Medi-Cal Children's Health Advisory Panel (MCHAP) Hybrid Meeting

May 4, 2023

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Webinar Tips

- Please use **either a** computer **or** phone for audio connection.
- Please mute your line when not speaking.
- For questions or comments, email: MCHAP@dhcs.ca.gov.

Director's Update

Michelle Baass, DHCS Director

Swearing in of Panel Members

Modernizing California's Behavioral Health System

Context

- Since 2019, California has embarked on massive investments and policy reforms to re-envision the state's mental health and substance use system.

- We have invested more than $10 billion in several efforts to build up the community-based care that the most vulnerable Californians desperately need. This includes investments in prevention and early intervention programs for kids, programs like CARE Act, and system improvements in Medi-Cal through CalAIM.

- However, more can and must be done. Now is the time to take the next step and build upon the foundation we have already established – continuing the transformation of how California treats mental illness and substance abuse.

Key Elements

1. Authorize a general obligation bond to fund unlocked community behavioral health residential settings
    - The bond would also provide housing for homeless veterans
2. Modernize the Mental Health Services Act
3. Improve statewide accountability and access to behavioral health services

Children and Youth Behavioral Health Initiative Integration within Schools

Autumn Boylan, Deputy Director, Office of Strategic Partnerships, DHCS

DHCS

What is the Statewide All-Payer School-Linked Fee Schedule?

The fee schedule will cover **outpatient mental health and substance use disorder services** for students up to age 25 at a school site or via a school-linked provider.

The fee schedule will:

» **Articulate the services and reimbursement rates**, and establish agreements of payment that the school and contracted providers can receive.

» **Will neither supplant nor duplicate existing funding sources,** nor requirements to accommodate and provide services to students with disabilities.

Vision for the Statewide All-Payer School-Linked Fee Schedule

Create a **sustainable funding source** for school-linked behavioral health services that:

» **Increases access to school-linked behavioral health services** for children and youth.

» **Applies to all payers**, easing the uncertainty for providers around a student's specific coverage1.

» **Eases burdens** related to rate negotiation and navigation across delivery systems.

» Creates a more **approachable reimbursement model for behavioral health services in schools,** given faster processes and federal match.

Statewide All-Payer Fee Schedule Intersections with Other Programs

Future State

Contracts with MCPs, county behavioral health, or commercial plans **for additional behavioral health services beyond the scope of the fee schedule** (e.g., Enhanced Care Management, SMHS)

Statewide all-payer fee schedule for reimbursement of school-linked behavioral health services from (as applicable):

- Commercial plans, **for all included services**
- Medi-Cal MCPs, **for included mental health services**
- Medi-Cal county MHPs, **for included SUD services**

Individuals with Disabilities Education Act (IDEA) funding for students with special needs, including Educationally-Related Mental Health Services (ERMHS)

Local Educational Agency Medi-Cal Billing Option Program (LEA-BOP) funding for approved health-related services provided by qualified health service practitioners to Medi-Cal eligible students

Other existing education funding for mental health: Community schools, Multi-Tiered System Support (MTSS), Positive Behavior Intervention and Supports (PBIS), etc.

➢ Due to the complexity of fee schedule implementation, and based on feedback from key partners, DHCS proposes a phased approach

	2024		2025 →
	January	**~July**	**~January onwards**
	Phase 1 – Early Adopters	**Phase 2 – Select Expansion**	**Phase 3-Rolling Opt-In**
Cohort Participants *All proposed cohorts include associated commercial plans, MCPs1 and county BH2 partners*	**Small group of LEAs3 with:** **Existing billing infrastructure** (e.g., Medi-Cal enrollment, LEA-BOP4 enrollment, partnership with MCPs1 who participate in SBHIP5) **Willingness** and capacity to participate	Expansion to **additional districts and/or school sites** Small number of **higher education campuses** (TBD)	**All LEAs, charter schools,** **California Schools for the Deaf and California Schools for the Blind -** on a rolling opt-in basis **Higher education** *Note: Ongoing opportunities to register / enroll every 6 months*

1. Managed Care Plan; 2. Behavioral Health; 3. Local education agency; 4. Local Educational Agency Medi-Cal Billing Option Program; 5. Student Behavioral Health Incentive Program;

➢ Support for schools in building fee schedule readiness capabilities through school-linked grants

Stakeholders have identified **in the need to build capabilities to bill to a fee schedule,** including:[1]

- **Workforce capacity to provide services,** especially those requiring licensed providers
- **Dedicated physical space** for schools to
- provide services
- **Expertise on managing patient data,**
- privacy, and consent
- **Sustainable partnerships** with external
- behavioral health providers

DHCS will disburse $550M in grants, with a goal to support **capacity, infrastructure, and partnerships** necessary for **fee schedule readiness**[2,3]

The school-linked grants program will include:

- **K-12 grants4** (~$400 million)
- **Higher education grants5** (~$150 million)

Examples of **fee schedule readiness expenditures** may include:

- **Interoperable data exchange/collection infrastructure** for the management of BH care
- **Partnership with a third-party claims**
- **administrator** to process BH claims
- **Administrative capacity** to facilitate the billing and claims process

(1) Fee Schedule Workgroup session on 12/5/2022; (2) See Children and Youth Behavioral Health Initiative Act, § 5961.4 (a) (1) – (4); refer to the Act for official text; (3) California Health and Human Services Agency; (4) For publicly funded schools, charter schools, California School for the Deaf, California School for the Blind, and Bureau of Indian Education schools; (5) For publicly funded higher education institutions: University of California system, California State University system, and California Community Colleges;

CYBHI Social, Emotional Learning (SEL) Programs Update

Programs and Implementing Partners

CalHOPE Student Support Program

Contractor: Sacramento County Office of Education, Term 2/1/2022 - 6/30/2024,

$45 Million

Schools for Mindfulness, Resilience and Well-Being Grants

Contractor: Sacramento County Office of Education, Anticipated Term 5/1/2023 - 6/30/2025, $65 Million

Role(s) and responsibilities

Launched in June 2020, **CalHOPE SEL** includes resources for:

» CA educators to provide training to teachers and school staff in identifying children in mental health distress, providing emotional support and crisis counseling.

» A toll-free phone line for students to connect with peer counselors for emotional support.

Well-being and Mindfulness Programs aim to:

» Support programs, provided in K-12 school or community-based settings, that teach wellness and mindfulness practices to teachers and students and support schools and community-based programs.

» Support students and schools to form on-campus clubs for mental health and mindfulness, including NAMI on Campus, Bring Change to Mind High School, and Mindfulness Clubs.

» Support schools, districts, and county offices of education with the adoption of evidence-based tools, resources, and programs that support equitable access to mental health and wellness for students, families, and staff. We propose to prioritize this programming support to schools with high numbers of American Indians, refugees, and English learners.

CYBHI: School-Based Services

Steve Zimmer, Deputy Superintendent of Public Instruction,
California Department of Education

DHCS

Questions?

Email: CYBHI@dhcs.ca.gov

Continuous Medi-Cal Coverage: Background and Unwinding

Cathy Senderling-McDonald
Executive Director
County Welfare Directors Association of CA

Three Years of Protection: Continuous Coverage

- Federal requirement, effective March 2020
- Initially tied to Public Health Emergency (PHE)
- Prevented loss of coverage and “churn” during PHE
- Counties worked with State to effectuate in CA

Redetermination Processing During PHE

- Highly automated process that *continued to occur*
  - Starts 90 days before renewal is due
  - Try to "autorenew" coverage first – *ex parte* renewal
  - If successful, beneficiary receives "congratulations" letter
  - If unsuccessful, beneficiary receives packet asking for needed info
- Normally, discontinuance would occur if:
  - Not enough information received from beneficiary to process
  - Information received demonstrates beneficiary ineligible
- Changes: Counties *did not process* returned packets and there were *no penalties* for not returning them

Unwinding Effort Started April 1, 2023

- December 2022 Consolidated Appropriations Act
  - Delinked continuous coverage requirement and PHE
  - Set April 1 as start date for unwinding requirement
  - States had choice on how to time the start
- California restarted 90-day clock on April 1
  - First discontinuances will not be effective until July 1
- States have 14 months to process all renewals
  - California mostly going by redetermination date
  - Roughly 1/12 of cases up for renewal each month

