State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

October 14, 2020 - Webinar

Meeting Minutes

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

Public Attendees: 60 members of the public attended the webinar.

DHCS Staff: Will Lightbourne, Jacey Cooper, Rene Mollow, Jim Kooler, Norman Williams, and Morgan Clair.

Opening Remarks and Introductions

Ken Hempstead, M.D., MCHAP Chair, welcomed webinar participants. He commemorated Dr. Bert Lubin's time on the panel, and said all MCHAP members will deeply miss him. He thanked Dr. Gilbert and Adam Weintraub for their service at DHCS.

Ellen Beck, M.D.: While I was serving as chair, Adam was such an amazing resource. If you had a question or wanted to understand something, or if our panel wasn't the best place to take a question, he helped. I hope we can send him a letter of thanks.

Ken Hempstead, M.D.: I think that recognition would mean a lot to him.

Jan Schumann: We extended our condolences from the Panel during Dr. Lubin's memorial service.

Liz Stanley Salazar read the legislative charge for the advisory panel aloud. (See agenda for legislative charge.)

Meeting minutes from June 5, 2020, were amended at the request of Dr. Eagilen and subsequently approved, 12-0.

Dr. Hempstead welcomed Director Lightbourne.

Opening Remarks from Will Lightbourne, Director

Lightbourne enjoyed his conversations with Dr. Hempstead and the Office of Communications staff who helped indoctrinate him on the important work of the Panel and appreciates the value added to the Department. As at the California Department of Social Services, the focus was on the well-being and advancement of children, a top priority at DHCS.

Lightbourne swore in Dr. Michael Weiss to a term ending on December 31, 2022.

Dr. Weiss provided a quick overview of his background. He is a general pediatrician and has practiced in the community for 25 years. He is currently the Vice President of Population Health at Children's Hospital in Orange County (CHOC), with oversight of their care management and telehealth programs and community outreach and relationships with schools. He is excited to represent hospitals throughout the state and contribute to improving the care for children in the state.

State Budget Update

Will Lightbourne, DHCS: At the time of the last MCHAP meeting in June, budget negotiations were underway between the Administration and Legislature. The May Revise was very much influenced by the downturn in the economy, resulting from COVID-19, and involved a number of entrenchments, including the postponement of initiatives as well as actual reductions in health care. As a result of negotiations, almost all of the health budget issues were restored. For DHCS' budget, we currently do not have any items that are subject to the trigger, which is due to go into effect on October 15, if federal stimulus funds are not received.

Ellen Beck, M.D.: Initially there was a plan to cover undocumented elders under Medi-Cal, similar to the SB 75 expansion. Could you speak to that element of the budget and what the plan is long-term?

Will Lightbourne, DHCS: It was unusual that the budget included intent language from the Legislature that was signed by the Governor. It was the state's intention to cover the elder undocumented population at such a time as the Department of Finance (DOF) says that state revenues can support that extension of coverage. It's unusual because I can't recall any other intent language. At this point, the next fiscal year budget will also be a highly stressed budget. Revenues are running better than projected as of recent reporting periods, but certainly not at the level that would lead one to believe there will be huge program expansions. The Master Plan for Aging is very emphatic on the need

for full coverage of older residents regardless of immigration status, and will remain a very high priority at the point of economic recovery.

William Arroyo, M.D.: More people continue to lose their health insurance due to the economy. Is there any plan underway to expand DHCS' budget?

Will Lightbourne, DHCS: We're in the budget development process. Actual coverage issues are based on the estimates that we do in conjunction with DOF to project what is likely to be caseload growth or decline. There is a level of uncertainty on the national level due to the upcoming election. There are also unknowns about the future of the Affordable Care Act (ACA). It would be state policy to cover individuals eligible for health care. If existing coverage is affected by any change at the federal level, we will have some profound policy choices and decisions ahead of us.

Children Now asked us to present to the MCHAP on the annual Preventive Services Report that DHCS is in the process of developing in collaboration with our External Quality Review Organization. Due to COVID-19, the report will be issued in two parts; by late December we'll issue a portion of the report dealing with statewide data, and by February 2021, we will issue a report on individual managed care plans. We can also bring this to the March 2021 MCHAP meeting and share the report and get feedback on its findings.

Medi-Cal Managed Care Plan (MCP) Procurement Overview
Slides are available on the DHCS website.

Jacey Cooper: DHCS is starting the process for MCP procurement. This is the first time we've done a statewide procurement of our MCPs. We are only procuring commercial plans; we do not procure our County Organized Health Systems (COHS) or our Local Initiatives; these are in place and will remain in counties where they exist. We're procuring for all commercial plans that are the second plan in two plan counties; Geographic Managed Care (GMC) counties; Imperial County; Regional; and San Benito County. DHCS will host a webinar to provide technical assistance to both counties and plans so they understand when they need to decide if they want to change the model of care.

DHCS is still determining the number of plans we will procure in a GMC. We've highlighted areas that we want to strengthen for MCPs participating in the Medi-Cal program: Quality, access to care, continuum of care, children services, behavioral health services, coordinated/integrated care, reducing health disparities, increased oversight of delegated entities, local presence and engagement, and emergency preparedness and ensuring essential services.

