State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

December 9, 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: 38 members of the public attended the webinar.

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

Opening Remarks and Introductions

Ken Hempstead, M.D., MCHAP Chair, welcomed webinar participants.

Dr. Eagilen read the legislative charge for the advisory panel aloud. (See agenda for legislative charge.)

Jan Schumann: On page one, it references that it is a webinar, so how is it meeting minutes? If it could be consistent with the minutes and/or references webinar on page one?

Meeting minutes from October 14, 2020, were approved, 14-0.

Opening Remarks from Will Lightbourne, Director

Lightbourne welcomed Jeffrey Callison as the Office of Communications' new Assistant Deputy Director. Lightbourne administered the oath of office to four members, Elizabeth

Stanley Salazar, Diana Vega, Nancy Netherland, and Dr. Beck, to terms ending on December 31, 2023.

DHCS is preparing to work with federal officials and is already observing changes at the Centers for Medicare & Medicaid Services (CMS). Direct contacts with the Biden transition team are going through the Governor's Office. DHCS is in the final stages of budget development so we're unable to disclose any budget details. Broadly, the initiatives that we're committed to are also receiving support by the Administration. There are hard decisions that ultimately the Department of Finance and the Governor's Office will need to make. We look forward to updating the MCHAP once the Governor's proposed budget is released on January 8.

DHCS partners with the California Office of the Surgeon General (CA-OSG) on the Adverse Childhood Experiences (ACEs) initiative. DHCS and the CA-OSG released a Request for Proposal (RFP) for a second round of ACEs Aware grants focused on growing a robust network of care system to support Medi-Cal providers and their communities in effectively responding to ACEs.

Jacey Cooper, DHCS: There are no broad changes in terms of COVID-19 flexibilities since the last update we provided at the October MCHAP meeting. California has a model called Hospital at Home. CMS recently announced that this is an allowable model; Medicare and Medicaid providers can apply to receive this flexibility as long as they attest to meeting certain requirements. We continue to closely monitor the surge that's happening throughout the state and deploy our resources as necessary. We will explore the rollout of vaccines in the coming weeks and months to our Medi-Cal beneficiaries.

William Arroyo, M.D.: Are there any discussions of extending the public health emergency (PHE) once it ends in January?

Jacey Cooper, DHCS: No confirmation yet, but we anticipate that the PHE will be extended.

Ron DiLuigi: Do local county health departments not have enforcement authority? As we move into the current surge, it's imperative that we work together.

Jacey Cooper, DHCS: The California Department of Public Health (CDPH) oversees those guidelines, and I am not familiar with the obligations for the local public health departments.

Ellen Beck, M.D.: What is the process for having the public charge rules changed at the federal level?

Will Lightbourne, DHCS: This likely will be a priority, and certainly for California. Attorney General Becerra was leading legal action to try to undo the public charge rule.

Michael Weiss, M.D.: In Orange County, we are thankful recipients of the current ACEs Aware award. Our understanding is that the award is in place through June 30, 2021, but there's no guarantee of that continuing beyond the six-month period, correct?

Will Lightbourne, DHCS: Technically, yes. Under the existing budget, the funds that support it sunset in June. Because we're hopeful that there will be additional considerations by the Administration and the Legislature, we're asking proponents to develop approaches that can be meaningful in six months, but have the capacity to extend beyond if there's budget action that makes more funding available.

Alison Beier: For Los Angeles County, the annual redetermination process has continued. It's my understanding that during the PHE, Medi-Cal beneficiaries wouldn't lose coverage. Would beneficiaries be disqualified on the first day that the PHE ends?

Jacey Cooper, DHCS: No. We are working closely with our county partners for an unwinding of the PHE plan, especially around eligibility and enrollment. We will have a large number of beneficiaries that will need to be evaluated. Once we have a better understanding of what that unwinding plan looks like, we'll share it with the MCHAP and have Rene Mollow lead that discussion. We need to follow clear guidelines from CMS and are still receiving incremental guidance from them.

Karen Lauterbach: As DHCS is creating the phased plan, I recommend that you utilize the partners and community health plans to send out messaging.

William Arroyo, M.D.: What are the deadlines for the waiver submissions to CMS?

Jacey Cooper, DHCS: The 1115 extension is currently with CMS, which expires at the end of this year. We are working closely with CMS on the 12-month extension request; if we don't come to an agreement on that request before the end of the year, DHCS will submit a 30-day extension to finalize those negotiations. We will post the 1915b waiver renewal for public comment in spring 2021, which will include at least two public hearings. We are still working with CMS on the timelines, and can keep the MCHAP updated.

Liz Stanley Salazar: Much of the work in the renewals was originally aligned with the California Advancing and Innovating Medi-Cal (CalAIM) initiative. How do you see the goals being integrated into waiver application?

Jacey Cooper, DHCS: When the final budget is approved, any changes would be incorporated in our request in the spring.

Will Lightbourne, DHCS: The Governor has referred to CalAIM as a continuing goal for Medi-Cal reform in California.

