State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

September 9, 2021 - Webinar

Meeting Minutes

Members Attending: Ken Hempstead, M.D., Pediatrician Representative; Jan Schumann, Subscriber 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.

Members Not Attending: William Arroyo, M.D., Mental Health Provider Representative.

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

DHCS Staff: Will Lightbourne, Jacey Cooper, Palav Babaria, M.D., Yingjia Huang, 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 June 24, 2021, was approved, 11-0.

Opening Remarks from Will Lightbourne, Director

Director Lightbourne provided DHCS updates. DHCS is looking to finalize the January 2022 budget proposal. The HCBS Spending Plan is now with the Centers for Medicare & Medicaid Services (CMS) for approval. There is still a significant gap between the vaccination rates of the eligible Medi-Cal population and the eligible population of the state as a whole. As of August 22, the state is at about a 75 percent vaccination rate, whereas the Medi-Cal population is just above 50 percent. Medi-Cal Rx was delayed due to conflict of interest issues with our vendor being acquired by a larger health care corporation. We feel that our concerns have been reasonably satisfied and are moving forward with a January 1 implementation date. Of all qualified pharmacies enrolled in Medi-Cal, 93 percent are in the pharmacy carve-out processing system, and DHCS'

Provider Enrollment Division is working to enroll the other 7 percent. We have submitted our waiver request to CMS that supports the transition to CalAIM. We expect most of our approvals for the 1115 and 1915(b) waivers will go-live on January 1, 2022. Lightbourne covered the CalAIM behavioral health initiatives timeline on slide 10.

Diluigi: Regarding the COVID-19 immunization statistics, is there anything that the County Organized Health Systems (COHS) or other health plans can do to enhance those efforts? Or is that strictly a county public health push?

Lightbourne: We have begun to incentivize increased vaccination rates for the Medi-Cal population. A month or two ago, we were relying largely on collecting data and reporting. We've moved DHCS' delivery system directly into the operation.

Beck: For Medi-Cal Rx, given your desire to increase provider education, have you reached out to pharmacy schools? They have a required pharmacy practice course. For physicians, have you reached out to primary care physicians (PCPs), family medicine residency programs, or medical schools?

Lightbourne: I will relay that information, and we will follow up.

Palav Babaria provided an update on the Health Equity Roadmap (slides 11-13).

DHCS is working on updating our comprehensive quality strategy. Three domains are going to be addressed:

- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

Based on Sellers Dorsey's research on best practices in health equity that other states and organizations have used, we are aligning our health equity work with existing priorities. We plan to launch a stakeholder engagement process to bring together a diverse group to think through our health equity roadmap and come up with a three- to five-year strategy to close any health gaps.

We know there are vaccine disparities between Medi-Cal beneficiaries and the state averages. We've been collaborating regularly with the California Department of Public Health (CDPH), California Medical Association, California Primary Care Association, Association of Public Hospitals, and other health systems to think through how we can support our beneficiaries, combat misinformation, and get vaccines to those who need them. We have a multi-pronged strategy that includes close collaboration with our managed care plans (MCPs) and Home and Community-Based Alternative waiver programs. Our vaccine data on the DHCS website is updated every two weeks. Earlier this month, we launched the Medi-Cal COVID-19 Vaccination Incentive Program to reduce vaccine disparities. We have $350 million dollars allocated for this project, which started September 1 and runs through February 2022: $100 million is available for beneficiary gift cards as incentives to receive the vaccine; and $250 million is allocated