Additional Details – California Process

- Process has started
  - Takes a bit of time to run matches (15m+ people!)
  - Packets being sent out now (Yellow Envelopes!)
- Certain undocumented immigrants processed later
  - Individuals found eligible as young adults & who “aged out” of coverage group during PHE provisions
  - Cases “deprioritized” to end of process
  - Health4All expansion will be in place

Potential Issue: Discontinuances

- Could be significant discontinuance numbers
  - DHCS estimates of 2m-3m possibly disenrolled
  - Combination of truly ineligible and procedurally disenrolled (i.e., failure to respond to request for info)
- Why might person be nonresponsive?
  - Address/contact information changed
  - Not understanding “now it’s real”

Mitigations: Discontinuances

- DHCS mailings to check return rate, update info
- Messaging around updating info if it has changed
- Messaging around needing to take action
- Engaging with plans to report updates
  - Federal guidance allows counties to accept plan information without having to double check it
- Making use of 90-day reinstatement window
- Automated Covered California enrollment

Potential Issues: Staffing

- County staffing challenges
  - Varying vacancy rates – just like all other sectors
  - Many newer staff haven't ever processed a renewal
- Significant requests for state fair hearings
  - Could tax system that serves all safety net programs
  - Both Administrative Law Judges and county staff needed to cover the anticipated caseload

Mitigations: Staffing

- Counties continually hiring and training
  - DHCS offering refresher trainings for counties
  - Recruitments ongoing! (Send your friends!)
  - Bringing back retired staff, authorizing overtime
- CWDA requesting temporary funding for county hearings staff to handle influx of requests
- Reminding beneficiaries to self-serve online
  - BenefitsCal.com

Key Takeaways

- Redeterminations will become meaningful starting in April, with first discontinuances possible in July
- Not everyone needs to call their county – only if their information has changed and they haven't told us already (can also self-serve online)
- Not everyone will receive a packet, but those who do must act in order to keep their coverage!
- Look for the yellow envelope!

Questions?

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Break

California Children's Services (CCS) Updates

Integrated Systems of Care Division and

Enterprise Data and Information Management

DHCS

Outline

- Whole Child Model (WCM) Evaluation: Overview of results
- CCS Quality Metrics Workgroup: Status update
- CCS Performance by Selected Measures: Analysis of Child Core Measures

WCM Evaluation: Overview of Results

CCS WCM Program Evaluation

- In 2016, the California Legislature passed Senate Bill (SB) 586, authorizing DHCS to establish the WCM program in 21 designated counties.
- SB 586 also required DHCS to contract with an independent entity to conduct an evaluation to assess Medi-Cal MCP performance and the outcomes and the experience of CCS-eligible children and youth participating in the WCM program, including access to primary and specialty care, and youth transitions from WCM program to adult Medi-Cal coverage.
- DHCS contracted with the University of California, San Francisco – Institute for Health Policy Studies to conduct the evaluation and prepare the evaluation report.
- The WCM Evaluation Report and accompanying Appendices were released to the State Legislature and published on March 30, 2023.

Research Question 1: What is the impact of the WCM on children's access to CCS services?

Conclusions

- Overall access to care was maintained in the WCM with high rates of continuity with primary care and specialty care, high rates of authorization approval, and a lower grievance rate as compared to Classic CCS and generally.
- While specialist visits use outcomes were mixed in this evaluation, less than 13% of families reported unmet specialist needs. While not statistically significant, a higher proportion of Classic CCS respondents have higher unmet specialist needs as compared to WCM clients.
- The increase in emergency department visits in the WCM warrant further investigation and quality improvement work.

Research Question 2: What is the impact of the WCM on the patient's and family's satisfaction?

Conclusions

- The WCM was successful in either keeping satisfaction unchanged or improving satisfaction for CCS-related services as compared to Classic CCS after implementation.
- On most measures of satisfaction, the majority (>70%) of parent respondents in all WCM study groups indicated they were "satisfied" or "very satisfied" with the various specialty and CCS related services they have been receiving. Only 3% had any grievance reported indicating high levels of satisfaction with CCS services in the WCM.

Research Question 3: What is the impact of the WCM on providers' satisfaction with the delivery of services and reimbursement?

Conclusions

- Key informants from the CCS program reported increased CCS staff workload experienced immediately after the Specialists WCM implementation and suggested more funding support to account for this unanticipated increased workload.
- Key informants from the durable medical equipment (DME) vendor were quite satisfied with a quicker and more efficient authorization process in the WCM, compared to the lengthy DME authorization process in Classic CCS.
- Providers were mixed on reimbursement on the provider survey, which likely depends on what services are being rendered and billed. The survey results mirror the findings of the key informant interviews, with satisfaction with DME, but also dissatisfaction, which may stem from difficulties with contracting providers and differences in provider networks.

Research Question 4: What is the impact of the WCM on the quality of care received?

Conclusions

- Overall, the quality of CCS-level care in the WCM appeared to be maintained at a similar level with that of Classic CCS clients. The majority of survey respondents in each WCM study group indicated that since the transition to WCM, the quality of services remained the same.
- Healthcare Effectiveness Data and Information Set (HEDIS) quality measures (depression screening and vaccinations) mostly improved or stayed the same.
- For those who thought care was worse, subgroup analyses showed that those with greater specialty use and poorer self-reported health status were associated with higher dissatisfaction with the WCM. Further investigation would be needed to evaluate the impact of the WCM on the more medically complex patients.

Research Question 5: What is the impact of the WCM on care coordination?

Conclusions

- Care coordination, as executed by high-quality case management, has been identified across families and key stakeholders as a critical core of the CCS program.
- Key Informant (KI) reports in the first year of the WCM, CCS case management was different from MCP case management. In MCPs, case managers were not as easily accessible to CCS clients, and MCP case management was neither centralized nor coordinated by one person, but instead was fragmented, and CCS clients accessed services through a telephone triage system.
- Despite the KI reports, the majority of survey respondents in all WCM study groups (69%) were "usually" or "always" able to get as much help as they wanted with arranging or coordinating health care. The differences between the WCM study groups and Classic CCS comparison group were not statistically significant.
- Overall case management claims were higher as compared to and outcomes similar to that of Classic CCS.

Conclusions

- The WCM had either no difference as compared to Classic CCS or a positive impact on the majority of CCS client participants across the majority of evaluation measures as compared to Classic CCS clients.
- Areas of improvement for both WCM and Classic CCS are noted in this evaluation and are discussed by research question.
- The CCS WCM maintained services and provided CCS-level quality of care for most CCS clients in the WCM.
- There were little differences between WCM and Classic CCS on outcomes and satisfaction on most measures.

WCM Evaluation Report – Resources

- Accessible versions of the WCM Evaluation Report and Appendices can be found on the DHCS website: CCS Whole Child Model (ca.gov)
- DHCS provided an overview of the report methodology and results by research question, presented during the April 12, 2023, CCS Advisory Group AG meeting. The slides for this presentation can be found in the April 12 CCS AG PowerPoint: Advisory Group (ca.gov)

CCS Quality Metrics Workgroup Update

Quality Metrics Workgroup Update

- DHCS will reengage with stakeholders in summer 2023 to set up a quarterly CCS quality metrics workgroup. Main activities of the workgroup include but are not limited to:
  - Landscape review of quality metrics that are currently collected or easy to collect for CCS members in WCM and Classic CCS.
  - Creating an inventory of CCS quality metrics for consideration.
  - Creating a roadmap for implementation and collection of the data required.

