State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

June 5, 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.

Public Attendees: 55 members of the public attended the webinar.

DHCS Staff: Bradley Gilbert, Jacey Cooper, Adam Weintraub, and Morgan Clair.

Opening Remarks and Introductions

Ken Hempstead, M.D., MCHAP Chair, welcomed those on the webinar. Shared gratitude for being able to meet and leverage technology.

Ron DiLuigi 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 April 24, 2020, were approved, 10-0.

Adam Weintraub, DHCS: A response to the follow-up list have been posted to the MCHAP web page. Dr. Arroyo mentioned that when DHCS was selecting members for the California Advancing and Innovating Medi-Cal (CalAIM) Foster Care Model of Care Workgroup, that we had not included an MCHAP member on the panel. As a result of

Dr. Arroyo bringing that to our attention, the Behavioral Health team at DHCS has selected Nancy Netherland as a parent representative.

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

Director Gilbert announced that he has decided to leave the Director position. He retired from the Inland Empire Health Plan in July 2019, and decided to retire permanently to join his family in southern California. It's been an honor to be the Director. He thanked the MCHAP members for their important contributions. Jacey Cooper, State Medicaid Director and Chief Deputy Director for Health Care Programs will be working directly with the Panel.

Jacey Cooper, DHCS: I had the opportunity to meet many of the members when I presented at the January MCHAP meeting with former Acting Director Richard Figueroa. I look forward to continuing my work with the Panel.

Presentation slides are available here:
https://www.dhcs.ca.gov/services/Documents/MCHAP-Presentation-060520.pdf

Director Gilbert provided updates on the Foster Care Model of Care Workgroup and the Behavioral Health Task Force.

State Budget Update: May Revision

Ken Hempstead, M.D.: I think it might be helpful to bring the Panel up to speed in terms not only understanding the revisions, but the context of those decisions and specifically, where we're at in the Senate and Assembly on the budget. What are the levers, decisions being made, and next steps?

Adam Weintraub, DHCS: The majorities in both houses in the Legislature have reached a broad agreement on another version of the budget that does not include cuts as deep as those in the May Revision, and include assumptions about federal funding that could be forthcoming. The two branches involved in the budget (Legislative and Executive) will discuss the differences between the two proposals. The state constitution requires that a balanced budget be passed by the Legislature by midnight, June 15. Current law requires that a bill be in print 72 hours before the Legislature can take legal action on it, which means that the budget must be in print by June 12. The Legislature must approve the document, then route it to the Governor to sign, veto, or modify with a line-item veto.

Bradley Gilbert, DHCS: There has been an agreement between the Senate and the Assembly on a budget proposal that is fairly significantly different than the Administration's proposal. Hopefully they can reconcile a proposal. We are not part of those discussions. Our role would be to help with anything that changes in relationship to budget bill language or trailer bill language in relation to DHCS, different than what was proposed by the Administration.

Ken Hempstead, M.D.: That was what I was hoping for in terms of initial context. To the extent that we may come back to those issues as we explain some of this, it's helpful context for the Panel to understand.

Ron DiLuigi: It would be helpful to hear an iteration of the significant changes that the Legislature is proposing to the Governor's May Revision.

Adam Weintraub, DHCS: It contemplates less deep cuts and includes some continuation of programs that were not continued in the Governor's May Revise. Given that the negotiations are ongoing, our staff are aware of them in broad terms, but until we see the details, it's hard to drill down on specific aspects because so many are still subject to change. Once we have a bill in print, we'll be better able to answer that. The Legislature have posted a version of that and we can see if we can track down what they've outlined their explanation of the key points and we can distribute it to the Panel.

William Arroyo, M.D.: We're most interested in getting the pieces that directly relate to our charge.

Adam Weintraub, DHCS: This will be covered in the presentation, but a lot of the cuts that have been discussed when the budget was released have to do with adult benefits and not children's benefits. The EPSDT provisions maintain a lot of those services for children, even when the optional benefits that are in parallel are removed for adults.

William Arroyo, M.D.: Yes, the EPSDT is an entitlement and cannot change. The Prop. 56 funding that would have enhanced supplemental reimbursement for primary care doctors; those are the doctors the children depend on. We need to focus on these items if we're going to provide any meaningful input.

Ken Hempstead, M.D.: Rather than getting super granular about one particular line item, we can speak more broadly to the priorities. We'll have plenty of time for overall discussion on this, but in terms of the contextual information, does anyone else want to make any comments at this time?