for process and outcome measures for MCPs for addressing vaccination rates. Every participating MCP has submitted a comprehensive vaccine plan, including how they will combat misinformation and how they will work with PCPs to become COVID-19 vaccine providers. We are seeing disparities at many levels, including any given age group as well as with racial and ethnic groups. We recently added public data on our website stratifying COVID-19 vaccinations for all of California versus Medi-Cal beneficiaries by the equity metric, which uses the California Healthy Places Index. We are currently in the Request for Proposal (RFP) process of our Medi-Cal managed care plan procurement, and we received public feedback on the draft RFP. There have been notable changes to drive health equity as we reengage our commercial health plans. All MCPs are going to be required to have a health equity officer and a quality improvement and health equity committee, which includes representation to increase the diversity of voices that inform our programs. We've broadened what used to be called Cultural Competency Training to include new health equity concepts and renamed it Diversity, Equity, and Inclusion Training. The new quality improvement report includes health equity findings. All of our MCPs will have policies and procedures for sharing data with third-party entities and county programs to better integrate social needs and drivers of health. Yingjia Huang addressed the equity work being infused into recent benefit changes.

Huang: We're working on a State Plan option for the postpartum care extension to be reviewed and approved by CMS. Effective April 1, 2022, pregnant individuals currently on Medi-Cal, regardless of immigration status, will have coverage expanded to 12 months. DHCS is working to make sure we are operationally ready. On January 1, 2022, our community health workers (CHW), asthma prevention, and doula services will be launched. All three benefits will be available in the managed care and fee-for-service (FFS) delivery systems. We will hold a series of virtual stakeholder engagement meetings in September and October to elicit input and create advisory workgroups. Remote patient monitoring (RPM) was implemented on July 1. Continuous glucose monitors for individuals 21 and older with Type 1 diabetes is something we are looking to launch on January 1, 2022. Those under age 21 already get this benefit through the Early and Periodic Screening, Diagnosis, and Treatment Services program.

Stanley-Salazar: Have you systematically reached out to the child welfare parties to give them the opportunity to be included in stakeholder groups?

Huang: I don't believe we have. I will take note and share this with staff.

DiLuigi: Particularly for federally qualified health centers (FQHCs) or PCPs who may be unable to charge or utilize at-home readings that are not done in the clinic, can you talk more about what RPM is?

Huang: RPM is an extension of our telehealth modalities. DHCS is activating necessary codes for this so we can cover the cost of the technology associated with it.

DiLuigi: Will there be an ability to get better data via RPM?

Huang: Yes.

Babaria: Patients can upload their own data into patient-facing electronic health records from their own home, as long as they have a broadband connection. It then becomes fully integrated into the medical record. There needs to be catch-up with the standardized national quality metrics, which still require the measurement to be done in office. I anticipate those metrics will be able to be transmitted electronically.

Beck: Regarding the health equity officer roles and responsibilities, what is the method for accountability and monitoring, and their role in the system?

Babaria: Tackling health equity and having monitoring and compliance around health equity is part of DHCS' strategy.

Beck: Related to stakeholder engagement for the CHW benefit, can we make recommendations for the advisory group members? What is the best process for that?

Huang: We already solicited interested stakeholders who would like to participate. We are prepping now to meet with the CHW workgroup, and launch an email mailbox (Medi-Cal.Benefits@dhcs.ca.gov) for stakeholder feedback.

Beck: The California Academy of Family Physicians is another statewide organization that might be helpful. In some of the language we use, sometimes people get used to those terms, and they may not reach out as quickly. If we use new language, such as "help us design a new system", it may lead to more excitement.

Babaria: CMS recently launched a learning collaborative for improving infant well-child visits. DHCS is participating as a multidisciplinary collaborative. We have health plans and public hospitals participating to figure out the best solution to improve infant well-child visits and eliminate disparities.

Hempstead: We have many communities with their own representatives and leaders that are not engaged in formal processes within health care or the government. Many of them have no knowledge this is happening. The email link should be sent to the whole MCHAP so we can provide feedback. Can you explain more on how we establish who stakeholders are and can we have a list of who we currently have as stakeholders?

Huang: We did consider that. We have been cognizant and deliberate in ensuring we have various pockets of expertise represented. We are happy to share the full list. We are putting together a webpage specific to this stakeholder engagement, as well as working documents.