CCS Performance Indicators: Analysis of Select Child Core Set Measures

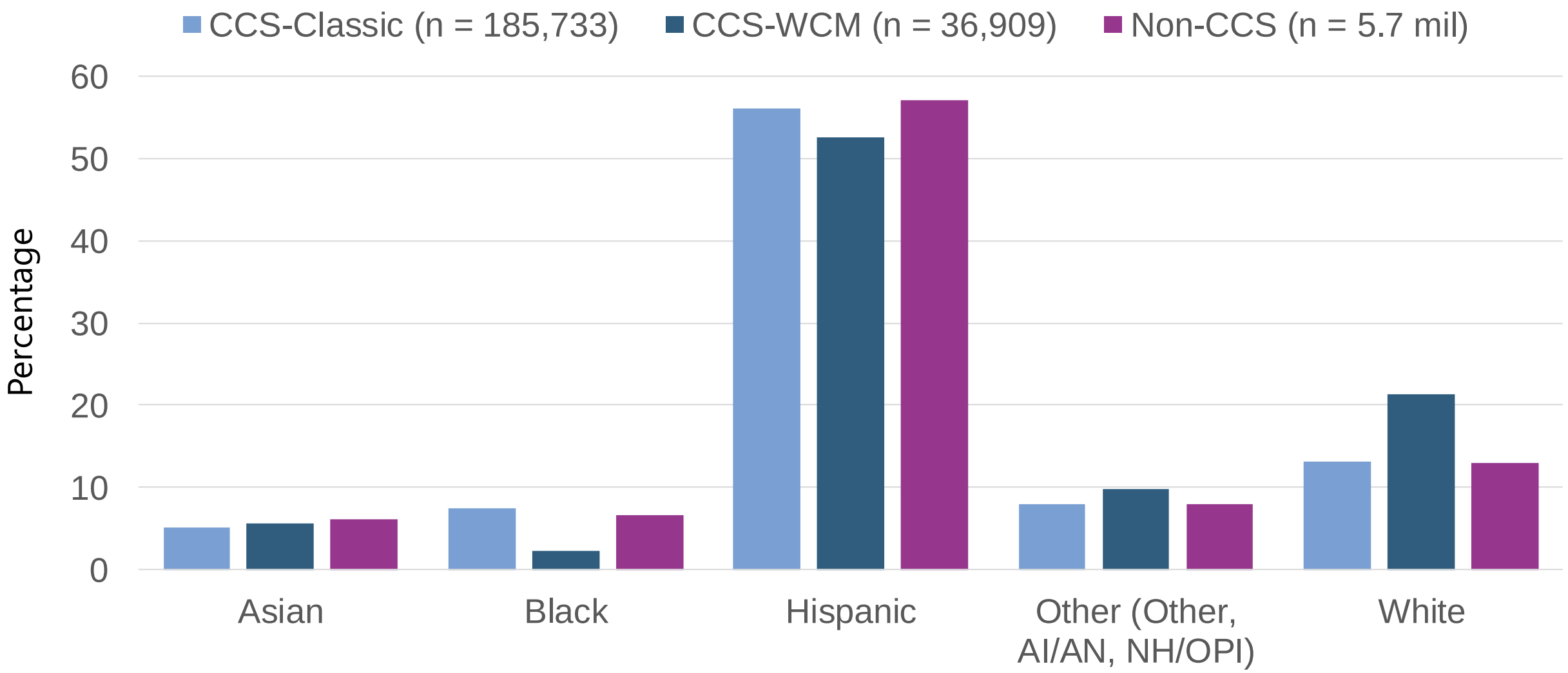
Centers for Medicare & Medicaid Services (CMS) Child Core Set Measures

- Well-Child Visits – First 30 Months (W30-6-CH)
- Child and Adolescent Well-Care Visits, Ages 3-21 (WCV-CH)
- Emergency Department Visits, Ages 0-19 (AMB-ED-CH)
- Screening for Depression and Follow-Up Plan, Ages 12-17 (CDF-CH)
- Measures are reported by age (per clinical guideline) and:
  - CCS Program Status and Measurement Year (MY) 2020 and 2021
  - Race/Ethnicity: American Indian/Alaska Native (AI/AN), Asian, Black or African American (Black), Hispanic or Latino (Hispanic), Other, Unknown, White
  - Healthy Places Index (HPI): Quartiles 1 – 4

Child Core Set Analysis Terms

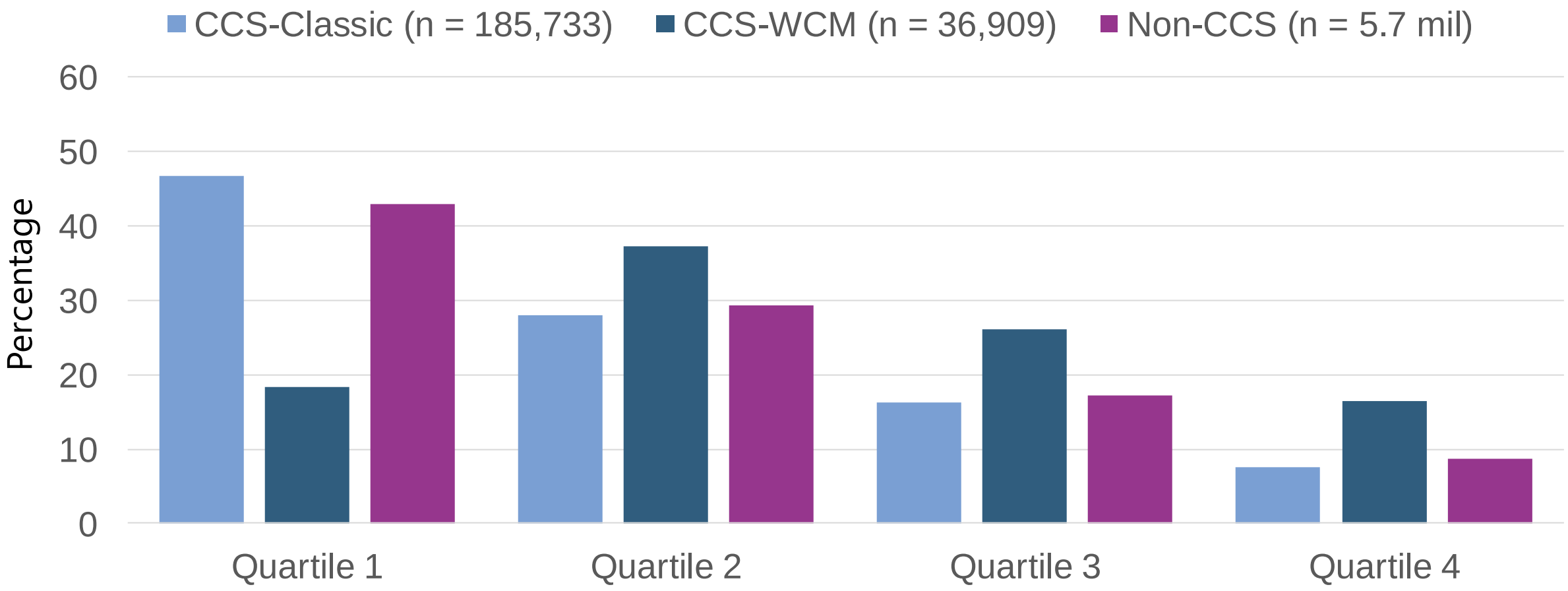
- CCS connects special health care needs children with health care professionals/services
- Eligibility: from birth to 21 years old; chronic medical conditions, including cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries; infectious diseases with major sequelae
- WCM – Implemented in 21 counties and 5 health plans in January 2019 to improve care coordination by incorporating CCS services for eligible youth into a Medi-Cal MCP contract
- Classic CCS – Covers participants in traditional (non-WCM) counties
- Measurement Years (MY) included in analysis: 2020 - 2021

Medi-Cal Enrollment, Ages 0-20, Calendar Year 2021
Percentage by CCS Status and Race/Ethnicity

