State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

July 14, 2022 – Hybrid Meeting

Meeting Minutes

Members Attending In-Person: Ken Hempstead, M.D., Pediatrician Representative; Jan Schumann, Subscriber Representative; Kelly Motadel, M.D., County Public Health Provider Representative; Alison Beier, Parent Representative Representative.

Member Attending Virtually: Ellen Beck, M.D., Family Practice Physician Representative; Diana Vega, Parent Representative; Nancy Netherland, Parent Representative; Jovan Salama Jacobs, Ed.D., Education Representative; Elizabeth Stanley Salazar, Substance Abuse Provider Representative; Michael Weiss, M.D., Licensed Disproportionate Share Hospital Representative; Ron DiLuigi, Business Community Representative; William Arroyo, M.D., Mental Health Provider.

Members Not Attending: Karen Lauterbach, Nonprofit Clinic Representative; Stephanie Sonnenshine, Health Plan Representative; Katrina Eagilen, D.D.S., Licensed Practicing Dentist.

Public Attendees – In person: 1 member of the public attended.

Public Attendees –Virtually: 61 members of the public attended the webinar.

DHCS Staff – In person: Michelle Baass, Erika Sperbeck, Lisa Murawski, Jeffrey Callison, Morgan Clair.

DHCS Staff – Virtually: Pamela Riley, M.D., Palav Babaria, M.D., Rene Mollow, Joseph Billingsley, Bambi Cisneros, Norman Williams, Tyler Sadwith, Autumn Boylan, Harry Hendrix.

Others: Bobbie Wunsch, DHCS Consultant.

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 December 9, 2021, was approved, 10-0.

Opening Remarks from Michelle Baass, Director

Baass introduced Riley, DHCS' new Chief Equity Officer and Assistant Deputy Director for Quality and Population Health Management. Riley provided her background, and said she is excited to focus on improving care for children in Medi-Cal.

Governor's Budget Overview

Baass provided a budget overview, including updates on the expansions of Medi-Cal coverage, Medi-Cal's Strategy to Support Health and Opportunity for Children and Families, reducing premiums to zero, maternal health, children's mental health and behavioral health (BH) investments, and other efforts that support DHCS' goal to improve the health and well-being of all Californians.

Netherland: Regarding State Children's Health Insurance Program Health Services Initiatives (formerly Healthy Starts), potentially we're under-claiming for the federal draw-down rate. We may be eligible for an extension up to $300 million.

Baass: Please follow up in writing and we'll get back to you.

Public Health Emergency (PHE) Operational Unwinding Plan

Baass: In May, DHCS released a detailed COVID-19 PHE Operational Unwinding Plan outlining the flexibilities related to the PHE, and what the plan will be once the PHE has ended. We anticipate that the PHE will be renewed for at least another 90 days, so redeterminations likely won't happen until 2023. The DHCS Coverage Ambassadors provides materials and a toolkit on updating beneficiary information and next steps.

Schumann: Can DHCS use the National Change of Address database through the U.S. Post Office to automatically update beneficiary's information without violating any regulatory restrictions?

Baass: I will check, but I don't think that is an option.

Beck: The groups I work with serve a large population of undocumented individuals, and we're encountering fear about public charge. Are the DHCS Coverage Ambassadors and other groups working to encourage undocumented individuals to embrace Medi-Cal? Are we giving training in how to address public charge?

Baass: The Coverage Ambassadors is a campaign for updating contact information for redeterminations. The budget also includes funding over a few years for health navigators who would have training to understand the public charge implications.

Beck: As a follow up, is DHCS ensuring that in each community we are reaching those groups (that are already serving those populations with this additional information) and navigators? Are we using some of that education funding to look statewide and make sure that we are covering organizations we may not yet know about?

Baass: That is one of the goals. We also have a public education campaign related to this, so those pieces are intended to ensure that we have coverage and mapping. We're also considering marrying the Census information with the campaign and navigators. I will bring this back to the team.