Election of Chairperson for 2021

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

The panel approved Dr. Hempstead as Chair, 13-0.

Discussion of Public Health Emergency End – Draft Letter to DHCS Director

Liz Stanley Salazar: There has been tremendous flexibility during the PHE and DHCS has done an excellent job. We're also now seeing the impact of the pandemic and delivery of services (decreases in well-child visits, increases of emergency room visits). We asked for a six-month continuation or half of the original time of the PHE, but what is your advice on timing? What were we thinking when we put this together in terms of our own recommendation?

Ken Hempstead, M.D.: I defer to Jan as the author of this letter on the timing.

Jan Schumann: Six months was the starting point for MCHAP to discuss the term.

Liz Stanley Salazar: The reactivation to get DHCS and CDPH back on track will take a longer period.

Panel member Jan Schumann presented an overview of the letter.

Ken Hempstead, M.D.: Any DHCS reflections, and specifically for the six-months or half the PHE for waiver extensions?

Jacey Cooper, DHCS: At a minimum, three months has been DHCS' messaging, but six months would be better for unwinding. Effectively communicating to beneficiaries, providers, MCPs, and counties is important. It would be in line with DHCS' recommendation to Sec. Azar.

Liz Stanley Salazar: As we go forward, how will we review progress and outcomes in terms of keeping the relaxation of regulations and measuring the metrics? We need to track this.

Jacey Cooper, DHCS: We can engage in this discussion at future meetings, especially the COVID-19 data points for children. We've approved over 60 waivers and not all will continue after the PHE. Some of those flexibilities have been beneficial for our beneficiaries and providers, and we'll look at these in the future.

William Arroyo, M.D.: What is the tenor of the National Association of Medicaid Directors when making this request?

Jacey Cooper, DHCS: California and other states have advocated collectively to CMS. CMS isn't the only organization that makes that decision; it is the President and Secretary of Health and Human Services (HHS) who ultimately make the decision of the PHE end. We've provided clear examples of how it impacts the states and the work needed to unwind. It wouldn't hurt for HHS to hear from groups in regards to how important that is to ensure that we unwind from the PHE in the best possible way, and that we know in advance when the PHE ends so we can plan accordingly.

Ellen Beck, M.D.: Thanks, Jan, and group. I think we should say a minimum of six months, or six to 12 months given the recent surge in cases. For children and families there are consequences of having had this illness. What would be the mechanism of coverage for those children? We also need to allow time to have a plan for how beneficiaries will continue to receive coverage or modified coverage and connect with community partners.

Ken Hempstead, M.D: The six to 12 months extension request is a separate issue. What we're focused on is once the PHE is declared over, how many months are we suggesting for the unwinding process?

Ellen Beck, M.D.: Maybe I misunderstood. I thought that in the letter, we were being asked what should be the timing of the PHE extension?

*Jacey Cooper, DHC*S: In case this helps the panel, DHCS' messaging requested prior notice for when the PHE would end. In federal law when the PHE ends, certain flexibilities are triggered immediately, at the end of a month, or at the end of the quarter. What DHCS has requested is prior notice; we've been told about PHE continuations a few days before expiration. If they didn't communicate the PHE end in advance, that wouldn't allow enough time for an unwind. For example, if the PHE is slated to end at the end of January, we are assuming there will be another 90-day extension to get us through to April. DHCS is advocating for prior notice of six months. That would allow us proper planning time to still keep the flexibilities under the declared PHE.

Mike Weiss, M.D.: The enrollment issues are very important, but we also have an opportunity to include telehealth. Some of the waivers around telehealth have shown advance access and I think we need to focus on this, and it's not specifically called out in this letter. The request to consider ongoing waivers around some of the telehealth regulations would be in scope for this letter. With respect to the six months, I don't know that it applies to telehealth. Telehealth has been well received and has advanced access to care, and that should not go away. We should support continuation of telehealth.

Ron DiLuigi: It sounds like we should go for a longer timeframe, such as 12 months.

Mike Weiss, M.D.: We should use the valuation of efficacy for next steps.

Katrina Eagilen, D.D.S: What is the specific definition of the PHE end? Are we looking at levels of infection and reinfection rates and a specific period? It just seems that we don't know how long it will take for the population to be vaccinated and whether it will continue to spread.

Jacey Cooper, DHCS: DHCS does not set those parameters, or parameters that are clearly articulated in federal law. There's a lot of discretion for the President and the HHS Secretary to make decisions around when the PHE is declared and continued. If there are things that MCHAP should be considering for the continuation of the PHE, you can include those in your letter. However, the federal law is quite vague and flexible in

order to meet the needs of the President and HHS Secretary as they assess facts and make decisions.

Ken Hempstead, M.D.: Jan, can you clarify? I'm concerned that we're conflating the length of the PHE, versus your letter, which is recommending the continuation of flexibilities beyond the conclusion of the currently declared PHE for at least six months. The specific intent of the letter was dealing with once the PHE ends, correct?

