

State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

July 11, 2019

Meeting Minutes

Members Attending: Jan Schumann, Subscriber Representative; Kenneth Hempstead, M.D., Pediatrician Representative; Marc Lerner, M.D., Education Representative; William Arroyo, M.D., Mental Health Provider Representative; Katrina Eagilen, D.D.S., Licensed Practicing Dentist; Karen Lauterbach, Non-Profit Clinic Representative; Ellen Beck, M.D., Family Practice Physician Representative; Diana Vega, Parent Representative; Terrie Stanley, Health Plan Representative; Bertram Lubin, M.D., Licensed Disproportionate Share Hospital Representative; Ron DiLuigi, Business Community Representative.

Members Not Attending: Julie McReynolds; Parent Representative; Nancy Netherland, Parent Representative; Elizabeth Stanley Salazar, Substance Abuse Provider Representative.

Members Calling in to Public Phone Line: Pamela Sakamoto, County Public Health Provider Representative.

Attending by Phone: 37 stakeholders called in

DHCS Staff: Jennifer Kent, Norman Williams, Morgan Clair, Bambi Cisneros, Sam Willburn, Catherine Hicks, Jim Elliott.

Others: Stephanie Wakefield, Alameda Alliance for Health; Rebecca Boyd Anderson, Partnership HealthPlan of California; Katie Andrew, Children Now; Haley Garland, California Dental Association; Chris Stoner-Mertz, California Alliance of Child & Family Services; Susan McLearn, California Dental Hygienists' Association; Dennis McIntyre, Anthem Blue Cross; Michael Nguyen, Molina Healthcare; Kelly MacMillan, Children's Specialty Care Coalition; Kathryn Page, Fetal Alcohol Spectrum Disorders in Northern California; Deb Kong, Packard Foundation; Anna Garzon, Coalition for Compassionate Care.

Opening Remarks and Introductions

Ken Hempstead, M.D., MCHAP Co-Chair welcomed members, DHCS staff and the public and facilitated introductions.

Dr. Marc Lerner read the legislative charge for the advisory panel aloud. (See [agenda](#) for legislative charge.)

[Meeting minutes](#) from April 4, 2019 were approved 11-0.

Norman Williams, DHCS: Responses to the follow-up list have been posted to the [MCHAP web page](#).

Opening Remarks from Director Kent

Budget highlights, effective July 1, 2019, include:

Three eligibility expansions:

- Removal of senior penalties for individuals who are aged, blind, and disabled, and bringing their eligibility income level up to 138 percent of the federal poverty level
- Full-scope benefits for individuals up to age 26 regardless of documentation status
- Coverage expansion for individuals with pregnancy-only services; if diagnosed with a mental health condition, they can remain on full-scope coverage for a year after delivery

Additional investments include:

- \$15 million payment was approved for an asthma mitigation;
- \$15 million for health enrollment navigators;
- \$5 million for a medical interpreters pilot;
- \$20 million for behavioral health counselors in emergency rooms
- \$120 million into our Whole Person Care (WPC) program; \$100 million will go to existing WPC counties for housing, and \$20 million will go to non-WPC counties for the start of an anticipated statewide expansion of the program;
- \$3.6 million for a peer-run warm line for mental health services;
- Restoration of all remaining optional Medi-Cal benefits that were removed pursuant to the recession in 2008, with the exception of chiropractic.

Prop 56:

DHCS is continuing all physician and dental payments for supplemental payments from prior years, including the Family Planning, Access, Care, and Treatment (Family PACT) program, free-standing pediatric subacute, home health and pediatric day health care.

A summary of the Department's budget highlights can be found at the attached link:

<http://www.ebudget.ca.gov/2019-20/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf>

For CalHealthCares physician and dental loan repayments, in addition to the existing funding that was provided in last year's budget, the Department also received an additional \$120 million in this year's budget. DHCS announced the first round of funds to 247 physicians throughout 40 counties in the state. The dental awards were provided to 40 dentists in the state for loan repayment. This is the first of at least 5 annual awards to eligible physicians and dentists in California.