Terrie Stanley: DHCS was going to put the managed care contracts out for rebid starting in 2020, but some were pushed back. Was any of that impacted by the May Revision?

Jacey Cooper, DHCS: Nothing in the May Revision should have an impact on the managed care procurement. We originally planned to engage in a Request for Information (RFI) in April, but it was postponed while we were responding to COVID-19. We will be announcing new dates and a timeline for the RFI to allow for comments on the procurement. New information will be available this summer.

Bradley Gilbert, DHCS: As I'm going through the May Revision, we can focus on specific items that relate to children. These are going to be negotiations between the Administration and the Legislature.

Director Gilbert reviewed information from the meeting slides on the May Revision. There are modifications to proposals included in the January budget, especially in light of the significant General Fund (GF) budget shortfall. We're looking at a very large deficit for next budget year and also going forward. There is a real concern about the amount of revenue that will be available for this budget year. DHCS' focus was on maintaining current eligibility; some of that focus was due to the public health emergency and the increased Federal Medical Assistance Percentages (FMAP), which created rules about what could be changed or not. There was also a policy goal for maintaining eligibility for individuals that had coverage now, including children and young adults that do not have full documentation; and specialty eligibility (such as) breast cancer, Every Woman Counts, cervical cancer, and prostate cancer. In addition, there are federal guardrails around what can be altered or changed. All of those things had us propose very difficult decisions about programs, supplemental reimbursement, and optional benefits. The optional benefit reductions don't impact children.

Our spending will be up, and a lot of that is due to the estimated increased enrollment. Projected caseload will increase by about 2 million over the current year forecast, which will impact both the GF and federal matching funds. COVID-19 costs are included; a lot of the flexibilities that were added have a cost, which increases our budget. The state budget deficit, increasing caseload and the requirement to put forward a balanced budget meant difficult budget recommendations. We also have federal and state restrictions that narrow the options we can consider. The reductions include 2019 programs and items in the proposed January budget that are not yet or were very recently implemented, optional benefits, repurposing of Proposition 56, and fund transfers.

- $50 million GF reverted funding from various augmentations that were included in the 2019 Budget Act. This includes health enrollment navigators, Medical Interpreters pilot, and other programs that affect seniors.
- $600 million GF in savings related to proposals in the January Governor's Budget that have now been withdrawn. This includes postponing CalAIM, including potential impacts to children through the Enhanced Care Management, In Lieu of Services, and behavioral health components.
- $150 million GF related to the elimination of various adult optional Medi-Cal benefits. This includes the Behavioral Health Quality Improvement Program, postpartum mental health expansion, Medicare Part B, undocumented older adult coverage, Supplemental Payment Pool for Non-Hospital 340B clinics, and hearing aid grant program. Adult dental is a reversion back to 2014 benefits. It eliminates the Multi-Purpose Senior Services Program (MSSP) and Community-Based Adult Services Program (CBAS). Optional benefits changes do not apply to children on Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT), individuals in long-term care facilities, pregnant individuals, or if services are provided in a hospital or an FQHC.
- $1.2 billion GF to reflect the redirection of Proposition 56 revenues to offset GF costs of Medi-Cal caseload growth. This includes elimination of supplemental

payments to both physicians and dentists, value-based payments, developmental screenings for family planning and women's health, supplemental payments for intermediate care facilities for developmentally disabled and CBAS centers, value-based payments and behavioral health integration, CalHealthCares cohorts 2-5, reduced funding for trauma screening, and no change to home health and pediatric day health centers, freestanding pediatric subacute facilities, and HIV/AIDs waiver program.

- $390 million GF in various Medi-Cal rate reductions and program efficiencies. This includes reducing managed care capitation rates by 1.5 percent and implementing a risk corridor for the bridge period, Family Mosaic Program, estate recovery, a small health insurance payment program. Also calls for elimination of the Child Health and Disability Program (CHDP) county case management, which is a relatively small program. Most, if not all, of these children are also in managed care and have case management support.
- $330 million GF to reflect the redirection and transfer of certain special funds and some revenues from the proposed E-Cigarette Tax to fund Medi-Cal.

Two other key factors in the revised budget estimates are a decrease of $1.7 billion GF from the recently approved Managed Care Organization (MCO) tax that offsets GF costs in Medi-Cal in 2020-21 and an increase of $1.4 billion GF to return federal funding where we incorrectly drew down federal dollars for services in state-only programs. The Family Health Local Assistance program caseload is projected to remain relatively stable. The trailer bill language and a list of resources are included in the presentation slides.