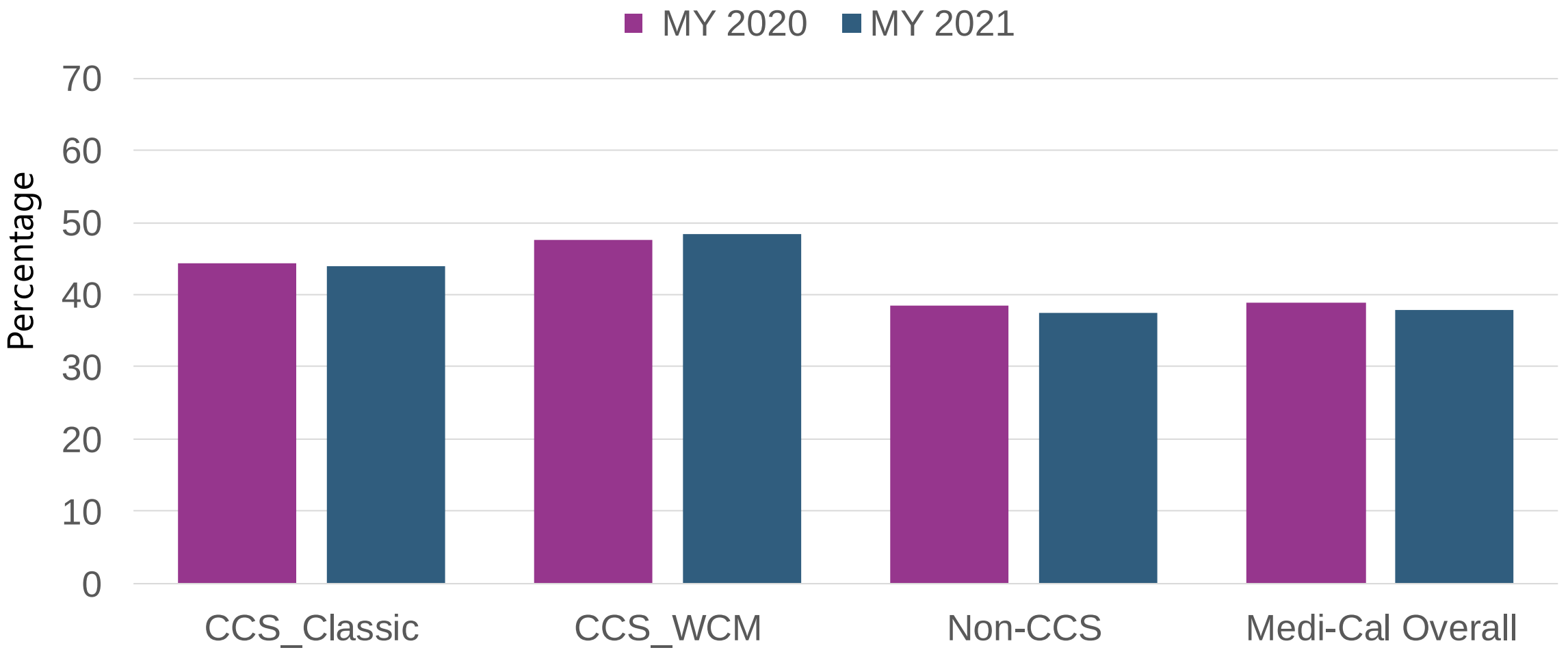


Medi-Cal Enrollment, Ages 0-20, Calendar Year 2021
Percentage by CCS Status and Healthy Places Index (HPI)

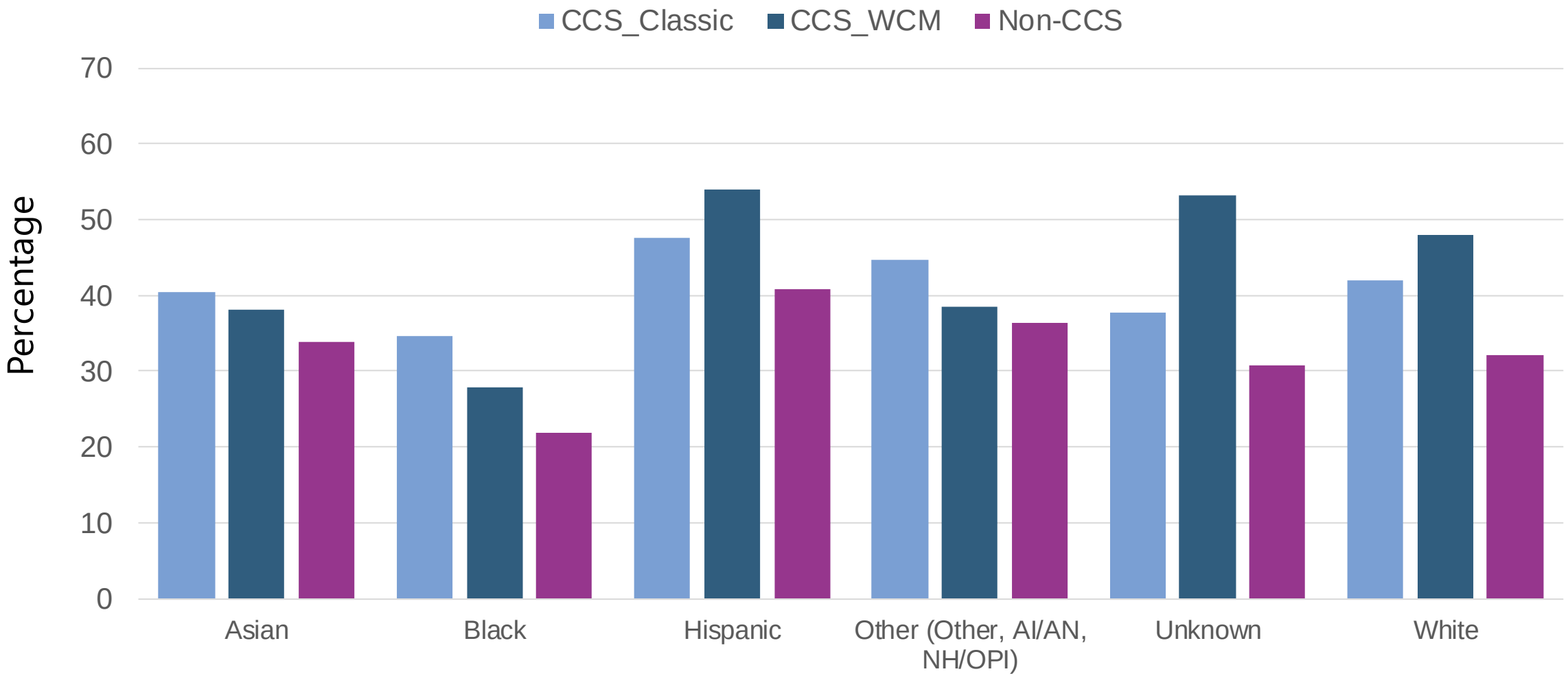
lower quartile indicates less healthy community conditions



Well-Child Visits in First 15 Months of Life by CCS Status and MY



Well-Child Visits in First 15 Months of Life by CCS Status and Race/Ethnicity, MY 2021