DHCS released a Request for Information (RFI) on September 1 for a 30-day public comment period. We hosted a webinar that provided an overview of the RFI. The comment period closed on October 1, and we are now reviewing the comments and feedback. DHCS will release the draft RFP in early 2021, and we will incorporate

comments received on the draft RFP into the final RFP. The plan is to release the final RFP in late 2021, and proposals would be due in early 2022. We anticipate that Notices of Intent to Award would be released in early to mid-2022, with a go live date of January 2024.

William Arroyo, M.D.: Prior to COVID-19, the progress of the California Advancing and Innovating Medi-Cal (CalAIM) and MCP procurement efforts were in much better alignment. How was it decided to delay the CalAIM process, but to move forward with MCP procurement?

Jacey Cooper, DHCS: As you know, we were actively moving forward with implementing CalAIM by January 1, 2021. When the COVID-19 public health emergency (PHE) happened, we received letters from counties, provider networks, health plans, and hospitals urging DHCS to delay the implementation of CalAIM by one year, and submit an extension of the 1115 waiver in order to bridge that period. Given the immense impact to our delivery system because of the PHE, many of our partners felt that they would not be ready for the massive change. We listened to that feedback and quickly worked with the Centers for Medicare & Medicaid Services (CMS) to request an extension of our 1115 waiver. Given that one-year proposed delay, DHCS is internally working to update our CalAIM proposal with timelines, which we anticipate to roll out in early 2021. We're still very committed to CalAIM, but the PHE and current budget crisis changed things. We are taking a thoughtful approach with the CalAIM proposal, but we must continue with the MCP procurement. We will be able to incorporate the CalAIM components into the RFP since the plans we are procuring won't go live until January 1, 2024, while most CalAIM proposals will go live prior to 2024. So things are still aligned.

Jovan Jacobs, Ed.D: As part of the public school system, we're concerned about how our children will come back and the kind of behavioral health services they'll need, from social and emotional supports, to not being around their peers, to children with disabilities. Once you go through the RFP procurement, what is the collaboration with school districts? We're concerned about our low-socioeconomic students as we've learned that distance learning has not been equitable across the board. How do we prepare for when our students return to some form of in-person schooling?

Jacey Cooper, DHCS: You definitely don't want to wait until the RFP process to do that since these changes won't go live until January 2024. DHCS is focused on the impact to children given the PHE.

Jim Kooler, DHCS: We are on the verge of getting good news from FEMA on our crisis counseling program grant. A significant portion of this grant relates to schools in what we call CalHOPE school support. We will provide approximately $100,000 to each of the 58 county Offices of Education for them to use to look at what they're doing to support young people and parents in their districts and counties dealing with stress and anxiety due to the PHE. They will develop communities of practice to share best practices and develop tools to share across the state to ensure that we're reaching the

most vulnerable communities and students. There was an element in the application that was denied that we may go back and try to get FEMA to reinvest in, which was money for mini-grants to implement more programs. The initial effort is to look at the social and emotional learning environments that are being created, along with the challenges of distance-learning. We are starting to understand the challenge that parents who are now working and teaching from home are now feeling.

Foster Care Model of Care Workgroup Update
Slides are available on the DHCS website.

Jim Kooler, DHCS: We wanted to provide a quick overview of the Foster Care Model of Care Workgroup, which was part of the CalAIM effort and started a little later than some of the other CalAIM components. This workgroup focuses on ensuring that young people in the foster care system are getting behavioral health and social services. We're looking at the system of care that we can provide to make sure we can move beyond the silos in which we traditionally live. We've had three meetings so far. Nancy Netherland is kind enough to be the bridge between MCHAP and the workgroup.

Ellen Beck, DHCS: Do you have teenage foster youth as members/participants?

Jim Kooler, DHCS: As with other state workgroups, we host meetings during the time in which young people should be in school. We've worked to hold focus groups with young people in the foster care system to get input on their experiences, then we will check in with them again with some of the recommendations from the workgroup. While it would be great to get younger members as core workgroup members, it's usually not an effective experience for them, from being overwhelmed with a large group of adults to being taken away from things they normally would be doing during the times we convene. We have agencies on the workgroup who represent young people.

Ellen Beck, M.D.: When you're asking for their input, are you also asking for solutions?

Jim Kooler, DHCS: Yes, that is our hope to ask what their experience is and how to make it better.

William Arroyo, M.D.: Many members of the Governor's Healthy California for All Commission have concluded that COVID-19 has unmasked a fragmented, inadequate health care system in California. My concern about the foster care system is if there is a different system for them, it will only fragment our health care delivery system even more. Do you anticipate any of these threats would emerge?

Jim Kooler, DHCS: I'm not familiar with the unified funding model. The models and discussions within the workgroup look at the challenges and fragmentation today where young people get lost between the handoffs and the different systems. Much of the recommendations are looking at whether a single system for their physical health would make more sense. Would regional models for their behavioral health make more sense? We're looking at what has been done and what we can learn from other states..

Separating out and providing better services for foster youth could create more fragmentation. That would be an unintended consequence. I will consider this issue going forward.

William Arroyo, M.D.: The intent of continuum of care reform (CCR) is to normalize the lives of children and getting back to family-like settings. For the parents who have biological children in the Medi-Cal system, and who decide to make room for a foster child, learning about another health care system only undermines the intent of CCR.