Beier: I received renewal mail from Los Angeles County. You said that redeterminations wouldn't happen until 2023. What should we do with the renewal letters?

Baass: Alison, please follow up with those letters. Renewals shouldn't be going out yet.

Netherland: In a consumer stakeholder workgroup, some counties talked about capacity issues at their level. What will DHCS do to ensure that counties don't have capacity issues? With the increased access to BH through schools, what might disenrollment or reenrollment look like since enrollment impacts the funding for school-based care?

Baass: Last year's budget included about $36 million, and this year's includes more than $100 million to bolster county capacity to process redeterminations. In our PHE Operational Unwinding Plan, we detailed some of the readiness processes. It's a big workload and that's why we're asking beneficiaries to update contact information now.

Netherland: Noting my concern about workforce capacity, an issue we're hearing from counties, even with the extra funding. Also, an inquiry that if California Children's Services (CCS) updated the address for a child, would that qualify as updated for redetermination, or must the family go through another address redetermination?

Beier: Would In-Home Supportive Services (IHSS) qualify as well?

Mollow: We do have DHCS Coverage Ambassadors underway, but ultimately the updates need to get back to county partners. For IHSS and CCS, if they are collecting that updated information in their own databases that does need to get transferred to county partners via the Statewide Automated Welfare System (SAWS). It's really important that those connections are made. My assumption is that IHSS and CCS would make those connections, but if not, let us know, and we can do internal follow up.

Netherland: There's not a mechanism for that data to transfer directly? CCS will need to make sure it gets into the correct database, or an enrollment ambassador or someone else will need to go through the county.

Mollow: We'll take it back and get additional steps to make sure the information is updated. Ultimately, the messaging we have released is that this information needs to be transferred to the counties. If individuals have an online SAWS account, that individual should update their online account.

Provider Enrollment for Managed Care and Specialty Mental Health

Baass: There was a question if the provider could just enroll or credential in one system. For provider enrollment and the non-specialty mental health services (SMHS) side, we have an enrollment system called Provider Application and Validation for Enrollment

(PAVE) where managed care plans (MCPs) can enroll a provider through a NCQA accreditation process. Then on the county SMHS side, they must enroll via PAVE, too, pursuant to federal regulations where both systems have to enroll their providers. Eventually, getting a SMHS PAVE would simplify this, but it's not available today.

Consumer Advisory Committee

Baass: DHCS will launch a Consumer Advisory Committee by the end of this year. We're working with the California Health Care Foundation, Center for Health Care Strategies, and California Pan-Ethnic Health Network regarding the design of the committee. The goal is to hear directly from Medi-Cal consumers.

CHDP Update

Billingsley provided an update on CHDP and the Children's Presumptive Eligibility Program, which will replace the CHDP Gateway. Slides: https://www.dhcs.ca.gov/services/Documents/071422-MCHAP-presentation.pdf.

Beck: The lead screening program has been proactive in both prevention and identification of children and testing. Could some of these prevention programs have a consultative lead at the state level so all the managed care programs can consult with this lead? I'm concerned about the continuity of dental and BH care across our partners.

Billingsley: That is something that was clearly identified in the authorizing legislation for this sunset - as part of our transition plan for the stakeholder engagement process. DHCS will take necessary actions and work with CDPH to ensure continuity.

Netherland: How will DHCS engage local health departments, CHDP program staff, and families? Is there time to ensure stakeholders are engaged and reflected in plans?

Billingsley: Good points. By October 1, we must take necessary steps to get information out early to the right people regarding this process.

Netherland: This is an important benefit to fragile former foster youth. I hope these will successfully transition, but I do have concerns about this benefit given recent findings from an audit report in terms of current performance for MCPs. I hope there's an opportunity for stakeholders to share the narrative and craft solutions with DHCS.

Billingsley: The goal is not a reduction of services, but a realignment of how those services are accessed.

Wunsch: We might want to hear an update at our September meeting on engagement process and timeline.