Well-Child Visits in the First 15 Months of Life by CCS Status and HPI, MY 2021

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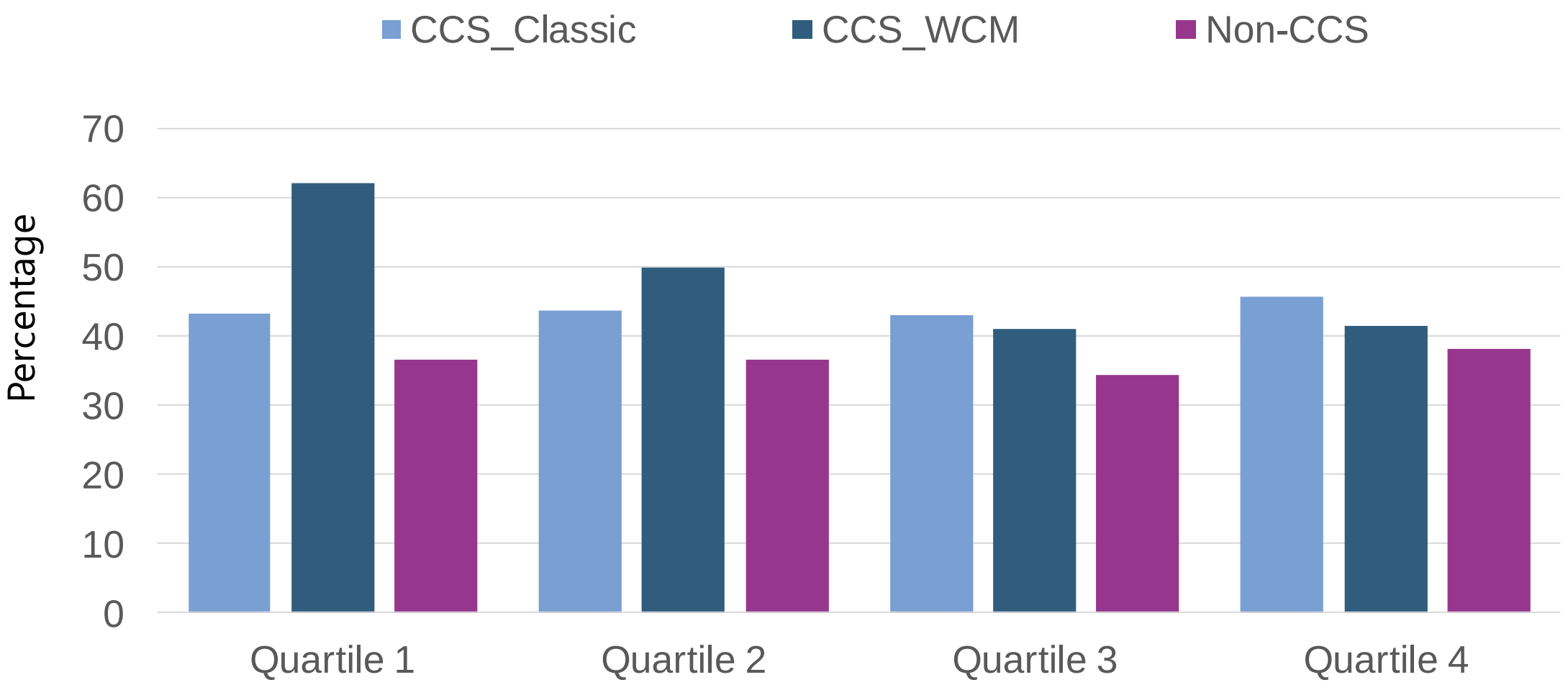
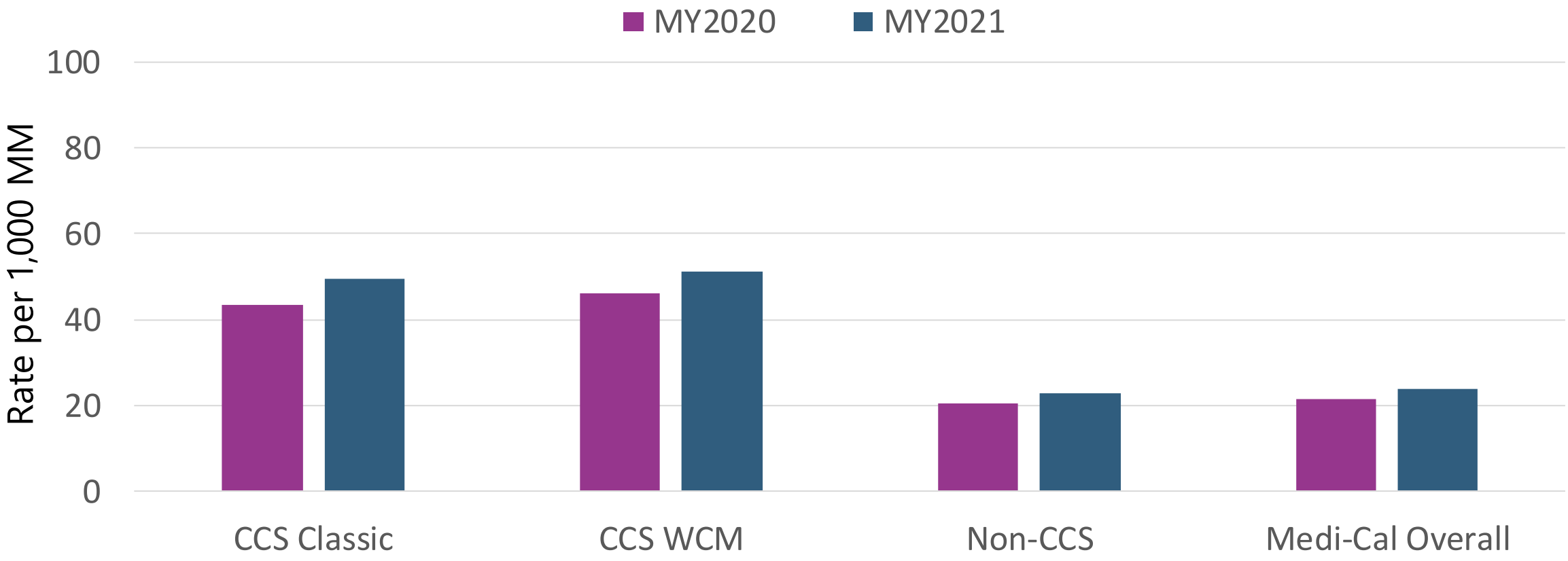


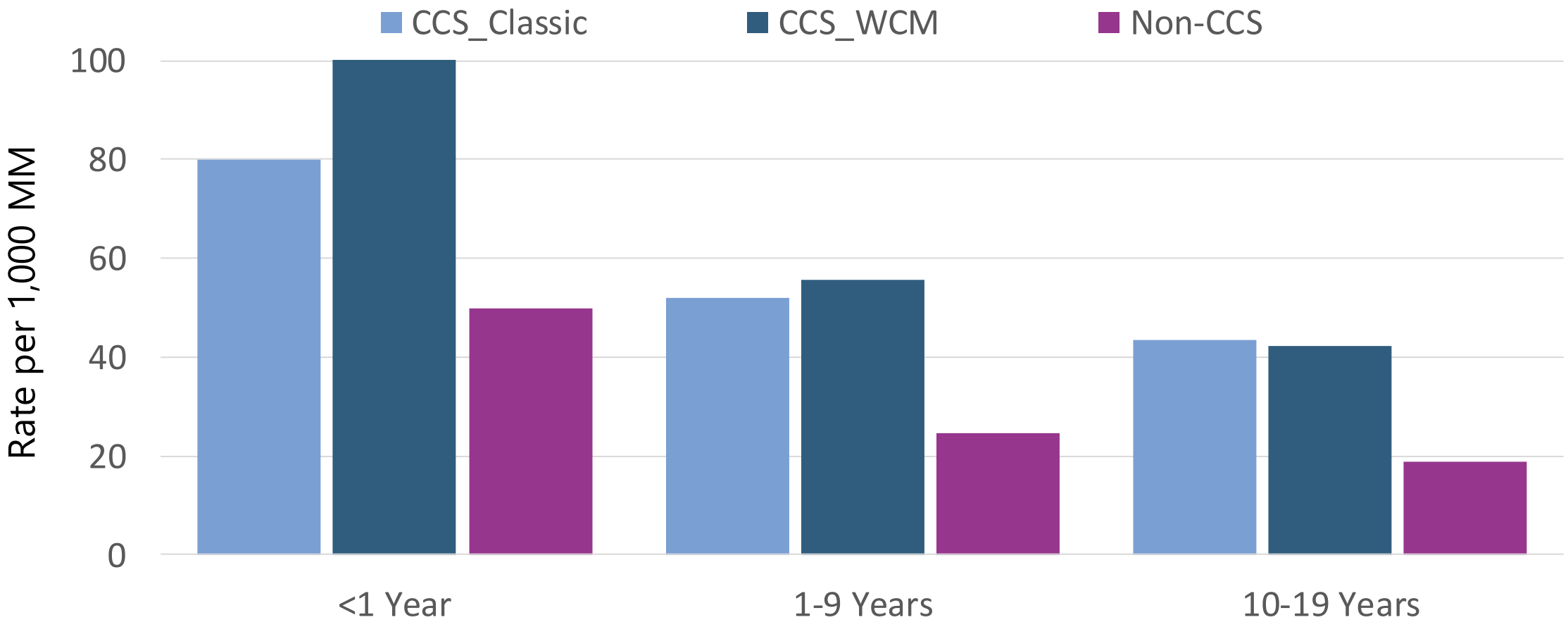
Emergency Department Visits Per 1,000 Member Months by CCS Status and MY, Ages 0-19

