State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

January 26, 2021 - Webinar

Meeting Minutes

Members Attending: Ken Hempstead, M.D., Pediatrician Representative; Jan Schumann, Subscriber Representative; William Arroyo, M.D., Mental Health Provider Representative; 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; Kelly Motadel, M.D., County Public Health Provider Representative; Elizabeth Stanley Salazar, Substance Abuse Provider Representative; Karen Lauterbach, Non-Profit Clinic Representative; Stephanie Sonnenshine, Health Plan Representative; Michael Weiss, M.D., Licensed Disproportionate Share Hospital Representative.

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

Public Attendees: 57 members of the public attended the webinar.

DHCS Staff: Will Lightbourne, Jacey Cooper, Mike Dutra, Anna Lee Amarnath, Linette Scott, Norman Williams, Jeffrey Callison, and Morgan Clair.

Opening Remarks and Introductions

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

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

Meeting minutes from December 9, 2020, were approved, 11-0.

Opening Remarks from Will Lightbourne, Director

Lightbourne administered the oath of office to two new members, Stephanie Sonnenshine, to a term ending on December 31, 2023, and Dr. Kelly Motadel, to a term ending on December 21, 2022.

Lightbourne shared updates on Governor Newsom's 2021-22 proposed budget, and noted DHCS' budget highlights. Equity is a key focus of the Administration, including in its response to COVID-19. Initiatives in the proposed budget related to equity include:

- Expanding telehealth flexibilities, including remote patient monitoring costs.
- Adding continuous glucose monitoring systems as a Medi-Cal benefit for beneficiaries ages 21 and older with Type 1 diabetes.

Other highlights include:

- California Advancing and Innovating Medi-Cal (CalAIM) implementation.
- Behavioral health continuum infrastructure funding.
- Increased access to student behavioral health services.
- Delaying the suspension date by one year for a number of Proposition 56 expenditure items, including the recent expansion of postpartum care eligibility.

Questions from the MCHAP Members Regarding Budget Update

Ellen Beck, M.D.: Can you speak to school funding eligibility to extend behavioral health services to cover all schools and community colleges, and will the funding go to the counties? Will the district receive funds and then work with managed care plans (MCPs)?

Jacey Cooper, DHCS: No full roll out plan yet, but we have requested staffing in the budget to allow for technical assistance. The incentive funding will flow through the MCPs to mobilize locally and inform school districts on incentive payments. The one-time allocation spans three years, allowing for planning. The majority of children do not require Specialty Mental Health Services (SMHS); this is to incentivize the embedding of lower-level non-SMHS, mild-to-moderate behavioral health services in the schools.

William Arroyo, M.D.: Community schools, which serve the highest need students, should be a special focus. Many schools don't have Medi-Cal on site. There's also no mention of commercial plans at school sites.

Jacey Cooper, DHCS: It's complex, which is why the incentive funding is specifically aimed at infrastructure, capacity, and partnership building to help tackle those concerns.

William Arroyo, M.D.: What about Local Educational Agency (LEA) Medi-Cal?

Jacey Cooper, DHCS: About 50 percent of school districts participate in the LEA Billing Option Program (BOP), and some levels of participation varies due to federal rules. We're trying to maximize Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) at school sites.

Will Lightbourne, DHCS: Theoretically, every student has some Medi-Cal coverage and parity between plan types.

Ken Hempstead, M.D.: Are there stakeholder groups related to this?

Jacey Cooper, DHCS: There will be more to come on engaging in this work.

Jan Schumann: If the proposed budget does decrease, do you anticipate an increase in federal funds to help offset the loss?

Will Lightbourne, DHCS: It would be helpful to let the budget committees know that these are priorities and should be maintained in the budget.

Mike Weiss, M.D.: Any discussion on the development of provider networks?

Jacey Cooper, DHCS: Bifurcation is happening; Medi-Cal MCPs and county behavioral health plans are required to have network adequacy to ensure that we have adequate access. Flexibility is needed to maximize the existing behavioral health infrastructure. We have identified gaps in frequency and volume of behavioral health services. By intervening earlier, we will be able to avoid some crises. However, we need time to build that capacity. We're looking at bringing on additional providers to meet the need, and the new flexibility for behavioral health peers will help expand the workforce footprint.

Stephanie Sonnenshine: Do you have a vision for the duration of building the infrastructure? Does this align with incoming timeframe?

Jacey Cooper, DHCS: It's a one-time appropriation of $400 million for a three-year expenditure authority.

Ron DiLuigi: In terms of the bifurcation, is there flexibility that communities have to put together a model that works for them?

Jacey Cooper, DHCS: We need to hold certain deliverability systems accountable for the services that they're responsible for providing.

