State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

September 15, 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; Nancy Netherland, Parent Representative.

Member Attending Virtually: Ellen Beck, M.D., Family Practice Physician Representative; Diana Vega, 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; Alison Beier, Parent Representative; Karen Lauterbach, Nonprofit Clinic Representative; Stephanie Sonnenshine, Health Plan Representative.

Members Not Attending: Katrina Eagilen, D.D.S., Licensed Practicing Dentist.

Public Attendees – Virtually: 77 members of the public attended the webinar.

DHCS Staff – In person: Michelle Baass, Joseph Billingsley, Jeffrey Callison, and Morgan Clair.

DHCS Staff – Virtually: Pamela Riley, M.D., Palav Babaria, M.D., Karen Mark, M.D., and Norman Williams.

Others: Shannon Thyne, M.D., Co-Principal Investigator of the UCLA-UCSF ACEs Aware Family Resilience Network; Cheryl Treadwell, California Department of Social Services (CDSS); 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 July 14, 2022, was approved, 12-0.

Opening Remarks from Michelle Baass, Director

Baass covered questions on the dashboards related to mental health data and behavioral health (BH) and asylum seekers from the previous meeting, and responses are included in the follow-up document. She said that the Public Health Emergency Operational Unwinding Plan was updated in August. The plan describes DHCS' approach to unwinding and making permanent any of the flexibilities used under the public health emergency. Baass also gave an update on the DHCS Coverage Ambassadors program and mentioned the mailing list for partners to keep apprised of the work.

Beck: Thank you for the clarification on asylum seekers. One of the organizations I work with is Survivors of Torture, International – San Diego chapter, and I don't think they are aware of this. Can DHCS more clearly communicate that those who have documentation issues include asylum seekers? Related, are there other groups that have fallen through the cracks and may not be aware?

Baass: I will take it back by clarifying that the messaging includes asylum seekers. Do you have outreach suggestions?

Beck: I recommend radio, social media, and maybe media interviews. Also, the DHCS website should clearly identify this messaging so those of us working with organizations can refer them there.

Arroyo: Dovetailing Dr. Beck's comments, I suggest DHCS convene a group and ask how they can better be engaged. I would like to review the BH dashboard that was mentioned earlier and make formatting recommendations.

Baass: We would be happy to convene groups that can help message, so part of it is getting ideas from you and others on who those groups might be. We'll do a dashboard review at a subsequent meeting.

Wunsch: We'll put the dashboard on the December meeting agenda.

Netherland: Does the dashboard include mild-to-moderate data? Is it disaggregated by race and ethnicity? It would help to have a comprehensive look at how kids on Medi-Cal are accessing the continuum of care for specialty mental health services (SMHS). For SMHS, will it be able to track juvenile justice and welfare-involved children?

Baass: Yes, it's managed care data that's all in one place now. It was part of our 1915b renewal. I believe foster youth is included, but I'm not sure about juvenile justice youth.

Netherland: Maybe we can shine a light on this at the December meeting.

Salazar: You mentioned in your update that this is managed care data, and Nancy brought up the mild-to-moderate element. At the last meeting, I asked about utilization inside the specialty use delivery system. Being in the field and working in collaboratives with the counties, services are underused and yet there's a demand.

Baass: I acknowledge there's still work to do on the substance use disorder service (SUDS) delivery side, and we're looking to incorporate that into future iterations of the dashboard.

Beck: Returning to the asylum question, counties often have a designated person related to refugee assistance. The California Department of Public Health (CDPH) also has an excellent office, so DHCS and CDPH should collaborate. And informing federally qualified health center workers who are signing people up for care would be helpful. Also, I recommend including Adverse Childhood Experiences (ACEs) on the dashboard.

Arroyo: I would like to see the child and youth data related to SUDs treatment services separated.

Netherland: Are there redetermination estimates for how many may not have coverage?

Baass: Generally, 2-3 million may no longer be eligible for Medi-Cal.