Netherland: There is a substantial amount of procurement material that is not very accessible to those in which the policy decisions are going to impact. What kind of consumer representation is there?

Babaria: Internally, we have been discussing this. One of the four goals of the quality strategy is incorporating member voices. We've been thinking through a multi-pronged strategy on how we can do that.

Lightbourne: Many of us found the procurement documents indigestible. Our staff would say this is how you have to draft a contract. I hope you will see in the final release an emphasis in bringing the values to the forefront. The health care system as a whole has been less accessible in terms of being an equal player and partner with the community. As we move forward with CalAIM, we're trying to imagine how we can build in the services provided by the community.

Netherland: There are robust models for engaging consumer voices in a significant way that enhances public health outcomes.

Weiss: I applaud the broad scope of the health equity areas of focus. There is a huge social determinant of health component there. How will the work that is in process align with CalAIM in lieu of services (ILOS)? In a previous meeting, I asked about DHCS' alignment efforts with CDE and the Dignity in Schools Campaign program. We are missing a great opportunity to bring more effort to schools.

Babaria: In regards to the health equity area of focus, are you referring to specific areas, or just a broad picture?

Weiss: How are the services going to relate to the ILOS scope?

Babaria: A lot of it is organizing so we are not working in silos and duplicating efforts. DHCS has been engaging MCPs and counties, local health jurisdictions, public hospitals, clinics, etc. Coordination is required so there is no duplication of effort. We are looking at how we work with providers that are rooted in the community and have partnership at the local level. We are regularly meeting with CDPH and other partners to make sure our efforts are aligned. One of the outcome measures for vaccinations is increasing the enrollment of practices to become COVID-19 vaccine providers.

Lauterbach: For beneficiary input, all FQHCs must have 50 percent of board members as patients. Many also have patient advisory councils. We could look to them for input.

Babaria: The FQHCs are at the top of my list due to their robust infrastructure.

Schumann: I wanted to further touch on our partnership with CDE. Has Director Lightbourne had the chance to meet with their director to discuss strategies? Is any funding available to get medical transportation for patients to a clinic to get vaccinated? Some people in Medi-Cal may not be able to afford transportation to clinics. I did not see mention on collaboration efforts with CDE on the presentation slides.

Lightbourne: Fortunately, I have had the pleasure of knowing Superintendent Thurmond. Dr. Daniel Lee, Deputy Superintendent, will provide an update

Cooper: We're working on a number of pieces on vaccinations in schools, including using the Local Educational Agency (LEA) program. We're working with CMS to see if we could cover the COVID-19 vaccine under preventive services. Vaccines are carved-out of MCPs' fiscal responsibilities, which means any enrolled Medi-Cal provider can bill FFS and get reimbursed for providing the vaccine. Each school is approaching vaccines differently; sometimes they bring on an established provider. We already cover nonemergency medical transportation within Medi-Cal available to all beneficiaries.

Schumann: Is there anything this panel can do to help facilitate approval from CMS? Either an advocacy letter or anything to support that?

Cooper: Right now, no. If for some reason we hit a roadblock, we will reach out and ask MCHAP for support.

Sonnenshine: Pairing the concept of cultural competency and humility seems needed to produce results. I support the idea that those who serve individuals must think about how we envision member engagement. I'm impressed by how deep and intensive the work is to achieve a cultural change that would yield equity. It speaks to the need to put strategies together to achieve equity. It needs to be an intentional process.

Beck: The organizations that I work with have been working on how all voices can be heard safely. A group that often doesn't feel safe is staff. How can staff voices be heard safely? We've implemented a "safe person you can send a chat to" and they raise the questions anonymously. Related to CHW, it is important to look beyond staff who don't have college degrees; the best person should be chosen, not necessarily the person with a certain amount of prior training. These individuals can bring wisdom, experience, and trust to their communities.