COVID-19 Impact on Medi-Cal Utilization

Dr. Linette Scott provided an overview of the COVID-19 public health emergency's (PHE) impact on Medi-Cal utilization (slides 10-40). Slides are available here: https://www.dhcs.ca.gov/services/Documents/012621-MCHAP-presentation.pdf

Jacey Cooper, DHCS: On the vaccine piece, it doesn't adjust pure volume counts. We have to make up for the missed vaccinations from earlier in the year to meet normal levels. We need beneficiaries to reengage with their health care, vaccine doses, etc.

Ken Hempstead, M.D.: For the testing rates, I was surprised to see such a gap between the Medi-Cal and general populations. Is this an access issue?

Linette Scott, DHCS: We must be careful about identifying that as a gap. The testing for all Californians relates to daily data from the California Department of Public Health (CDPH). The data for Medi-Cal population is based on what DHCS was billed for, so it could be an undercount. One of the challenges is that CDPH's data system doesn't have a unique identifier in common with our system. We're working with CDPH on data linkage between the systems.

Alison Beier: Can you speak to the children's hospitalizations and the emergency department visits? I'm not sure of the long-term effects of not having the in-patient numbers or emergency visits. Are we keeping an eye on this so support can be offered later?

Mike Weiss, M.D.: Appreciate the sensitivity. There are some federal dollars that have been made available. We're having an ongoing conversation about what that coverage looks like and support for safety net hospitals.

Ellen Beck, M.D.: Could the information on the telehealth slides be stratified according to socioeconomic status within Medi-Cal?

Jacey Cooper, DHCS: We don't have data to do that stratification.

Jan Schumann: Is there a language barrier that needs to be addressed for access?

Jacey Cooper, DHCS: We're very focused on identifying gaps and disparities in our data, which will help inform us on how to close these gaps.

Update on Preventive Services and Health Disparities Reports

Mike Dutra and Dr. Anna Lee Amarnath provided an overview of the Preventive Services Report (PSR) and Health Disparities reports (slides 42-71). Slides are available here: https://www.dhcs.ca.gov/services/Documents/012621-MCHAP-presentation.pdf

Bill Arroyo, M.D.: For depression and treatment measures, are there data specific to under age 21?

Anna Lee Amarnath, DHCS: For specific quality metrics, there is a quality measure for antidepressant medication management that is included in this report, and includes members age 18 and older. There is also a depression screening and follow-up care metric that is for members who are age 12 or older that is not included in this report.

Mike Dutra, DHCS: The screen for depression is in the PSR.

Liz Stanley Salazar: The highest utilizers have a high rate of mental health and substance use disorders. What can we do to help the MCPs improve outcomes, and what measures and conversations should happen across the SMHS plans? There's an initiative to embed Adverse Childhood Experiences (ACEs) in primary care settings. How is DHCS working to include health plans in the discussion in terms of meeting the goals? If we identify children with high ACE scores, how do we link these data discussions at the practice level?

Anna Lee Amarnath, DHCS: Great point about how the MCPs can integrate SMHS better. One of the steps we've taken for our next set of quality metrics is to add a couple measures that require that type of coordination. MCPs have also been very involved in ACEs screenings effort. These conversations with the MCPs will continue to happen and involve the health plan leadership to address quality and inequities.

Ellen Beck, M.D.: Do you have comparative data for teen well-visits and when those visits occurred?

Mike Dutra, DHCS: We have not used that data for an exploratory analysis. Something we could explore in future analyses.

Jan Schumann: Is there data related to depression on prescribing or therapy courses?

Mike Dutra, DHCS: That's not part of the metrics, but something we could explore in future analyses.

Bill Arroyo, M.D.: What is the basis for selecting measures for the PSR? Do these metrics align with those published by U.S. Task Force Prevention Services?

Mike Dutra, DHCS: We explored metrics from the Preventive Services Task Force and the Bright Futures list of services. We examined both in conjunction with the data that MCPs are reporting.

Structural Racism in the Health Care Delivery System

Director Lightbourne facilitated this discussion.

Will Lightbourne, DHCS: We want to get the panel's reactions. We're collaborating with the California Health Care Foundation (CHCF) to review available data, particularly looking at what we don't have and need to get, and then to suggest realistic but meaningful measures. We'll continue the dialogue with different committees.

Alison Beier: I recommend reviewing the Department of Developmental Services' recent study on reducing disparities to services for regional centers for Black and Latino families.

Bill Arroyo, M.D.: Can you share preliminary guidance from CHCF? Is the California Office of Health Equity involved?