Netherland: Will that be tracked? For children who don't get redetermined, is there a process to identify why?

Baass: DHCS monitors the county processes and redeterminations monthly for discontinuance reasons. These reports will be posted online once we start again.

Netherland: The dyadic benefit was a huge win for DHCS.

Baass: It goes into effect in January 2023.

Statewide Medi-Cal Child Core Set Measures

Babaria provided an update on children's clinical outcomes and the Comprehensive Quality Strategy, which is DHCS' overarching strategic document for quality and health equity. DHCS envisions a cycle of continuous quality improvement that starts with understanding how our system is doing in providing critical care to children. This is largely focused on preventive care, screening, and upstream intervention, but also for children who need more complex downstream intervention. Slides are available on the MCHAP webpage.

Beck: There is a lack of dental resources and lower levels of fluoride screening in the state's far northern area. There are models, such as local community dentists and orthodontists, and teams from other parts of the country who are willing to provide resources. Thank you for the role of the doulas in postpartum depression screening.

Motadel: On immunization data, you astutely mentioned that the flu is probably bringing down the numbers. Can we see the numbers without flu data? Particularly because those are vaccines that children will need for preschool, which 2 year olds will need soon, so I want to ensure that's not delayed.

Babaria: We can share that. We've been advocating to our national partners that reporting on these vaccines, plus and minus the flu, may be helpful for that reason.

Hempstead: I was going to make the same comment; combo 10 is a brutal measure in that if you miss one flu shot, you won't make the measure. I recommend that it is carved out.

Netherland: Thank you for this multi-prong strategy for improving children's health outcomes. Where are the BH metrics and measures?

Babaria: On the Managed Care Accountability Set (MCAS) for Medi-Cal managed care, there are a number of BH measures that span to children and adolescents. We are working on synergies for the managed care side; we have the same measures in MCAS for the county BH systems to support joint accountability. Policies, such as No Wrong Door, reinforce that. We are also working with Autumn Boylan, who oversees the Children and Youth Behavioral Health Initiative (CYBHI), so as we develop all of the work streams, we fully intend to pull them into this strategy.

Weiss: One area for consideration is the adolescent to young adult transition. There are newer metrics; are they on your radar? It's not only a quality and clinical issue, but a big economic issue for the overall system.

Babaria: I haven't looked at this new measure, so please send any information.

Schumann: Regarding the cumulative chart year over year for well-child visits, I recommend having a three-year analysis starting with 2021 to see if the deficit is made up.

Babaria: We can do that, but also this is based on preliminary data. I will underscore that our delivery system post-COVID is not only not in a place to make up those deficits, but is significantly struggling largely due to the workforce crisis. We will partner with other state departments and local communities on this.

DiLuigi: The white population for childhood immunizations and adolescent immunizations has low vaccine rates. Is that a sign of the anti-vaccination effort?

Babaria: This is tied to the concepts of intersectionality. We know we don't have a homogenous white or Black population across the state. When you drill down into the white vaccination rates, they are very regionally distributed. It is often rural north or inland Sierra areas that have different attitudes toward vaccination that are contributing to the bulk of those lower vaccination rates, and not necessarily areas like the Bay Area with a high vaccination rate across the board for all populations.

ACEs Aware Update

Mark and Thyne provided ACEs Aware updates. Slides are available on the MCHAP webpage.

Salazar: It's frustrating for a clinician to identify a service need and interventions and then have no access to those services. I'm hoping for accountability at the system level. The SUDS delivery system falls out of line with high-risk, high-need populations. The

Drug Medi-Cal (DMC) benefit required that providers coordinate with primary care and mental health through a care coordination benefit. It's probably one of the most underutilized benefits we have. What work have you done across the system, especially managed care plans (MCPs) and SUDS or county government agencies, to bring focus and alignment? How can we prioritize the low barrier access in the existing network of care and build it out?

