State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

April 24, 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; Bertram Lubin, M.D., Licensed Disproportionate Share Hospital Representative

Public Attendees: 104 members of the public attended the webinar.

DHCS Staff: Bradley Gilbert, Anastasia Dodson, Erica Bonnifield, Adam Weintraub, and Morgan Clair.

Opening Remarks and Introductions

Ken Hempstead, M.D., MCHAP Chair, welcomed those on the webinar. Hoped everyone has weathered the storm as successfully as possible. We are honored to have our new DHCS Director.

Dr. Hempstead read the legislative charge for the advisory panel aloud. (See agenda for legislative charge.)

Dr. Hempstead asked the members to introduce themselves.

Meeting minutes from January 30, 2020, were approved, 12-0.

Dr. Gilbert swore in Dr. Bertram Lubin to a term ending Dec. 31, 2022.

Adam Weintraub, DHCS: A response to the follow-up list have been posted to the MCHAP web page.

Opening Remarks from Bradley P. Gilbert, MD, MPP, Director

Dr. Gilbert provided a brief overview of his background. He is a physician who is board certified in general preventive medicine and public health. Most of clinical career has been as a general practitioner treating Medicaid patients of all ages. Clinical settings include county clinics, federally qualified health centers, and Planned Parenthood. Was a physician and Medical Director for a jail system in San Mateo. Worked at a methadone clinic. Significant experience with substance use disorder treatment. He also has exposure to working with individuals with significant behavioral health issues.

COVID-19 Status and Update

Bradley Gilbert, DHCS: The impact of COVID-19 has been so fundamental across all parts of our economy and communities. Our response to COVID-19 is the absolute highest priority. There are different resources to access on COVID-19: state's comprehensive website, https://covid19.ca.gov/, and the DHCS website with COVID-19 guidance and resources.

Presentation slides available here:
https://www.dhcs.ca.gov/services/Documents/MCHAP-Presentation-042420.pdf

Section 1135 Waiver Requests:

Under the Medicaid program, states can request these waivers during the declaration of a public health emergency by the President of the United States. States are able to ask for flexibilities, including to certain rules and delivering care. The Centers for Medicare & Medicaid Services (CMS) have released extensive blanket Medicare waivers for hospitals, Skilled Nursing Facilities (SNFs), ambulance providers, physicians, etc., available on the CMS website. Any dual provider is able to use the flexibilities within these waivers.

DHCS thought it was important to give flexibility around provider participation and enrollment, including out-of-state providers, which helps address access for subspecialties. We've also streamlined Medi-Cal provider enrollment for quicker certification.

The ability to provide care at alternative sites is also important. The Governor has worked to move homeless individuals into more stable situations. We've also converted Sleep Train Arena into a treatment center. Normally, CMS wouldn't allow us to pay for care at those types of sites, but we asked for the flexibility to allow for care to be delivered and paid for at those alternative sites.

How do we ensure that other pieces work well? We have:

- Waived prior authorization requirements (in fee-for-service (FFS));
- Flexibility with durable medical equipment (DME) and supplies;
- Allowing some non-physician prescribing of services, including other licensed clinicians, who can prescribe nonemergency medical transportation;
- Ensuring that we can deliver care in a timely manner;
- Lengthening time frame to request State Fair Hearings.

DHCS is requesting that COVID-19 testing and treatment be considered an emergency service for Medi-Cal beneficiaries regardless of site of service. For individuals on limited-scope Medi-Cal, the emergency service does two things:

1. It is exempt from the Public Charge rule;
2. Allows the emergency service to be delivered anywhere.

We've been able to significantly increase our flexibility for telehealth and virtual visits. We wanted to open this up in two ways:

1. Additional flexibilities for providers, including FQHCs;
2. Telephonic visits are permitted, since not everyone has the programs or equipment to conduct visual visits.

The virtual visits are paid at the same rate as if they were in-person visits, assuming that it was a comparable visit.

Well-Child Visits: We don't think it's possible to do an entire well-child visit virtually, but significant pieces can be done by telehealth. Our guidance asks providers to outreach to the parent to help them feel comfortable, and it makes the in-clinic visit significantly more time efficient.

We've asked for flexibility for counties for Substance Use Disorder (SUD) and mental health (BH) services to change the funding to provide additional support now.