Will Lightbourne, DHCS: I'm a member of the Healthy California for All Commission. We are on pause until 2021. We must be careful of further fragmentation, but there are several levels of thought and planning. The California Health and Human Services Agency (CHHS) has a Behavioral Health Task Force that is looking at behavioral issues across all coverage systems in California. DHCS has the Behavioral Health Stakeholder Advisory Committee (BH-SAC) that is looking at behavioral health issues for everyone that we cover, especially for children, as well as the Foster Care Model of Care Workgroup. The common theme that I see emerging in all of those conversations is the importance of serving children in a dyadic mode, where we're not simply identifying the child as the client. If a child has behavioral health needs, then we must serve the needs in terms of a family setting where the parents are also engaged in services. Simply by virtue of the circumstances that have led them to be foster youth, they have suffered trauma. Removal from a family setting is traumatic, and the underlying cause of removal is traumatic. We must acknowledge that trauma is enough to trigger our full suite of behavioral responses.

Nancy Netherland: I was reflecting on the comments about the challenges of families navigating both systems. As a foster parent, and having Medi-Cal that is carved out for former foster children who are medically fragile, I encounter a lot of providers who are unfamiliar with that program. This leads to significant delays in getting care and referrals. How can we educate the different stakeholders in the service delivery system on what that product ends up looking like? The subgroups that I've been on have some former foster youth who are young adults working at represented agencies. The diligence they are showing to make sure youth voices are represented is profound. These groups are holding sub panels with the youth they serve and are bringing back real-time information from the young people they work with. I wanted to thank the architects of the group for having such mindful representation. The providers on the group will not make any definitive statements without having that youth representation.

COVID-19 Updates
Slides are available on the DHCS website.

Jacey Cooper, DHCS: The U.S. Department of Health and Human Services extended the PHE for an additional 90 days through January 21, 2021. This extension is made on a 90-day basis. For previous extensions, they announced a few days prior to the expiration so we had more notice than before. Multiple state agencies and other state Medicaid programs are collectively advocating for Secretary Azar to give states and

Medicaid programs at least a three-to-six months prior notice before ending the PHE. Unwinding the PHE will take extensive work at DHCS. We have obtained 50 or more programmatic flexibilities by CMS. Those flexibilities will expire at the end of the PHE, so we must effectively communicate changes to providers, beneficiaries, and delivery systems so they know when those flexibilities have ended, and make sure they understand that we'll need to revert to existing federal and state laws in a number of areas.

For enrollment efforts, our eligibility workers must reevaluate cases at the end of the PHE, which will take a significant amount of time. By the time the PHE ends, we could have 1 million to 1.5 million people who would have to be evaluated through that process and who potentially may not otherwise be eligible for Medi-Cal. We've enrolled 200 additional providers in our streamlined emergency enrollment process, and they will have to go through the full enrollment process per federal law after the PHE ends. We've modified a large number of auditing and licensing protocols and various onsite visits due to the PHE. After seeing a large spike in COVID-19 cases, we did get additional Home and Community-Based Alternatives waiver and Assisted Living Waiver enrollment flexibilities to protect beneficiaries from potential COVID-19 infections. DHCS worked closely with the managed care plans (MCPs) in the Central Valley to identify hotspots, and if we have additional hotspots throughout the state, we would use this same model. DHCS created Home and Community-Based Services (HCBS) resource guides for each of the counties so there can be coordinated efforts for health plans, hospitals, and others during the PHE. We're also working with CMS on the Benefits Improvement and Protection Act (BIPA) waiver and with our Program of All-Inclusive Care for the Elderly (PACE) organizations to be able to transition people into PACE plans.

For CalHOPE, we have a smaller grant and are currently working with FEMA and SAMHSA on a larger grant.

Recent eligibility and provider guidance has been posted on the DHCS website. DHCS also provides a weekly update through the stakeholder listserv.

William Arroyo, M.D.: Is there any special effort to encourage beneficiaries to get the care that they have delayed because of COVID-19?

Jacey Cooper, DHCS: We're working closely with MCPs to develop toolkits on issues like immunizations for children, flu shots, and routine care that has been delayed. The Department of Managed Health Care is also working with its health plans on outreach. We've started to see some increases in utilization, but still nowhere near where we anticipated for enrollments. We'll continue to monitor and work with our partners on outreach.

Ron DiLuigi: With the community spread of COVID-19, some localities have abandoned contact tracing. I raise this because it has such an impact on the health care delivery system. Is this related to the California Department of Public Health (CDPH) or DHCS?

Jacey Cooper, DHCS: Contact tracing is led by CDPH and CHHS. They've released comprehensive guidelines on contact tracing, which is initiated by the individual public health departments. A large number of state employees have been redirected to help with contact tracing. I would encourage you to contact CDPH for more recent updates.

Ron DiLuigi: Recognizing how interagency related this prevention is, I appreciate the urgency that it's passed along to CDPH.

Jacey Cooper, DHCS: We will do that and, in fact, we have a call later today with CHHS.

Jan Schumann: Has the COVID guidance been communicated with beneficiaries to keep them updated in terms of coverage and resources? I recommend the Panel draft a letter encouraging continuity of coverage for at least six months following the PHE end.