Jan Schumann: Yes. The PHE is declared pursuant to section 319 of the Public Health Service Act. It is broadly defined there. The motion on the table is to revise it to at least 12 months or equal to the period of the exact number of days of the current PHE.

Jacey Cooper, DHCS: Again, I would just flag for the purposes of providing technical assistance, once the PHE ends, you lose the federal waiver flexibilities that DHCS has. I just want to make sure that the members are understanding that. Under federal law, it immediately will trigger certain things as I previously mentioned, unless there's a change in federal law. It is the extension of the federal PHE, which retains our ability to plan, communicate, and continue those flexibilities until which time the PHE ends. They carry two different weights and mean two different things. I just want to make sure that I'm providing the technical assistance you need and understanding how the PHE is tied to the flexibilities. They essentially end when the PHE ends.

Ron DiLuigi: It seems to suggest that longer is better? Is there a downside to us asking for a year?

Jacey Cooper, DHCS: Not necessarily. It makes sense to ensure that there's additional evaluation and putting plans into place.

Ken Hempstead, M.D.: If we extend it for too long of a period, it becomes a certain argument that we're taking away resources from others who need it.

William Arroyo, M.D.: I recommend that we continue with the original intent of letter. However, I would suggest that the last paragraph be expanded to include activities that Jacey mentioned so it's clear to the reader of the letter that there are a myriad of practices that states must implement in order to prepare for the federal law post-COVID-19.

Ken Hempstead, M.D.: So we're trying to understand the "why"? Why we would need additional time?

William Arroyo, M.D.: The last paragraph should include the practices that Jacey mentioned. That's the only detail missing from this letter. In so far as the definition of PHE is concerned, that's a whole different request and goes beyond the purview of this group, but maybe something we should tackle later.

Ken Hempstead, M.D.: I want to be mindful of time. Our process is to take the feedback from the panel, and in terms of the future, we can vote on an action that the Chair and DHCS can work together to produce the letter through final editing. We should clarify

the timing issue. I personally think the way that it is currently written is fine, and I would suggest that we leave it as written.

Jan Schumann: Can we do a hand vote for six months or 12 months?

Will Lightbourne, DHCS: We should do two roll call votes: the first will ask for six or 12 months and then a second roll to confirm the preferred position.

Ken Hempstead, M.D.: By voting for six months, you would be voting for the current verbiage in the letter. By voting 12 months, we would change to, "for at least 12 months or equal to the total days". We are just simply looking at what that number is and the rest of the verbiage would remain.

12 members voted for six months and three members voted for 12 months.

Jan Schumann: I make a motion to remove the watermark, incorporate the suggestions made during the public meeting, record it in the minutes, include the final vote, and authorize execution by the Chair to finalize the letter.

Alison Beier: May I request more clarification? I thought that Dr. Hempstead said that we would agree on the nuts and bolts, and then we could tweak it. Then Jan said we would send it as is? Are we voting on sending it as is?

Jan Schumann: No, I said remove the watermark and incorporate the changes made during the public meeting.

14 aye votes were recorded.

Ken Hempstead, M.D.: I do want to thank Jan. This was an important action that was taken.

Telehealth Discussion with Focus on Beneficiary Experience

Presentation slides are available on the DHCS website.

Rene Mollow, DHCS: Glad to provide a continued update on telehealth. Today's intent is to have a facilitated discussion with the MCHAP members in terms of the telehealth policy. I previously presented at the October MCHAP meeting on the work that DHCS has done pre-COVID-19 and during, and that we are doing an internal review and analysis of the next steps for telehealth post-COVID-19. During the COVID-19 PHE, DHCS and the federal government, via blanket waivers, implemented broad flexibilities relative to telehealth modalities, which enabled Medi-Cal's delivery systems to adjust to meet the health needs of our beneficiaries and reduce risk of potential exposure. As I indicated in my last presentation, we're also completing work to evaluate what flexibilities will continue post-COVID-19. There are questions on slide 17 that I would like to open up for member discussion.

Nancy Netherland: I'm a parent to children with complex and chronic health conditions. Some of the pros I see with telehealth modalities is the travel and cycle times for waiting

for appointments. These can be prohibitive and interfere with my child being able to go to school and taking part in their childhood. I presented data for a recent Family Voices of California meeting. We're saving up to 10 hours a week on travel and cycle time. My child can often wait up to two hours for appointments. Being in a setting that doesn't cause stress or retrigger medical trauma has been helpful. There are barriers: I'm well-wired and can use technology, and am not worried about people seeing my house when I'm on camera. Our experience generally has been very positive and I see my child engaging more directly with those providers in her visits than when we're in the clinic.

Ellen Beck, M.D.: We've had an incredibly positive experience in terms of using telehealth. We work with a very underserved population that often live in fear, and have limited transportation and literacy issues. Our visit attendance rate has gone up. We recently released a satisfaction survey, and I can share data via email. People are very satisfied. What has been very successful for us is having a patient navigator around for the technical support – Zoom, telephone, etc. – and having sufficient Wi-Fi access while teaching people how to use it to get online and stay online.

