State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

June 24, 2021 - Webinar

Meeting Minutes

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

Public Attendees: 54 members of the public attended the webinar.

DHCS Staff: Will Lightbourne, Palav Babaria, M.D., Susan Philip, Michelle Retke, Rene Mollow, Bambi Cisneros, Norman Williams, Jeffrey Callison, Morgan Clair, Audriana Ketchersid.

Opening Remarks and Introductions

Ken Hempstead, M.D., MCHAP Chair, welcomed webinar participants. The legislative charge for the advisory panel was read aloud. (See agenda for legislative charge.) The meeting summary from March 16, 2021, was approved, 14-0.

Opening Remarks from Will Lightbourne, Director

Director Lightbourne provided an update on COVID-19. DHCS is matching Medi-Cal data directly with California Department of Public Health (CDPH) vaccination data, and we're seeing significant gaps in vaccination patterns. As we do the data match, we are sending the information to managed care plans (MCPs) to encourage them to conduct outreach to unvaccinated beneficiaries. There are slides in today's presentation that show significant gaps in vaccination rates among Medi-Cal beneficiaries. The only area showing more than a 50 percent Medi-Cal vaccination rate is the west Bay Area. Vaccination rates are a significant issue in the Central Valley and Inland Empire. We are working with CDPH, Cal GovOps, and the California Surgeon General to encourage

outreach messaging. The Governor's Office (GO) released a schedule of emergency executive orders (EOs) that will end on certain dates, through June 30 and September 30. The first EOs to be relaxed are the allowed suspension of in-person licensing visits. The administrative EOs will be relaxed later this year.

Netherland: In terms of vaccine access, is it possible to get that data broken down for children age 18 and under?

Lightbourne: Yes, we will provide this information.

Netherland: Do you think there needs to be a different type of messaging to get children vaccinated? Is there a difference in vaccine hesitancy?

Lightbourne: Not enough time has elapsed with the age 12 and older population to note discrepancies. The Medi-Cal population and dual-eligible populations are significantly unvaccinated.

Motadel: As mass vaccination sites close, is there adequate access and care to get these vaccines? I think those who are hesitant as well as those in the pediatric age range will be most comfortable getting the vaccine in their doctor's offices, and those offices may have storage issues. This needs to be looked at more closely as younger populations become eligible.

DiLuigi: Is there a robust effort by local MCPs and county health on outreach for immunization efforts?

Lightbourne: Overall, yes, a lot of interest, engagement, and understanding of the importance.

Weiss: There are a lot of local efforts at the school level, but is there any thought at the California Department of Education (CDE) to help facilitate vaccinations at school sites?

Lightbourne: I don't know, but I'll follow up.

Beck: School-based health centers (SBHCs) can reach out both to children and families. There is an issue with trust and safe spaces; some people may not feel safe going to a large institution, or they may not have transportation to get somewhere. What is the extent of outreach to the community base in which there is already trust and partnering with them to get more people vaccinated?

Lightbourne: We intend to share this information. A sense of complacency is setting in.

Eagilen: What about involving pediatricians in the rollout of vaccinations to the eligible child population? They may not have all of the infrastructure, but that is where children have historically received their vaccinations. Perhaps a multipronged approach to vaccinating the pediatric population is more appropriate.

Lightbourne: CDPH is working with the provider community.

Vega: What is DHCS' involvement with My Turn? I tried to schedule appointments for my children, but haven't heard from them. Maybe they could assist with scheduling and transportation.

Lightbourne: It has been a widespread experience. Online verification for vaccination status is also an issue.

Vega: How do we ensure that it's fixed?

Lightbourne: The California Department of Technology, which runs the site, has been working with SalesForce to fix the glitches. Reportedly, it has been going much more smoothly.

Lauterbach: From the community clinic perspective, we've seen the vaccination numbers drop off. We've heard from families who are concerned about vaccine side effects and not being able to take off work. Those who have less resources find it difficult to take time off, and we're not sure how to address it.

Arroyo: Has CDPH issued a strategy to vaccinate children?