Adam Weintraub, DHCS: One measure that Dr. Beck has raised was the expansion of benefits to the aged 65 and older population regardless of immigration status. This is a case where the May Revision did call for pulling back and reverting that; the Legislature proposal still includes it, so it will be subject to ongoing negotiation.

Ken Hempstead, M.D.: As you said, these are extraordinary painful decisions and prioritizations that ultimately need to be made. It becomes part of our charge to review.

Discussion of Governor's May Revision to the 2020-21 Budget

Katrina Eagilen, D.D.S: Please provide information on the sunset of the MLK Hospital payments.

Bradley Gilbert, DHCS: There is a proposed reduction of the GF contribution for MLK Hospital. If MLK is able to come up with a local match, then those dollars would be available. The proposal from the Administration is to remove the GF contribution for that match.

Katrina Eagilen, D.D.S.: What was the rationale?

Bradley Gilbert, DHCS: It was part of the process to meet what was needed in terms of GF savings.

Katrina Eagilen, D.D.S: What other county hospitals have been affected in this way?

Bradley Gilbert, DHCS: This one is very specific and different than any other county hospital setting. This funding is specific to MLK.

Katrina Eagilen, D.D.S: This particular population that the hospital covers is disproportionately affected by COVID-19.

Bradley Gilbert, DHCS: I understand your concerns. Those concerns have been communicated by the hospital and others.

William Arroyo, M.D.: The Prop. 56 loan repayment program will eliminate the remaining cohorts, including 18 slots for child and adolescent psychiatrists for this year. There have been at least two statewide behavioral health taskforce reports issued in the last 5 years that identify child and adolescent psychiatrists as being desperately needed throughout the state. This would impact 18 slots, and whether they still work with the Medi-Cal population given this proposal remains to be seen. This is not a budget item for DHCS, but it does impact children who have Medi-Cal, is the Black Infant Program (BIP). $4.5 million would be eliminated in the proposal in the May Revision. Given what we know about perinatal mortality, and the level of vulnerability for black infants, I think we should keep this in mind when considering any request of the state Legislature.

Bradley Gilbert, DHCS: Appreciate your comments on the Prop. 56 funding, and the BIP funding comes out of the California Department of Public Health, but your remarks are appreciated.

Ellen Beck, M.D.: For the funding cuts to mental health services for pregnant women, it is such a needed area. I did want to ask details about the Song-Brown Healthcare Workforce Training Program funding and what the proposed Legislative bill does?

Bradley Gilbert, DHCS: The (Song-Brown) funding is from Office of Statewide Health Planning and Development. We can find out and get back to you.

Ron DiLuigi: As we're trying to determine what our recommendations will be, I would make the point that we wouldn't be able to do it without detail. Otherwise we risk taking the approach of recommending extremely broad categorization of services.

Bradley Gilbert, DHCS: Well said. I think it would be helpful to focus on the most important, so when those negotiations are occurring, the input is there.

Ken Hempstead, M.D.: It will be a bit of a challenge to draft something that is impactful and constructive.

Alison Beier: You discussed the cut quickly. One of the things I heard was the elimination of a program having to do with disabilities.

Bradley Gilbert, DHCS: I apologize for going too quickly. There were three places where I mentioned disabilities that are being withdrawn:

1. Developmental screenings as part of Prop 56; the additional supplemental payment to physicians.
2. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) receive a supplemental payment through Prop 56.
3. There was a proposal to increase the federal poverty limit for eligibility for SPDs.

Alison Beier: When you eliminate something that has supplemental health, do you know how many are affected?

Bradley Gilbert, DHCS: By using the term supplemental, I do not mean to imply that it's any less important in terms of the significance of the reduction. For developmental screenings, the additional supplemental payment is relatively new so we don't have a lot of data on how many are being done, and don't want to minimize the impact this will have. It is a normal piece of what a pediatrician or family practitioner should do during a well-child visit. We don't have good data on whether the supplemental payment made a difference on more screenings being done.

Katrina Eaglien, D.D.S: Alison brought up a very valid point about the supplemental payments. From a dental perspective, rolling back the reimbursement for dentists back to the 2014 levels. We fought for it to bring it to the level that was almost up to par. California's health, and especially dental health, has fallen so far behind the rest of the country due to insufficient funding. With this removal of the supplemental payment, it places us in the same place where we were. We will lose a lot of Medi-Cal providers because of these rollbacks.

Bradley Gilbert, DHCS: This is an example of where the legislature has a very different proposal, so it would be a place where comments would be appropriate.