Liz Stanley Salazar: In your presentation, these new standards would be applied to providers or services. In DHCS' analysis, how does that apply to a Drug Medi-Cal (DMC) setting where the clinics are certified, not providers? Is DHCS applying the same flexibilities to that process?

Rene Mollow, DHCS: We are.

Jacey Cooper, DHCS: Just flagging that there's already extensive flexibility for DMC-Organized Delivery System (ODS) around telehealth that existed prior to the PHE. We're still evaluating across all specialty DMC and DMC-ODS for equity.

Liz Stanley Salazar: I agree with Dr. Beck about the need for technical support. There are so many equity elements that can be serious if we're not collecting this information and knowing who is able to access the services. In the SUD system, there was a tremendous amount of flexibility to use telehealth pre-PHE, but yet it was not used. Because of COVID-19, the provider network and counties pivoted to support telehealth. What was missing was the technical support in the actual practice of telehealth. We have to help providers build the capacity. There's a tremendous amount of success in individual work, so it's made a huge difference for counselors and navigators, individuals, teams, and younger children to connect to services through the individual approach. We haven't unlocked good group work in the telehealth space. The biggest issue that I see is the huge digital gap and not having access. There's also a huge privacy gap for youth. Many individuals did not want to use their phones, or had to compete with siblings or parents for access to those tools. Even with telephone work, there are privacy issues.

Rene Mollow, DHCS: With some of those issues, have you found any best practices to employ in that space?

Liz Stanley Salazar: Yes, with outreach and education. Our grantees pivoted to social media and used it to engage and bring in participants. They were able to reach and provide services on an individual basis. Interestingly enough, they were able to work effectively through school sites and work with providers to link with parents to help navigate children in services they needed. The group work is an area where we need content support. To Nancy's point, removing transportation barriers for youth and teens has increased access and participation.

Jovan Jacobs, Ed.D: For our school district, we have over 40,000 students and had to move to distance learning and telehealth. Within our special education department, we had many students receiving speech and language services, mental health services, and counseling. We did see the digital divide at the beginning. Our district was committed to providing each child with hotspots. There is some need for in-person services still.

Nancy Netherland: There are some successful online group programs for teens through UCSF. It's not ideal, but they're finding ways to find privacy for the youth in those programs. It would be helpful if someone could capture successful things happening in Medi-Cal for kids who need the services. The possibility for replication is huge.

Ellen Beck, M.D.: From a best practices point of view, having a funding stream for support is necessary, especially for underserved communities. We need to very clearly establish privacy with the physician or health professional reinforcing that. For group settings, we'll mail supplies for an online activity that can be worked on collectively.

Terrie Stanley: Prior to the PHE, the process to do telehealth was expensive for a practice site, including the equipment needed. Opening it up to other modalities has given so many more providers the ability to do telehealth on platforms they haven't used on a regular basis. If we rolled it back, it would be very difficult for providers to do telehealth.

Rene Mollow, DHCS: Can you speak more to those platforms? As we think about the policies that we had pre-COVID, they were quite robust. What I heard from the MCHAP today and at the previous meeting, telehealth just wasn't used a lot. Now we're forced to use telehealth because of the PHE. What was the one thing that you believe changed during the PHE that you believe was not in place prior to the PHE?

Terrie Stanley: Prior to the PHE, I don't believe platforms like Zoom were allowed. Zoom has really made a difference for providers.

Jacey Cooper, DHCS: That was waived under the PHE by the federal Office of Civil Rights (OCR) to allow providers to use that modality for telehealth. Our understanding is that OCR would have to change flexibility in that regard for it to continue beyond the PHE; that's not a choice DHCS can make. We have advocated for the OCR to reevaluate HIPAA requirements around telehealth services. I just want to make sure this group is tracking requirements that DHCS has the ability to implement through our State

Plan Amendment (SPA) versus through federal laws that we will still need to maintain after the PHE ends.

Terrie Stanley: That's one of the things we could help advocate for. If these policies are removed, we'll go back pre-PHE levels because of the complexities to do telehealth. Can this be requested within the waiver?

Ellen Beck, M.D.: What can we do as a panel? Thirty-four percent of our patients are doing telehealth via Zoom. If we don't have Zoom, we will not be able to provide telehealth to our patients. Jacey, how can we support this effort? Through a letter or providing input to DHCS?

Jacey Cooper, DHCS: It's complicated because of where the authority lies at the federal level with OCR. We tried advocating and having conversations with CMS, but they have deferred to their OCR colleagues. We've asked provider associations to get us information about the percentage or number of providers using HIPAA-compliant software in services; the majority are saying they are on HIPAA-compliant platforms. We are trying to understand this more, so this feedback is good for us to hear. The modalities is something we've raised in most of our telehealth meetings. I just want to ensure that this group is tracking where the waiver flexibilities have come from. We will continue to advocate for these pieces, as well as protecting the beneficiary's rights and privacy, and making sure the platforms can meet the level of security. You will likely see a number of platforms come up that are compliant with federal law to make it easier for providers to utilize them.