Jacey Cooper, DHCS: We have a listserv for all DHCS stakeholders. Each Friday an email is sent that includes links to new guidance and relevant federal approvals. We also provide updates through the electronic provider bulletin. Additionally, we mailed a letter to 13 million beneficiaries with extensive information about their rights for eligibility, accessing telehealth services, the Medi-Nurse Advice Line, and CalHOPE. We are doing everything we can to advocate for a transition period, but CMS has not opined, and we would need federal approval.

Jan Schumann: Would it be beneficial for MCHAP to write a letter to supplement DHCS' effort?

Jacey Cooper, DHCS: It wouldn't hurt. There are other groups that are also advocating this to Secretary Azar.

Jan Schumann: We can potentially include this as a future agenda topic.

Jacey Cooper, DHCS: DHCS announced a CalAIM postponement earlier this year. In light of that effort, we requested an extension of the current 1115 waiver from CMS. On October 1, 2020, CMS confirmed that we met completeness requirements. A 30-day federal public comment period ends on November 1, 2020. After the federal public comment period, we will go into negotiations with CMS on the one-year extension. We are hoping for approval at the end of 2020, which is an aggressive timeline. Both CMS and DHCS are committed to working closely as with previous waiver negotiations. If we don't have approval by the end of 2020, CMS will extend a technical amendment (one to three months) to get us through that period. In parallel, DHCS is still actively working to submit our formal 1115 waiver and 1915(b) request to CMS that would go live in January 2022. We anticipate that the larger waiver changes will go through the public comment process in spring 2021.

Medi-Cal Enrollment Update
Slides are available on the DHCS website.

Rene Mollow, DHCS: We have been doing a lot of work around shoring up our Medi-Cal enrollment numbers. The data demonstrate that we haven't seen the number of enrollments we were expecting. We're tracking and analyzing some of the reasons we haven't seen the uptake of coverage as we originally anticipated.

This presentation shows a comparison of applications from 2019 to 2020. The application numbers are based on data pulled at the end of September 2020. We usually look at a full year to get complete data. On the eligibility front, it takes a couple of months because of our policies on retroactive eligibility and the timing of when the application is received versus adjudicated. Application data looks at the number of applications submitted, and there could be multiple individuals on applications.

There are many pathways in which applications can be made. In 2019, we had more individuals submitting in-person applications versus online applications. However, with the PHE, while we have seen increases in online applications, it still hasn't made up for gaps in the number of people coming in versus online. For online applications, this is information that may be submitted by county offices and applications filed through CalHEERS (online system that is used to apply for Medi-Cal and Covered California). We've also seen an increase in phone-in applications because of the PHE. For new enrollments by mail, there is a slight drop off for children (ages 0-17) enrolling.

In some of the earlier PHE months, there was a bigger drop off in terms of individuals who are Hispanic. The numbers are trending up slightly, but it's still a drop from what we had in 2019 for this same population. Similarly, we also have drops in African Americans who are applying. There's about a third of the population that isn't reporting their race/ethnicity. Another issue is public charge for our immigrant population. Given the policies in California, and especially for individuals through age 26, they have the ability to have full-scope coverage in Medi-Cal regardless of immigration status. More importantly, anyone can apply for Medi-Cal regardless of immigration status. We also recognize that there are some federal policies that might affect who may be applying for public services.

During the PHE, we have requirements to not disenroll anyone except for very specific reasons. Re-enrollment churn has been a lot less than in prior years, and part of that reason is that individuals are required to stay in Medi-Cal coverage.

We are taking a deeper dive into the data to better understand why we haven't seen increases in enrollment as we had originally anticipated due to the rise in unemployment caused by the PHE. Some data may suggest that employers maintained coverage for employees longer. There could've been many low wage earners who were already enrolled in Medi-Cal. Information may also suggest that because of the PHE, some were not enrolling in coverage and avoiding the health care delivery system unless they had a specific need for care or coverage. Even though unemployment income didn't

impact Medi-Cal eligibility, it may have been enough to support them to maintain employer-supported coverage. As a PHE continues, we'll likely see enrollment numbers increase.

Given the concerns over lack of enrollment, we've developed outreach messaging to remind individuals about the availability of the Medi-Cal program. The Governor's Office and CHHS have released messages about Medi-Cal availability. We have released messages through social media and are working with our advocate partners to share our messaging. The messages reflect that immigration status is not a barrier to applying for coverage and specifically target pregnant individuals.

We gave direction to counties about conducting renewals on the Medi-Cal population and to defer any type of discontinuances or negative actions that might occur based on reported changes for an individual. These directions went into effect on March 16, 2020, and will continue through the end of the PHE. There are three permissible exceptions for disenrollments: If someone voluntarily requested to be disenrolled, moved out of state, or passed away. DHCS has been working closely with county partners and vendors that manage the county eligibility and enrollment systems to help identify individuals who may have been inadvertently discontinued, and we have been working to have coverage restored. The number of restored individuals is reflected in the data. As of October 1, 2020, about 110,000 individuals have had their coverage restored by the state. Those individuals have been informed of the restoration of their coverage, and where applicable, we will also restored those individuals into their last known Medi-Cal MCP for continuity of care and services.

