State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

December 8, 2022 – Hybrid Meeting

Meeting Minutes

Members Attending In Person: Ken Hempstead, M.D., Pediatrician Representative; Jan Schumann, Subscriber Representative; Nancy Netherland, Parent Representative; Karen Lauterbach, Nonprofit Clinic Representative.

Members 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; Stephanie Sonnenshine, Health Plan Representative; Katrina Eagilen, D.D.S., Licensed Practicing Dentist.

Members Not Attending: Kelly Motadel, M.D., County Public Health Provider Representative.

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

DHCS Staff – In person: Michelle Baass, Jeffrey Callison, Morgan Clair, and Clarissa Sampaga.

DHCS Staff – Virtually: Palav Babaria, M.D., Vivian Gerlach, Erika Cristo, Susan Philip, and Minerva Reyes.

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 September 15, 2022, was approved, 12-0. Administration of oaths was completed for four MCHAP members: Beck, Lauterbach, Schumann, and Weiss.

Opening Remarks from Michelle Baass, Director

Baass provided updates on federal legislation supporting mental health services (see slide 5)

Arroyo: Do you have updates on the federal omnibus bill?

Baass: No, I don't know the status.

Beck: Regarding Senate Bill (SB) 4306, can you tell us what Medicare support for peer support specialists will be?

Baass: I don't have those details as it's a pending federal bill. When it's passed, we will do an assessment.

Netherland: Can you please share the presentation from yesterday's Children and Youth Behavioral Health Initiative's webinar with the MCHAP as there is useful information on the new grants and evidence-based practices?

Baass: Related, DHCS recently issued a presentation on Medi-Cal Children's Initiatives, which is the complete picture of what DHCS is working on regarding children and youth.

Netherland: Can you provide an update on the concept paper?

Baass: With the release of the California Behavioral Health Community-Based Continuum Demonstration draft concept paper, DHCS intends to build on investments by pursuing a new Medicaid Section 1115 demonstration to expand access to and strengthen the continuum of mental health services for Medi-Cal members by focusing on three populations of focus (see page 12): children and youth (including those involved in child welfare), individuals living with serious mental illness (SMI) or serious emotional disturbance (SED) who are experiencing or at risk of homelessness, and individuals who are justice-involved living with SMI and SED. There are both statewide efforts and specific elements for counties opting in to participate. Public comments are due by January 13. DHCS will update the proposal based on feedback received.

Arroyo: One of my reservations with this proposal is the optional pieces, which might inadvertently create an incomplete continuum when comparing counties. Another area of concern is child welfare. Is the juvenile justice-involved population included?

Baass: Yes, it does apply to the juvenile justice-involved population.

Arroyo: It would be prudent for MCHAP to submit a formal comment on this proposal. The deadline is January 13. Perhaps a draft could be circulated so our voices could be heard.

Hempstead: Let us consider it, but I don't know how we could accomplish that in such a short time frame since it wasn't on the agenda. Maybe we can discuss further the specific proposed question during our break.

DiLuigi: Candidly, how is our progress on CalAIM?

Baass: We are conducting a listening tour to hear how things are going on the ground. People see the movements and new community-based organizations that are joining the Medi-Cal program through Community Supports. We'll need to work through implementation issues. That's why we're in the field hearing about different experiences.

DiLuigi: As we move forward, we hope to hear updates.

Sonnenshine: Is it possible to note the location of the proposal that Ron was discussing? If we're touching on various proposals that have been posted, it would be helpful to include those in the materials.

Schumann: Regarding outreach organizations, is there a direct path to access and any appeal rights for those seeking services provided through CalAIM through an organization, and if they are denied, is there an appeals process?

Baass: The plans are the organizers of these services under CalAIM. A family should contact their plan about what might be available because each plan is offering their own Community Supports, which was part of the proposal from the beginning.

Schumann: Is there a direct path of access?

Baass: They should go to their plan, which will make the connection. For children, the Enhanced Care Management (ECM) benefit does not go live until July 2023. Once the plan connects them to their ECM provider, that provider will help them navigate.