We did request add-on payments for long term care and intermediate care facilities.

Presumptive eligibility (PE) allows people to be immediately eligible for Medi-Cal when seeking care in certain situations to certain providers, hospitals being the most common. There was no PE for over 65 aged and disabled populations, so we're requesting that option be added.

We have individuals that pay share of cost (SOC) and have to spend out of pocket before they are Medi-Cal eligible. If they're coming in for COVID-19 testing and treatment, the SOC should be waived and they should get access to certain services. We don't want anyone avoiding care for COVID-19 testing and treatment.

1115 Waiver requests: These requests are around generally paying for things that Medicaid normally would not pay for.

- Changes to rules for Institutions for Mental Disease (IMDs) to allow us to go beyond the 16-bed limit (moving people out of acute care site facilities);

- COVID-19 testing and treatment as an emergency service at alternative care settings;
- Paying for individuals in jail to get their COVID-19 testing and treatment on site paid for by Medi-Cal;
- Anyone who needs COVID-19 testing and treatment will be allowed to seek treatment, aimed at uninsured individuals;
- Request to pay for temporary housing through Whole Person Care Pilots;
- Retainer payments for Home and Community-Based Services (HCBS) in order to help providers stay as whole as possible;
- Some flexibility for SUD services;
- Loosening rules for Public Hospital Redesign and Incentives in Medi-Cal (PRIME) and Quality Incentive Program.

Anastasia Dodson provided an overview of the Appendix K waivers that DHCS submitted to CMS for flexibilities around 1915c programs. The 1915c programs are HCBS programs that have a wide-range of beneficiaries, the largest is the HCBS waiver for Californians with developmental disabilities.

Anastasia Dodson, DHCS: There's a template that we follow for Appendix K waivers; it's a standard document that all states use in the event of a disaster. All are for the period of February 4 through June 30, 2020, and the end date may be reassessed.

Appendix K for 1915c Waivers: Developmental Disabilities – Allows for temporary changes to service location so that day services can be provided in the home; modifies provider qualifications; plan development requirements for in-person attendance; allows option for telephone and live video in lieu of in-person visits; authority to make retainer payments for rehabilitation, behavioral, intervention, and day services.

Appendix K for 1915c Waivers: Home and Community Based Alternatives – Allows family caregivers or other legally responsible individuals to provide services; modifies provider types to allow CNAs to provide private duty nursing; evaluations and reevaluations to be conducted over the phone; waives disenrollment for individuals who are reinstitutionalized beyond 30-day limit.

Appendix K for 1915c Waivers: Assisted Living Waiver – Similar to the previous waiver flexibilities.

Appendix K for 1915c Waivers: HIV/AIDS – Allows flexibility between face-to-face nursing and psychosocial assessments using telephonic or live video conferencing for assessments.

Appendix K for 1915c Waivers: Multipurpose Senior Services Program – Allows flexibility to conduct telephonic assessments in lieu of face-to-face assessments.

Flexibility for California Community Transitions – California receives federal funding for this program to help transition individuals in skilled nursing facilities into the community. Allows flexibility for assessments using telephone or live video conferencing options.

Bradley Gilbert, DHCS: We recently convened our California Children's Services (CCS) Advisory Group and received feedback on some issues relating to access to care. We will provide CCS-specific guidance to make sure that children with special and complex medical needs are getting the care they need.

***Disaster State Plan Amendment (SPA)**:*
This SPA complements the Section 1135 Waiver pieces.

Anastasia Dodson, DHCS: For IHSS, DHCS sought flexibility to conduct assessments and reassessments via telehealth. The Department of Social Services published guidance on that.

Brad Gilbert, DHCS: The telehealth and virtual/telephonic communications guidance is posted on the DHCS website.

The Governor recently released his six criteria for relaxing the stay-at-home order. People who may need preventive services are not receiving them, particularly children. There was a recent report about vaccination and immunization rates that was not positive. So these two pieces are together: one is about giving flexibility to the well-child visits, but also, what are the things we need to think about for increasing health care in general. What are the types of considerations that a local region or area, and eventually the whole state, need to think about in terms of elective surgeries, preventive services, primary care, etc.? The well-child visits guidance will be posted to the website shortly.