Uninsured Group: Through a disaster State Plan Amendment, California elected to cover uninsured individuals. By virtue of being uninsured and not having access to COVID-19 testing or testing-related services, they could apply for Medi-Cal coverage. There are no income or age restrictions. When individuals are identified for enrollment into this program, DHCS has also elected to provide associated treatment services, testing, and testing-related services. Coverage is for 12 months or through the end of the PHE, whichever comes later. We first leveraged our Presumptive Eligibility (PE) program, but had to revamp the PE because of federal guidance. One noticeable revamp for the Uninsured Group is that we need to verify citizenship status. As of October 2, about 32,000 people have been enrolled into this program.

William Arroyo, M.D.: Does DHCS partner with the Employment Development Department (EDD)? Could EDD send unemployment benefits and a link to apply for Medi-Cal?

Rene Mollow, DHCS: With some of the challenges that EDD has experienced, we have not established those relationships.

Karen Lauterbach: On eligibility, what we noticed in our enrollment program is that we have a lot of people who are recently unemployed wanting to apply for Medi-Cal, but their unemployment benefits (not taking into account the supplements they received) is putting

them at the bottom of Covered California. We had an uptake in Covered California applications. Are Covered California numbers reflecting an increase?

Rene Mollow, DHCS: They are.

Karen Lauterbach: The unemployment was barely kicking them over to Covered California, accounting for some of the lower Medi-Cal enrollment numbers.

Rene Mollow, DHCS: When they do apply through CalHEERS or county portals, it will run the data through the federal data hub. For applications that are eligible for Covered California, they will be sent over to Covered California. As a reminder, Covered California does offer state subsidies that helps those in the lower income tiers offset the cost of the premiums.

Pam Sakamoto: For beneficiaries who were discontinued, though their Medi-Cal coverage should have continued, what we noticed was that beneficiaries in the Whole Child Model (WCM), had their Medi-Cal coverage continued, but the capitation rate to the WCM plan was not paid. Therefore, they were switched to Medi-Cal only. This changed their case management back to the county for services. We're continuing to see clients maintain Medi-Cal, but do not have their MCP. Is that being addressed?

Jacey Cooper, DHCS: When our systems accidentally disenrolled certain individuals, we rectified this. Unfortunately, MCPs were receiving fees from our eligibility system, which is probably why they were flipped on the CCS side. We've since rectified this and added their eligibility back to the original time period, including reenrolling them back into their assigned MCP. We hadn't heard of these disenrollments you've mentioned, so we will work with our CCS staff and Rene's team to make sure those reconnections happen. We are not adjusting share of cost during the PHE.

Rene Mollow, DHCS: I'll follow up with eligibility on this issue.

Ellen Beck, M.D.: Are the 32,000 people enrolled in the Uninsured Program still at risk for the public charge issue? I would encourage us to think about a transition plan at the end of 12 months, especially if the patient has other conditions. Do you have any suggestions for raising enrollment for the Latino and African American populations?

Rene Mollow, DHCS: The Department of Homeland Security has indicated that individuals seeking coverage for COVID-19 treatment or testing would not be subject to public charge. The challenge is the underlying fear. Through CHHS' website on public charge, we are ensuring that the messaging is clear about public charge and how it may or may not apply to individuals, especially during the PHE. In terms of transition for the Uninsured Group, the group is only effective through the end of the PHE. DHCS will not summarily discontinue people; we'll look at if the individuals are otherwise eligible on a different basis. We're reviewing outreach strategies to help raise enrollment for African American and Latino groups, and are working with our health enrollment navigators programs throughout the state. We're covering 53 of the 58 counties to target outreach

messaging and strategies to those populations. We're also working with our advocate communities to get those messages out. We welcome thoughts and considerations. We also write a report of the work that the health enrollment navigators are doing through the Consumer Stakeholder Focused Workgroup. For more information, contact DHCSCFSW@dhcs.ca.gov.

Ellen Beck, M.D.: I recommend that partnering FQHCs provide a list resources that individuals of the Uninsured Group can receive even if they no longer qualify for coverage.

Rene Mollow, DHCS: We can look into this.

Nancy Netherland: Is there a way to parse the enrollment data by under age 18? Is there a way to tease out how COVID-19 is impacting the enrollment of children?

Rene Mollow, DHCS: On slides 35 and 36, we do list enrollment identified by age.

Nancy Netherland: Does that show the method by which they're enrolling? When we discuss increasing navigation resources, it would be helpful to know ways that children are being enrolled into the system. Depending on how people are accessing systems of care will impact how we do outreach.

Rene Mollow, DHCS: It does not. I will take this back to my team for review. We're interested in different ways to capture this information. We may not have some of this information at the granular level.

Nancy Netherland: I'd really appreciate reviewing data that's composite and can look at the 0-18 population.

Rene Mollow, DHCS: The way it is currently arrayed is by ages 0-17.

Michael Weiss, M.D.: With respect to child beneficiaries who are inadvertently losing coverage, I appreciate that those cases are being researched and aggressively mitigated. In terms of vulnerability and risk, is there any priority given for those who are WCM or CCS children versus standard Medi-Cal?