Stanley-Salazar: A comment was made about reaching provider agencies. In public systems of care, particularly to treat substance use disorders (SUD), we have community-based providers. The SUD system lacks understanding of what is going on. What is the communication we need to send out to embrace provider organizations?

Lightbourne: Intermediary organizations can help us bring the unexpected player and provider to the table. Not the usual institutional players we're familiar with.

Stanley-Salazar: Maybe there is a toolkit to provide so there is a common message that intermediary organizations can use in their community. I'd hate the conversation to distill down at the provider level and administrative agents. It gets too complicated. We should help agencies embrace vision and the potential to provide better services for consumers and make it easy for them.

Eagilen: If you want to get providers on board, give them information in a succinct presentation that shows how they can integrate and implement new changes in an easy way. Those providers will then tell other providers, because it was easy to share. We should revisit the way we market to the patients. If we're able to directly reach out to them, it's more impactful.

Lightbourne: I agree.

Beier: I spend very little time looking at mail from DHCS. One time I received a packet with pretty pictures and colors. That was great; it gave a ton of information on when to take my child in and what was expected. It was uniquely different.

Netherland: I received a smoking cessation thing in Spanish, and that's not my primary language. I hadn't read a full packet in maybe 10 years, but I did read the most recent one fully. DHCS should use a multi-page foldout. It's probably a legal thing. The documents have to be mailed to my residence. Sometimes things are printed upside-down or crooked. They don't feel like a lot of care has gone into creating the forms.

Schumann: A lot of material comes in the packets, and to be honest, they aren't read. Too much information is so burdensome it becomes a waste of time. DHCS should simplify this, such as by sending a postcard one topic at a time, maybe once a month or every two months.

Eagilen: All of the information sent out is important, but it should be simplified and presented in an appealing way. I'm not sure that's happening right now.

Hempstead: We have done deeper dives on this specific issue of looking at communications and discovered the tension that exists. There is from a legal standpoint some things that need to be done. If we're not dealing with legal stuff that needs to be mailed, do we typically have an email conduit that we can do email blasts?

*Coope*r: We're in the process of updating the Medi-Cal application to be able to collect an email address, but we're getting approvals to send these via email. It's not a required field right now, so we would like it to be required in the future so it can be a better way of communicating. MCPs do sometimes get permissions for newsletters and different forms of communication.

Beier: Looking back, that trifold [mentioned earlier] was from one of the plans.

Cooper: That's what I assumed because DHCS doesn't send a lot of those types of materials. The MCPs are responsible for member education and communications. We send more formal transition notices. All of the feedback is still very important. Those big changes need to be communicated in a friendly way. I've already pinged some of my team members. Our communication strategy needs to be really tight.

Netherland: The informational packet that I received was from my MCP. I would appreciate if there can be a different tenor to the packages that get sent out instead of threatening legal action. Perhaps a content list or opening summary would work.

Beck: Something we've discussed on this panel many times is level of literacy, which is Grade 6. We need to have another conversation on the level of literacy expected on documents, as well as the level of fear. We have clients come in with those letters who are terrified and confused. I realize there are legal issues. I suggest having a paragraph

at the beginning or a phone number you can call to hear everything conveyed in the document in the beneficiary's primary language.

Beier: Most of the mailings I receive bring a sense of panic; if you lose Medi-Cal, you lose your livelihood. Even if it is warm and friendly on the inside, there is the initial panic that comes when you get those documents in the mail.

Children's Behavioral Health

Slides: **https://www.dhcs.ca.gov/services/Documents/090921-MCHAP-presentation.pdf**

Jacey Cooper provided an overview on the Children and Youth Behavioral Health Initiative.

Beier: Is something being addressed for youth in the homeless population?

Cooper: They would have full access within this initiative to all of the services I mentioned. We are focused on homeless individuals within CalAIM where we are putting together the Enhance Care Management for providers who will be street-based to identify service needs and connect them with ILOS.