Anastasia Dodson, DHCS: For the well-child visits guidance, DHCS is relying heavily on the guidance published by the American Academy of Pediatrics. They have a number of guidance documents available on their website.

Diana Vega: Can you clarify whether the flexibility for documentation is for providers or for people trying to enroll in Medi-Cal?

Brad Gilbert, DHCS: It's what documentation must be supplied by a provider to go through a faster process to become a Medi-Cal provider.

Ron DiLuigi: Do you have any additional autonomy that you can draw on or do those need to go back through an 1135/1115 waiver?

Brad Gilbert, DHCS: There's a fair amount of flexibility at the local level; MCPs have a lot of flexibility around creating different payment methodologies. In general, the Medicaid program is not very flexible. There's always the issue of what can be reimbursed by the federal government. The counties have some flexibilities with their

contracts with behavioral health providers; everything is reconciled with cost of care. Within that, you have flexibility.

Elizabeth Stanley Salazar: I'm amazed by the flexibilities and forward thinking that DHCS is using. You asked how things are in the field, I wanted to talk about the California Youth Opioid Response grant. Our providers and grantees are jumping into this and learning to find solutions using the flexibilities granted to them for telephonic and telehealth work. In face of emergency, we have found opportunities to reach more teams and in more diverse ways. We are still figuring things out, but the lessons being learned everyday are helpful. Through practitioner surveys, many do not understand how to access the preliminary SUD system. There's work to be done to bridge collaboration in defined, structural, and incentivized ways between the health care system and the specialty SUD system in the state.

Brad Gilbert, DHCS: That's a really good point; it's the concept of familiarity. What are people familiar with and how do they deliver care? Integration is important.

Ellen Beck, M.D.: For telephone visits, there are some individuals who just don't have the capacity for telemedicine. What is the plan for covering undocumented people over age 65? For medication prices, prescriptions like insulin have doubled; what is the government doing to rectify? Also, there is so much fear and misinformation in the undocumented community; how are you working in Spanish translation?

Brad Gilbert, DHCS: The coverage for the over-age-65 population is still in the budget discussions. Those individuals, if uninsured, can get COVID-19 testing and treatment now. For your medications question, I haven't heard anything specific to shortages and prices. We will look into it. For your last comment on fear in the undocumented community, we will issue information for the uninsured that will clarify that they can get COVID-19 testing and treatment.

Terrie Stanley: What are we doing for our most vulnerable individuals in skilled nursing facilities (SNFs) and long-term care facilities? On the Medi-Cal side with long-term care, is anything happening at the state level that the panel should know about?

Brad Gilbert, DHCS: This is difficult as there is a lot of infection occurring in SNFs, both among the patients and staff. There's a lot of attention being paid to it to move individuals out. There's more focus on testing capabilities at those sites. The good news is that there's a very significant focus on this. There's a whole discussion on how we think not only about SNFs, but on congregate living facilities.

William Arroyo, M.D.: I'm curious about the process that DHCS has in place for consideration of waivers. For example, are there recommendations entertained from providers for certain provisions of the SPA, or were the specific provisions identified by staff for request from CMS to consider?

Anastasia Dodson, DHCS: We have a lot of feedback from provider organizations in developing these, both at the department, Agency, and Administration levels. We

appreciate that providers, MCPs, counties, and beneficiaries are a critical part of our health care delivery system. Communication is very important, now more than ever.

William Arroyo, M.D.: Is there a formal mechanism for suggesting waivers?

Anastasia Dodson, DHCS: In a normal time, we would be circulating drafts and getting stakeholder feedback and find great value in their feedback. However, because of the urgency of the situation, feedback from CMS and other states has also been really informative. CMS has suggested a list of flexibilities, FAQs, and updates on their website, which we review daily.

William Arroyo, M.D.: Can I send ideas to DHCS?

Brad Gilbert, DHCS: Of course.

William Arroyo, M.D.: Are COVID-19 tests required to be FDA-approved, and are there parameters for approving testing?

Brad Gilbert, DHCS: Not my expertise, but what I know is that the FDA is doing an emergency use authorization, so they are not fully approving some tests. Our California Department of Public Health (CDPH) team have a specific group that are looking at the lab tests. For example, there are some concerns about the antibody tests; CDPH is looking at them specifically on legitimacy and which should be used. The state is trying to be thoughtful and careful about the testing.