Elizabeth Stanley Salazar: We need a different solution for the continuation of services at MLK Hospital. We may need a set of principles that we communicate in this letter. For cuts, it's the augmentations (last funded) that are considered first. When you cut the enhancements, the innovations are getting cut that include increase to access, equity, and social determinants of health (SDOH). The government also treats cuts equally across the board; cuts should not be equal. There are enormous gaps in workforce and equity. There should be some demands we need to make for changes to the cuts. I applaud changes that have been made in 3-4 months to respond to COVID-19, but we have a public health epidemic on many levels in this country and we need the same level of response post-COVID to those issues.

Ken Hempstead, M.D.: If we're looking at total budget increases for the Medi-Cal program, when looking at dentistry in particular, most practices have been shuttered. If

that funding hasn't been paid to providers, then it would appear that it would be helpful to the budget and help offset the supplemental payments.

Bradley Gilbert, DHCS: Some of those utilization deductions have already been included in the budget as a reduction of cost.

William Arroyo, M.D.: This budget needs to be finalized in 10 days. For us to develop any elaborate principles, it would be a daunting task. Our basic principle must be improving access to care. If there are certain budget items that affect access to care, we must be explicit in our letter.

Ellen Beck, M.D.: It's important to clarify from our expertise some of those areas related to access. We should go one at a time and suggest items that are most important.

Ken Hempstead, M.D.: I'm hearing a lot of challenges with the work in front of us. What can we come up with in terms of a letter and strategy? Where do we see these divisions between the May Revision and what's currently being contemplated by the Legislature? Part of our focus may be to emphasize the support.

Adam Weintraub, DHCS: The way we've drafted this letter includes a general framework in broad terms for the support for children's services, including the services that preserve and support the health of the entire family. We also included two specific amendment recommendations, which were both submitted by Dr. Beck. Because those were not general principles, they would require a vote by the panel. We could have a motion on the table to add a specific point about addressing the restoration of the Prop. 56 supplemental payments. The panel could vote on that. We could gain general approval from the panel on that topic, and specific language would be delegated to the chair.

Ken Hempstead, M.D.: I would be in favor of that as we wouldn't spend the entire meeting wordsmithing it but it would require some entrusting in me and DHCS leaders to come up with a final draft. We need the panel's overall consensus.

Katrina Eagilen, D.D.S: Your idea to get all of the major points down and have us all in agreement initially makes the most sense. If we run out of time, perhaps we can email specific language.

Adam Weintraub, DHCS: Because this is a panel action, it would require a vote by the panel. These meetings are subject to a Bagley-Keene Open Meeting Act and they are required to be conducted in public. The panel's charge is to make recommendations to Director of DHCS. As a point of information, you can also voice your individual opinions as constituents.

Ellen Beck, M.D.: In addition to the proposal to have us determine together what key elements are important, suggest having the Chair work with the team to wordsmith because I don't think we have the time during this meeting.

Ron DiLuigi: I'm supportive of the approach that authorizes the Chair to finalize the letter. What is the reality of the state going beyond June 15 timeframe for finalizing the budget?

Bradley Gilbert, DHCS: A proposition was passed requiring the Legislature to pass a balanced budget by June 15 and they must have a bill to review 72 hours before. There will be intense negotiations and will pass a budget. They can look at it later. We need to think about giving input right now.

Ken Hempstead, M.D.: If anyone has a problem with how we're proposing to proceed with this, please speak up now.

William Arroyo, M.D.: I support the framework. However, we've fallen short on the array of items that we should be concerned with in the budget.

Ken Hempstead, M.D.: That's exactly what I'm proposing. As long as we have a consensus for how we should attack this, I would like to get everyone's input and find out what additional items should be included. Do we agree with the language that we have, how do we feel about the amendments, and what additional language should be included?

William Arroyo, M.D.: Amendment A needs to be strengthened as far as children's interests are concerned. The May Revision would compromise care of ages 65 and older. There's a statement that some of these individuals are caregivers to children, so the welfare of children is very much dependent on the health of the care givers.

Ken Hempstead, M.D.: Any specific language that you would edit or change? I feel broadly it's addressed in the amendment, so that's why I wanted to clarify.

Adam Weintraub, DHCS: That point is also made fairly strongly in the third paragraph of the framing letter by calling out the role of families and supporting the health of their children.

William Arroyo, M.D.: That's critical framing, however, I could argue that no item in the health budget should be eliminated. We need to be laser-focused.