Lightbourne: Not that I've seen. I'll check and will circulate with this group if there is one.

Beck: I want to promote the idea of promotoras, who are trusted persons in the community. The reason we were able to get such high vaccination numbers is because they reached out to hard-to-reach people. We're reaching that point where it needs to be community-led.

Lightbourne: I'll talk now about the proposals in the May Revision, then where we are in the budget enactment process. The major proposals that were added in the May Revision include:

- Coverage of undocumented people ages 60 and older; the Legislature has a proposal to cover undocumented people ages 50 and older.
- We moved from 60 days to 12 months coverage for postpartum care.
- Community health workers were added as a Medi-Cal provider for reimbursed services.
- Doula benefits, which will have a meaningful impact on maternal mortality for Black women.
- The California Advancing and Innovating Medi-Cal (CalAIM) dental benefit is effective as of July 1 to avoid the gap in the renewal of the 1115 waiver, since we weren't able to continue the Dental Transformation Initiative. *[Note: Clarification - DTI is continued as DHCS received CMS clarification on the financing structure and through the budget, there was an appropriation to covering the funding for these services through the end of the waiver; the CalAIM dental benefit will start on Jan. 1, 2022.]*
- There was a significant investment ($4 billion) for children and youth behavioral health to ensure all children in the state (Medi-Cal, privately insured, etc.) have

access to early prevention services and full access to specialty mental health services (SMHS). This is in addition to the $400 million included in the January budget proposal for behavioral health in schools initiative. The goal is to provide behavioral health resources up to age 26 in schools and in the community.

- The January budget included a $900 million investment in building out the behavioral health infrastructure continuum. That was increased in the May Revision to $2.4 billion, with $225 million specifically for behavioral health infrastructure needs for children and youth.

The Legislature adopted a placeholder budget on June 14. Negotiations are continuing, but much of the health-related budget is done. No major changes are anticipated in DHCS' provisions that are related to children and youth.

In President Biden's American Rescue Plan Act (ARPA) of 2021, there were a number of provisions that affect DHCS. There's a significant funding opportunity for mobile crisis support that will be addressed in the November budget estimate because it can't begin until April 1, 2022. Another item in the ARPA was an increase in the federal matching rate for home- and community-based services (HCBS) for a one-year period. Those services will see an increased fund support of 10 percent, which translates to about $3 billion. Although it's federal enhanced funding, it can be used to further match federal funds. The funding must be used in a three-year period, and during that time states can't reduce their program benefits on a structural level. We received direction from CMS on May 13, and were originally given 30 days to submit a spending plan. They extended the response by another 30 days. The Administration developed a spending plan, which we circulated widely to stakeholder groups. We delayed the submission to July 14. HCBS are focused on seniors, people with disabilities, homeless adults, etc., but there are significant proposals for children and youth with intellectual and developmental disabilities.

Beck: What is the coverage timeframe for undocumented older individuals to start receiving care? For mental and physical health home care, there's tremendous work to be done, so how do we get that funding?

Lightbourne: The start date for system changes for older undocumented Californians to gain access to full-scope Medi-Cal is April 1, 2022 *[Note: The coverage policy will begin May 1, 2022.]*. Normally we don't start writing instructions for the Medi-Cal eligibility systems until the budget is enacted and signed, but in this case we started writing instructions as soon as the May Revision was released to make sure this change can happen as quickly as possible.

Beck: MCHAP made recommendations for when coverage was expanded to undocumented children, so if you want to reach out to the community partners who provided perspectives during that discussion, we can offer those contacts.

DiLuigi: The public health function is absent from the budget. Any thoughts on getting the spotlight back on public health?

Lightbourne: In the Governor's May Revision, the funds that were proposed were intended for a year's-worth of study to see where the system is working, where it is weak, and what it needs. There is an expectation that the next budget would include significant funding to build those out.

DiLuigi: I hope that you would pass along MCHAP's perspective that the public health element is of interest to us. It is crucial to providers.

Lightbourne: Susan Philip, Deputy Director of Health Care Delivery Systems, will provide an update on the Timely Access Report.