Waiver Renewal Updates:

- 1915(b) Medi-Cal Specialty Mental Health Services (SMHS) waiver will expire June 2020
- 1115 waiver will expire in December 2020
 - Dental Transformation Initiative (DTI), Whole Person Care, Public Hospital Redesign and Incentives in Medi-Cal (PRIME), Global Payment Program, and Drug Medi-Cal Organized Delivery System (DMC-ODS) are included in this waiver. Both waivers will need to be renewed or reauthorized. The Department has had discussion with CMS about extending the SMHS waiver to match the December timeline
 - Many of the current initiatives such as Whole Person Care will not be reauthorized in the next waiver. The Department is discussing incorporating the best elements of those programs into different waiver or state plan authorities moving forward
 - DMC-ODS and GPP will remain in a smaller 1115 waiver
- DHCS will share its proposal for the new waiver starting this fall. There will be individual breakout sessions for different components of the waiver

Ron DiLuigi: Was the \$100 million in housing assistance for housing or housing services?

Jennifer Kent, DHCS: Housing, and funding will flow by formula. Each county with an existing WPC pilot will receive a set amount based on the formula.

Marc Lerner, M.D.: Is DHCS establishing metrics to show that this is improving care for children? What are the outcomes linked to these various programs (asthma funding, dental payments, etc.) and how will they be tracked?

Jennifer Kent, DHCS: Some of the individual appropriations require an evaluation, some don't. Prop. 56 funds are more stable, so we will be able to do an analysis at some point in the future. For the asthma funding, it's a one-time allocation.

Marc Lerner, M.D.: Is there a role for MCHAP for examining some of these evaluation materials?

Jennifer Kent, DHCS: Yes.

Bert Lubin, M.D.: Is telehealth included in any of the appropriations?

Jennifer Kent, DHCS: Telehealth is an existing benefit in Medi-Cal, so nothing has changed. Providers can bill telehealth across all modalities. We're finalizing the draft telehealth policy that was submitted for public comment.

Diana Vega: Is the Family Response System a call service?

Jennifer Kent, DHCS: There will be a state hotline operated by CDSS for families/children in the child welfare system and it will be a warm handoff to a county response team.

Jan Schumann: Will chiropractic services be added to Medi-Cal benefits?

Jennifer Kent, DHCS: If the Legislature decides to add it to a subsequent budget, perhaps.

Ellen Beck, M.D.: For the 1915(b) waiver, in thinking about some of the challenges for the carve-out for SMHS (access to resources for child psychiatry, access to care for rural areas, etc.), is this the time or place to suggest some of the changes be implemented in the new waiver?

Jennifer Kent, DHCS: There won't be any broad changes to the carve-out since they are constitutionally protected funding streams. We are considering a variety of options, including integration pilots whereby counties can voluntarily partner and integrate services through a single entity, such as through managed care plans (MCPs).

Ellen Beck, M.D.: What are some areas in the waiver that could be incentivized? You mentioned there will be smaller workgroups for the waiver discussion input.

Jennifer Kent, DHCS: County mental health plans are paid through a cost-based system using certified public expenditures in order to draw down federal funds. They don't operate the same way as MCPs. That's one of the foundational things that the waiver would provide: could we pay the counties using a different rate methodology that would help get them out of the continuous documentation cycle?

Terrie Stanley: With value based payments (VBPs), has there been any thought to aligning it with the waiver?

Jennifer Kent, DHCS: There's \$250 million for VBPs. We released guidance on four key domains for comment; pre- and post-natal care, early childhood pediatric preventive services, chronic disease management, and behavioral health integration, which is all done through managed care. We can share the guidance. The clinical measures that we're proposing is through the plans using their contracted network providers to

incentivize outcomes and quality measures as opposed to strict utilization. On the behavioral health integration, we released that document. We're still calculating the values for these payments.