Netherland: I'd like more information about the continuous coverage workgroup. In terms of the waivers that need to be submitted, I'm wondering if we can revisit this early in 2023.

Baass: We have a lot of work that isn't going to start until 2025, so setting the expectation that we're not having these conversations tomorrow.

Netherland: I appreciate work being done on foster youth. At the next meeting, can there be a presentation on the foster youth concept paper?

Election of Chairperson

Dr. Weiss was the only member to express interest in the position and provided highlights from his vision statement.

The panel approved Dr. Weiss as Chair, 12-0.

Dashboard Discussion

Gerlach and Philip provided an update on DHCS' dashboards. Presentation slides are available here: https://www.dhcs.ca.gov/services/Documents/120822-MCHAP-presentation.pdf

Gerlach presented three behavioral health dashboards: Specialty Mental Health Services (SMHS) Performance, Centers for Medicare & Medicaid Services (CMS) Mental Health Measures, Mental Health Services Demographic Dashboards (AB 470), and the other dashboards. DHCS is committed to continuing to make data available, meaningful, useful, and easy to access for a variety of audiences.

Philip provided a quick update on ECM and Community Supports, with focus on building relationships and infrastructure.

Salazar: How do we make this system more transparent? As we discuss behavioral health (BH) services, substance use disorders (SUD) is carved out in implementation; there is an underutilization of services reported and gaps in services. What are your plans to elevate SUD utilization and bring it into the data dashboard?

Gerlach: Great questions that I'll take back to the team.

Weiss: As these dashboards were developed, who were the audiences in mind? Have you thought of any outcome metrics to determine efficacy? Do you view these as a population health tool or the point of care to drive changes in how care is delivered?

Gerlach: It's an evolution that we build over time for a broad general perspective. We are looking to hit these outcome measures specifically and very broadly, over time. We also want to evolve population health. In terms of point of care delivery, we'll need to defer to program partners on how to evolve and use the data.

Baass: For the population health management (PHM) strategy, we presented the service platform that we plan to launch, and that's where we want to use the data. These data will be available to the plans so they can view of all the Medi-Cal services provided and use the data to define and drive care.

Arroyo: This is directly related to our statutory responsibility, and it's difficult for us to advise DHCS without having good data and analytics. I really appreciate this because it will better inform our advising, and I look forward to having you come back once we look at it in further detail.

Beck: I'd like to hear more about current outcome measures and ones you're hoping to do, where you've identified gaps, the process for raising those gaps, and what data is rising to the surface.

Baass: Earlier this year, DHCS released the Comprehensive Quality Strategy (CQS), which has specific outcome measures for all of our delivery systems.

Beck: Are those measures visible in the dashboards?

Baass: The dashboards are really just presentations of the data. As we go through our CQS and we start reporting on those metrics, that will be available via another dashboard for plans, providers, and others

Netherland: I really appreciate seeing data by county and provider, as well as DHCS' responsiveness. With ECM, what are the populations of focus for youth, specifically recently incarcerated or juvenile justice-involved? Is it possible that we can capture numbers DHCS anticipates for those categories for additional needs and utilization by program, etc.? Also, I hope to see information from Dr. Riley on equity and access data for Medicaid.

Baass: Many are identified in the CQS. We have specific metrics related to some of the disparities.

Netherland: Maybe Palav could provide a refresher on the CQS as it impacts the new programs coming on board for CalAIM. There's a decline for all settings for specialty mental health services (SMHS). What happens to data when we see those types of trends? Will we see a decline in access?

Baass: We use the data to inform our policies and figure out what we must target in particular areas or regions.

Netherland: I recommend reviewing some of the highs/lows of that data outcomes for children and youth.

Philip: For the ECM request, the intent is to provide information by populations of focus. You'll see that in the fact sheet that we will release in a couple of weeks.

Schumann: In slide 19 about Medi-Cal enrollment, I noticed that in June, there were 126,000 new applications. Is there a way to integrate the disparity and the reasons why the number of applications don't match the number of enrollments? Are they pending citizenship or income verification? How many applications are pending? Also, what is the percentage and age breakdown of the children in the program and their families?