Rene Mollow, DHCS: We look at all children as being vulnerable and at risk, so our goal has been to cover all children. The joint efforts between the county and the state occur swiftly. We take time to identify the cases and make sure they were inadvertently discontinued because some of the discontinuances are appropriate. The cases are getting restored at the county level. If there's a gap where the county couldn't do the restoration, then the restorations are occurring at the state level within a couple of days of us receiving the information. When we learn of discontinuances, based upon the month in which their eligibility ended, it will go back to that month to ensure there are no gaps in coverage.

William Arroyo, M.D.: Are public service announcements available in Spanish? The Latino population has a lot of essential workers who have been exposed to COVID-19. Is it in the purview of DHCS or MCPs?

Rene Mollow, DHCS: For outreach purposes, it would not be DHCS. I will check in with our health enrollment navigators to see if that's a space they've delved into.

Telehealth Observations and Lessons
Slides are available on the DHCS website.

Rene Mollow, DHCS: Prior to PHE, we had a robust telehealth policy that allowed our providers to provide telehealth services via synchronous and asynchronous modalities. We gave deference to our Medi-Cal providers in terms of making decisions about modalities in which services could be provided via telehealth. Given the PHE, we expanded telehealth provisions. With the PHE, we delved into additional expansions in terms of telephone use and allowing other virtual communications. DHCS is reviewing areas where we could continue telehealth post-PHE. We want to take some time to get feedback from members in terms of their use of telehealth.

Katrina Eagilen, D.D.S: From a dental perspective, there are many procedures that can't be performed and many that can. Some procedures would be helpful to continue. Many of the teaching and training codes would be ideal to continue (there are about 11 codes in dentistry that we're using); most providers are happy with the codes. Obviously, we can't do fillings over the phone, but there are many other things that can be discussed and monitored. We're welcoming it in our field.

Karen Lauterbach: From a community clinic perspective, we can't say enough good things about telehealth and telephonics (since there's a huge gap in Wi-Fi access). One of the areas we really find it useful for is follow-up care. For example, someone who may be diabetic and has changed medication, the follow-up is helpful for those cases. Providers have seen such a huge difference in how they're able to check in with the patients and make adjustments to medications.

Ellen Beck, M.D.: Our experience has similarly been excellent. We serve a population that is very underserved and food insecure. Our show rates (previously affected by transportation and other issues) is now close to 100% using Zoom/telephone. I would encourage you to study the show rates. We have a mechanism where we're delivering food and medication to people's homes after the medical encounter. We've also discovered that it's very helpful to identify a staff person (Spanish speaking) who can work with individual families to identify the modality. Once established, the feedback with patients has been outstanding.

Elizabeth Stanley Salazar: From my experience of working with providers in several networks in the substance use delivery system, overall, telehealth has been well received. We've seen better engagement and retention in the treatment process. What's working is a combination of meeting the client where they're at, providing multiple

avenues for them, and removing transportation barriers. Providers are struggling in the SUD system because the benefits and payment structures are more rigid than the mental health side. Providers are struggling with enforcing those policies with patients. The biggest challenge we've had is the digital inequities. I've seen some amazing work with youth through the opioid response grant. One of the main concerns is the privacy issue among youth when talking to their counselor.

Michael Weiss, M.D.: One of the major benefits that we saw is the broadening of allowable services. Specifically, we've done thousands of speech therapy visits, which is even more important now as children are having challenges getting back to school, which may be their only source for speech therapy. Providing speech therapy as well as mental health services has been a game changer for us. One challenge is that organizations will need to gear up their infrastructure and operations to meet the needs of telehealth. The uncertainty of what this will look like in 6 or 12 months makes it challenging for organizations to successfully gear up for telehealth.

Nancy Netherland: As a consumer for two medically complex children, there have been months where we've had 39 medical appointments, including specialty care appointments, infusions, PT/OT, mental health, etc. This has been revolutionary as it cuts back on commuting, parking, time, and expenses. The amount of school and work that we miss because most of these appointments happen between 9 a.m. – 5 p.m. has been dramatic. The other thing I wanted to mention is that we have no care coordination in terms of managing the appointments. This is the first time that providers from different specialties have been able to be in the same consultation. I don't know how the billing has worked out yet, but in terms of having focused care and real-time coordination, there has been a huge shift. There are things that we can't do with telehealth. I will say that telehealth has allowed me to make up travel time and allowed me to make sure things don't get passed over, like well-child visits and non-emergency behavioral health.

William Arroyo, M.D.: Telehealth opportunities have been fabulous in terms of care. But it also has helped on the provider side, especially those who have been leery about meeting with potential patients who may be infected. That's something to keep in mind as the PHE continues.

Rene Mollow, DHCS: For the clinicians on the panel, have you had someone who hasn't reacted positively? We heard the concern about MH/SUD and confidentiality. Have there been any negative feedback or concerns from beneficiaries?

Ken Hempstead, M.D.: I would echo all the positives mentioned. Telephone visits have been easy. Video visits have been wonderful, but can be frustrating to some families as they get used to the technology. Another potential negative is accidentally leaving families with the impression that we will not see them in the office. There does need to be purposefulness to the messaging that we are here to help and see you when needed, and this is an additional modality to help you. We don't want people to feel like they're not being cared for.

Diana Vega: In terms of accessibility, I feel like we're not taking into consideration families who do not have access to Wi-Fi. They may not know how to do video calls. What kind of outreach are we providing for families?