Mike Weiss, M.D.: I agree with everything that has been said. For clarity, there is a HIPAA-compliant medical Zoom that is safe to use and fairly common. We have a responsibility to ensure that we have a secure system going forward. Most important components of the current relaxation of the regulations are the location of the provider and the parity of reimbursement. This is all about access, so I think allowing doctors to perform this at home, allowing patients to be in any location and not having to be in a clinic setting, and parity of reimbursement is important. We also need quality metrics to measure clinical quality so that we can demonstrate to those writing the checks that the care being delivered is equal to or better than the care being delivered today.

Jacey Cooper, DHCS: DHCS is looking closely at how to ensure continued quality for the expanded access. Telehealth services grew so rapidly that we need to ensure that we are maintaining quality of care through those practices. When you mentioned that there wasn't payment parity before, could you provide more information? DHCS' policy was payment parity between state-to-state and synchronous telehealth services. Could you clarify if you were saying payment parity beyond that, or is that the requirement in fee-for-service? Are there other modalities in which you are advocating for parity?

Mike Weiss, M.D.: It's fairly specific to our region in that we have a lot of delegated models and managed care. It can be a Medi-Cal-covered benefit and it can be parity at that level, but if the Independent Practice Association requires an authorization and

approval for the visit. If they set up their own criteria that is independent of DHCS'; that can be a challenge. They may mandate a face-to-face. In a managed care environment, there's that added layer of complexity, which is some of the parity to which I'm alluding. The MCPs shouldn't have a different set of rules than the FFS plan.

Diana Vega: Do we have any data on patients who are not accessing telehealth because of access issues? And if there are issues, what is being done to support them? What are we doing for mental health emergencies, especially in teens, during the PHE? Many teens are feeling disengaged, especially in families with multiple kids or parents who are working from home, and may not feel comfortable sharing their issues.

Rene Mollow, DHCS: We wouldn't necessarily have that data because we don't have a formal way of accessing the extent to which telehealth was offered and someone didn't use it. We need to know from our providers what modality was used. Something to think through in the future is how to glean more information in terms of a beneficiary experience. Our policies both pre and during the PHE have been about patient choice, but we do recognize that there may be limitations in terms of the practice, and if they have those capabilities or not.

Jacey Cooper, DHCS: We extended all the same flexibilities to mental health delivery systems. We put in flexibilities for when children or adults go into crisis and how that's handled during the PHE. We received a large grant from SAMHSA and FEMA for a statewide crisis response called CalHOPE. A portion of that grant included working on children's mental health services. We can provide the panel with additional information on how that will roll out in the next few weeks. Between the stay at home and school closures, we are very attuned to some of the growing behavioral and mental health concerns in children and youth. We are working closely with our public health colleagues as well as within DHCS to ensure children, especially when they are home and not in schools, can continue to get the services or have someone's eyes on them flagging personality changes. Your point is well taken and we're trying to think through different ways we can deploy through CalHOPE crisis intervention. The duration of PHE has strained that particular area in ways we've never experienced before. We saw somewhat of a mental health crisis even before PHE, in regards to increase in MH hospitalizations for people under age 21. Access to mental health services is a priority of DHCS.

Diana Vega: Are you collaborating with school districts? If a child is having a mental health crisis, who should they go to?

Jacey Cooper, DHCS: Normally schools would be a touch, but right now it's more difficult. If a child in Medi-Cal needs mental health services, the parent or caregiver should immediately reach out. In Medi-Cal, we have a no-authorization requirement for mental health services, especially for lower-level services. For higher-level services, assessments are needed. For the non-specialty mental health side (anxiety and depression), we're seeing higher utilization of those services in 2020. We're also

working on outreach. If there is a crisis, they would need to work with the county behavioral health department if they're enrolled in Medi-Cal. The local touch points are available on the DHCS website; the plans and/or county access points are slightly different depending on where you live. We're seeing significant increases in telehealth for behavioral health services in both individuals and group counseling during the PHE.

Nancy Netherland: Can you say more about the no-authorization piece?

Jacey Cooper, DHCS: Payment parity rolled out for Medicaid mental health services in 2018. For the mild-to-moderate services, you should have access to the behavioral health visits. Then once you have a treatment plan, it may require ongoing authorization based on the providers' recommendations. There should be no barriers for the initial visit and having access to the assessment for the mental health treatment plan.

Nancy Netherland: Is that true for the carve-out for former foster youth? That has not been my experience. There have been mandates for authorization for assessment for mild-to-moderate.

Jacey Cooper, DHCS: You can send that to us offline. It depends on the time for which those assessments took place and whether the parity requirements were in place. The requirement came out in 2018 and rolled out to the MCP and mental health plans contract in 2019.

Nancy Netherland: It would be helpful to have the specifics for the rule. The more policy-based information we have would be helpful to educate our communities and systems of care.

Jacey Cooper, DHCS: The Mental Health Parity Final Rule is available on the DHCS website.