Beier: I didn't see anything concretely for who you were partnering with or what the process was for ensuring all appropriate stakeholders were included.

Billingsley: There are entities that will and must be included, and we will work with them to identify additional stakeholders.

Wunsch: Can you provide a list of all stakeholders engaged in the process?

Doula Services as a Medi-Cal Benefit

Murawski provided a brief overview of doula services as a Medi-Cal benefit. Slides: https://www.dhcs.ca.gov/services/Documents/071422-MCHAP-presentation.pdf.

Weiss: Are there certifications for a doula? What are the qualifications, and are they clearly delineated in the statutes?

Murawski: The language is in the State Plan Amendment (SPA), which will be submitted for federal approval. There are training and experienced-based pathways. The training pathway is 16 hours of training that relate to perinatal and birth services, and doulas must provide support at a minimum of three births. The experience-based pathway is five years of active doula experience and attestation to various skills, and they need client testimonial letters or professional letters of recommendation. This is new, as we will enroll unlicensed practitioners who meet the qualifications defined in the SPA.

Schumann: Could individuals providing spiritual access be providers in the program?

Murawski: That's not something we identified in the SPA. Doulas are supposed to provide supportive, nonmedical care. To the extent there is emotional support that relates to that care, it's part of that relationship, but not something we identified.

Schumann: If they're a religiously-centered organization that provides doula support, then they won't be excluded? What are the organizational qualifications?

Murawski: I will follow up. A doula can enroll as an individual provider. We are looking at enrollment as a group. The way we envision it now is the individuals enroll.

Beck: Is there an intention to provide training to all entry doulas, whether or not they are experienced? An area of focus is identifying areas of postpartum depression and how to collaborate to address those needs. The need for thorough prenatal care is also an issue. I encourage good partnering with health care providers. If a person would like a doula, is there a clear request mechanism?

Murawski: We're looking at ways to make requesting a doula as accessible as possible. The federal regulation has parameters that a licensed practitioner needs to recommend the service; we are exploring other avenues for that to take place. For postpartum depression, we decided on not requiring training as part of minimum qualifications, but will be listed as a recommendation in provider manual.

Beck: I would like to see it included as part of the required training.

Motadel: I want to second what Dr. Beck said; postpartum depression is so impactful on a child. What efforts are being made to ensure cultural diversity for doulas?

Murawski: We've had a diverse range of doulas who have provided feedback on how this benefit should be structured to encourage diverse providers. We're thinking about

making it very accessible and honoring the experience they have in the community. We can take that back and give more thought to it as we build the foundation.

Baass: As this becomes a managed care benefit, MCPs will look at the needs of their population and will find providers that match those needs.

Population Health Management (PHM) and Care Coordination Framework

Babaria provided an update on PHM and the care coordination framework. Slides: https://www.dhcs.ca.gov/services/Documents/071422-MCHAP-presentation.pdf.

Weiss: For clarity, I would rethink the term "transitional care services", as it could imply adolescents transitioning to adults. As we understand Enhanced Care Management (ECM) fitting into the CalAIM framework, nontraditional providers are jumping into the arena of providing ECM. If it doesn't exist already, perhaps a more specific definition of who can provide case management and the reporting and regulatory requirements?

Babaria: I do recognize the naming issue, and we can work to provide additional clarity. On ECM, I could provide a deep dive presentation at a later date on ECM for children and youth, specifically where we can address a lot of those other issues.

Salazar: Has there been interest on increasing the focus for alcohol spectrum disorders within developmental screenings?

Babaria: We recognize that we have a lot of work ahead of us with infants. DHCS is participating in CMS' infant well-child visit learning collaborative with several other states. It's illuminating a lot of issues and barriers as to why our infant well-child rates are so low. I see this as a body of work that we have to focus on for the next few years to collectively include developmental screening and those nuances that you pointed out.

Salazar: There is not a bridge in data or dialogue between the child welfare and juvenile justice systems; we can count youth but we can't match. Are there opportunities for cross-system system sharing of data?