Ken Hempstead, M.D.: I wonder if we're having miscommunication over the word "strengthen?"

William Arroyo, M.D.: It's the children's welfare that needs to be front and centered.

Ken Hempstead, M.D.: This current draft is quite focused on adult situation and has no specific mention of Prop 56. It feels like there needs to be further discussion from the panel on if they're happy with the letter as it stands or if there should be potential modification of the language or additional language that further clarifies.

Jan Schumann: Are we looking for a motion to add an additional amendment to preserve Prop. 56 funding?

Ken Hempstead, M.D.: Sounds great to me, what does the panel think?

Katrina Eagilen, D.D.S: We do need to preserve Prop 56. By cutting funding now, downstream there will be a greater fiscal impact.

Adam Weintraub, DHCS: Here are the major points that have been discussed. Maybe we can discuss a single motion to incorporate all?

- Explicit connection to welfare of children.
- Restoration of supplemental payments under Prop. 56, particularly for physicians and dentists.
- Restoration of MLK Hospital funding.
- Song Brown workforce funding, which is mentioned in Amendment B.
- Continuing the CalHealthCares loan repayment program, particularly for child psychiatrists.

Jan Schumann: Also wanted to add the preservation of Prop 56 funding.

Ellen Beck, M.D.: The one I mentioned before about mental health services for either pregnant women or women who had just given birth. Are we still including the first amendment that was focused on elders that are primary care givers?

Adam Weintraub, DHCS: That's at the pleasure of the panel; if you want to take a motion on the existing letter, all amendments, and additional topics we've discussed, that would be appropriate.

Alison Beier: It seems like we don't want to repurpose Prop 56 revenue. Are there pieces that we could agree on as a panel that could be recommended to be cut? For example, the reduction for rate pay for trauma screenings. We could re-appropriate funds as long as we have something later on that we could play catch up.

Ken Hempstead, M.D.: Well taken, and we would need to give thought on how we put that into something more actionable. It might suffer from what we've mentioned about lack of specificity. Agree with idea and tone. We can phrase this in the sense that we support Legislature's efforts to maintain Prop. 56 funds. It sounds like we've come up with a list of additional ideas to place in the letter that will dilute out what is currently a more adult-focused letter. Any other discussion on these amendments?

William Arroyo, M.D.: Once there is consensus that we have identified every item that the panel thinks is important to address in the letter, then we can consider a motion.

Bradley Gilbert, DHCS: We can pull out items that could potentially affect children:

- Health enrollment navigators
- Medical interpreters pilot project
- Hearing aid proposal (not Medi-Cal)

- Prop. 56 (supplemental payments, developmental screenings, value-based payment program, base supplemental payments to physicians and dentists, loan repayments after the first cohort, CHDP county case management)

William Arroyo, M.D.: Dr. Beck mentioned the needs of postpartum women (the revision would remove $40 million).

Ken Hempstead, M.D.: There's a proposal that we would support maintaining coverage for postpartum care. I don't know if we necessarily need to call out the health enrollment navigators, medical interpreters, hearing aid, and the case management as cuts we would support. The panel could come to a consensus about maintaining our neutrality by not prioritizing those.

William Arroyo, M.D.: Before we agree to that, I would want to know the data on the primary language of enrollees.

Brad Gilbert, DHCS: To be clear, medical interpreters is a required benefit overall, both in managed care and fee-for-service. This was a relatively small pilot project to see if there were better ways that interpreters can be utilized. The benefit of interpreters in Medi-Cal is not changing.

Karen Lauterbach: The role of the medical health navigators is extremely important. Medi-Cal is a complex system to navigate. I know this program also leaves a federal match.

Bradley Gilbert, DHCS: Yes, it is matched.

William Arroyo, M.D.: If we keep in mind that the Governor's priorities are COVID-19, homelessness, and fires; any of these items that would further burden the state in those areas, we should consider leaving in our communications.

Ken Hempstead, M.D.: Do we need further discussion on the health enrollment navigators?

Ellen Beck, M.D.: I'm supportive of it. For hearing aids, it's already a covered item so how is it different?

Bradley Gilbert, DHCS: This is for children that are above Medi-Cal financial eligibility. It's a non-Medicaid benefit that was being paid through DHCS.

Katrina Eagilen, D.D.S: Could you elaborate on the FQHC/RHC elimination of carve outs for pharmacy and dental services?

Bradley Gilbert, DHCS: Because of the way that FQHCs will be paid after Jan. 1 through FFS, they estimated a gap in what they're currently paid. The supplemental payment was intended to close the gap.