lower rate is better



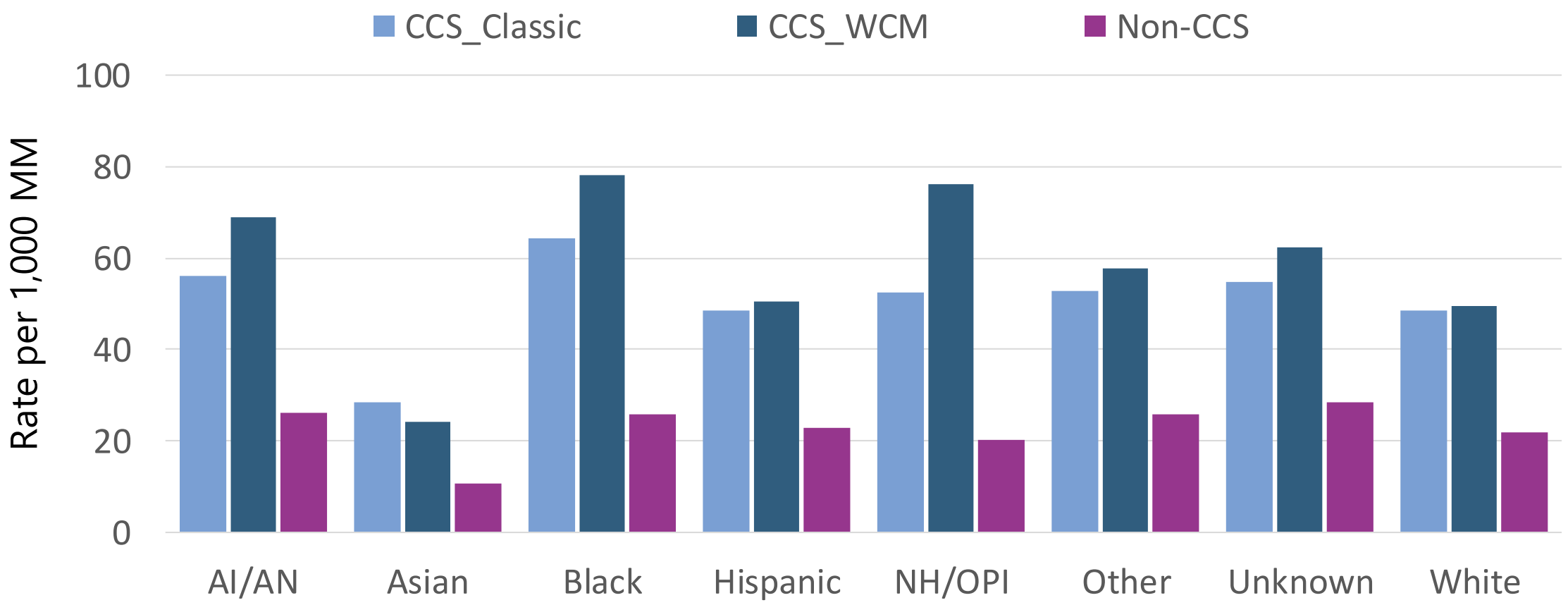
Emergency Department Visits Per 1,000 Member Months by CCS Status and Age Group, MY 2021

lower rate is better



Emergency Department Visits Per 1,000 Member Months by CCS Status and Race/Ethnicity, Ages 0 – 19, MY 2021

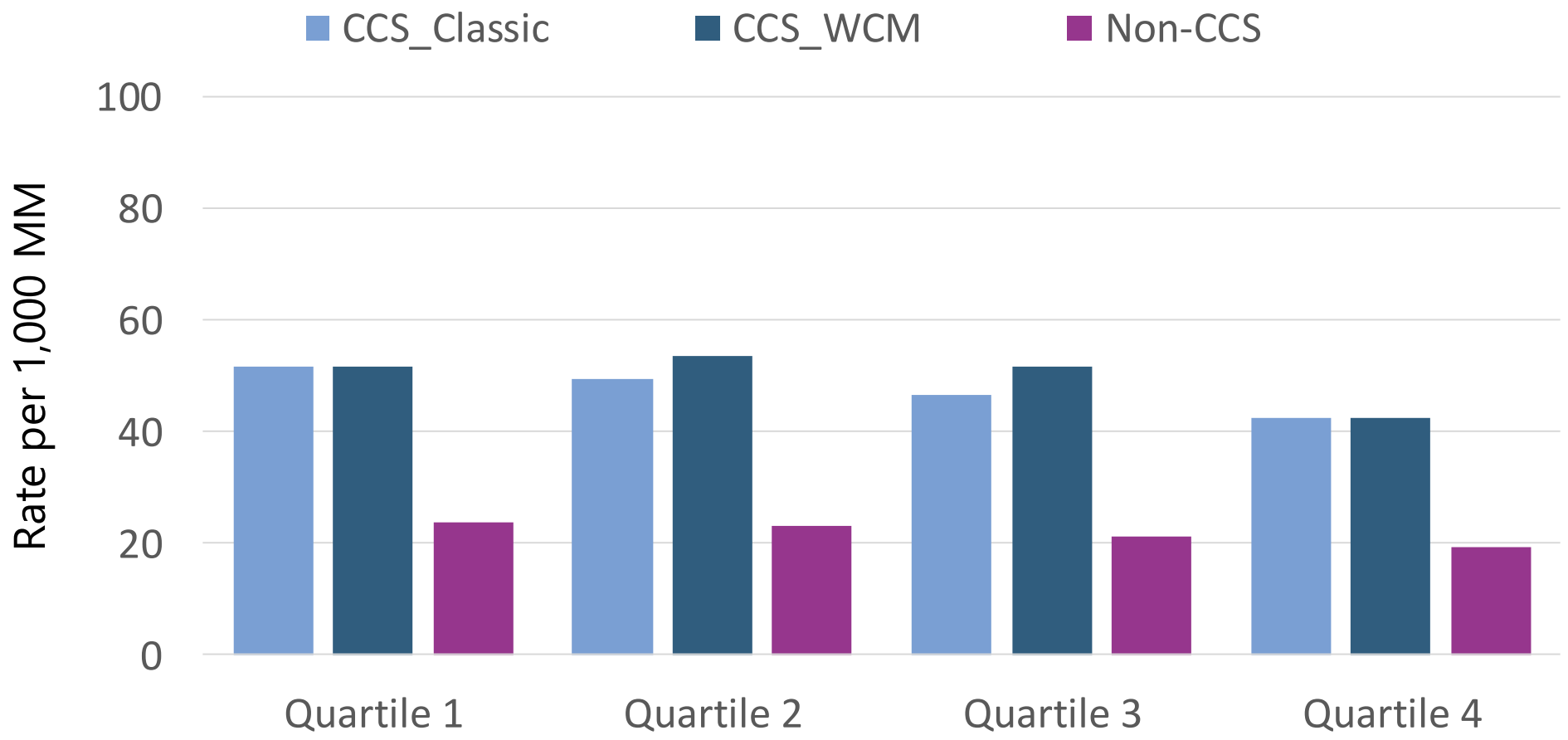
lower rate is better



Emergency Department Visits Per 1,000 Member Months by CCS Status and HPI, Ages 0-19, MY 2021