Susan provided an update on the Timely Access Report. DHCS has a responsibility for monitoring and enforcing timely access standards for Medi-Cal members and is open to improving our methods. The last Timely Access survey was released in December 2020. The survey rates are calculated annually to assess compliance with appointment availability and wait times standards, but due to COVID-19, we did allow some flexibility and we paused the survey for this year. We are restarting the survey in calendar year 2022.

The Timely Access Survey results are provided to the Medi-Cal managed care plans quarterly through the Quarterly Monitoring Response Template (QMRT) process. The QMRT is used to gather managed care data for routine and ongoing monitoring, which is shared directly with plans to ensure access to concern. Due to the PHE, we allowed flexibility and paused this data collection with the exception of Grievances and Appeals reporting. We will notify plans via an All Plan Letter (APL) about how DHCS is going to eliminate some of these flexibilities and restart the monitoring activities, including restarting the QMRT survey in October 2021. In order to improve methods to enhance our ongoing monitoring activity, we will be establishing clear compliance thresholds. As part of this process, we plan to work with the Department of Managed Health Care (DMHC) and also launch a stakeholder input process to help with policy guidance development. Some measures we want to establish clear thresholds for in the first iteration include access to urgent primary care, access to urgent specialty care, call center wait times, and nurse advice line wait times. The APL will include guidance about what the corrective action plans (CAP) will include if the compliance thresholds are not met.

Netherland: I want to know more about the stakeholder input process and how you plan on engaging them, especially Medi-Cal beneficiaries. If those CAPs aren't made in a timely manner, what happens? What will be different with the new program?

Philip: We have several levers, including CAPs and sanctions.

Cisneros: The 2019 Timely Access Report overview was provided at a Managed Care Advisory Group (MCAG) meeting previously. When we restart the survey in 2022, we intend to engage the MCAG again. There are standards in Knox-Keene and in our contract for appointment availability and timely access standards. Our goal is to develop

benchmarks for which to hold Plans accountable, and at that time we will engage stakeholders. DMHC is also working on setting benchmarks through regulations. Regarding CAPs, we have a process in place to oversee and monitor plans. We can provide technical assistance, impose CAPs, and enforce financial sanctions. The results are posted on DHCS' website. As part of our Annual Network Certification corrective action plan process, Plans are required to provide bimonthly updates until all of their deficiencies have been resolved. If they aren't, we'll take on a heavier enforcement hand.

Weiss: We're looking at a perfect storm of a supply and demand mismatch. We need to do these surveys, but we're also dealing with rising Medi-Cal enrollment, a reduction in our Medi-Cal provider workforce, and challenges surrounding access. As we do this survey, we should proactively prepare for improvement at the micro (local) level as well as the macro level to raise the volume of the workforce to create a better match with advanced practice professionals and community health workers. As that evolves, we can look at our access survey differently in terms of what really is access. Is it a physical appointment or telehealth access? How do we define access and address it at the macro and micro level?

Cisneros: As part of the Timely Access work, we seek to assess what access means. We've been providing MCP data to other plans in order to help facilitate contracting arrangements. We're engaging with our External Quality Review Organization to conduct a statewide network analysis, of which one of the goals is to identify all providers statewide in order to bring more providers into the MCP networks. There are some pockets in the state where access issues exist, especially in rural areas. The 2022 Timely Access Report will include questions on telehealth to assess the member's experience when they call the health plan's call center. We're looking at appropriateness of telehealth services as well. We are taking a multi-pronged approach to address all of these things.

Philip: The comment about community health workers and other provider types who can support the continuum of care is really important. When we look at CalAIM and think about enhanced care management (ECM), who are the providers from a care management perspective? We are thinking of those questions.

Weiss: Our highest risk children are in the California Children's Service and Whole Child Model (WCM) program. Our care managers and/or patient care coordinators are having daily or weekly interactions with those families. To me, that's access. Evidence-based shows that access is just as effective, if not more effective, in preventing emergency department and in-patient stays and improving quality in terms of care management and interactions.