William Arroyo, M.D.: There has been an issue related to same-day mental health visits versus a general health visit. In those cases in which there may be a crisis, is there any flexibility during the PHE in regard to getting physical or mental health services from a FQHC?

Jacey Cooper, DHCS: No changes to that during the PHE.

William Arroyo, M.D.: That would make it challenging for families who have a working relationship with FQHCs, where there is a mental health professional. That would be a disincentive for FQHCs to provide the mental health crisis visit.

Liz Stanley Salazar: There is an administrative, funding, and care coordination silo that exists between the specialty mental health and substance use for the FQHCs. There is a huge chasm that exists in some situations where the individual needs to have more care coordination, especially for medication assisted treatment. I will send you something to outline the issue as it's rolling out in the community.

Karen Lauterbach: Thank you for looking at this from the beneficiary perspective. We've done both a patient survey and our telehealth visits platform does a net promoter score. I can share these. Beneficiaries are very happy with these services, especially in the pediatric population where we can provide some services and have people come in for a quicker service like vaccines. Most of our families, if coming in for health care, are potentially looking at losing work for the day and it can be quite cumbersome for them. In terms of our teams in telehealth, we are seeing a bigger uptake in behavioral health services. We have a school program and we've seen those numbers increase. Some of the things those teens are saying is that there's less stigma because of the way they can access it via a phone and it's easier. For telehealth, you can be more mobile if you're doing it on the phone and find different places for privacy. Our platform can be used with free phones; a minimum barrier is that we wouldn't participate in anything they couldn't use with their phones. And if you have Medi-Cal, you automatically qualify to get them.

Jan Schumann: As Karen mentioned, my child can step out of class to attend a telehealth session. Telehealth visits are a convenient way to allow a teenager to continue with their day, and allow parents to jump on the telehealth visit when needed to address medical needs.

Rene Mollow, DHCS: I appreciate the time and interest that the Panel has taken on this discussion. I look forward to our ongoing engagement. In the interim, if there is any information, data, or studies, please send those to us.

Gaps in Coverage Due to COVID-19

Jacey Cooper, DHCS: As DHCS has been reporting since May 2020, we have seen a significant decrease in well-child visits taking place across the state. We have large decreases compared to previous years of immunizations because they typically take place at the well-child visit. The PHE has had a significant impact on the delivery system. During summer months, we encouraged beneficiaries to reengage in their health care. Based on our data, it can take up to six months to get more complete encounter data. Now that we're approaching the six months, we are seeing that children have a lot lower utilization of telehealth visits than we are seeing in adults. There are a number of factors in this, including some clinics issuing rules regarding in-person visits (you can only bring yourself and the child who is coming for the visit instead of the whole family). This has hindered some families from seeking well-child visits. We also know that some providers have encouraged beneficiaries to come in to visits because it's an important check for signs of abuse or neglect. What are you hearing about beneficiaries reengaging in normal health care (well-child visits, immunizations, etc.)? Once we are in 2021, how can we mobilize community-based organizations, providers, and various associations to get the word out to reengage families into regular health care services and start closing the gaps?

Ellen Beck, M.D.: I would add dental health. Families may not think that dentists are available. The effort that dental offices have gone through to provide care in a very safe way might be something that Medi-Cal may want to remind beneficiaries of and promote.

Jacey Cooper, DHCS: Thank you for that reminder. We've seen a big decrease in dental service utilization statewide during the PHE.

Karen Lauterbach: For vaccinations, we have found that we need to make it as quick as possible, such as registering beforehand. Can you provide us with the data? If we knew vaccinations were down by 10 percent or more, that would resonate with providers and families. There are messages that we can develop around this and help promote the importance on social media. What's resonated with our patients is an acknowledgment that we are in a pandemic, but it doesn't mean we should discontinue care.

Jacey Cooper, DHCS: We are working to get data out. The last data that I've seen was the 40 percent immunization drop, and I know it has since improved. CDPH has put together a toolkit on this. We also developed messaging for our managed care plans; I will see if these are available for sharing.

Alison Beier: We did receive the LA Care Health Plan package, which I assume is part of the rollout that you just did. It's phenomenal. We also received a notice from our private insurance offering a gift card if I take my daughter in for an annual visit. Even with the information provided by the health plan and the $25 gift card, I still haven't taken her in for a visit.

Jacey Cooper, DHCS: I appreciate your honesty. Those are the things we need to hear. It's good that the tools we're putting together are helpful for your family.

Liz Stanley Salazar: California's health care delivery system is so complex, and there are so many access points. I would like to see the plans send materials with an envelope stuffer explaining how and when to split off to the 24/7 access line, and when to use the substance use delivery access line. The carve-outs present particular problems to the general public and to the MH/SUD community about how to access that. If we can get basic contact information out from a centralized point, that would make more sense. It would also destigmatize mental health and substance use disorder if it came from the health side of the house.

Jacey Cooper, DHCS: Our delivery system is complicated so your feedback is important.