Katrina Eagilen, D.D.S: What would close the gap?

Bradley Gilbert, DHCS: They would lose funding without the supplement, according to their estimation. It costs them a certain amount to buy medication. The way they are paid now, there is a difference between those two payments that's significant. Under FFS transition in January, that difference would be much smaller. They would still get paid for providing the medication.

Katrina Eagilen, D.D.S: How does that carve out affect dental services?

Bradley Gilbert, DHCS: It does not affect dental. If they delivered dental services, they could continue to do that at the full level of delivery for dental services as an FQHC.

Ellen Beck, M.D.: For the hearing aid proposal, I recommend going to 250% of FPL. For undocumented elderly, there was supposed to be a private/public match; is that still on the table?

Bradley Gilbert, DHCS: This was state GF supported. There was another program that the Governor proposed on income subsidy that did have a private payment piece.

Adam Weintraub, DHCS: I believe there was a separate stipend program.

Jovan Jacobs, Ph.D: Can we prioritize any items that could be saved from being cut?

Bradley Gilbert, DHCS: Prop. 56 is the biggest benefit, but it's complicated since there's an assumption that relies on federal funds.

Terrie Stanley: One of the single biggest is the Prop. 56 issue, where the money was originally intended for a specific purpose. I would like to see the panel focus on this. For optional benefits, some were benefits that were taken out and then put back in.

Ron DiLuigi: We're affected by lack of information. Dr. Arroyo's earlier comment is important: we need to be laser-focused on children in Medi-Cal, and then on specific programs. Taking a position that tries to preclude repurposing Prop. 56 revenue will not be useful. We need to focus on specific programs related to Prop. 56 revenues.

Adam Weintraub, DHCS: In hearing the discussion, we are starting to hear a cluster of Prop. 56 specific payments that we could call out as individual bullet points to reflect the general will of the panel:

- Medi-Cal expansion to ages 65+ regardless of documentation status, specifically about its influence on the care of children.
- Song-Brown funding was already mentioned in a proposed amendment. I took Dr. Arroyo's comment to include a clear and specific focus on the child components/
- For the Prop. 56 payments, it sounds like the discussion was on maintaining supplemental payments, particularly in regard to base payments for physicians and dentists, value-based payments, developmental screening, CHDP county case management, health enrollment navigators, MLK Hospital payments, the provider loan repayment program, and mental health services for perinatal

(continued coverage during the postpartum period for women who have mental health issues, expansion from 90 days to 1 year).

Ken Hempstead, M.D.: This addresses everything.

Jan Schumann: Do we have a motion to amend the letter as outlined by Adam, and directing the chair to finalize the letter and forward it as addressed?

The panel approved amending the letter as discussed with a 14-0 vote.

Adam Weintraub, DHCS: We will work with Dr. Hempstead to amend the letter, and deliver it to the Director and copied legislative letters by Friday.

Ken Hempstead, M.D.: We will make our good faith effort to be representative of the panel's wishes.

COVID 19 Updates

https://www.dhcs.ca.gov/services/Documents/MCHAP-Presentation-060520.pdf

Director Gilbert reviewed series of actions and flexibilities related to care delivery such as DHCS guidance and flexibility for providers and managed care plans. In particular, he referenced the pivot to services by telephone and telehealth services as something DHCS wants to learn about for the future. DHCS has minimized administrative burdens for providers including moving to virtual audits, postponing audits and other flexible deadlines. We issued a large number of guidance announcements on the DHCS website.

Adam Weintraub, DHCS: Jan Schumann raised an issue since the last meeting about the end date for the delay in processing redeterminations and discontinuances. It was originally set to end on May 31, but has been extended throughout the duration of the public health emergency.

Bradley Gilbert, DHCS: DHCS has been monitoring managed care health plan networks through daily reporting on physician office and facility closures, even if temporary and due to the emergency. Managed care plans have provided support to providers, such as providing advance payments, accelerating pay-for-performance incentive payments, advancing capitation or claims payments, shifting to capitated provider payments, enhancing rates, providing grants and funding PPE, and telehealth services and supports. For behavioral health, we've received flexibilities on opioid treatment and licensing. DHCS implemented new flexibility in payments to county partners for behavioral health services, on both the interim methodology and the county administrative portion.

DHCS received an award of $1.7 million in immediate Federal Emergency Management Administration (FEMA) funding and requested $84.6 million in additional funding over nine months for three elements:

- Expand the media campaign as an intervention and increase access to the CalHOPE website and the CalHOPE Warm Line.