Sonnenshine: From the health plan perspective, we are committed to getting members into care. The provider pipeline and workforce is particularly an issue in rural communities. We hear from our providers that they are struggling to hire enough staff to

meet the demand. It's important to continue to highlight policy that creates more providers in the system.

Lightbourne: As Dr. Ghaly has said, the PHE has been an accelerant for a lot of things. We must work through issues of utilization management. We can't put people into a setting where they can't get the services they need. While it's a slow process, there are significant investments in the Office of Statewide Health Planning and Development (OSHPD) for professional development and support. Within the Children and Youth Behavioral Health initiative, $400 million is dedicated to training and reimbursements for behavioral health workers. As significant as the shortage is, it's even more acute in the behavioral health and substance use disorder (SUD) space.

Beck: There are models for training that we're not exploring yet. For example, a yearlong fellowship for a family physician who wants to do mental health work in rural or underserved communities; they don't necessarily need to be a child psychiatrist. I would encourage that you explore these fellowship models.

Arroyo: Can you speak to the collaborative treatment code, which would expand behavioral health care in the primary care setting with behavioral health consultants? There's a step in that direction, Ellen, to expand that. I haven't seen that operationalized yet. There needs to be a robust professional development effort to expand the workforce for the behavioral health in schools initiative, otherwise having money for services is moot. Director Lightbourne indicated that DHCS would implement an expansion of services ($400 million) linked to behavioral health expansion in schools, and there was a consulting group that was hired by DHCS to formulate a plan. Is there an outline of this plan?

Lightbourne: The consulting piece was related to health equity work, not children's behavioral services. We've been working with the California Department of Aging and the State Board of Education to flesh out their interest in three-way partnerships between MCPs, county behavioral health, and schools. Assuming passage of the budget, the trailer bill will follow right away. There will still be a lot of design work with subject matter experts looking at evidence-based practices to promote. In terms of personnel needs on the education side, part of our resources are for developing a program for coaches with lived experiences who are able to support and assist young people. The timeframe of implementation will roll out over a four-to-five year horizon.

Hempstead: Nancy brought up the important issue of same-day billing issues with physical and mental health. Do you have any thoughts on whether that is something that is more federally dictated and less controlled at the state-level? How do same-day billing exclusions play into that?

Netherland: It has to do with some of the efforts to remove restrictions to eliminate same-day exclusions, which has a big implication of removing barriers to behavioral health care and other types of encounters.

Mollow: We have been working with the associations on this. From last year's budget, we have worked to try to address some of those issues that you're identifying in terms of those same-day exclusions to grant flexibilities. Historically, we have looked at those costs being already built into those reimbursement rates.

Netherland: It's my understanding that this is not a CMS issue. It's possible at the state level to make a policy decision for same-day billing. I have to make a decision if I need to pull my daughter from school, or if I need to step out of work if I want her to access behavioral health. It would be more convenient and developmentally more appropriate to have my daughter see someone when she's with her pediatrician and have a second encounter.

Mollow: Those costs are already built in for the reimbursement rates. If you have a need for a physical and mental health service, the cost of care is included in that reimbursement structure.

Netherland: Behavioral health services are in the same prospective payment system (PPS) structure?

Mollow: Correct.

Netherland: There is a role in taking care of our most vulnerable children to rethink that structure. I understand the complexities of PPS.

Hempstead: This may be something for the panel to return to.

Managed Care Plan Procurement: Request for Procurement Draft Release

Slides are available here: https://www.dhcs.ca.gov/services/Documents/062421-MCHAP-presentation.pdf

Michelle Retke provided an update on the Medi-Cal managed care plan procurement. Sample contract is for all model types.

Weiss: When these contracts are solicited and health plans are engaged, I ask respectfully for something specifically on the delegated model. In this model, it may not be apparent at the state level that many requirements are pushed to the frontline provider level. We must be cognizant of doctor burnout. If requirements are going to be placed on them without added resources and support, I think there needs to be clear delineation. When the term MCP is used, it's meant to be the health plan, but it sometimes ends up being the delegated entity, which in turn pushes these requirements to the provider.