William Arroyo, M.D.: Do COVID-19 tests need to be administered in certain settings?

Brad Gilbert, DHCS: The public health departments, academic centers, Quest and LabCorp are all controlled and regulated. The state is looking at creating testing centers that would be spread throughout the state for high-volume testing, and monitored by CDPH.

William Arroyo, M.D.: Do the waivers for MH and SUD require the same documentation? I'm interested in the requirement for the client signature on a treatment plan.

Brad Gilbert, DHCS: We have waived a number of in-person signature requirements and will need to get back to you on that one.

William Arroyo, DHCS: What is the viability for community-based organizations to provide mental health services? Many cannot survive without generating expenses. Has DHCS monitored units of service to project what the viability is of the network of providers throughout the state?

Brad Gilbert, DHCS: We're not at that granular of a level; the relationship is between the counties and the contracted entities. We have been monitoring this concern by surveying at the county-level. We've heard concerns about the entities delivering those services about cash flow, patients coming in, etc. We have seen counties going to a 1/12 payment methodology and reconcile costs after it's done. This is a concern across

the board for all providers: Dentists, primary care, hospitals not doing elective surgeries. Health plans have stepped up to provide that support; the state can't directly provide that support.

William Arroyo, M.D.: There will be a major economic downturn and my concern is that there won't be funding to support the mental health network.

Jan Schumann: Does or will the special coverage for COVID-19 testing include antibody testing? For State Fair Hearings (SFH), by lengthening the timeframe to file, does it affect the response times of appeals for beneficiaries obtaining timely responses for denied treatment? I want to ensure that beneficiaries aren't delaying their care as it relates to the administrative flexibilities and hearings. Have beneficiaries been notified regarding the extension of eligibility to submit their annual recertification and what methods have been used to relay this information?

Brad Gilbert, DHCS: We're not delaying the SFH process; we're making it more flexible through telephonic means. Beneficiaries can submit their denials right away, and then we would respond in our normal timeframe.

Adam Weintraub, DHCS: All of the guidance related to the individual care systems are located on COVID-19 webpage.

Anastasia Dodson, DHCS: DHCS issued a provider bulletin about antibody testing being a covered benefit.

Brad Gilbert, DHCS: There hasn't been a specific notice to the entire Medi-Cal population on renewal packets/annual recertification yet.

Anastasia Dodson, DHCS: DHCS will continue to partner with the counties on this effort.

Nancy Netherland: I have medically fragile former foster kids that require extensive hospital-based care. My child receives home infusions. Historically, Medicaid would deem it medically unnecessary for her to go to the hospital for those infusions. Her team is reluctant to do home infusions because it would set a precedent. Limited home-based infusion is weighing out risk of infection versus risk with infusions. I'm curious about other types of services that would be affected?

Brad Gilbert, DHCS: It can be an issue where if you deliver something in a different setting, it's then determined that you don't need it in the other setting that you normally get it in. We'll need to look into it at your case very specifically. We're hoping to provide guidelines on increasing access to the health care delivery system. For example, depending on where you live and the circumstances on rate of infection and other considerations, you should be getting services for your child at the hospital.

Nancy Netherland: Remote physical therapy has been great to be able to avoid some of the communal areas in hospitals and medical office buildings. The changes that have

been made so far have been fantastic. I'm hoping to see telehealth visits extended in other areas for children who need support for chronic illnesses.

Brad Gilbert, DHCS: Good to know that it's actually working at the individual level. To your second point: How do we think about some of these flexibilities that have been created and are available, post-COVID-19 and ongoing potentially? This includes looking at primary care, physical therapy, and other services in a way differently than how we've thought about it in the past. We'll look at the issue around the benefit that you've described because that's applicable to many circumstances.

Katrina Eagilen, D.D.S: Dental offices have been closed, only allowing for emergency care. Dentists are working on protocols and procedures and many are talking about the COVID-19 quick tests at the office during the pre-appointment procedure. One of the things being discussed is specific locations for testing, and that might not be the best situation for all concerned citizens.

Brad Gilbert, DHCS: This has been mentioned quite a bit. I think we're still in the phase of not having enough testing. You will see testing expand over time.

Katrina Eagilen, D.D.S: With the increased amount of infection control procedures, will there be billing codes that providers can use? Dentists are already at the highest level of infection control. If dental offices are unable to do the quick tests at the offices, then PPE costs will go up exponentially.