Mike Weiss, M.D.: Is there an opportunity to relax regulation around Vaccines For Children to allow nontraditional sites to provide vaccinations and to help fund additional storage of vaccines? Schools may not have refrigerators.

Jacey Cooper, DHCS: We have been considering this and maximizing our footprint for vaccinations for children statewide. We've been partnering with CDPH.

Karen Lauterbach: We have a platform called CareMessage that sends text messages. We can use our data to determine who needs vaccinations and specifically message the families and track the response rates. The more we can share best practices is helpful.

Ken Hempstead, M.D.: Anything we can do to educate and reassure the public, but also apply visual tools for engagement. Can we have people waiting in their cars instead of a waiting room? Can we have drive-through facilities? Safety and convenience are incredibly important. Even post-PHE, why are we having kids missing half a day of school to attend appointments instead of a telehealth visit? My long-term goal is figuring out how to leverage our existing infrastructure to better support telehealth visits. Perhaps there could be a physical space within the school with Wi-Fi and a phone to access their care privately? Similarly, is there any way to leverage existing infrastructure of the FQHCs? Maybe a person experiencing homelessness may not have a smart phone, but they know where the clinic is located. If they need other specialty care or need to access a remote location for care, how can we leverage those? The long-term possibilities are endless.

Structural Racism in Health Care Delivery System and Outcomes

Presentation slides are available on the DHCS website.

Director Lightbourne framed the topic. Within the Administration, we're conscious that we're at a pivotal moment as we reflect on how our broad health, social care, economic, and justice systems operate and interact. The fact that we have very disparate outcomes for different racial groups isn't a matter of racial disparity in the sense of there is something about the race that is producing a different outcome; it is that there are structural forces at play. At DHCS, we need to focus on things that we have the means to do things about. We influence the economic and justice institutions of the state.

COVID-19 has made disparities very visible. Population data obscures some of the impact. However, when we review the mortality rates per 100,000 from COVID-19 by race/ethnicity, it shows a stark picture. What are the levers that we have that can change these outcomes? What are the systemic and structural factors that we think contribute to these racialized outcomes? From previous stakeholder group meetings, people have identified a number of factors: fragmentation of the system, a clinical view of the health care system, exclusion of social determinants, and a disconnect between the workforce and the consumer base it serves.

DHCS has collected a lot of data, but has done relatively little with it. We need to construct the delivery system with an eye to those who are having difficulties accessing it right now. Looking to the things that are reachable for the health care delivery system, are there ideas or things that we can bring into place that would have the same structural improvement for communities that are poorly served by our system? Have we constructed the system that is more appropriate for a population other than the one that we're covering?

I doubt there are any easy answers to this. We discussed at other stakeholder groups what are the things that we think contribute to the inequitable outcomes that exist, and what can we do about those things (how we construct, fund, measure, or oversee the system), what are those things that can change the outcomes? This is a very long conversation, but I wanted to put it on the panel's radar and embed it in all of our conversations going forward.

William Arroyo, M.D.: This is incredibly fundamental. Is there a unit within DHCS that is charged with ensuring that health disparities are eliminated? Is there an effort to adopt what is commonly referred to as an anti-racist framework in reviewing every new regulation that is being considered by DHCS to identify exactly which populations would be adversely impacted by a new policy?

Will Lightbourne, M.D.: The Strategic Growth Council, which is a cabinet-level function, has declared dealing with racial inequities as a priority. The Governor has said it is one of his five priorities. Within the Health and Human Services Agency, CDPH has the Health Equity Office, which has been in existence for about six years or longer. Department of Social Services created a branch to oversee equity. For DHCS, at this point it's me. We're at the stage where we're trying to drive a conversation. The Legislature has been much more sensitive to this issue. The difficulty is not in producing more policies that have racist outcomes, but to look back at the underlying construction of the institutions we've built over the decades and say in what ways do they need to refocus. That's where the real resource base is. When we think about the $114 billion budget, how should it be focused and restructured?

Ellen Beck, M.D.: Thank you for the openness to look structurally and systematically at statewide change. In terms of several areas from a health care point of view in working with disenfranchised populations:

1. We need trust bridges and a truly community-centered, patient driven service, such as a promotora, or a trusted person in the neighborhood who can facilitate the care. It can also be a formerly homeless person or peer educator.
2. Health professional training. We need to look at the data that proves racial inequity and how people are treated.
3. The income disparities and bias, and placing resources in neighborhoods, strengthening where they go for care and how to place services where people already gather either in a social or religious setting. We're too provider-driven and not patient-driven.

Mike Weiss, M.D.: I applaud exactly what you've said. This is also about care model design. There's not one answer, but multiple answers. It's policy, legislative, and programmatic change. There needs to be a fundamental change in how we deliver care at the point of care.