Retke: It's definitely on the radar. Delegation is touched on in draft RFP webinar as part of the overarching goals. There are enhanced requirements and updated definitions around network provider versus subcontractor delegated entities. Delegation is one of the top priorities that you'll see listed in the RFP.

Beck: For accountability, you listed a health equity officer and broadening cultural training. How are these values implemented? It's not simply the training, but actionable changes, so these values permeate everything we do.

Retke: The values are implemented through the narrative form proposal where plans can provide detailed information of how they will meet those requirements, as well as within the actual contract where the various requirements and deliverables are outlined. We encourage feedback on any gaps you're seeing.

Arroyo: Can you speak to the "Behavioral Health incentives for primary care" included in the presentation? Can you comment on the mandated contract between the MCP and the Local Educational Agency (LEA)? While the regulations have not been issued for Senate Bill 855, there will be new requirements for MCPs related to mental health parity. I imagine the contracts will need to change as soon as regulations are finalized.

Retke: As things change between now and 2024, we do contract amendments based on legislative changes. Language is included within the RFP that speaks to that.

Lightbourne: We want to strengthen the provision of behavioral health. In terms of requiring the contract with LEAs, half of the children in California schools are covered by Medi-Cal. Plans should have a relationship with a local school authority. Other local partnership requirements include working with the local public health and social service network.

Netherland: For the coordination and collaboration of services, there is a need for additional care coordination across domains. What does that look like in the contract? It sounds like we are going to have a fair amount of school-based links and behavioral health. What is the thinking on these contracts, and what might that structure look like?

Retke: Regarding the draft RFP, you will see stronger language for coordinating across domains. We are trying to enhance the language and make it clear to the plans that those are requirements across many domains. We are looking for any gaps, and we'll want to hear from stakeholders.

Lightbourne: The re-procurement is paralleling the implementation of CalAIM. The goal of CalAIM is to emphasize ECM for people with really complex needs. The requirement in the contract is the plans must contract with an enhanced care manager; they cannot do it themselves.

Retke: DHCS' website includes the ECM and In Lieu of Services attachment. It includes a full template of requirements, defines services, and provides guidance to plans.

Netherland: Will the benefits directly reimburse peer-to-peer parent support? How will this be addressed, and is there a possibility for inclusion? What about the role of the innovative workforce?

Retke: We've completely restructured the contract, so there's an opportunity under the care coordination and access to care attachment. There's now an easier way to review

all those requirements in one place, whereas in the current contract, things are more spread out.

Cisneros: With the CalAIM ECM benefit, we envision that plans will work with community-based organizations. We want the providers to meet members where they are and provide the right care at the right time in the right setting.

Sonnenshine: We're working with our county partners to implement the ECM benefit and the initial focus on the WPC population. I would encourage DHCS to visually represent everything that's being carried forward with an eye toward the populations that would be impacted by each initiative. ECM in its initial implementation likely won't address that care coordination need that parents experience. As we look to deliver new services in new ways, I want to be transparent with our partners about priorities.

Cisneros: We've been thinking about the different intersections among programs as well and are developing a crosswalk.

Salazar: The amount of changes for many agencies is overwhelming, so the roadmap concept is important. The information, in general, is not flowing down to the provider level. How is DHCS thinking about supporting providers? We don't want to lose the rich network of local agencies that represent their communities. To do this work, we need an onramp and must start thinking about it.

Lightbourne: It is challenging right now partly due to the function of timing since everything is still technically a proposal. We need to be strategic about how the readiness work begins.

Family First Prevention Services Act (FFPSA) Draft Plan

Angie Schwartz from the California Department of Social Services provided an update on FFPSA. Slides are available here: https://www.dhcs.ca.gov/services/Documents/062421-MCHAP-presentation.pdf

Salazar: One of the entry points to determining risk is the prenatal and OB/GYN delivery setting in the hospital. Are you doing any deliberative work in terms of plan for safe care, or are there any updates on that with MCPs and hospitals?

Schwartz: We do not have specific answers to that, but I will take it back to my team. We must determine the imminent risk in order to provide the prevention services.