Terrie Stanley: Would the dollars flow to the plan?

Jennifer Kent, DHCS: Yes. It also incentivizes providers to submit better encounter data.

Ron DiLuigi: In terms of the waivers, it didn't sound like there were many opportunities to bring about more robust integration.

Jennifer Kent, DHCS: Not from a large, statewide perspective. We will look toward working with the health plans and counties for integration pilots.

Ron DiLuigi: Do you see anything new that serves as a true incentive?

Jennifer Kent, DHCS: Making fundamental changes in how the program is run, both at the county and at the state level, frees up barriers that have prevented people from doing things differently. The waivers are great opportunities for the state and counties to consider different approaches.

Ron DiLuigi: Dr. Insel's new efforts are also exciting.

Jennifer Kent, DHCS: Yes, Dr. Insel is an advisor to the Gov. Newsom and to Secretary Ghaly and leading work on how to change the state's current mental health system. DHCS is focusing on integration of mental health and SUD into behavioral health. It's an important policy change to recognize that a lot of individuals with mental health issues also have SUDs. Also wanted to mention the Surgeon General's work in the trauma screenings for provider training and technical assistance.

William Arroyo, M.D.: Have you considered how MCPs might participate in the SUD world for youth treatment?

Jennifer Kent, DHCS: It's a county responsibility.

William Arroyo, M.D.: Has there been any discussion about plans providing that service?

Jennifer Kent, DHCS: No.

Ron DiLuigi: The Medi-Cal portion of the mental health funds are constitutionally protected?

Jennifer Kent, DHCS: It's a combination of tax dollars that flow from the state to the counties through realignments, which are constitutionally protected funding. As a state, we have said that these dollars will always flow to these accounts, and in exchange, you accept responsibility to provide these services on the states' behalf: Mental health, EPSDT, SUD, etc.

Election of MCHAP Chairperson for 2019

Dr. Hempstead was the only member to express interest in the position and he provided a few brief statements from his [vision statement](#). Dr. Hempstead thanked Dr. Lubin for his contributions.

Ellen Beck, M.D.: The more interactive these meetings are the better.

Marc Lerner, M.D.: The Panel is often in an education-receiving mode. Are we adequately representing our constituencies and voicing their concerns? We'd have a stronger voice if we were activated by some of that engagement.

William Arroyo, M.D.: Want to reiterate that we advise DHCS as to how the waivers move forward pertaining to children and youth.

Jan Schumann: I mentioned before expanding this meeting to different parts of the state to allow for more public input. Additionally, we should reach out more to our constituents, and advocate for our budget to allow us to be more involved in other subgroups as Dr. Arroyo mentioned. Also, encourage you to have a co-chair in place, as I was for Dr. Beck, to represent the panel in the event of your absence.

The Panel approved Dr. Hempstead as chair, 11 – 0.

Child Vaccination Letter

Dr. Hempstead introduced his [draft letter in support of SB 276](#) and emphasized that the Panel shouldn't feel pressured to support or sign the letter and didn't want to digress in a debate about policy or vaccines. Wanted to provide the opportunity for panel members felt inclined to sign their name that was distributed in draft form.

Marc Lerner, M.D.: I support this letter because it relates to emerging trends in the care of children within our charge. We've had an increase in the number of medical exemptions. I continue to be more concerned within our Dashboard for data related to [childhood immunizations status -- combination 3](#), where there was a drop from 75% to 70%. Is this a trend that DHCS observes, and is it happening in other states/environments? We should consider inviting the California Department of Public Health.

Ken Hempstead, M.D.: We can include this on our potential topic list and do a deeper dive on what we can do for vaccine rates. I propose leaving the letter as is and panel members can let Morgan know that they would like to sign the letter at lunch. Does that sound fair?