Baass: We can take that back.

Hempstead read Dr. Eagilen's concern on data lag within the dashboards.

Gerlach: Appreciate the feedback. We are aware of this issue and working to improve.

Arroyo: There are data related to patient satisfaction; can it be incorporated within one of the dashboards? Where do that data exist, relative to all the data that you are collecting?

Babaria: Annually, we conduct consumer satisfaction surveys (Consumer Assessment of Healthcare Providers and Systems (CAPHS)) across all delivery systems and have made policy changes. It is posted in the External Quality Review Organization (EQRO) technical reports. One of the major barriers to the CAHPS surveys are low response rates, resulting in numbers that are too small to publish. There are a number of strategies that we are exploring with our EQRO vendor to increase response rates.

California State Audit on Children's Preventive Services

Babaria provided an update on the California State Auditor's report and DHCS' efforts for quality improvement (QI). Slides are available here: https://www.dhcs.ca.gov/services/Documents/120822-MCHAP-presentation.pdf

Arroyo: Given that we know about ZIP codes and health outcomes, does your team deploy any specific strategies related to that in health plans?

Babaria: The short answer is yes, but we need to translate that into action and build out the Healthy Places Index into the dashboard to strategize and target the outreach and intervention in a more targeted way. We can do it at scale in a much more gradual way.

Dr. Weiss: Because of the data lag, by the time DHCS receives an audited result, it's likely that a managed care plan (MCP) is already working on their subsequent year's approach and showing improvement. Is that part of the QI approach?

Babaria: We must validate audited rates for enforcement and accountability, so that lag will always be there. Most of our MCPs will have current data, but it might not be finalized because of the claims lag.

Weiss: Can you elaborate on the technical assistance for quality improvement and what is available for MCPs?

Babaria: Our team meets with our MCPs to do annual performance improvement projects. We now also do regional calls where we will pull together teams across multiple MCPs in different regions. We will share our collaboration for well-child visits and analyze what has worked with that broader learning approach.

Weiss: It's a great opportunity for us to publicize and collaborate on that. Regarding a systems change, when a child is born within the first 30 to 60 days from birth, the child is attached to the mother's insurance. It is challenging to get claims related to well-child visits and immunizations that they have been given within those 60 days. Is there an opportunity to look at a systematic approach to how we can link those more efficiently and effectively at the state level?

Babaria: Yes. This has consistently been raised as a barrier in our infant learning well-child collaborative work. There are local best practices that we've found. There are plans that work directly with their hospitals to make sure the infant is enrolled and has their own Medi-Cal application in the works prior to discharge. There is a lot of work that needs to be done. There are policy opportunities to address this problem.

Beck: For provider trainings, I have found it beneficial to hear the voices of people on those trainings who have experienced challenges in order to get the attention of providers. Also, in the brochure you mentioned you were going to send out, the level of literacy, of course, is always an issue. In addition to having the brochure available online, it would be beneficial to have something in hand to see and hear.

Babaria: I appreciate the suggestions, and will send René Mollow and Pam Riley a note.

Lauterbach: I'm just wondering about the rationale and background of renaming the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

Babaria: More than a third of states have renamed EPSDT to something that is more user-friendly and focused on getting our message across. Many families may not know

what EPSDT stands for, so we are conducting user-testing. More to come as we get that direct feedback from our members.

Lauterbach: That's great since the initials don't really mean anything to me. For the provider trainings, have there been comments on administrative burden with the program?

Babaria: Yes, I would say there is a lot of administrative burden across health care for all providers. I'm not sure if we received feedback for EPSDT-specific burden but will take it back. In terms of training, we often post our provider manual about webinars and other opportunities.

Lauterbach: For the infant being linked to a mom's Medi-Cal, make sure you're looking at everything. We've seen situations where the baby was linked to managed care, but needed specialty care, creating a lot of barriers. We had to get them out of the plan because it wasn't quite complete care. We're happy to provide any of those details. We want innovation, but also to make sure you're getting all the details right.

Babaria: Yes, that's so important. Please email me any materials.