Brad Gilbert, DHCS: I don't know if there will be billing codes specific to costs related to infection control.

Bert Lubin, M.D.: Will the physicians or patients in the clinics have access to the information and how would you improve that?

Brad Gilbert, DHCS: The best place to view this guidance is on the DHCS website.

Bert Lubin, M.D.: Over 50% of visits in FQHCs are by telehealth. The doctors using telehealth get an introduction to the family in a way they didn't get before.

Brad Gilbert, DHCS: That's an interesting point and part of why we want to think about this for the future.

Bert Lubin, M.D.: The Governor said for education, children should have either a computer or a laptop in the home; Televisits are education, in my opinion.

Alison Beier: For the Appendix K HCBA Waiver, it was noted that there were no children included in this waiver. About 5% are children, which is the medically fragile population. That community feels like they are overseen because it's a small percentage and they are lumped into an adult waiver. With In Home Supportive Services (IHSS), you had mentioned that assessments via telephone. For the pediatric population on the IHSS waiver, has there been discussion on adding hours to the weeks for those families? For the well-child visits, is it one payment at the end of the telehealth and physical visit?

Brad Gilbert, DHCS: Yes, it's a well-child visit that is divided into two parts: telehealth and in-clinic visit. Based on the American Academy of Pediatrics' Bright Futures guidelines and how the codes work for it, you need to have all the pieces together.

Alison Beier: Inevitably, there will be families that do the phone call but won't come in for the second visit, so providers will not be reimbursed. Or, if the family doesn't need the vaccinations, they may feel like they don't need to come in for the vitals.

Brad Gilbert, DHCS: The way we would approach that is you would bill a regular E&M code for the telehealth visit and would not bill the full well-child exam. To your point, the clinic and physician would need to be aware of that billing process.

Alison Beier: Perhaps this can be considered on a case by case basis, but there are some children at home who are being abused or a severely fragile child. The need to have that child in the office supersedes doing anything on the phone.

Brad Gilbert, DHCS: When you think about telehealth in general, it should only be for the right circumstances at right time. It's not the solution to everything.

Alison Beier: If you have pushback with physicians, they need to know there is flexibility. For the office visits, are there guidelines for how each office handles patients? Are you going to give broad guidelines or allow each facility to have guidelines for COVID-19?

Anastasia Dodson, DHCS: The American Academy of Pediatrics has guidance for clinical practices around waiting rooms and how to serve patients based on whether they're well or ill. It's a broader question not specific to Medi-Cal.

Erica Bonnifield, DHCS: Guidance has been issued for COVID-19 preparedness strategies for health care facilities for screening best practices as recommended by the CDC and CDPH.

Alison Beier, DHCS: Are these just suggestions?

Brad Gilbert, DHCS: They're just suggestions. The reality is that some facilities will not be able to do these things and will have to do the best they can to try to control infection.

Karen Lauterbach: For the long-term plan for telephonic visits, another benefit that we see from our patients is for them not having to travel. Many take public transit and don't have flexible work schedules, so they've enjoyed telephonic visits. For enrollment guidelines, is there statewide guidance for helping people enroll in Medi-Cal?

Brad Gilbert, DHCS: Best way to enroll is online through https://www.coveredca.com/. We are surveying the counties on level of service; are there any in-person visits happening, what are the telephone capabilities, etc.? We did receive additional funding for the counties to handle additional caseload to assist with the higher levels of unemployment.

Karen Lauterbach: We heard issues about online enrollment and the website crashing or slow, so it's hard to tell if the application was submitted. These individuals have been unable to reach anyone. I would encourage a way to troubleshoot this issue.

Brad Gilbert, DHCS: We will follow up specifically. We hadn't heard of any issues with the website.

Diana Vega: Has CHHS issued any guidelines for prioritizing Medi-Cal treatment for disabled, people of color, LGBT community, etc.? For Hydroxychloroquine, it hasn't been proven effective, so why is it still being used?

Adam Weintraub, DHCS: There was joint guidance that set forth a non-discrimination policy. The guidelines that we issued were for the off-label use of chloroquine and hydroxychloroquine, and were in parallel with the CDC for cases where they were thought to be beneficial. That's at the discretion of each individual doctor. I don't know if we've seen a lot of usage of that billing code.