Weiss: As you put this together, it would be important to see a single page show how it all lays out so we can form coalitions and brainstorm ideas to float to Sacramento.

Cooper: We plan on launching a full website to keep people up to date. We need to make sure we're coordinated across Agency as well. Agency is going to work to put together a larger structure to help all departments involved stay coordinated. There is so much energy in increasing access to services in schools across the spectrum. Digesting that can be challenging for external people. We are working through the best way to communicate this information.

Weiss: I would like to offer my services to be able to help inform that, if desired.

Cooper: Thank you.

Hempstead: I don't think the importance of the virtual platform can be over-emphasized. It's easy to overlook and say we're going to get more workforce, but if our goal is to reach more children, the numbers don't add up. There's no way to hire enough therapists to reach every child. The scalability of the virtual platform makes it very attractive. We're always going to need excellent therapists. Partnering with apps, such as Headspace and Calm, can be helpful.

Lauterbach: We've had a behavioral health program at a local high school, and a benefit of the pandemic was accessing services virtually. We saw a greater uptick of people using services. They like the anonymity of it. I see that you are providing funding for schools to do this, but how will you tackle the managed care issue?

Cooper: In the budget, there was a state law that requires all MCPs in California to participate. We can do that by mandating that all plans provide the defined list of services at the fee schedule. Behavioral health counselors will be enrolled to various schools in a network.

Hempstead: The stigma and inconvenience of access to care are well-supported by virtual options as it allows the privacy of their own home, on their own time, rather than simply being referred to appointments.

Dr. Daniel Lee presented on Behavioral Health and Medi-Cal in schools.

Lee: A concern I have is that we must get buy-in and get people to participate in the process. On the recent youth voice panels, adolescents said work needs to be done around destigmatizing mental health. If we can ground innovations in a framework that makes sense to schools, we'll get more buy-in. Another piece is integrated care. We must blend these services together and break out of siloes. We are looking for opportunities to integrate behavioral health coaches in the field that complement existing school and community-based services while resolving the tension with school-based and community-based behavioral health professionals. We must focus on a continuum of care model that looks at both sides of the school door. At CDE, we are looking at a student equity-needs index and are partnering with the state Board of Education to do a resource map driven by equity to help us consider a plan to roll out initiatives. We want to start building capacity and infrastructure with high-need communities first. We have a student mental health workgroup that will help us think through policies and actions. One task for the workgroup is to look at the continuum of care model to get guidance out to the field. We're also looking at workforce issues and concerns around staffing shortages. We are going to do a webinar on youth mental health to elevate these concerns. We received grant funds from the Blue Shield of California Foundation to work on a youth mental health first aid 2.0 to make it more user friendly in school settings. We also want people to start having conversations about how schools should be different. The California Community Schools Partnership Program is looking at how we center the transformative work at community schools and using behavioral health initiatives. We're looking to pull these services together and sustain them. The SB 75 Medi-Cal for Students workgroup is preparing a final report, and this has been a vehicle that allowed us to collaborate with DHCS. SB 75 addresses sustainability, building infrastructure, and recommends establishing a clear partnership with DHCS. We also are creating an Office of School-Based Health, which will be instrumental in telehealth regulations and guidance related to schools. We received $5 million for a demonstration pilot project to help understand the role of behavioral health in schools. We're making sure that from a whole child perspective, we take advantage of all the investments we received from the Newsom Administration to rethink and reshape what schools can be.

Hempstead: Please forward the link to the webinar.

Jacobs: As a director of special education for the Pasadena Unified School District, we have seen a huge uptick in anxiety and depression with our students having come back to school in person. Medi-Cal billing is very complex and takes a huge amount of time from our providers. Is any of that $250,000 being used to streamline that process?

Lee: Yes, it's used for a position that focuses on that. It is a two-pronged approach; we are going to be working with DHCS to talk about how to jointly communicate information.