Ellen Beck, M.D.: We could include in the letter that we are an independent, 15-member statewide advisory panel to make the letter stronger. That's a way to show the level of support.

Jan Schumann: I like Dr. Beck's recommendation and would like to move to make an amendment to state that we're a 15-member panel.

The motion did not carry: four ayes to seven nos.

Update on State Audit Report

Jennifer Kent, DHCS: The Department provided its [60-day response](#) to the preventive services audit. Recommendations were consistent with how the changes were made to the MCPs and expectations; movement to include all of the pediatric and adult core set measures in this year's measurement year; and require the plans to meet a 50% minimum performance level (MPL) in all of those measures. We also sought resources from the Legislature for additional staffing as well as additional expenditure authority to our external quality review organization. All of those resources were approved by the Legislature. Additional resources to secure an outside contractor to help us with an outreach campaign were also approved. We will do an outreach campaign to targeted populations or for targeted services. We will advise beneficiaries about the benefits provided to them in terms of preventive services for children, which is similar to what we did for the dental program. We are still working through some of the technical details of those additional core set measures of the plans. We are proceeding as planned in terms of the activities laid out to increase utilization.

Ken Hempstead, M.D.: Can you remind us on next steps over the next year?

Jennifer Kent, DHCS: We'll follow up with the Auditor in March 2020. DHCS is tracking its internal activities, and we're working with the health plans. We held webinars and technical assistance on the core set measures. If the health plans do not meet the expectations of those measurements, and the MPL expectations, we will move to put them under a corrective action plan or sanctions.

Ellen Beck, M.D.: What happened with recommendation 6?

Jennifer Kent, DHCS: We didn't agree with the recommendation. Increasing providers is not our direct responsibility at DHCS. The loan repayment is a good example of where we are doing something to encourage additional providers.

Ellen Beck, M.D.: Where is that responsibility within the state?

Jennifer Kent, DHCS: The Office of Statewide Health Planning and Development (OSHPD) is the health workforce entity within our Agency. There are also various health-related boards and community colleges that will help build the pipeline for shortages. OSHPD has a lot of expertise and other programs that encourage workforce development and training to maintain the body of knowledge around designated shortage areas.

Ellen Beck, M.D.: Can you work collaboratively with them to recognize shortages in areas?

Jennifer Kent, DHCS: We work collaboratively with OSHPD and other entities.

William Arroyo, M.D.: Did you have an opportunity to review the draft recommendations?

Jennifer Kent, DHCS: Yes. We try to shape recommendations when we feel that they are incorrect.

Jan Schumann: I would recommend collaborating with agencies to reach out to the Housing and Urban Development to offer a grant for a program such as the 'Physicians Next Door', similar to the Teachers or Officers Next Door programs.

Jennifer Kent, DHCS: We will provide an update once we secure a contractor to help with the outreach campaign. We'll need input on who to target, what to target, how best to do it, through which venue or modality. We're not on track to have that secured until the start of 2020. This Panel will be particularly helpful in getting feedback in that area.

Ken Hempstead, M.D.: We can keep a small spot on the agenda for these updates as appropriate.

Overview of Rural Access to Primary Care

Sam Willburn provided an [overview on the access to health care in rural areas](#). California consists of 541 Medical Service Study Areas (MSSAs), and about half of them are rural. Geographically, California is a rural state, as MSSAs represent about 80 percent of the total land mass.

Ron DiLuigi: Did you focus on the standard metropolitan statistical areas?

Sam Willburn, DHCS: It's different from the U.S. Census and we did that intentionally. If you are using the metropolitan definition, you have huge counties with significant amounts of geography that are considered urban, like Riverside.

Ron DiLuigi: Are there resources that would go along with the designation changes?

Sam Willburn, DHCS: Yes. Rural designation requires meeting the population density requirement, and if 80% or more of the MSSAs in the county meet that rural density requirement, then the county is considered a rural county for our purposes.