Diana Vega: A family member was just released from the hospital and was given hydroxychloroquine.

Brad Gilbert, DHCS: Physicians have not necessarily been following these guidelines. There hasn't been much evidence other than a small study out of France that started this hydroxychloroquine movement. Yet, more recent studies show that it may be harmful.

Adam Weintraub, DHCS: We'll follow-up offline.

Director Gilbert provided an overview on access to treatment through COVID-19 Presumptive Eligibility (PE). A Medi-Cal aid code was created that allows the provider to bill for the testing and/or treatment-related services.

Adam Weintraub, DHCS: The COVID-10 PE category allows anyone, regardless of immigration status, to receive testing and care for the disease.

Director Gilbert provided an update on CalAIM. Given COVID-19, DHCS' focus has been on responding to the public health crisis. DHCS is moving to extend its existing Section 1115 and 1915b waivers for another year to allow time to think about CalAIM starting in 2022. We moved the Foster Care Model of Care Workgroup first meeting to June instead of April 2020.

Erica Bonnifield provided an overview of the Medi-Cal Rx timeline and provided an implementation update, including but not limited to that. DHCS executed our agreement with our contractor, Magellan in December 2019. The "go live" is January 1, 2021.

Brad Gilbert, DHCS: The underlying principle of the transition plan is designed to ensure beneficiaries receive the medications they need.

Ellen Beck, M.D.: How does this address county carve outs for mental health medication? How does this help for price controls? I didn't hear the full response around

what physicians should do telephone visits in a more comprehensive way; I couldn't find the guidance. For the stipend that will be given to undocumented individuals, how is the state going to reassure and select the community organization?

Brad Gilbert, DHCS: The telehealth guidance is available on the DHCS website. There's a lot of flexibility; as long as you do a visit that's comparable to an in-person visit, you can bill for it at the same rate. For the medication issue, we should have information on a statewide platform when a particular drug is suddenly increasing in price or when availability becomes an issue. DHCS will not be administering the stipend to undocumented individuals.

Adam Weintraub, DHCS: I will follow-up with you offline.

William Arroyo, M.D.: Who is negotiating the drug pricing: DHCS or Magellan?

Erica Bonnifield, DHCS: Our Medi-Cal drug reimbursement methodology/pricing is set in statute. Federal and state drug rebate negotiations and contracting will remain with DHCS as part of the department's overarching Medi-Cal Rx responsibilities.

William Arroyo, M.D.: When will the state's medical drug list be available?

Erica Bonnifield, DHCS: The Contract Drug List (CDL) consists of Federal Food and Drug (FDA) approved covered outpatient drugs, consistent with federal Medicaid requirements, which have an approved CMS rebate agreement on file. Most drugs on the CDL do not require an approved prior authorization request (PAR) for coverage. The Medi-Cal CDL is available on our website, but a much more user-friendly version will be available on the Medi-Cal Rx platform. We're standing up the website in phases, starting in June 2020; the CDL will come alongside the provider training, which will be in the fall 2020.

Elizabeth Stanley Salazar: Will you be looking at the medications for the Medication Assisted Treatment project? These medications aren't consistently available; Vivitrol, for example, is so expensive it prohibits use.

Erica Bonnifield, DHCS: We cover these drugs through SUDs and MH programs; they all come through our FFS fiscal intermediary today. Those drugs will be pulled into Medi-Cal Rx for purposes of claims administration and PAR adjudication, based upon DHCS' Medi-Cal pharmacy policy. MAT is outside the scope of Medi-Cal Rx.

Elizabeth Stanley Salazar: Inside of the DMC-ODS system, you're referencing FFS, but inside the DMC, these medications are built into the DMC billing rates. It's something to look at in the future as to the efficiency and cost.

Karen Lauterbach: Will a delay for Medi-Cal Rx be considered?

Brad Gilbert, DHCS: At this point, we're moving ahead and aiming for January 2021. If circumstances change, we'll evaluate.

Alison Beier: Can we have a quick update on the implementation on ACEs trauma screenings?

Brad Gilbert, DHCS: They were implemented January 1. Two pieces: trauma screening payment, and training of providers. Both are moving along successfully.