Schumann: If a telehealth situation is not suitable, resources should be available. I want to ensure our youth aren't lost in a crisis. We don't just make resources available, but help coordinate the hand-off. If a school district bills for a service, and a community-based organization (CBO) provider also bills, would one be denied and one paid?

Lee: From my experience, no.

Cooper: Can you clarify the question?

Schumann: If a student is receiving counseling services within the school district, can they also receive community-based counseling with the same billing code at the same time if they need additional services?

Cooper: We are still building the pre-determined services and how that works. We'll make sure to contemplate those types of things as we're building the provider and CBO networks.

Lee: I think that makes sense because you need continuity of care. We can be conscious of warm hand-offs and follow-ups. We can build that into practice.

Salazar: Jacey mentioned that we are going to integrate the mental health and SUD services. I would ask if we could add mental health and SUD every time we say it. When we hear the words "behavioral health", it's strongly related to mental health.

Lee: I've been hearing this consistently, too. Most people ask "What about substance abuse?" One of the units we're forming is Tobacco Use and Prevention Education, which will look at nicotine, marijuana, and vaping. I'm interested in that and linking it to this work around early psychosis.

Cooper: We have a five-year road map to improve integration incrementally across SUD. Some providers may not be able to do both, so we would still allow for providers who are only mental health or SUD. We need to update our administrative side first.

Member Updates

Netherland: It is tragic that we have to wait for children to fail or get a diagnosis before we take action to provide them with wellness resources. Can same-day exclusion be

revisited to ensure children on Medi-Cal are getting access to services? Telehealth has provided more access, and it benefits from behavioral health services.

Cooper: On the topic of no diagnosis before services, it has been included in state law.

Netherland: Presumptive eligibility is a huge win.

Cooper: On same-day inclusions, we track it very well. The way we pay FQHCs is based on costs they provide in the clinic, whether it's for behavioral health or physical health services. They can do warm hand-offs and see individuals on the same day. Some clinics choose to have beneficiaries come back another day because of the guidance that exists. They get paid cost-based rates. Technically, if they only see one part of the service in a day, it's actually an overpayment, since we cover the full costs.

Netherland: When I look at the rates of pay, which can be inclusive for behavioral health and primary care, I don't know that it's sustainable to do those kinds of assessments.

Cooper: If FQHCs need to do a scope-change, they can update their prospective payment system (PPS) rate. We know FQHCs are critical partners in providing services to beneficiaries. We would have to change the way we bill the PPS rate. We have put that on the table for many years, and FQHCs are hesitant. The way the funding is built, we can't pay over the cost, so we build the costs in. FQHCs can provide same-day visits today. We process scope changes and updates to PPS all the time. They make business decisions for bringing people back in, and that is separate from the policy.

Beck: A curricular class teaching young people to be youth health promoters, especially for mental health, can be very helpful. Also, having clinics onsite to serve the whole family, not only the children, worked well. As young people become more mentally ill, having to see different providers is a huge issue. If we can make that continuity smooth, that would be great. I'm hoping we can create a fellowship in community mental health for PCPs who are interested in serving the community, especially the youth.

Public Comment

Doug Major, O.D., Optometric Care Associates: This interface between school nurses and connections with doctors and early intervention is near and dear to my heart. Vision care is an essential benefit that has been forgotten. The demographics have changed. Many Latino children have vision problems that affect their early learning before kindergarten. We have a sister program with First 5 California in which we've seen more than 100,000 children in preschool and Headstarts. I see the results of inadequate vision care all the way to county jails. Last year, children had to wait 7-8 months to get glasses, but in county jails, many received glasses within 10 days. For the next MCHAP meeting, I would like to see an agenda item on vision. We can put together information on the state of vision care and specific things we can do right now to improve things.

Kelly Hardy, Children Now: I appreciate the discussion from consumer representatives around consumer communications. There is great appetite to improve communications. I appreciate DHCS' interest in the CMS learning collaborative on infant well-child visits.