Will Lightbourne, DHCS: We are consulting with the Office of Health Equity. CHCF and the California Pan-Ethnic Health Network (CEPHN) have been doing significant research and analysis. Their work is already available.

Bill Arroyo, M.D.: If MCPs were incentivized to raise visits in zip codes that are the least served, is that a viable incentive?

Will Lightbourne, DHCS: Yes. We need to encourage community health workers and peers, develop learning opportunities, and perhaps refresh the toolkits on how to provide care to different communities.

Mike Weiss, M.D.: We should explore universal education for those who are providing care to these populations that highlights inherit bias. If you attack the issue structurally, but also at the point of care, there will be better outcomes.

Ken Hempstead, M.D.: I would favor the approach of incentivizing training on implicit and unconscious bias at the point of care.

Alison Beier: It should be mandatory for programs that are receiving Medi-Cal funding that there is an inherent bias program.

Ellen Beck, M.D.: In working with existing physicians in underserved communities, there are so many structural barriers. We're working with people in complex situations and we need more time to be more effective. We also need to support and work with promotora. The best solutions often come from the patients. For outcomes, are people actually receiving the treatments needed and is their health improving?

Stephanie Sonnenshine: If it's clear systemically as to what we want, it's easier to align our work. We need a shared definition of what success looks like and hold ourselves accountable to achieve that result.

Bill Arroyo, M.D.: Has CHCF thought about the challenge more broadly? There are some studies concluding that medical interventions only account for about 20 percent of outcomes, and the remainder are social determinants of health (SDOH). Is there a way at the state level that other components are mobilized to achieve better health outcomes given that medical interventions account for a small portion of outcomes?

Will Lightbourne, DHCS: That's so much a part of CalAIM, using two components of the initiative to address SDOH: Enhanced Care Management and incentivizing MCPs to provide In Lieu of Services that are outside the clinical lines.

Liz Stanley Salazar: How do we prepare and build capacity and readiness in the network, particularly for community-based clinics? How do we build value based purchasing?

Ken Hempstead, M.D.: Is DHCS or CDPH leading the effort to help reduce vaccine hesitancy in communities that are disproportionately affected by COVID-19?

Jacey Cooper, DHCS: CDPH is leading this work. There will be a lot of planning about how to get the messaging out. There are also partnerships with local public health departments and key providers across the state to move the needle on vaccines. There are strong connections between our MCPs and CDPH to get the messaging out. There has also been a lot of work on equity and targeting certain communities.

Karen Lauterbach: I wanted to add to the inherent bias trainings discussion. Clinics started this process a while ago. There's a lot of follow-up work and support to move this forward. I want to make sure that we're including the community that it affects.

Public Comment

Susan McLearan, California Dental Hygienists Association: I wanted to commend the depth and breadth of this discussion. Regarding the fluoride varnish metric, is it a comparison of Medi-Cal benefits or to the application to the public at large? Will this metric be used for outcomes such as for caries experience?

Mike Dutra, DHCS: Those metrics in the report show the dental fluoride varnish in three different ways. That is only relevant to Medi-Cal children, so there's no comparison to

commercial or nationally. One of the things we need to look at is how to tie to our expectation for fluoride varnish, and how to carry it over to a different delivery system.

Mike Odeh, Children Now: Thank you for the robust data discussions on equity. The data presented in the reports are alarming. Is DHCS considering a quality improvement incentive program that ties to dollars paid for children's care to outcomes and inequities?

Will Lightbourne, DHCS: It's part of our deliberate thinking; the procurement ties payment to outcomes.

Jacey Cooper, DHCS: CalAIM's infrastructure allows for exactly what you are mentioning, Mike. We are moving toward pay-for-performance with our MCPs and incentivizing certain pieces. We are looking at this to inform our future CalAIM and procurement efforts.

Member Updates and Follow Up

Ken Hempstead, M.D.: Moving forward, we'll want to examine any major changes with budgetary items, COVID-19, CalAIM, DHCS' telehealth proposal, and coverage gaps.

Mike Weiss, M.D.: I'd like to have an open dialogue on the budget in regard to the Office of Health Care Affordability?

Will Lightbourne, DHCS: I would invite the undersecretary from Agency to participate in that conversation.

Ellen Beck, M.D.: I want to mention the issue of literacy as an area to explore in relation to structural racism.

Ron DiLuigi: I have optimism about the major initiatives within the budget. Are there other aspects that we might want to focus our advocacy on? We need to raise our voices.

Jan Schumann: I reached out to the California Office of the Surgeon General about the current vaccination plan. By March, will be in phase 2. If access to care is preventing people from getting a vaccine, how do we communicate with them? Maybe we should have Dr. Burke Harris brief us on the plan.