Karen Lauterbach: Are tribal health centers also rural, or are they a mix of both urban and rural?

Sam Willburn, DHCS: I was speaking to only the tribal health centers that are rural, not the urban tribal health clinics.

Karen Lauterbach: Have you seen a trend of less rural areas in California?

Sam Willburn, DHCS: We're waiting for the 2020 Census. Due to the recession, droughts, and wildfires, we may see a shift to different areas.

Marc Lerner, M.D.: What is the penetration of school-based health centers (SBHCs)? What has been the effort of DHCS to co-locate health care services at schools and to utilize or track the growth of telehealth for beneficiaries living in rural areas?

Sam Willburn, DHCS: I will look into the number of licensed SBHCs. The number of federally-qualified health centers (FQHCs) and tribal health clinics do have satellites that are on school grounds, and I can gather that information.

Jennifer Kent, DHCS: We've struggled on school health centers because FQHCs can go into schools, but SBHCs have to take everybody to draw down federal financial participation.

Marc Lerner, M.D.: It's a worthy area for pilot efforts to try to see the availability of a telehealth hub that can be used by multiple MCPs.

Jennifer Kent, DHCS: We have encouraged the SBHCs to contract with the MCPs and have not seen success, but if you think there's an opportunity for contracting, we can discuss.

Ken Hempstead, M.D.: If the FQHCs have to take everyone on the school grounds, you're not just having to potentially contract with the MCPs, but also with everyone else?

William Arroyo, M.D.: How do the FQHCs, tribal clinics, and rural health clinics access mental health services, especially those related to SUD services?

Sam Willburn, DHCS: All of the clinics can employ mental health professionals, and they can be reimbursed through Medi-Cal. Licensed clinical social workers, psychologists, psychiatrists are all reimbursable providers for those clinics. If they choose to provide those services in the primary care capacity, they are required to be reimbursed through the Medi-Cal program. Some have contracts with the county specialty mental health plans. In terms of SUD services, if you're referencing counseling, you will most likely be referred to the county SUD organization. In the tribal health programs, there is a separate Indian health service specifically for youth in residential treatment in California. Medi-Cal does pay for residential treatment in American Indian youth.

William Arroyo, M.D.: Do they use telehealth?

Sam Willburn, DHCS: Yes.

Ken Hempstead, M.D.: For J1 visa, is there a cap?

Sam Willburn, DHCS: The cap is in federal law; it's 30 per year. The federal fiscal year begins in October so usually by January the 30 slots are gone.

Ellen Beck, M.D.: What are some of the challenges or hope for a direction in your work?

Sam Willburn, DHCS: Extraordinary to see the growth in services after the passage of the ACA. I would hope we could continue to grow because there still is a demand.

William Arroyo, M.D.: Is there any data related to children served in the three health structures that you could share at a future date?

Sam Willburn, DHCS: The health data that I did report comes from our interview survey, which is adults self-reporting. We do have data from OSHPD's annual clinic report. They report that about 50 percent of the children in the California Health Interview Survey depend on Medi-Cal as the payer source. In the FQHCs and the tribal health clinics, they report between 60-90 percent of their patient population are Medi-Cal enrollees. As far as the health status for children, we could probably dig it out but we don't have it readily available.

Marc Lerner, M.D.: Can you share some of the geomapping that defines rural versus non-rural?

Sam Willburn, DHCS: Annually, the California State Office of Rural Health compiles those inventories and combines the databases. We will begin to make those available by the end of this year.

Jennifer Kent, DHCS: If you go to our Performance Outcomes Systems [webpage](#), there are data broken out by different counties for children's mental health.

Updates on DHCS' Telehealth Policy

Catherine Hicks [provided an update on DHCS' telehealth policy](#). In October 2018, DHCS shared draft telehealth policies with more than 1,500 stakeholders. Over 30 organizations provided feedback. The Provider Manual section should include the updated policy in July 2019.

William Arroyo, M.D.: Does the provider need to be licensed in California?