Thyne: The focus has been on building a network of care. It shouldn't just be clinics and community-based organizations, but rather something in the middle. In the two years since we've been doing this work, we've helped our health plans understand the difference between SMHS and mild to moderate. We built an internal roadmap for referrals. We recognize this, and that is the focus of the PRACTICE (Preventing and Responding to Adverse Childhood Experiences-Associated Health Conditions and Toxic Stress in Clinics through Community Engagement) grants, but health plans must be fully engaged.

Salazar: There are strong levers with mental health and primary health plans. There's also language in DMC to require the county to have a relationship with their specialty SUDs plans. None of this has been enforced, and there are no accountability levers. That's what we should focus on next through incentives and grants.

Beck: Are you partnering with the California Department of Education (CDE)? I'm also interested in long-term population health tracking of ACEs, and people with higher numbers of ACEs. MH and neurological conditions are affected by ACEs. How can we link this to outcome measures for long-term tracking and population health outcomes?

Thyne: We're absolutely interested in partnering with CDE, and we have. For clarification on ACE screening, the reimbursement comes from a clinical visit with a licensed provider. We're sensitive to having the screenings in schools where it's not directly connected. It doesn't mean it couldn't happen, but it's part of the infrastructure setup. Our early outreach has been with school-based health centers (SBHCs) where that is a possibility. For population health tracking, I agree. If you have a lot of stressors, it can lead to more mental health conditions. Conditions like Alzheimer's, asthma, and hypertension are not as intuitive. Our data management team is working on heat maps, and some are available on the website. We're starting to do mapping with ACEs and associated health conditions. Because we've partnered with the CHIPs survey, we're also able to access some of the Medi-Cal data to build better mapping.

Jacobs: We've been looking at ACEs scores for more than 13 years, and I'm excited that we're also looking at how that affects our health and engagement. Due to COVID-19, we've seen an uptick in services for social and emotional support, but there are so few providers for complex needs. I was shocked by the county data map; within a county, will that be broken down by different cities? The data appeared skewed for some of the county areas.

Thyne: We're working on interactive heat maps to get meaningful data that can be used at a very local level. We also recognize that when you share data that potentially highlights a particular area for something that is challenging, we want to make sure that we don't introduce information that people don't fully understand. What you need to do if you want to interpret that data is to know what your denominator is and which types of clinics are screening. I want to get us to a place where there's more universal screening so we have a better representation. We'll have ZIP code data that we'll share as soon as it's safe and meaningful.

Jacobs: Could you elaborate on how you plan to bridge work that you're doing with the schools, such as through SBHC screenings?

Thyne: I don't have much more to say than I said before. We think about meeting people where they are, and that's where the kids are. Whatever we do needs to be integrated with the educational system. So far, our education and training is developing modules on trauma-informed care that we're delivering. That would be an option to do in any school system because you can now do it as a statewide initiative. Please reach out to UCAAN with any questions via questions@ACEsAware.org.

Arroyo: Your research should better inform on ACEs. While it's a great tool for population health, I question its use to predict a single individual's health. Furthermore, you may be familiar with the area of research on risk and protective factors, which has been going on for 50 years, and the National Academy of Sciences has monographs related to that body of research. That research discusses a whole array of protective factors, which ACEs don't touch. That's a major downside of the use of ACEs. And the other consideration is the administrative burden in medicine, and how it contributes to physician burnout.

Thyne: We named our group UCAAN for a reason. UCLA used to have the ACEs Aware Family Resilience Network because the move in ACEs is to focus on resilience and strength building. Where I work, we ask the resilience question at the end, which helps start the dialogue for discussing how to address the ACEs. We've partnered with PACEsConnection to think about positive childhood experiences and how those can help influence your future. The ACE screen is not perfect. I want to approach this work in trauma with a framework that supports us moving forward. We're exploring the best way to do that, and right now we feel we're building on a strong foundation that has some evidence behind it. On burnout, we worked with RAND on an assessment in our early implementation that we're now building on. We did a provider and annotation survey with large numbers across multiple sites that the providers felt positive about.