Arroyo: In reviewing the IV-E prevention services and the perinatal period, one of the programs that is supported is nurse-family partnership, which begins during the second trimester of pregnancy. I think that addresses some of Elizabeth's concerns. Having been in a leadership position for Los Angeles County to train mental health staff in many of the evidence-based practices identified in the clearinghouse, it takes an enormous amount of labor. In Los Angeles County, we exhausted the national training time so that no one else in the country could contract with the training resources. Your challenge is daunting. It will take a while to draw down federal dollars. Your workforce is not going to

be prepared by October. The fact that this federal law provides for substance use treatment services for parents is an incredible opportunity.

Netherland: Do counties opt in?

Schwartz: Part one is optional, and part four is mandatory.

Sonnenshine: I know there's work to do for the Foster Care Model of Care workgroup related to how children in Medi-Cal are receiving their services. As that work progresses, is there a relationship in this work, and how does that look? Will there be connections across delivery systems of which health plans must be aware?

Schwartz: There has to be an interrelation there, and I'll let Director Lightbourne talk more to that. With the prevention services that are available with federal dollars, there's a payer of last resort provision. We have to figure out where and how we can access the Medicaid funds and services first. There's language in the trailer bill that states DHCS and CDSS must develop guidance on what prevention services are available, and then figure out when and how to leverage the IV-E dollars for those prevention services.

Lightbourne: The Foster Care Model of Care workgroup within CalAIM has accomplished important steps in defining needs and identifying gaps. We're taking a pause to work through administrative proposals, then we'll bring it back to workgroup in the fall with the expectation of having a final product. It does have to mesh with the FFPSA work, and also with the Children and Youth Behavioral Health initiative.

Quality and Population Health Management (PHM) Updates

Slides are available here: https://www.dhcs.ca.gov/services/Documents/062421-MCHAP-presentation.pdf

Babaria: There are some clinical areas that have been hard hit by the pandemic that need extra attention and support as we're building our long-term infrastructure. These three areas will serve as the initial backbone of our quality and health equity strategy:

- **Children's preventive care**: The PHE has led to a large equity gap in children's preventive care. We must improve upon what we are doing.
- **Behavioral health integration**: We still don't fully understand the mental health toll of the pandemic on top of where we were started.
- **Maternity outcomes and birth equity**: While California has done a good job of driving down maternal mortality through largely hospital-based interventions, we still have significant disparities, especially for Black mothers. We recognize the postpartum period as a risky time, both from complications of chronic diseases (such as diabetes and hypertension) and from mental health and substance use disorders. We're thinking through what we can do to help new mothers and families prepare for success.

Babaria: What are your key priorities for children that you would like DHCS to focus on?

Arroyo: I don't think we can improve population health without providing care for pregnant persons from these marginalized communities.

Weiss: As CalAIM and ECM are implemented, we should look at the Seniors and Persons with Disabilities program, the WCM/CCS program, and the ECM opportunities in order to create something that is streamlined, makes sense to families, and reduces reporting redundancy issues.

Babaria: The May Revision included a proposal for the PHM service, which DHCS envisions to be a service and population health analytics platform to look at our highest risk populations, better understand what the outcomes are, and what changes we must make to address that.

Beck: I'm excited that you're looking at early maternal health and pre-pregnancy as a focus and how that overlaps with social determinants of health and behavioral health. For focus groups, look at young mothers who wished they went into care earlier, or grandmothers who are watching their teenage granddaughters become pregnant. How do we reach those who are considering pregnancy or are already pregnant, to have them come in and feel welcome and supported?

Beyer: Regarding the high-risk population, I had a mom text me asking how to get straight Medi-Cal. In our population, we are still having issues getting access to specialty care through the MCPs. The key to success is using MCPs because there is great oversight and people are paying attention.

Babaria: We have to figure out, whether through straight Medi-Cal or managed care, how to ensure that everyone is receiving the appropriate level of care.

Salazar: Much of our work depends on data and information sharing. I'd like to see my colleagues in the SUD system look at these data and then brainstorm early engagement and intervention. How do we use these data to inform the system to support the ones who are falling out and not getting access?