Arroyo: I was wondering if the recent report out of Ohio on 56 cases of measles gave your team any pause and compelled you to look at any data sets.

Babaria: I haven't been tracking that report. In terms of the CIS 10 combo that we do track, it's not hard for children to fall behind on, especially with flu vaccine. I'll take that back with our California Department of Public Health colleagues. Across every measure we're tracking, there has been a decline in 2020 and 2021 because of the pandemic, and if we don't aggressively catch up, I imagine more situations like this could arise.

Beck: If you had a magic wand and could put resources to where you feel the greatest need is, what could give the biggest and most effective change?

Babaria: I'm biased because I am a primary care provider, but what the pandemic reaffirmed to me is often what makes the difference between whether or not someone gets the health care they need and deserve: if they have a trusted relationship with a provider they see regularly. What else can we do in medicine? How do we think about investing in that system? Are we training enough to be in the communities that have language and cultural differences?

Beck: I'm so glad you raised that issue because so much data shows that behavior changes when there's a trusted relationship. I recommend looking into the idea of trust and looking at that as an initiative within MCPs.

Babaria: As we're thinking about measuring disparities and equity in health care, both at the state and national level, trust is something we're looking at capturing in our member experience. There is a California Health Interview Survey that we regularly review, showing disparities in Medi-Cal members vs other commercially insured populations.

Hempstead: As a pediatrician, vaccine confidence is a very thorny issue. It's difficult to find the county-by-county breakdown on some of the vaccine data. Are there ways of accessing the local ZIP code or county level data to better inform those discussions?

Babaria: The short answer is yes. Currently, the way we measure vaccinations is by looking at the administrative claims data and validation from plans, including hybrid measures that they submit to us annually. Everyone has the same barriers because of vaccine hesitancy. How do we figure it out and learn from it? I think the two opportunities for the future are: working on these dashboards and making them more publicly visible down to the county level, and our future promise of our data exchange framework for real-time data on all these measures, especially with vaccinations.

Hempstead: We need a control group to figure out what's happening county-by-county. A push for more county data on general vaccinations would be a worthy discussion.

Netherland: There seems to be a data lag regarding non-COVID vaccines. I think it's an important indicator and could be more readily available.

Hempstead: We understand that there is limited resources and difficulty in tracking information in real-time. Again, this particular subject has so many quickly changing variables as public trust changes. It would seem like a particular area to get more real-time data.

Netherland: CDPH is doing research to see how federally qualified health centers (FQHCs) can improve non-COVID vaccination rates.

Sonnenshine: Thank you, and this really just follows the line of conversation that others are raising. I'm thinking about the interventions that might be needed through health plans or other community partners that are so often directly related to the resources available in the communities. I encourage you to think about root causes of resource constraints in these areas where we're seeing kids having access to fewer services. I'm really struck by that idea of trust. We're seeing that there aren't many pediatricians in all of those communities. There is an opportunity to rely on this data to inform policy and funding.

Schumann: Is DHCS re-educating members on the efficiency of vaccinations? For example, are you releasing any annual renewal notices?

Babaria: We can take it back. As we did a deep dive on COVID vaccines, the member focus group testing at the state, federal, and local levels showed that mass messaging was ineffective; it was the community messengers that made a difference.

Hempstead: I couldn't agree more, and it all boils down to individual micro-communities and family-trusted providers.

Arroyo: How does one manage data with respect to homeless children? What are your challenges there?

Babaria: Homeless children are a specific population of focus as a part of our ECM program for CalAIM. There are many challenges. How do we identify these children? At the provider and plan levels, there are screenings that occur around housing status for all of our members and their families as one point of identification. We're working on building more robust referral pathways from other entities. As we start getting ECM data, that can help us increase identification and awareness of which children are suffering from homelessness or the risk of homelessness. Providers are reliably using z-codes, but that system is imperfect. As we fill out our PHM service, we are looking to link to statewide data for homelessness to identify children and better serve them.