Sonnenshine: Our quality improvement staff have been working with the community and providers to explore the barriers to providers engaging in ACEs work. I'm struck by how this fits into the broader conversation this morning on quality outcomes and the impact of COVID-19 on children's ability to access services during that period. We're also asking the delivery system to transform and think beyond medical delivery services and

treating disease, and move toward wellness. As a panel, we should be providing recommendations around policy and programs to hold ourselves accountable, but also considering the pace of transformation that the existing delivery system can digest.

Thyne: The community, patient, and clinic are ripe for figuring out how to do this better, and I think that attitude is going to help move us forward.

Family First Prevention Services Act (FFPSA) Update

Treadwell provided an update on the FFPSA. Presentation slides are available here: https://www.dhcs.ca.gov/services/Documents/091522-MCHAP-presentation.pdf

Arroyo: Thanks for the update on FFPSA, and I'm glad that you're interested in expanding partnerships with other state agencies. I recommend you connect with Autumn Boylan, who oversees the CYBHI at DHCS. I know that in FFPSA there's a SUD piece; can you elaborate on the rollout timeline?

Treadwell: That segment allows us to fund placement of a child with a parent in a residential substance abuse facility. We've set it up so that payment can occur, but we have not yet rolled out any policy, including the process for placement and how that will occur. We are still coordinating with DHCS. And thank you for mentioning the CYBHI; that is a conversation we need to have.

Salazar: It's important to draw attention to child welfare and the BH services units that are coordinating these discussions, specifically around plans of safe care and the perinatal network. I appreciate the work that you're doing, and the CalAIM vision and goals, along with the effort in coordinating these systems of care. There is a true chasm between MH and SUDS services; we're not at a place yet where those two systems are anywhere near aligned. One of the most underutilized assets is the perinatal substance abuse network, which is funded by the block grant under DHCS. Evidence-based practices around this exist, but we have to elevate them.

Sonnenshine: I saw there was a workgroup for the payer of last resort. I suggest that DHCS/DHSS coordinate on shared communication from the county perspective (MH and SUDS side), to then be shared with the health plan for expectation setting. For CalAIM and the implementation of Enhanced Case Management (ECM) for children and youth and for the foster care population, I request that the health plans are kept informed as the policies are being designed by different state departments. The state should also evaluate policies together and then share the communications to the plans and counties. It supports us in being able to design our implementation planning as opposed to trying to connect the silos across the system.

Treadwell: That's an aspect that we are not as informed on in terms of the health plans, so it's important for us to get more information about that intersection. I agree with you on the joint guidance.

Child Health and Disability Prevention (CHDP) Program Sunset

Billingsley provided an update on the CHDP. Presentation slides are available here: https://www.dhcs.ca.gov/services/Documents/091522-MCHAP-presentation.pdf.

Netherland: Eighty people is a large advisory group to engage with on specific policy issues. What is your vision?

Billingsley: Great point. There's is a significant list of representatives identified by Senate Bill 184, so we need to ensure we're including those representatives. One thing we plan to do is have these larger meetings where we'll provide updates on the process, but then have smaller meetings that are related to each part of that transition plan.

Netherland: I encourage you to have consumer representation. I sit on another advisory group that's beginning to develop metrics for stakeholder engagement. I would appreciate hearing about what successful engagement would look like, especially on some of the mandated decisions. In terms of the provider training that is done for Child Health and Disability Prevention (CHDP) staff, how does that occur in the transition?

Billingsley: That does fit into transition planning, and updates are being done to tie it into the process.

Netherland: It's an exciting opportunity to dig deeper into the Whole Child Model process.

Lauterbach: One group that I didn't see listed in the stakeholders was community health centers (California Primary Care Association); they provide a lot of CHDP care. They are a key group that should be involved.

Billingsley: I can verify.

Beck: I agree that it's great to have the voices of consumer participants, including those who may have issues with documentation status. Some of those families will only use CHDP. They have been afraid to sign up for Medi-Cal. It's an important time to engage with this group during the transition, but also to help them get full Medi-Cal coverage.