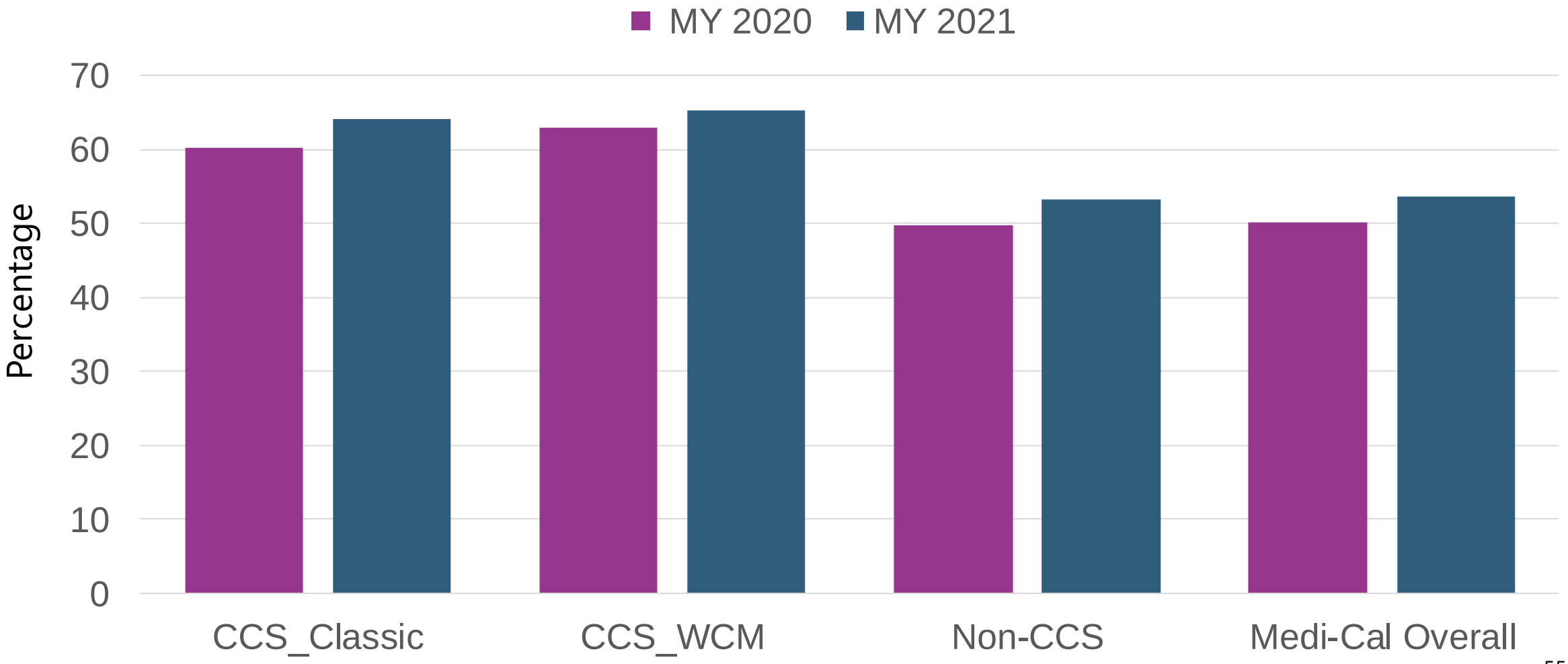
lower rate is better

lower quartile indicates less healthy community conditions

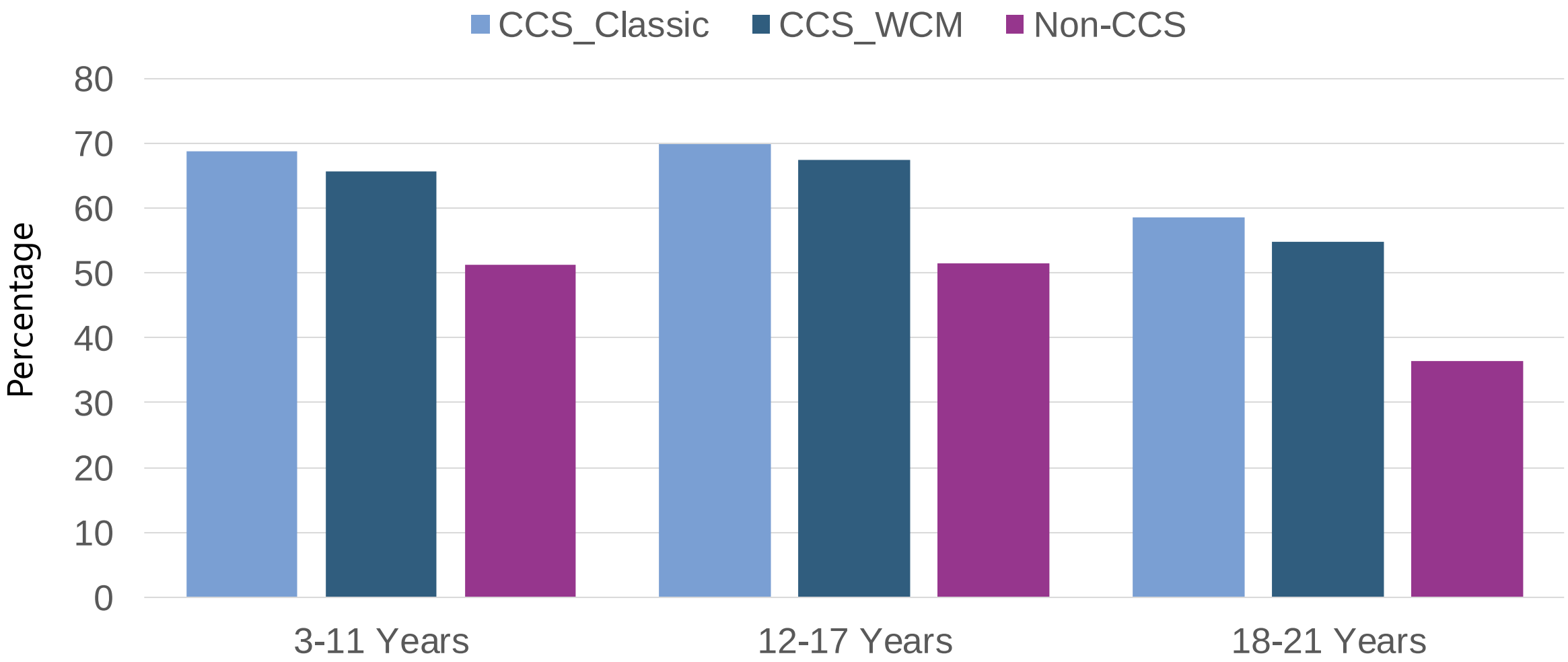


APPENDIX

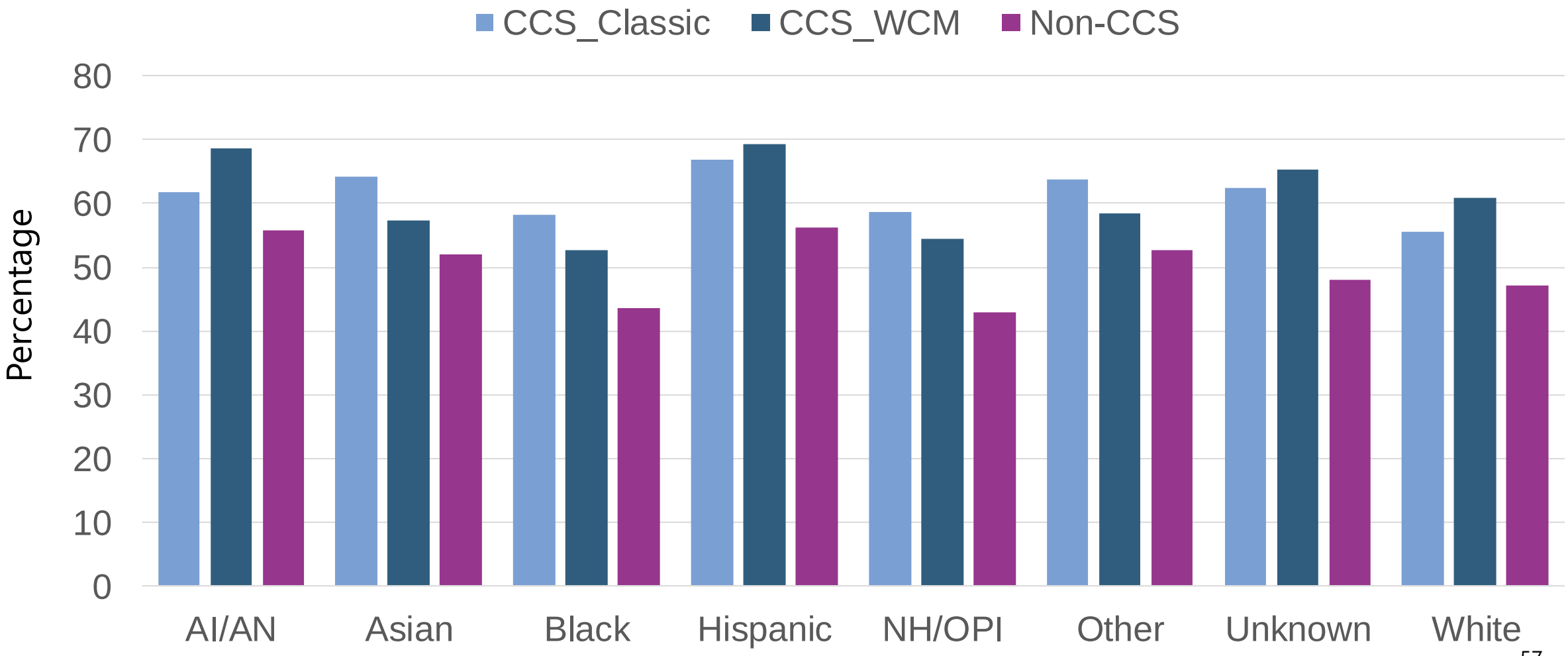
Child and Adolescent Well-Care Visits by CCS Status and MY, Ages 3-21