Public Comments:

Angela Vasquez, The Children's Partnership: We appreciate the efforts that DHCS is making for children's preventive health services and QI. We strongly encourage DHCS to disaggregate their data findings by children and youth subgroups, 0-1 (infants), 2-3 (toddlers), 4-5 (pre-school-aged children). This would allow advocates and early childhood health professionals to find equitable and timely solutions for any gaps and needs for young children in California. We also agree with Dr. Arroyo's recommendation for geographical analyses, at minimum by county, but ideally, by ZIP code, would be essential to ensure equity across the state. With respect to the Medi-Cal mobile crisis service benefit, we encourage DHCS to include peer support specialists with certifications. We recommend DHCS county staff crisis lines for youth, ages 14-17, with experience, to work as hotline operators. With respect to standardizing the dispatch tools and procedures, DHCS should create two separate tools: one that's child and youth-specific and one that is tailored to adults, because children handle emotions differently than older youth. Lastly, we recommend clarifying how the mobile crisis team will ensure that the youth information will remain confidential when using a telehealth crisis tool in a public space.

Susan McLearan, California Dental Hygienists' Association (DHA): I want to thank you for your emphasis on publicly presenting data, but as dental care has been classified as one of the most common childhood diseases, DHA would like to see a printed audit document detailing concerns and efforts toward providing preventive dental care, including preventive dental visits, fluoride, and varnish and sealant application. If this isn't appropriate for DHCS, and perhaps it should be addressed to CDPH, we would appreciate that information.

Doug Major, O.D., California Children's Vision Now Coalition: I would like to present some quick claims data for children's vision care that is not yet accessible. In 2018, 580,000 children received exams; in 2019, 513,000 children received exams; in 2020, 340,000 children received exams; in 2021, 427,000 children received exams. This year, we are in line to be under 400,000, according to the Multi-Ethnic Pediatric Eye Disease study. This is the time to look at the vision issue. Here are some other numbers: the number of children in surveillance of metric in the system, currently 0; the number of children vision metrics in the dashboard, 0; the number of times that MCHAP has

provided agenda or vision care, 0. Providing access to the vision care is about equivalent to an adverse childhood event. As a person that, on alternate weeks, sees the children at school and then goes to the local county jail, these things are interconnected with behavioral health. I believe in the power of metrics, so let's get the metrics in the system and allow this problem to be fixed.

Premilla Banwait, UC Berkeley Optometry Clinic: I'm also emphasizing the importance that we start to share more insight on the state of vision care for students through data collection. This past fall, I took the liberty of providing vision screenings in public and private schools throughout Northern California. I could see the firsthand state of vision care and access to our students. I screened about 40 public and private schools ranging from pre-kindergarten to high school. At the age for 5 or 6, you could expect about 1 in 6 children needing eyewear, quickly increasing to 20 to 30 percent in middle school, and up to 40 percent in some districts for high school. When you go into the more special needs type classes or special-needs schools, you can see up to 50 percent of kids needing glasses. So, ultimately it is very evident that there is a huge disparity in eye care access when you compare more well-to-do districts, such as Orinda or Lafayette, to areas such as Oakland or Richmond. Additionally, I was able to speak to a large group of California school nurses recently about their input and vision care needs. They see firsthand how lack of vision care impacts academic success and mental health, as well as other things, but their hands are tied once they provide vision screening results to families, and they know how limited vision care resources is for children, especially on Medi-Cal. So, there is a lack of eye care providers that do provide eye care to children on Medi-Cal. There is up to a 4-to-6 month waitlist at UCSF currently. School nurses are going to be a key stakeholder in our improvement of this area.

Member Updates and Follow Up

Hempstead: I think we are all aware, as veterans of these meetings, that if you don't have it formally on the agenda, it's not realistic to schedule another meeting in between the holidays. You can forward your suggestions to DHCS. As always, we encourage everyone to provide individual commentary on the CalBH-CBC Demonstration concept paper; not speak for the panel. For upcoming meetings, it sounds like some occasional dashboard updates, an update on the CQS, and the foster benefits review.