Netherland: I would like to see the expansion of dashboard data metrics, sorted by county and MCPs, so that I can look at high achievers in different performance areas. It would show where people are struggling or need more resources. I would like to look comparatively at what's being offered through Medicaid. Similarly, if you're going to collect equity metrics from MCPs as part of the re-procurement, it would be great to see that data. Also make the data accessible to the general public.

Babaria: Linette Scott, DHCS' Chief Data Officer and Deputy Director for Enterprise Data and Information Management, is working to create more visually friendly data for the plans. The vision is to have that data so that we can understand who the star performers are, what we can learn, and best practices.

Beck: My wish would be exactly what you just said. We must shift our measurements to outcomes. There's an equity lens when looking at outcomes.

Motadel: Not only do outcomes and data need to be accessible, but end-users need to know that it's accessible and how to access it. There are many times when the feedback never gets back to the doctor who is doing the work.

Eagilen: I appreciate your focus on maternal and child care, and the behavioral health aspect. We've seen an increase in child and teen suicides during the pandemic. With the extension of the 12-month pregnancy coverage, it's another way to look at quality in the postpartum period. We also must focus on the oral health side because there are links in the pregnant and maternal population.

Babaria: For early children's preventive care, oral health is very important. We will look at maternal oral health as well since it's so critical to long-term health.

Member Updates and Follow Up

Arroyo: Through the budget trailer bill process, we can't provide input, but it would be useful for us to review language pertaining to children's health.

Weiss: With the May Revision, it appears that the $400 million in behavioral health infrastructure in schools will happen. I would like to hear an update on this.

Beck: I thought the suggestion on same-day billing will be good to look into. I would also like to circle back to the coverage for the undocumented adults, and whether there's input we can provide around application language, outreach, and other communications.

Salazar: There is a need to communicate changes to the general public. We must normalize integration, collaboration, and building trust.

Hempstead: Not only do we have the problem and challenge of overcoming in terms of all of these new changes that we've been addressing today, but we have a problem with barriers in underserved communities. I would like to see us build upon what we just said as an overarching discussion to identify gaps in these communities.

Netherland: I appreciate what was said about same day exclusion. There is Assembly Bill 316, and I would like to know the arguments against it or barriers to permitting same-day billing in California. My understanding is there is not a federal restriction. I also want to bring up constituency engagement and education: how are constituents being engaged in sharing that message? What are some of the barriers for communication and trust? Finally, I would like MCHAP to look at increased accountability measures that have been discussed with the plans through the re-procurement. I'd like to talk about the kind of information we might want as a panel on the accountability of health plans and how we might support it.

Hempstead: As a reminder to everyone on the call here, there are restrictions on how we address bills that are still in process. Nevertheless, I'm sure there are ways for us to address those issues without bumping into that quagmire.

Schumann: Is there still a need for virtual meetings?

Lightbourne: Our various meetings will continue virtually through end of this year, simply because people may not be able to make travel arrangements. Perhaps it would be appropriate to put on the September agenda discussion of the panel's preferences going forward.

Schumann: Can we do a survey of the members offline between now and then?

Lightbourne: If there was an interest for an in-person meeting or hybrid, we could arrange for it.

Public Comment

Susan McLearan, California Dental Hygienists' Association: I am looking for DHCS' definition of prevention in order to create a population with oral health. Secondly, in terms of preventing chronic disease, such as caries and tooth loss in both children and adults, I would like to see more emphasis on that. Perhaps have Dr. Eagilen confer with the dental hygienist association in terms of having more focus in that area.

Kelly Hardy, Children Now: The Hearing Aid Coverage for Children Program is launching on July 1. It's a new benefit for households up to 600 percent of the federal poverty level. I'm hopeful that work is being done around this at DHCS. Children Now looks forward to working on timely access monitoring, especially on the survey. On the dental managed care to fee-for-service transition, which impacts 360,000 kids in Sacramento and Los Angeles counties, we want to make sure that DHCS' communications with members are in the members' primary threshold language. We want to make sure kids and adults are taken care of during this transition.