Member Updates

William Arroyo, M.D.: Our next meeting is after budget is signed by the Governor. If our charge is to advise DHCS, this panel may want to have a meeting prior to the final budget to help DHCS prioritize children's health needs.

Brad Gilbert, DHCS: The difficulty this year is that it will be truncated with fewer public hearings, so I can't speak to the process this year. We can look at our options.

Adam Weintraub, DHCS: We won't have a full picture of revenue until after July, I suspect there will still be time to reshape any emergency budget adjustments. The June meeting may be sufficient to get us in between first and second decision point.

William Arroyo, M.D.: Some of these programs are entitlements, and would need to be continued despite the state's revenue shortage.

Elizabeth Stanley Salazar: It's a question for the panel, and is it feasible to attend and support the meeting? Do we need to change the meeting date from June to May?

Ron DiLuigi: Bill's point is very important and goes to the purpose of our existence. If you find that our recommendations can't get inputted quickly enough, maybe we interact directly with the Legislature. What's the most constructive approach we can take?

Brad Gilbert, DHCS: That's something to consider and you certainly have the ability to go directly to the Legislature.

Adam Weintraub, DHCS: We do run into a timing issue because the May 27 Stakeholder Advisory Committee meeting is set as a public hearing where we would accept comment on the CalAIM proposal. When we have a more detailed understanding of the Governor's May Revision, perhaps it would be appropriate for us to draft an update for the Panel. Once we know what the proposal will include for DHCS programs, then the panel might be in a better position to decide whether a change in the meeting schedule is appropriate.

Jan Schumann: Would we run into issues regarding public notice?

Adam Weintraub, DHCS: As long as an agenda is issued at least 10 days in advance of the meeting.

Jan Schumann: When the proposal comes out, will that give us enough time to help DHCS and possibly the Legislature to produce recommendations?

Brad Gilbert, DHCS: Appreciate the concern. I look to the Panel to decide.

Ken Hempstead, M.D.: No strong feelings either way; it sounds like we have some flexibility with early June versus June 18.

Ellen Beck, M.D.: We should at least have a date and cancel it if necessary.

Ron DiLuigi: We need to lean on best judgment of staff based on the timing.

Ken Hempstead, M.D.: We can see if there's a date that would work for everyone and do the reconnaissance now. Even if we didn't have all of the information after the May Revise, what would be the harm in having the meeting a couple of weeks earlier?

Brad Gilbert, DHCS: That works for us.

Ken Hempstead, M.D.: Initially, we were expecting a surge in delivering care which would be very costly to the MCPs, but now the pendulum has swung the other way where so much care has not been delivered. We've already had many discussions with this panel on network adequacy and rural areas; how are these hospitals and providers going to remain solvent through all of this? Are there any checks and balances that DHCS can provide in those types of discussions?

Brad Gilbert, DHCS: We have seen utilization increase across the board for ER, hospitals, etc. There's a need for federal funding to flow into California. The first $30 billion that came out was distributed based on Medicare billing. Proportionally, California did not do very well under that. They are adjusting the formula so it will be interesting to see how that, particularly rural hospitals, will be affected. We have to look at it over time. There is a lot of pent up demand for services, from the well-child exam to elective surgery.

Public Comment

Kelly Hardy, Children Now: I wanted to follow-up on the well-child visits. There are reports that up to 80% of children aren't seeing their pediatrician right now. We're concerned about COVID-19 infections, but this could lead to low vaccination rates for other diseases. It sounds like the response has been to make it as easy as possible to get reimbursements for telehealth visits, and linking that to the in-office vaccinations. Is there anything else that DHCS or we all can do to encourage well child visits where appropriate?

Brad Gilbert, DHCS: Yes, part of the focus is making the telehealth visits a significant part of the visit. We are working on guidelines for increasing access in general to the health care system. There will be specific comments made about access to well-child visits in those guidelines.

Kelly Hardy, Children Now: We will do what we can to spread the word.

Upcoming MCHAP Meeting and Next Steps

Ken Hempstead, M.D.: We're looking forward to determining when our next meeting will be held.

Adam Weintraub, DHCS: In the near term, we will continue to hold these meetings virtually. We encourage everyone to register for the webinar in advance and to use the web tools if possible since it makes it easier to see who has a comment. We'll follow up with the materials that were promised and will follow up with the June meeting date.