Weiss: I just want to publicly thank you for your service and for the time, energy, and effort that you put forth in this. I know that you have a deep passion for children's care, and it comes through in your engagement in this committee. Even though I've only been with you for a little over a year, I really admire that and I know everyone on the panel thanks you for all that service. I wonder if there's an opportunity for this panel to be presented with some updates on what some of the dental and vision approaches are within the model. Then, my last suggestion is a potential opportunity to see if there's any way to do any comparison between the Whole Child Model, counties, and the standard CCS counties as it relates to quality outcomes, utilization, and satisfaction.

Arroyo: Ken, I too want to echo the comments about your leadership and your commitment to guiding this group. I echo the dashboard follow-up comment. There are reports that we are headed toward at least a $25 billion revenue shortfall for this coming year. That means that everyone's favorite programs are at risk, including many children's programs. This panel previously considered the budget related to all the kids' line items. I don't know if that should compel us to hold an extra meeting or a longer meeting, but I just want to raise it.

Lauterbach: I would like to hear any updates about the ending of the public health emergency. I am not sure where we are on that, and I know we have already heard great presentations about the Coverage Ambassador program, which I think is amazing. But I would like to hear little bit more about the county readiness.

Schumann: Second that.

Hempstead: We'll have a 60-day notice, and we'll be well into 2023. So, a good forward-thinking opportunity.

DiLuigi: Thanks again for just a superb job. I appreciate Bill's comment on the budget deficit we are facing. I think it reinforces the advocacy role that we, as a panel, take very seriously. In the past, we always had Dr. Pan as a champion, but since he has termed out, we need access to other members of the Legislature who are champions of this very important mission.

Netherland: I really want to thank you. I would like an update on the Child Health and Disability Prevention (CHDP) transition and formalizing of the workgroup. I also think it would be great to hear about the dyadic benefits, including rates. I would appreciate an update on ECM when those final populations of focus have been determined and when the rates are going to be reimbursed. Also, I would like an update on some of the new workforce allocations and designation with community health workers and peer-based workers.

Beck: Thanks to Dr. Hempstead. We should think about some of the gaps in psychiatric and dental care in some of the remote areas of the state. Also, how can we build provider trust, and what are strategies to build trust with community health workers? There are structural recommendations on how you improve trust. I still have concerns with literacy levels for certain populations, and sometimes I feel that DHCS' literacy levels for communication are still very high. I am grateful when DHCS brings programs or areas to us so we can have useful input. With community health workers, a number of us have a lot of experience working with that population. We need to limit the expectation of how many degrees are needed, but rather take into account their community life experience.

Schumann: We previously prioritized agenda topics by voting on which ones we found more important to address during the year. We should revisit this approach. As the PHE

begins to wind down, what is the capacity to handle member input and questions at the call center?

Eagilen: None of the programs that we are advocating for, or that we would like to see occur, are going to happen without the budget that we need in order to move forward. So, that is really something that needs to be at the top of our list. Additionally, we talked a little bit at some prior meetings about texting campaigns; it is a good way to consider tying that into the patient care lag. Dr. Babaria mentioned that sometimes the messenger is not listened to, but we must figure out ways to get the message across, maybe through some videos with trusted messengers or via texting. A few years back there was a big push regarding oral health, but I think it is time to circle back and look at the preventive measures. For the data lag, looking at information from 2015 and 2016 is not beneficial. We need to talk about a reasonable reporting time for data. Finally, Jan's idea about the possibility of voting on where our priorities are going to be makes sense.

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

Hempstead: I will just very quickly say, thank you for all of the very kind comments. It is a truly remarkable group, and I am not going anywhere, just to be clear. I also want to say thanks to Morgan and Jeffrey and the whole team. It has been an absolute pleasure to work with you. And thanks to the Director, of course, for actually coming to and attending these meetings. You can only imagine how many time constraints and prioritizations are happening in her world. So, your continued attendance is remarkable, and I think one of the greatest benefits of the work that we're doing here is knowing that we have you right here next to us. It is absolutely fantastic. So, thanks to the whole Department, and thank you everyone for being such wonderful panel members. I look forward to our continued work together in the next year. With that, I think we are adjourned. Happy holidays, everybody.