Member Updates and Follow Up

Hempstead: I've made a note that we've talked about review of the audit, dashboards, and talking more about the managed care plan procurement.

Arroyo: The Biden Administration redefined public charge, so we should have a conversation about how DHCS is implementing that new revision.

Netherland: Can we get an update on the continuous eligibility workgroup that's being planned? I'd also like to see what the intersections will be with FFPSA. I'd also appreciate an update on the 1915(b) waiver, including what it's going to look like, especially for the potential increased cost for counties, and if there's anything about the financing of that increase of access to services for SMHS.

Salazar: Earlier during the meeting, Nancy brought up questions about foster care and juvenile justice. There is an overarching initiative for CYBHI services. I'd like a presentation focusing on those specialty populations, what the next steps are in population management, and how these initiatives intersect to meet the needs of these two populations.

DiLuigi: It was clear in our discussions on ACEs, FFPSA, and CHDP the idea of bringing together all stakeholders. Help us understand how DHCS is going to engage the counties and health plans to make sure that these things are carried out as effectively as possible at the local level.

Jacobs: I would like an update on California's master plan for children's mental health (Assembly Bill 2058). It urges school districts to provide comprehensive educational counseling programs for everyone. We should identify what we can do as partners to support entities within the school systems.

Arroyo: There's new federal legislation that provides funding for children, and I'm familiar with pieces that support mental health services largely in schools. We may want an update on how that is impacting California. Additionally, there is a new mobile crisis network that will be supported by the American Rescue Plan. Lastly, I'd like an update on the 9-8-8 line rollout and what that's going to look like for kids and their families.

Netherland: Congratulations to California for the 2022 Medicaid Innovation Award.

Public Comment

Kristen Golden Testa, The Children's Partnership: I want to reiterate a comment that Nancy made about wanting to hear more about the continuous coverage stakeholder and implementation processes. I suggest taking a look at a report from the Assistant Secretary for Planning and Evaluation regarding unwinding data that showed children are going to be disproportionately impacted, particularly those who are going to lose coverage, but are still eligible. I also second the comments about wanting to hear more about the audit results that just came out this week. I want to also alert you to the recent 2020-21 data on quality performance from the Department of Managed Health Care; there were disturbing numbers where zero of the 18 Medi-Cal plans are reaching the 33 percentile threshold standard for well-child visits for children 15 months and younger. Finally, DHCS is doing Early and Periodic Screening, Diagnostic, and Treatment Services outreach, and I hope they'll engage you on reviewing the material and its distribution.

Doug Major, O.D., California Children's Vision Now Coalition: In San Miguel, California, we recently found 100 children who had a vision deficit, most of them with farsighted astigmatism. They entered kindergarten without the tools they needed. We had to talk to a 10-year-old about morale; he said he doesn't need glasses, and he's going to work like his dad. What a tremendous loss of human resources at that young age. We are doing a vision service plan mobile clinic, and we will attempt to give glasses to those

100 children. If you're not aware, Vision to Learn has more than 15 mobile labs throughout the state, with more than 40 doctors and 100 personnel staff. What a tremendous opportunity we have now to help these children with CalAIM's Population Health Management.

Jared Fine, D.D.S, Alameda County Dental Society: The presumption that Medi-Cal managed care can be responsible for ensuring access to dental services is one that needs to be scrutinized in the CHDP transition process. There needs to be adequate resources, infrastructure, and accountability metrics to make sure that that actually becomes reality. The local CHDP programs historically have been responsible for identifying gaps in service and filling them. This is something that can easily be glossed over as something that Medi-Cal managed care can do and never has done it.

Upcoming MCHAP Meeting – December 8, 2022, and Next Steps

Hempstead: Then remaining 2022 date for MCHAP is December 8. The 2023 meeting dates will be announced at the December meeting. As a reminder to the panel, I am terming out as chair. We're going to need a volunteer replacement. We'll solicit nominations via email for that position. The panel will vote at our December meeting on who our next chair will be.