- Expand the CalHOPE website and app-based tools for mental wellness
- CalHOPE Support provides the personal connection to a crisis counselor.

DHCS launched a new nurse advice line, Medi-Nurse, for FFS Medi-Cal and uninsured to get help related to COVID-19 symptoms, testing, enrollment and self-isolation. A Medi-Cal beneficiary notice and FAQ are being mailed to all 13 million beneficiaries with information related to eligibility, benefits, COVID-19 testing, and resources such as mental health services and what to expect during a telehealth appointment.

DHCS just sent 13 million letters to our beneficiaries. This comprehensive notice includes Frequently Asked Questions, information related to eligibility, COVID-19 testing, Medi-Nurse line, etc.

Child immunization rates have dropped in California, based on preliminary data from the California Department of Public Health. As we start resuming some of the deferred treatment, this will be really important for our pediatricians and others caring for children to catch up as best they can.

DHCS issued guidance that allows the well-child visits to be split into two different visits. It starts with a telehealth visit to make the connection with the child/family to recreate the connection with the patient and the family. The visit is then finished in-person with immunizations. You bill for one visit but you do it in two parts.

That is the overview of efforts on COVID-19. We have a series of questions for you for discussion.

1. As providers begin to resume deferred and preventive health care, what should DHCS consider?
2. What are the **new** emerging issues and challenges that are appearing as a result of COVID-19?
3. What opportunities, including new flexibilities (e.g., telehealth), have presented themselves that DHCS might explore to improve the effectiveness of the Medi-Cal delivery system moving forward?

Ken Hempstead, M.D.: I'm pleased to hear your report on the MCPs stepping up to provide support to providers.

William Arroyo, M.D.: CDPH includes data on COVID-19 infection rates among children. Although the Latino children comprise 36% of all the children in California, they account for 53% of infected children. The disparity of infection is something of great concern.

Bradley Gilbert, DHCS: That's really pertinent. Through our care delivery system, having providers being extra vigilant around certain populations in terms of being concerned about COVID infections.

Alison Beier: What is DHCS seeing with the number of children being newly enrolled in Medi-Cal due to the economic downturn? Advocates are concerned that we're not seeing an increase in enrollment.

Bradley Gilbert, DHCS: There's a lag in our data, but we're not seeing the volume we were expecting. We're exploring why that is and working with counties, eligibility workers, and CWDA.

Adam Weintraub, DHCS: We did see the increase in Medi-Cal take place more slowly than we saw in the upticks in unemployment payments, CalFresh, and CalWORKs. It's not completely unanticipated that it should take a slower timeframe for seeing that intake. At the Stakeholder Advisory Committee meeting last week, did hear from individuals in the field that it's possible that there's fear about receiving treatment because of the potential for exposure, and that we may be seeing slower uptake in Medi-Cal coverage since people are not going to the doctor yet.

William Arroyo, M.D.: Was there any discussion about the chill factor related to the public charge?

Adam Weintraub, DHCS: Not called out explicitly, but there was the larger context of fear among the immigrant and non-English speaking community. The state has taken steps explicitly to exclude COVID-19 coverage in the determination of public charge.

William Arroyo, M.D.: Appreciate DHCS sending out 13 million beneficiary outreach letters. Are there any plans underway to promote via social media?

Adam Weintraub, DHCS: Good point about getting outside of institutional lines of communication.

Jan Schumann: I would urge DHCS consider text messaging to subscribers.

Bradley Gilbert, DHCS: Some of the health plans already do that.

Ellen Beck, M.D.: There are increased cases of domestic abuse. Telehealth visits allows for these visits in homes. There are mental health implications across the board. Also, the level of literacy should also be considered.

Bradley Gilbert, DHCS: If we are funded anywhere around the requested level for the FEMA grant, the media outreach is significant. That will be a good way to get to people.

Adam Weintraub, DHCS: We sought significant input from advocates to ensure readability level (of the beneficiary letter) was appropriate.

Ken Hempstead, M.D.: As a pediatrician and communications consultant, I'd like to formally put it out there that if anyone from DHCS would like additional input, I would like to discuss further. The new normal and getting caught up on immunization rates and preventive care, much of it boils down to public fear and miscommunication with an ever-changing landscape. Some offices currently don't have the PPE to do the full spectrum of services quite yet; families have a misunderstanding on whether offices are

open/closed and it can change weekly for smaller practices. The fear factor is the bigger element. There's a lot of work to do around changing the perception of the public that it's safe to come in for care and immunizations.