Jim Elliott, DHCS: The licensing requirement is a state requirement, with the exception of primary Indian health clinics. There is a provision for out-of-state providers to provide services by telehealth if they have a connection with a billing provider in California. For example, a hospital in California contracts with a radiologist out of state, which is allowed under this new policy.

Marc Lerner, M.D.: What's required in terms of privacy, working with children and the work around consenting, etc.? Does DHCS have experience in determining the malpractice around telehealth? Is there some type of effort that is anticipated at the level of the plans to help us move this into action?

Jennifer Kent, DHCS: When we release it, it's across all the different delivery systems, which goes out through the provider bulletin. We'll have a consistent policy across all delivery systems.

Karen Lauterbach: Are you tracking the trends and the types of telehealth that's being used, and whether it's impacting any health outcomes?

Jim Elliott, DHCS: With the modifiers, we'll be able to better track the MCPs and also monitor usage and their facilities. We do run reports on telehealth usage.

Ellen Beck, M.D.: Is there any policy related to the frequency of telehealth? Is there a certain number of times per year that the patient would have to see the primary care physician, or could all of their care be through telehealth visits?

Jennifer Kent, DHCS: If it's appropriate in the clinical decision making, yes.

Marc Lerner, M.D.: Is it possible to make a diagnosis through some visual observation through telehealth, and begin a prescribing a Schedule 2 medication?

Jennifer Kent, DHCS: If a child was prescribed either a psychotropic or antipsychotic, a Treatment Authorization Request will need to be submitted with justification in order for DHCS to approve the prescription.

Ken Hempstead, M.D.: I think we're talking about the difference in billing for it; should I do it? Are we ultimately talking about FFS?

Jennifer Kent, DHCS: No, it's managed care. If you have a capitated relationship with a medical group or FQHC, and a physician says they can manage a patient through telehealth, the encounter would have a modifier that the service was provided via telehealth.

Diana Vega: How do patients feel about telehealth? Is this a cost savings, or making sure that everyone receives services on time?

Jennifer Kent, DHCS: The patient must voluntarily consent to a telehealth visit and the physician agrees that they are clinically appropriate to have the consultation.

Diana Vega: Is this due to a shortage of physicians?

Jennifer Kent, DHCS: If you live in a rural area, telehealth is infinitely easier to do a consultation. Telehealth is intended to allow for greater flexibility, reduce travel time, and increase access.

Diana Vega: For lower-income families who don't have access to technology, will it be provided?

Jennifer Kent, DHCS: It's usually in a clinic. Otherwise telehealth can be done wherever the patient is located, e.g., in the home, and has access to audio or visual technology to allow communication with the Medi-Cal provider..

Ellen Beck, M.D.: To clarify, a telephone call would be considered sufficient? There will need to be monitoring.

Jennifer Kent, DHCS: The services being delivered via telehealth would need to meet all of the requirements of our policy, and we will be monitoring for compliance. If we see a huge spike and physician utilization and encounters soar, they'll have to demonstrate their telehealth consultations.

Presentation on Continuity of Care

Bambi Cisneros provided an update on Whole Child Model (WCM) and [continuity of care](#). WCM incorporates the California Children Services (CCS) benefits into the managed care system so there is one single coordinator for the beneficiaries physical and behavioral health needs. The last phase of WCM recently went live on July 1, 2019, and is live in five MCPs in 21 counties.

Ellen Beck, M.D.: For those entering adulthood, what provisions are there to continue this care?

Bambi Cisneros, DHCS: The MCPs and the counties worked together on the transition plan, which included a process to identify members who were aging out (age 21) and finding providers.

Ellen Beck, M.D.: DHCS reviewed the plans for each county and determined that they were acceptable?

Bambi Cisneros, DHCS: The transition plans detail the different processes that the MCPs and counties had to share beneficiary information.

