing those start to come in and we're monitoring that.

Diana Vega: Who is overseeing their training for the trauma screenings? It's just an online training?

Jacey Cooper, DHCS: The California Surgeon General has been doing a lot of efforts around creating training materials and a roll-out plan. The screening did get added before the official trainings, but the trainings will be rolling out over the next several months. They've been leading a number of efforts across the state to ensure that physicians are trained on how to do trauma screening. More information is available on the ACEs Aware website.

Richard Figueroa, DHCS: There is an online training. There will be ongoing technical assistance for providers. There will also be a quality-improvement collaborative associated with it. They are also doing research on trauma in general.

Jan Schumann: I wanted to reemphasize on the statewide eligibility that it comes down to the MCPs for children who are going to college. They may be qualified in a county that they no longer reside in, and it may make it difficult for them to have continuity of care. We need to determine why these adolescents are falling off from coverage. Some of the MRMIB meetings were held in alternate locations other than Sacramento to make sure that we include people that might not be able to fly to Sacramento.

Jovan Jacobs, Ph.D.: On slide 10, it discusses ECM and the target population: Seriously emotionally disturbed children and youth with complex behavioral issues. Some of those children do fall under special education through their K-12 public schools. On slide 13, medically necessary and then within our school system, we also have those discussions, "Is it educationally necessary?" Sometimes when we deal with the Department of Rehabilitation Regional Center, Department of Mental Health, when we look at our complex children and the variety of needs they have, some with educational, some with mental health needs, we have a discussion of who will provide those services and who is paying for that? How are we going to look through all of those complexities to ensure that the children are covered? Our school systems are the payer of last resort for students who have disabilities. As we roll out ECM, how are we going to ensure that all stakeholders are addressed?

Jacey Cooper, DHCS: It does get complicated for school-based health services because we have LEA services and school-based health clinics that do contract with MCPs. Within the constructs of ECM, there would have to be a contract entity responsible for working with those entities.

Richard Figueroa, DHCS: The education community is coalescing on ideas they want to provide on how CalAIM would fit into the school context.

Jovan Jacobs, Ph.D.: I want to ensure that we look at the Individuals with Disabilities Education Act, which is an unfunded mandate. On slide 13, regional rates for Medi-Cal managed care, will there be a hold-harmless clause?

Jacey Cooper, DHCS: The rates are set at a county and plan level. It's ensuring that there's competition and ensuring adequate funding. It will be a phased approach: three phases for the regionalization, to group like-counties and comparable-cost areas to make sure there's a balance for how we pay our MCPs.

Nancy Netherland: I'm concerned about the timely access standard and the lack of data that has been collected by counties. MHSUDS Information Notice 19-020 goes into detail around the mandates for counties to start providing phase 1 and 2 data on timely access. I have some concerns about the quality and what may be replicated, not just for timely access for behavioral health, but also, where there are existing targeted case management services for medically complex, what the quality and timing of delivery is. I also want to make sure the funding goes to quality practices that have been assessed by a robust set of stakeholders. If there's a way to coordinate that effort, that would be huge to make sure that there is authentic consumer input into what's going to be replicated.

Jacey Cooper, DHCS: We received similar comments about how we will survey beneficiaries to get feedback on these processes.

Nancy Netherland: When I fostered, the number of systems impacted our lives and was profound; from Department of Social Services to Child Protective Services, to WIC. There wasn't a lot of care coordination or case management and the systems that were supposed to be creating a patchwork of care had mandates and regulations that put them at odds with each other. I'm fortunate that I had the nomenclature and some of the navigation skills through my career, but I do have a lot of concerns about foster children and former foster children since they carry a different type of benefits package.

Jacey Cooper, DHCS: DHCS will release our workgroup members in March for our CalAIM Foster Care Model of Care Workgroup. I strongly encourage you to apply. We have slots for both parent representatives as well as former foster representatives.

Nancy Netherland: Given the fact that it's already difficult to access behavioral health care with a straight ahead diagnosis, what's the path and resources for children who are shown to have an elevated ACEs score or toxic trauma that does not yet trigger a diagnosis? We already have a large number of children who cannot access BH care in a timely manner who have diagnoses.

Richard Figueroa, DHCS: We started making additional investments in mental health workforce last year in the budget. We're also going to look at mental health workforce capacities in the context of a Behavioral Health Task Force. The Governor is also interested in making sure that the Department of Managed Health Care on the commercial side is strenuously enforcing mental health parity on the private payer side. The Governor also announced that we will propose changes to the Mental Health Services Act, and one of the referenced items is workforce.

Jacey Cooper, DHCS: We need to also look to our MCPs for an obligation to provide mild-to-moderate services for children and making sure that they're not losing access to those services.

Ron DiLuigi: Adding resources to mental health is something that everyone applauds, but the lack of quality data is stark. County behavioral health systems have not been part of the drill and that has to change. Bifurcation is a profound problem; when you start separating responsibility within the behavioral health field, between mild-to-moderate and SMI, you run into tremendous problems.

Ellen Beck, M.D.: All of the changes are fantastic with the exception that you need to have baseline data to see what the multitude of changes you're making are doing.

Ken Hempstead, M.D.: We talked a lot about the "what", what's lacking in my understanding is more of the "who". For example, how much of these things will fall on the MCPs responsibility versus counties/state?

Jacey Cooper, DHCS: We will be holding the MCPs contractually responsible for ECM and ILOS and they contract with entities to meet the obligation.

Ken Hempstead, M.D.: Is there a site where we can learn more about that element?

Jacey Cooper, DHCS: In the proposal in appendix D, it would be listed in the table of contents. We will be releasing a revised version in February.

Public Comment

Susan McLearan, California Dental Hygienists' Association: We're happy about the general tone of the plan. I want to be sure that the following issue is on your radar: dental disease on children in school and lost school days. You can have a bigger impact by promoting school-based sealant programs to decrease disease and increase attendance. Through the Dental Transformation Initiative workgroups, I have not heard any support for the dental preventive services that could be provided with great cost-effectiveness by hygienists, especially in a school-based program. All of the incentives we've heard are provided to dentists, clinics, and offices that have been historically part of the system.

Jessica Moran, The Children's Partnership: CalAIM laudably works to address a WPC model statewide, however the target population is those who are seriously ill or with chronic conditions. We strongly recommend that the WPC model be extended to all

beneficiaries, particularly those with emerging risk and early childhood development with the intent to alleviate future conditions of onset.

Kelly Hardy, Children Now: What are the proposed oversight reforms related to the Child Health and Disability Prevention Program (CHDP) and CCS?

Jacey Cooper, DHCS: More details in the proposal, but we are ensuring that we will use quality metrics on the CCS and CHDP side and looking at standardized operational functions for referral timelines, authorization timelines, eligibility timelines, etc., and looking at oversight as a whole. Also publicizing quality metrics in that delivery system.

Upcoming MCHAP Meeting and Next Steps

Richard Figueroa, DHCS: Today, the Governor announced the appointment of DHCS' new Director, Dr. Bradley Gilbert. He's the former CEO of Inland Empire Health Plan. He's very knowledgeable and innovative in providing services to Medi-Cal beneficiaries. I've enjoyed my time as Acting Director.

Ken Hempstead, M.D.: We added a meeting, December 9, 2020. For any additional agenda items, feel free to email MCHAP@dhcs.ca.gov.