Babaria: I agree. A few initiatives are trying to tackle this: CalHHS-led Data Exchange Framework and the PHM service that we are in the process of procuring. Also under the new Medi-Cal managed care procurement for 2024 contracts, there are broad requirements for MCPs to establish Memorandums of Understanding (MOUs), including promoting data exchange with a number of entities.

Baass: We need to build local partnerships between our plans; that is a key component of our new contract where we are hoping to bridge some of those relationships.

Arroyo: DHCS should include in the rolling out of the strategic plan, particularly around the ECM piece, the justice-involved population and students who attend community schools. Children in those schools have extremely high rates of mental health (MH) and substance use disorder (SUD) problems.

Babaria: The justice-involved population is its own designated population of focus under CalAIM and will be covered; policy development is underway so we will give MCHAP an update later. I appreciate the second suggestion and will take that to our planning team.

Jacobs: In the presentation, you mentioned partnerships with Local Educational Agency school districts. How will you involve stakeholders? I want to ensure that we are looking at how to streamline the process and referrals, and the data management portion.

Babaria: The CYBHI is considering those same questions. It has numerous plans on how to conduct stakeholder engagement well and build upon what is working.

Beier: For vision and hearing data and metrics, I would like to see measurements on how quickly a child receives eyeglasses or hearing aids; from when they applied to CCS to when they received it. I would like the same metrics for wheelchairs. At the community level, I would like to ensure that ZIP code metrics are reviewed.

Babaria: We are looking at everything that you mentioned.

Behavioral Health (BH) Update

Sadwith provided an update on BH, including No Wrong Door, SMHS access criteria, and the BH Continuum Infrastructure Program. Slides: https://www.dhcs.ca.gov/services/Documents/071422-MCHAP-presentation.pdf.

Salazar: There's a long history of two silo specialty fields: MH and SUD. When we talk about BH, we always talk about MH and not SUD. The most affected children in the foster care and juvenile justice systems have high rates of SUDs or are at high risk. I propose that we include on the Medi-Cal Children's Health Dashboard the utilization data for the specialty SUD system, and for MCHAP to look at SUD utilization within DMC-ODS. When the SMHS system was initiated, the plans were mandated to have a MOU with the county SMHS system. In DMC-ODS, it's in the terms and conditions that the county will form a partnership with the MCPs, but it isn't necessarily activated.

Sadwith: MH is often prioritized; BH has been historically fragmented from the medical care establishment and, within BH, SUD from mental health. Under CalAIM, the BH administrative integration policy component is designed to consolidate and integrate MH and SUD into one BH managed care delivery system for counties that participate in DMC-ODS. Since the approval of DMC-ODS, 37 counties representing 96 percent of the Medi-Cal population are covered. DHCS recently issued an Information Notice clarifying county obligations to cover SUD services consistent with Early and Periodic Screening, Diagnostic, and Treatment Services, even in DMC counties that haven't yet opted into the program. The recommendation about the dashboard is helpful.

Schumann: I second Liz's dashboard recommendation. On Criteria 1, what is the juvenile justice definition?. Some youth are given a diversion program for counseling or other services; are those individuals eligible for access to this program?

Sadwith: DHCS issued guidance through a Behavioral Health Information Notice (BHIN), and definitions are included in the presentation appendix. With the updated access criteria for SMHS, there are a number of different pathways. These are designed to be broad and inclusive so that children and youth can access SMHS when that is the most appropriate delivery system instead of the non-SMHS that are covered by MCPs.

Netherland: I support the inclusion of a dual delivery system. I'm assuming, like juvenile justice, that any child who has been a part of the child welfare system is receiving adoption assistance and will be included in that category? For the trauma screening tool, we know from the evidence that kids with special health care needs have a disproportionately high level of downstream diagnosis for MH and SUD. Is there any way to examine that and have that be a trigger for SMHS? How will you determine what the trauma screening tool will be and the stakeholder engagement around it?