Child and Adolescent Well-Care Visits by CCS Status and Age Group, MY 2021

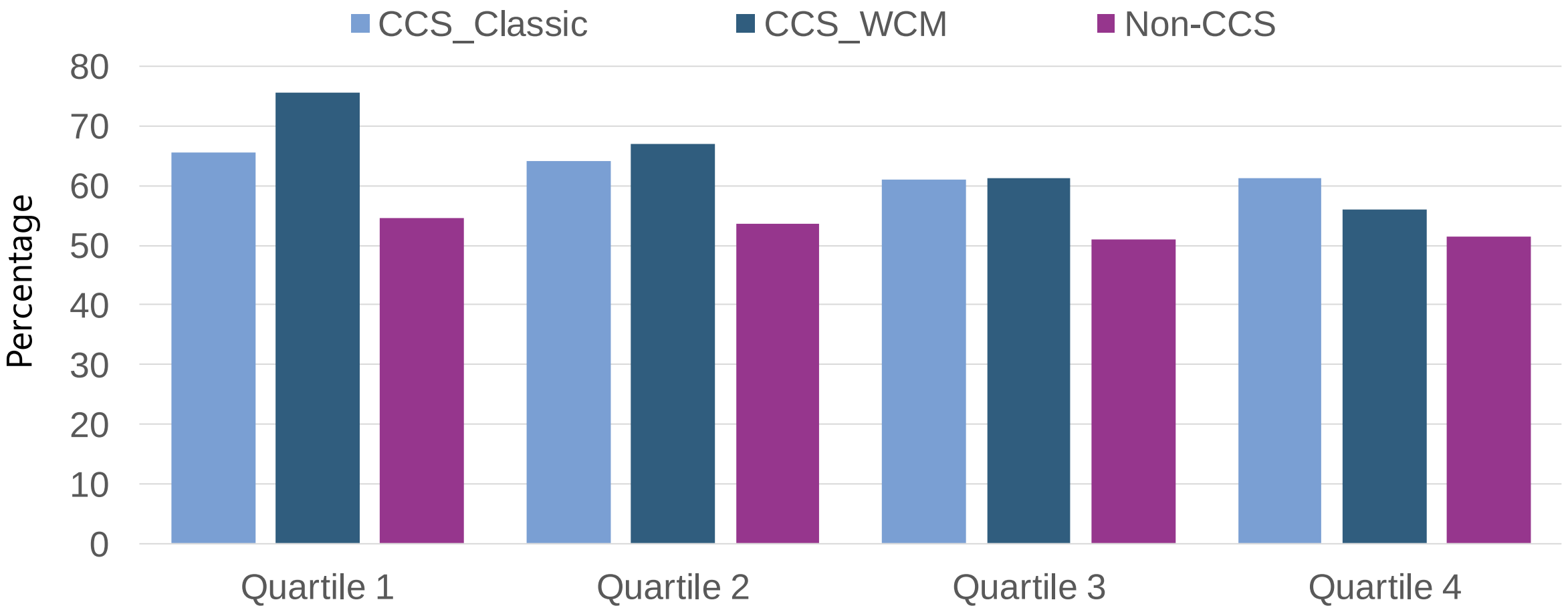


Child and Adolescent Well-Care Visits by CCS Status and Race/Ethnicity, Ages 3-21, MY 2021

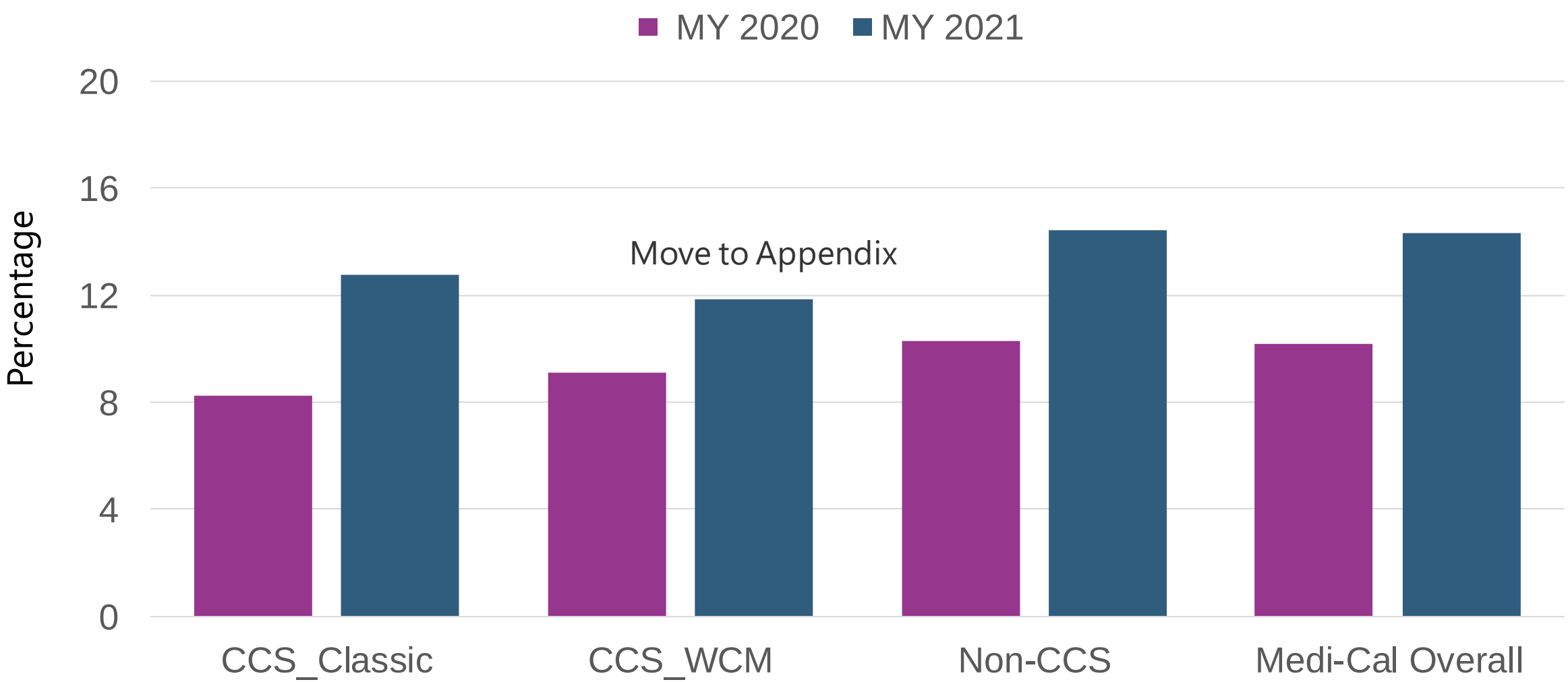


Child and Adolescent Well-Care Visits, by CCS Status and HPI, Ages 3-21, MY 2021

lower quartile indicates less healthy community conditions



Screening for Depression and Follow-Up Plan Percentage by CCS Status and MY, Ages 12-17



Questions?

Public Comment

Member Updates

Upcoming Meetings and Next Steps