Bradley Gilbert, DHCS: The Kaiser data on MI rates was very concerning. If we don't get over that barrier of people thinking that it's not safe to come in, then they won't

Terrie Stanley: The other issue is who can accompany the children? For parents who have more than one child who needs immunizations, they still have other children and they need to figure out who will care for them.

Nancy Netherland: At FQHCs, we've been using visual data which has made a huge difference in the engagement uptick. I would like to see that with my children's providers and from DHCS. I get information that isn't well sourced and I don't know where the data is coming from. The restrictions on who can go into the office when taking multiple children is difficult. For Medi-Cal in general, I do see extended wait times; even with reduced volume, the wait times are not necessarily reduced.

Ron DiLuigi: What does DHCS' monitoring show in terms of the effectiveness of contract tracing and testing within the various counties?

Brad Gilbert, DHCS: In general, we're indirectly involved. There is a really big push for contact tracing; 5% of our employees have been redirected to contact tracing. With employees being redirected, we're looking at how to pay for it?

Karen Lauterbach: On the enrollment issues, in Los Angeles, we're seeing an increasing number of individuals wanting to enroll, but we're seeing more barriers in working with our local partners. Many of the applications are being erroneously denied. When we do finally reach the eligibility workers, we find out they don't have all of the tools/programs because they are working from home. I would encourage DHCS to continue working with the counties. Happy to provide specific cases.

Bradley Gilbert, DHCS: Specific cases would be helpful because then we can track to see if it's systemic.

Ellen Beck, M.D.: The limitations on families that are able to be with children in the hospitals is troubling. Maybe there could be guidance to allow for support to allow families to be with their children to make it more safe.

Bradley Gilbert, DHCS: It's true in SNFs, acute care, anyone who is acutely ill. CDPH provides those guidelines. This has been raised in numerous forums, so I appreciate the reminder.

Public Comment:

Kelly Hardy, Children Now: Thank you to Dr. Gilbert for his service and all of DHCS. The documents that we submitted were on the May Revision on some of the cuts that we were urging to not be made. The Panel has already discussed the issues on Prop.

56. One thing that wasn't addressed was the Black Infant Health program, which was slated to be cut or reduced in the May Revision but was put back in in the Legislative proposal.

Bradley Gilbert, DHCS: That program is CDPH's, but you are correct in the difference between the two proposed budgets.

Ron DiLuigi: We should add the Black Infant Health program to our comment letter.

William Arroyo, M.D.: I originally brought it up. If those moms aren't taken care, it will be a major fiscal hit on Medi-Cal program later on.

Ken Hempstead, M.D.: We can include in the comment letter.

Janet Vadakkumcherry, Health Center Partners of Southern California: Our organization is San Diego County based, but we cover three counties, have 17 member health centers, three Indian health centers, 135 practice sites in those three counties with over 1 million patients served. 90% of the patients we serve are underserved or uninsured, and 72% are below the federal poverty level. I just wanted to provide context in regard to the 340B questions. As federal entities, health centers are able to realize savings from the 340B that they reinvest in the health centers, that cover things that might not normally be funded through FFS and the managed care system. The issue at hand is the savings that health centers are going to lose ($250,000). This will impact access to care, and we'll need to eliminate certain services and lay off staff. Highlights include: 22 health centers will reduce hours of operation, 3,600 fewer appointments on a weekly basis, 20 health centers will close at least one site, 36 health centers slated to open will not, 45 will be forced to stop subsidizing low-cost medications and low-income patients, 29 will have to eliminate nutrition and diabetes education programs, 25 will eliminate population health and chronic care services for the chronically ill, 24 will end outreach to members. I just wanted to highlight these points for the panel.

Member Updates and Follow-up

Ken Hempstead, DHCS: We have an understanding of next steps in terms of producing this letter. Our next meeting is scheduled for October 14.

Jan Schumann: I would recommend we schedule another meeting since we're about 20 weeks out for next meeting.

William Arroyo, M.D.: There may be an opportunity for us to weigh in on advocating for waiver changes and regulations that should be extended beyond the crisis. We may want to consider another meeting to focus on that.

Ken Hempstead, M.D.: I'm open to that. Silver lining to our new normal is that we have more flexibility to add a meeting or advance the timing of the October meeting. I would encourage any individual panel member to email DHCS with concerns that would alter the timing of our planned meeting. Thank you to Director Gilbert for your time and commitments to the MCHAP meetings.