Sadwith: The definition for and the specific criteria for involvement in child welfare is in BHIN guidance and in the appendix. With respect to the trauma screening tool, it will be a process that will require feedback from stakeholders.

Arroyo: Dovetailing on Liz's and Jan's recommendation with respect to data in the dashboard. While we have county SMHS data, and we are hoping to have county specialty SUD data, I would like to see managed care MH data. For the rest of the panel's purview, can you speak to the obligation of MCPs as far as SUD is concerned?

Sadwith: I will note the interest in the data. Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT) is a covered service by MCPs. Medications for addiction treatment are also a covered service by contracted MCP providers.

Beck: Is there a vision to proactively look at continuity between child and adult primary care so that this data being collected would be also useful in terms of following somebody's health and risk over many years? Related to SABIRT, I just want to ensure that behavioral change, counseling, and interviewing are built into these interventions.

Sadwith: The interest of the longevity view on health care conditions as individuals age is really important; it would be something to take back and incorporate into the PHM planning discussions. With respect to motivational interviewing, it's an evidence-based practice, and we know that using that and enhancement therapy is one of the strongest techniques that can be provided through the brief intervention. We can look into it as part of our medication-assisted treatment (MAT) expansion project.

Beier: I second Nancy's comment on children with complex medical conditions being a flag for traumatic experiences. Regarding children with complex medical needs, siblings are often an overlooked category who don't receive appropriate attention. With Adverse Childhood Experience screening, there's a question on discrimination, but you may not know or catch it, so I suggest having certain markers that could be automatic.

CYBHI Update

Boylan provided an update on CYBHI. Slides: https://www.dhcs.ca.gov/services/Documents/071422-MCHAP-presentation.pdf.

Beck: For the virtual platform, there is a potential for the voices of young people to be heard. I like the scaling model of training because it always has to be customizable so that they can set balance. In the Lemon Grove School District, we designed and implemented a comprehensive wellness program that led to very powerful outcomes in intercity schools. One thing that worked was the youth health promoter, in which they learned about common issues and took action, either at their own school or community.

Medi-Cal Rx Updates

Hendrix provided an update on Medi-Cal Rx, including phases for reinstatement and the CCS clinical liaison. Slides: https://www.dhcs.ca.gov/services/Documents/071422-MCHAP-presentation.pdf.

Beier: Thank you for the special population clinical liaison (SPCL). A dedicated team working with certain families or children with extenuating circumstances is vital.

Netherland: The SPCL team is remarkable. The process was absolutely seamless, and I noticed a marked change in the last couple of months. Thank you for remembering all the kids who do have special health needs because it's not always as routine to get those medications approved, especially with rare diseases.

Schumann: Is SPCL permanent? If a prior authorization (PA) is denied, do beneficiaries have the right to appeal?

Hendrix: To clarify the response provided at the meeting, the SPCL team is being piloted for an initial 24-month term. Over that 24 months, it will be reviewed by DHCS for effectiveness based on a number of metrics mutually agreed to by DHCS and Magellan. As for patient rights, the PA goes through Magellan, and if they recommend a denial, the PA then comes to DHCS' pharmacist staff. We review it to make sure it's appropriately denied based on DHCS' policies. If it is denied, and upheld by DHCS, then the beneficiary has the right to a fair hearing.

Schumann: During appeal time, does the beneficiary have rights to access to medications?

Hendrix: I don't believe there are situations in which that happens. They can request an expedited fair hearing if there are time constraints or factors that need to be considered. Also, if the medication in question is a covered benefit, a pharmacy can provide the beneficiary with a 14-day emergency supply, if necessary.

Schumann: During appeal time, does the beneficiary have rights to access to medications?

Hendrix: I don't believe there are situations in which that happens. They can request an expedited fair hearing if there are time constraints or factors that need to be considered.

We have had some focused stakeholder feedback from the CCS community that the Contract Drug List (CDL) is not kid friendly. My team will continue to review and add to the CDL, including essential need. Historically, we have focused on the essential need for adults, but now we're looking at it for some of the different formulations that impact children more than adults. Going forward you will see more liquid formulations.