Liz Stanley Salazar: I want to echo these thoughts. There are so many elements of this. There was so much direct community input 30 years ago that has more or less

disappeared. The community voice has been lost, and we need to reinstate and align with our decision makers' voice. We control what data we collect, how we analyze the data, what we prioritize, and what we do with it. We need to look at how the data is collected, and particularly the algorithms. Technology and tools can create barriers to social and racial equity and justice if in fact they're measuring the wrong things. You mentioned workforce, which is critical. One of the major steps we can take is to have enough conversations in our state and county to align our principles of what our values are for the health care delivery system. If we learned anything from this PHE, it's how important a common, strategic, value-driven messaging is to create an environment where change can occur.

Katrina Eagilen, D.D.S: California can be a leader and has always been ahead of the curve in terms of trying to move the needle. We need to accommodate the population that we're serving. As an African American provider, that's something that has always been near and dear to my heart, whether I was serving individuals that look like me or people who looked differently, always trying to take the extra step to accommodate that particular population. From a Medi-Cal perspective, so much can be done. Some of the easy drivers are to look at outcome-driven care, to provide incentives for patient success in terms of what treatments were administered and whether the actions were successful and then provide incentives to the providers. Also to provide fair reimbursements. Once again, Medicaid reimbursements automatically stigmatizes the patient. We should take that out of the equation; if there was a fair reimbursement for the treatment that's being performed, that will help. We need to have parity among the patient population, and the nationality and ethnicity of the provider. We talked about going into the community and meeting patients where they are. We're dealing with patients who may not have the resources, so we have to take extra steps and measures. We need to look at school-based programs where the access is so much easier to receive the care they need. If we take everyone's ideas, collectively we can come up with some ideal answers.

Ken Hempstead, M.D.: I'm thrilled to see the traction that this is getting with the group. I would suggest that we plan for this to be a prominent part of a future MCHAP meeting because there's clearly more discussion to be had. I would be curious to hear about what the other stakeholder groups have talked to DHCS about in terms of what the barriers are and where the solutions might be as next steps. The data already seems given.

Member Updates and Follow Up

Jan Schumann: Dr. Weiss mentioned an issue regarding the telehealth waiver that DHCS would run by OCR, and if this Panel would like to pick it up as a future item.

Mike Weiss, M.D.: It's extremely important that this Panel endorse where we believe the direction of telehealth should go in the Medi-Cal system. More research and opportunities are needed to help move this conversation.

Alison Beier: I would like to put racial disparities in the health care delivery systems back on the agenda, with the intention of setting a date and taking action on it.

Ken Hempstead, M.D.: We have the proposed time on January 26 for our next meeting. Our original intent was to address the emerging budget issues. It's difficult to predict where we'll be, but we'll know more after January 10. We'll have about five days after the budget is released on how much discussion needs to be had and what the timing will look like. It may be there's a lot that we'll want to review and digest, and then come back to it at our March meeting. We have flexibility.

William Arroyo, M.D.: The budget is always critical, and we should have at least a brief glimpse of the Governor's proposed budget, even if the preparation time leaves something to be desired. I think the structural racism discussion is critical, as much as the budget discussion. I endorse having both discussions on the January agenda.

Katrina Eagilen, D.D.S: I agree with Dr. Arroyo.

Ron DiLuigi: I also agree with Dr. Arroyo. Our action to add an additional meeting will give us more flexibility. We'll need to lean on DHCS in terms of budget process. Perhaps we get the quick overview in January. I defer to DHCS to think about moving the lion's share of budget discussion to a later date and filling in other items. I was pleased to hear the discussions this morning from this group, and particularly from the providers. DHCS should use their own best judgment for who they can depend on, whether it's the county or local health plan, and if they need to look elsewhere.

Ellen Beck, M.D.: I would like to suggest that if the Panel has a specific question about the budget, it might be helpful to email those in advance to MCHAP@dhcs.ca.gov.

Ken Hempstead, M.D.: Let's hold the full time for the January 26 MCHAP meeting. Please make a note that the March and September MCHAP dates did change.

William Arroyo, M.D.: There was a report that was published by the UCLA center that is education related. The report found that about 269,000 Kindergarten through 12th grade California students experience homelessness. At some point, we might want to look at the interface between the health care delivery system and this population. I can send the report if you'd like to see it.

Ken Hempstead, M.D.: We can consider that, but it sounds like, at a minimum, we have a full agenda for the January meeting. We will keep this in mind. We are finding more ripe areas for action. I'm thrilled that we're taking advantage of these changes. I do want to thank Terrie Stanley and Pam Sakamoto for their service.

Public Comment

Julie Moore: We hear so much about the adult COVID-19 vaccines. I have not heard about protecting our youth from COVID-19. Is there any discussion on if and when this will happen?

Ken Hempstead, M.D.: As a pediatrician and someone who is heavily involved in the vaccine world, ultimately all populations will be considered. There is a tiered system that is being finalized by CDPH. We also don't have many studies on children, so that will take some time and dovetails with the distribution plans.

Kelly Hardy, Children Now: Karen Lauterbach requested resources related to how to encourage families to bring children in for care. We're part of a Keeping Kids Connected to Care project. We are seeing large drops in accessing services, some are inevitable, but some we need to address as soon as we can, especially for vaccinations.