Jennifer Kent, DHCS: The aging out is related to the CCS program within the Integrated Systems of Car Division, and there's an entire workgroup that is involved in the county CCS programs and stakeholders around when to engage the child and family about the aging out of CCS, which starts as early as 14. Also depends on if the child will be Medi-Cal-eligible.

Marc Lerner, M.D.: Who will assist families needing supports to maintain relationships, access to medications? In the past, there were case managers attached to CCS. These children have multiple providers, so trying to fill out the forms for complex patients can be burdensome. What's in place or who is responsible at the plan level for providing assistance?

Jennifer Kent, DHCS: For WCM, one of the main tenets was a continuity of care request. If there was a provider that you wish to maintain, the plan would need to authorize and approve for at least 12 months and if at the end of the period the provider was willing to accept the rate and the MCP didn't have quality concerns, then you could maintain that provider. Continuity of care in the WCM is different than continuity of care for other populations transitioning into Medi-Cal.

Bambi Cisneros, DHCS: In terms of the administrative forms, CCS does continue to determine medical and financial eligibility. The MCPs would know who the beneficiaries are because we are providing them the data from the CCS program.

Terrie Stanley: The request for continuity of care can come in via a phone call. It's not a complex or complicated process because the MCPs realize that the requests come in from either the member or the provider. The provider must agree to the MCP rate, which can be the single biggest barrier. The MCP must then work to find the member a new provider.

Marc Lerner, M.D.: You are suggesting that that would occur one year out?

Terrie Stanley: The provider must agree to accept the rate for a period of time.

Marc Lerner, M.D.: There was concern that there would be quality differences. What's been the experience of maintaining the pediatric expertise in these transitions?

Bambi Cisneros, DHCS: The providers must be CCS-paneled in order to participate in the WCM program. DHCS did review the MCPs network to ensure that they are paneled and can take on the more complex CCS cases.

Jan Schumann: For slide 7, is there a timeframe, and is the prescription only valid for the next 12 months?

Jennifer Kent, DHCS: It's not time-limited. It's around brand vs. generic.

Member Updates and Follow-Up

Terrie Stanley: I'd like to request that First 5 LA attend the next MCHAP meeting. They formed a collaborative relationship with a number of plans in Los Angeles County. Their mission is to connect families to services and supports to improve maternal and infant health and to strengthen the family. In 2009, they invested in home visiting programs, the '[Welcome Baby](#)' program, and have done a lot of work to formalize referral relationships between the plans and the home visiting entities within the County.

Ken Hempstead, M.D.: We will keep that in mind.

Terrie Stanley: The launch of the WCM in counties is key and important. I want this panel to receive a regular updates and report on the monitoring. The metrics that DHCS is using for evaluation, and also a comparatively analysis across all the participating counties.

William Arroyo, M.D.: There's a catastrophic failure with health organizations in moving forward policies related to decreased consumption in sweet and sugared beverages, and failure of the state Legislature to move forward on this matter. We should do a deep-dive discussion on the health plans and the efforts within DHCS are addressing this issue.

Ken Hempstead, M.D.: This is an important issue, but is it directly related to DHCS? How would we advise DHCS?

William Arroyo, M.D.: Preventive strategy. If there is a health plan or organization that could speak to some benefit through Medi-Cal, we would like to hear about it and

continue to promulgate that thinking in order to ensure that children don't go down the trajectory of dental carries, obesity, diabetes, and so on.

Ken Hempstead, M.D.: Would DHCS help incentivize that work?

William Arroyo, M.D.: Any health plans who are ensconced in promoting this, and how they would do it through the Medi-Cal program.

Ellen Beck, M.D.: How are health plans and DHCS working to address the problem of childhood obesity, and prevent and treat? Would be interesting to hear about some innovative models.

Jan Schumann: Within Medicare, there's a program that allows for behavioral counseling for obesity. Is that available for children in the Medi-Cal?