Motadel: I suggest not putting age limits on who can use the liquids because it is not just kids who can't take pills.

Weiss: One issue that does arise as new biologics are developing is that there are some medications that cost $1 million. We should think about a policy addressing institutions carrying huge holding costs on such medications and the burden it causes.

Member Updates and Follow Up

Netherland: There are income-eligible children who need hearing aids, but are excluded because they have partial coverage. I know DHCS made huge steps forward with coverage of hearing aids, but I want to ask what will happen to kids who don't have that full coverage but still need hearing aids?

Beck: If we have recommendations for the Consumer Advisory Committee, to whom do those go? As we expand coverage for everyone, regardless of immigration status, one group that needs attention are asylum-seekers or people who are at various stages of approval related to asylum. What is DHCS' intention toward full Medi-Cal coverage for that group? For the work around BH with schools, how is DHCS' collaboration with the Department of Education, and is there anything as a panel we can do to help move that forward and strengthen that relationship?

Wunsch: Please send Consumer Advisory Committee comments to Michelle.

Salazar: The Department of Social Services has rolled out the Family First Prevention Services Act. It requires a plan of safe care, which is different than a case plan. This is a huge issue on the child welfare side of our services. How is that work being done in collaboration with DHCS? I'd like an update on the implementation plans of safe care, and having improvements made to the record-keeping or data collection.

Arroyo: Soon, everyone, regardless of their citizenship status, in California may be eligible for Medi-Cal. DHCS stakeholder groups, including this meeting, do not include any solicitation of members of communities who do not speak English. I would like a discussion of this issue in light of the new Medi-Cal landscape.

Public Comment

Susan McLearan, California Dental Hygienists' Association: I would like to acknowledge that dental was mentioned during the CHDP presentation. I follow up to ask: for more information around prevention and treatment of dental conditions; DHCS to explain how oral health assessment and prevention services will be increased, especially considering the current Medi-Cal dental utilization rates; how assessments will be

referred and handled in which venues with providers and how school-based services will include dental services; federally qualified health centers that do not have dental services how they will be encouraged to establish such services; and how DHCS is working with the California Department of Public Health, Office of Oral Health.

Doug Major, O.D., California Children's Vision Now Coalition: Thank you to MCHAP for meeting the vision of Dr. Pan to have an independent voice for all children. Our coalition is designed to help bring to light the issue of vision care for children and the state. We ask that you include vision care metrics as part of the dashboard. I have mentioned many times in this meeting, but there is no priority and no movement. As a comment, I urge you to contact Roseville Optometry Services to see that many of the children they care for receive California Prison Industry Authority (CalPIA) glasses.

Kelly Hardy, Children Now: There have been a lot of comments on CHDP, and I echo the question about how DHCS will identify and engage with CHDP programs, local health departments, and families and kids during the stakeholder engagement process. We look forward to hearing more on that and providing feedback on the transition plan.

Premilla Banwait, O.D., UCSF: I'm speaking on CalPIA glasses. I sit with my colleague Doug Major on the children's coalition vision team here in California. I am a pediatric optometrist at UCSF in the General Hospital and am also faculty at UC Berkeley. I see a very high prevalence of children who need strong eyeglasses. When these kids are unable to get access to their glasses due to long wait times with the CalPIA system, it's a detriment to their academic success, learning, and vision and brain development. I hope MCHAP can please include vision care metrics to meet this essential benefit for the 5.5 million children that you oversee. It would be an amazing piece that we can contribute to the children of California.

Monica Montano, California Dental Association: CDA appreciates DHCS' focus on oral health and especially with PHM work. However, we echo an earlier comment. We'd like more details on how oral health will be assessed, tying into the transition of the CHDP plan. We look forward to DHCS releasing more information on the stakeholder process. It is vital to have families with lived experiences and local programs at the table.