Elizabeth Stanley Salazar: For individuals who have difficulties using electronic platforms, they want to use direct care. As Dr. Hempstead mentioned, that must be made available and it must be understood that it's available. I also see that elders are struggling with it. They have telehealth visits, but they miss the social interaction of in-person meetings.

Diana Vega: For young adults and teenagers seeking mental health support, they might rather see someone in person than online.

William Arroyo, M.D.: For modalities of care that involve multiple clients for group intervention, telehealth is not ideal.

Ellen Beck, M.D.: We have to be careful to not be ageist and make assumptions that elderly individuals wouldn't be interested or couldn't learn. The idea of a navigator who is a trusted member on the team who can help troubleshoot technical issues is key, especially for certain subsets of patients. Sometimes the issue is Wi-Fi. Is there any way we can strengthen it by maybe providing a simple phone call? Thinking about having the technology so that the connection can occur and having a navigator to help that happen is key. We also have a support group for peer facilitation, and it's going very well. We must recognize that we need staffing and navigation.

Rene Mollow, DHCS: Prior to the PHE, was there expansive use of telehealth, or was it not considered in the delivery of services?

Elizabeth Stanley Salazar: In SUD, it was discussed. There was always some strategic thought given in many situations to expand telehealth, but it didn't expand extensively anywhere to my knowledge. There was also the issue of operationalizing this. That challenge to change the operational practices at the level we've done, it took the PHE to do that. There have been a lot of lessons learned.

Karen Lauterbach: We had a pilot project with hepatitis C treatment where in the middle of it we did telephonic care. It wasn't reimbursed, but it was very successful. For hepatitis C, it is a very prescribed treatment where there are four check ins, and there's a medication regimen. If the labs were coming back fine, then the two middle visits would be telephonic visits. We needed to check in, but there wasn't a need for face to face. We found there was greater compliance, people were happy with the program, and if there was a need for them to come in, they could. I would be able to share the results since we did many studies on this prior to the PHE.

Rene Mollow, DHCS: That would be helpful. In terms of the treatment modalities when looking at certain chronic medical conditions, are you seeing benefits in any type of best practices that you'd like to call out?

Ken Hempstead, M.D.: Slightly more adult-focused, but part of what would move the ball forward is what equipment might be available to beneficiaries at home? Could there be a benefit for a blood pressure machine or an oxygen saturation monitor? This would ultimately save money, but we would need to come up with mechanisms on how to provide home monitoring equipment.

Ellen Beck, M.D.: We did that. Through a donation, we delivered vital sign boxes to homes. People got exactly what you just described: a thermometer, blood pressure cuff, and oxygen meter. People learned to use them and report to us. For chronic care management, knowing sugar levels, following their exercise plans, etc., is excellent. We did a little before the PHE for counseling, dermatology, and ophthalmology, but we didn't do it the way we're doing it now.

Terrie Stanley: Medicare pays for remote patient monitoring (RPM). Has Medi-Cal considered this? We have seen more acceptance in the provider community given that Medicare is reimbursing a practice site, medical group, and health plan for that monitoring. With wearables becoming more accessible, it's definitely something that we're seeing more of.

Rene Mollow, DHCS: That was one area that we did not advance, so thank you for that.

Terrie Stanley: I can send you information on it.

Rene Mollow, DHCS: Is there anything else that people would like to share as it relates to telehealth?

Michael Weiss, M.D.: It would be valuable to have a structured deep conversation between families and providers to find the "sweet spot". What is appropriate for telehealth and what isn't? Both the recipient and deliverer of telehealth have opinions.

Rene Mollow, DHCS: Would some of that discussion entail what is or is not appropriate? When you're providing care, is there a "sweet spot" in terms of the number of visits that may be done via telehealth versus in person?

Michael Weiss, M.D.: That's part of it, but it's also incumbent upon us to develop quality measures that we can objectively use to determine that telehealth impacts outcomes. For example, if we have a patient with diabetes, today the standard of care may be the child is seen four times in a clinic visit per year for routine visits. Perhaps the "sweet spot" is two or three in person visits and two telehealth visits, and can we proactively measure that child's hemoglobin and emergency visits to determine where that "sweet spot" is.

Ken Hempstead, M.D.: I'd like to echo this. There are so many positives, but there is work to be done. We wouldn't want to sacrifice quality, and we wouldn't want overutilization where it's not benefiting the patient. I would hate to have the funding be

an incentive or disincentive to using virtual care in the setting that we know provides quality care. Similarly, we've had discussions about access. One could easily imagine that the different venues of virtual care can increase access, but a tension point would be without the loss of a medical home. Different health plans and specialty groups can work on their own guidelines to find where those "sweet spots" are and have some evidence base for it. With some of the technical problems, we would love to have more care coordination and health navigators; individual practices can have a medical assistant set up virtual rooming so the beneficiaries can be trained as super users so they can call the families and walk them through the steps. When the provider is ready to have the visit, they're not spending half of the visit trying to make the connection happen.