Dennis McIntyre, Anthem Blue Cross: This issue of childhood and adult obesity is getting worse. It's easier to identify as a problem than to solve. Even in the more progressive organizations that I'm involved in don't feel like they are moving the ball.

Marc Lerner, M.D.: Where are we in terms of immigrant children accompanied/unaccompanied in group settings throughout the state and where DHCS' efforts might be in helping to engage the children and support quality care from the time they arrive in the state?

Jennifer Kent, DHCS: That's CDSS, not DHCS. They are working with the detention centers.

Marc Lerner, M.D.: There's a desire within the pediatric health care community to bring child health expertise within those centers. In California, has there been some type of ability to successfully strengthen the expertise within those environments?

Jennifer Kent, DHCS: CDSS has the immigrant program responsibility. They're working on emergency shelters.

Ellen Beck, M.D.: In San Diego, two FQHCs are directly involved in addressing children's and family's needs in the temporary shelters.

Marc Lerner, M.D.: These children are here and are going to be receiving care. As we look to topics to focus on, perhaps bringing in folks directly involved in these efforts may be beneficial to us.

Bert Lubin, M.D.: I've been involved in setting up the Center of Excellence for immigrant children. We'll have a symposium on this, and I will circulate a flyer on this.

Ken Hempstead, M.D.: I wonder if any of those presenters be appropriate to talk to us.

Diana Vega: Seems like we're meeting less and we have a lot of issues to discuss. Why aren't we having more meetings?

Ellen Beck, M.D.: We started at six meetings, which felt like a large commitment. We're currently at 4-5 meetings per year, depending on various needs, budgets, and schedules. We have longer meetings now. We felt that if there were urgent issues, we have the capacity to think about an extra meeting.

Jan Schumann: I support Diana. We're parents and we need the ability to bring in and understand what's going on with emerging trends. We are legislatively charged to advise DHCS and in order to do that, we need to meet on a more regular basis like we did when we first merged over.

Public Comment

Kathryn Page, Fetal Alcohol Spectrum Disorders in Northern California: I'm currently working with Santa Clara County, which as a county, has decided to take on Fetal Alcohol Syndrome (FAS). According to CDC, 5 percent of the population are on the Fetal Alcohol Spectrum. We are not taught in psychology or medical schools about anything on FAS. Fetal Alcohol Spectrum Disorders are underdiagnosed; there are no diagnosis north of Los Angeles County. This is the most expensive population that is linked to homelessness and jails, disrupts placements in foster care because parents are not prepared. My current mission is to get anyone who is doing developmental screening in any context to ask about prenatal alcohol exposure and raise the 2-year awareness. I would be thrilled to send more information or speak on this issue again.

Ken Hempstead, M.D.: Please forward the information to the MCHAP@dhcs.ca.gov inbox.

Susan McLearn, California Dental Hygienists' Association: Through telehealth, are dentists able to bill through a store-and-forward exam?

Jennifer Kent, DHCS: Yes.

Katie Andrew, Children Now: Thank you for the efforts through *Smile, California*. We've heard from several stakeholders that it has had a positive impact. Related to the auditor's report, is there a timeline for hiring the contractor?

Jennifer Kent, DHCS: January 2020.

Anna Garzon, Coalition for Compassionate Care: In this setting, is there a place to talk about pediatric palliative care in California?

Ken Hempstead, M.D.: If you could communicate what you'd like to share with the group, that would be great.

Dennis McIntyre, Anthem Blue Cross: First time at an MCHAP meeting and I wanted to thank you for all the hard work that you are doing.

Deb Kong, Packard Foundation: Thank you for your work on behalf of kids. Our goal is that all children have access to quality health, early learning, and other opportunities so that children are safe, healthy, and on track to meet their full potential. We supported

increasing insurance coverage and access to young children by funding research, policy, advocacy, communications, and litigation. Now we're also interested in supporting systems of care that support children and families and their healthy development so that we see early intervention and referrals and appropriate services.