Nancy Netherland: I appreciate the idea of having multiple stakeholders in making these decisions. Something that is lost in policy discussions is what facilitates a developmentally appropriate experience for kids? I have kids of different ages, all with different medical complexities, and in some cases, telehealth has helped them open up to their providers more than being in a hospital setting, and in other cases not so much. There might be some richness gained from having consumers in this conversation. Telehealth has provided something that has been unexpected. When so much time is spent going to clinics, there is a lot of childhood that has been lost. When you have high utilizers with kids who have medical complexities, being able to free that time for childhood is impactful. I don't think there are any metrics to look at yet, but I'm really curious to see the impact long-term in terms of trauma load and also mental health wellness that's gained. I recognize that it's a small subpopulation, but I think there is a disproportionate number of kids with complex conditions on Medi-Cal, and it might be worth looking into.

Rene Mollow, DHCS: Thank you all. If you have additional comments or thoughts, please don't hesitate to contact us at MCHAP@dhcs.ca.gov.

Member Updates and Follow-Up

Norman Williams mentioned that DHCS will reach out to MCHAP members whose terms are expiring on December 31, 2020, to see if they are still willing to continue serving. Oath renewals will take place at the December 9 MCHAP meeting. Additionally, the panel must select a chairperson for 2021. A statement of interest and vision for the panel will be collected, and the December 9 meeting will include a formal action to vote and approve a chairperson for 2021.

Ellen Beck, M.D.: Director Lightbourne raised the idea of supporting families and the care of the child. I just want to reinforce that it's been a dream to be able to reimburse family therapy. For mental health services for pregnant women and postpartum, there were some issues about the funding being cut. I had also asked about the Song-Brown funding for family residency training in underserved communities. I realize it's not directly related to DHCS, but is there a response on what happened to that funding?

Will Lightbourne: The postpartum psychological services funding remained in the budget. The Song-Brown funding is related to OSHPD, but we will look it up and email the panel.

Ron DiLuigi: I wanted to take the opportunity to welcome Dr. Weiss to the panel. He is the one of the true thought leaders in pediatrics in Orange County.

Ken Hempstead, M.D.: We did want to mention that Liz Salazar suggested a few agenda items going forward. I think there's a lot of energy around virtual care, and I am particularly struck by the notion that we need more of that discussion, in particular more parent input. A continued discussion on virtual health may seem like a potential future agenda item, as well as continuing budget considerations and updates on the PHE. We've also been paying attention to gaps in delivery to care. I would personally point out currently missing from that discussion is overcoming health care disparities in terms of different racial disparities and the disenfranchised. There have been issues on school mental health issues as our children are struggling with the new normal and figuring out distance learning. Maybe by March 2021, we'll hear about CalAIM updates and the Preventive Services Report. If the Panel has additional considerations for agenda topics, you can always email ideas to MCHAP@dhcs.ca.gov.

Pam Sakamoto: An update in early March on how the pharmacy turnover to Magellan is going and if there are any problems.

Katrina Eagilen, D.D.S: I want to make sure the Panel has an opportunity to give advice on the Governor's Budget. Perhaps we can shift the meeting dates or add a new date after the proposed budget is released.

Ken Hempstead, M.D.: Part of the advantage of a virtual platform is that it does afford us some flexibility.

Will Lightbourne, DHCS: January 10 is the release of the Governor's proposed budget, and May 15 is the release of the May Revise. Between January 10 and May 15 is the legislative hearing period. Although there are hearings after May 15, it's a fairly fast process toward completion of the signed budget by the end of June.

Ken Hempstead, M.D.: At what point do we think is the best bang for the buck? We can decide later.

William Arroyo, M.D.: I would echo the comments made, and maybe we decide on a late January date.

Katrina Eagilen, D.D.S: This year we submitted our letter after the May Revise. I'm wondering if it would make sense to submit a letter earlier in the game.

Jan Schumann: I agree with those comments.

Ron DiLuigi: The reason we submitted the letter late in the game was because so much changed. If we have another situation like that where we have a lot of major changes at the end, then we'll want to provide comments sometime between March and June.

Ken Hempstead, M.D.: Certainly, we'll still have the March meeting. We just don't know what will change and what the situation on the ground will be. We can pick a tentative date at the end of January. We can come back to it at the December meeting.

Public Comment

Kelly Hardy, Children Now: Thank you for the meeting and DHCS' leadership. We're looking forward to the presentation on the children's Preventive Services Report and how the state will get us on track for making sure that kids get the care they need during this time. As we know, kids have not been getting preventive care at the levels they were in Medi-Cal pre-COVID-19. I want to echo one of the comments from Dr. Hempstead for more parent and youth input. It's so critical during this time, the unique knowledge that parents and youth have that we might not necessarily have insight into. Looking forward, a dive in the disparities in Medi-Cal services for different races and ethnicities for children may be a good topic for a future meeting. I want to thank Ms. Netherland for the focus on kids and their experiences; the lost childhood piece is such a critical piece for this Panel to focus on, the child's experience and what children are getting or not getting and the importance of getting it right quickly because a childhood doesn't last very long.

Susan McLearan, California Dental Hygienists' Association: I want to echo Kelly's comments about preventive care, and I'm hoping that dental preventive care is included in that report. I also want to echo her comments about the staff. You've done a wonderful job, and I see a real difference in dialogue. It's very positive and heartwarming in terms of our commitment to prevention and childhood caries. I hope to hear more in the future about child dental preventive care.