State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

March 17, 2022 - Webinar

Meeting Minutes

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

Members Not Attending: Alison Beier, Parent Representative.

Public Attendees: 49 members of the public attended the webinar.

DHCS Staff: Michelle Baass, Jacey Cooper, Palav Babaria, M.D., Rene Mollow, Bambi Cisneros, Norman Williams, Jeffrey Callison, Morgan Clair, Audriana Ketchersid.

Others: Bobbie Wunsch, DHCS Consultant.

Opening Remarks and Introductions

Ken Hempstead, M.D., MCHAP Chair, welcomed webinar participants. The legislative charge for the advisory panel was read aloud. (See agenda for legislative charge.) The meeting summary from December 9, 2021, was approved, 12-0. Hempstead introduced Wunsch.

Opening Remarks from Michelle Baass, Director

Director Baass provided DHCS updates on the Governor's proposed budget for Fiscal Year 2022-23. Slides from the Director's Update are available here: https://www.dhcs.ca.gov/services/Documents/031722-MCHAP-presentation.pdf.

Medi-Cal Rx Update

Baass: Medi-Cal Rx launched on January 1, 2022. There were implementation challenges at the beginning of the launch, including long wait times on hold and delays in processing prior authorizations (PA). However, PA mitigation strategies were launched in early February, and we increased staffing at call centers. Wait times are currently at less than one minute with no PA backlogs. We are working to create a clinical liaison for our California Children's Services (CCS) efforts. We're also working to conduct education and outreach to our providers and pharmacies to ensure they understand the pharmacy process and changes resulting from Medi-Cal Rx implementation.

Unwinding of the Public Health Emergency (PHE)

Mollow: We do not have the end date of the PHE. The Centers for Medicare & Medicaid Services (CMS) has been building upon state guidance for the unwinding of the PHE since December 2020. Once the PHE ends, DHCS will resume the renewal process for Medi-Cal beneficiaries. Individuals were not discontinued from coverage during the PHE. DHCS is planning an extensive outreach strategy during which we will need individuals who can become DHCS Coverage Ambassadors to help get the message out to Medi-Cal beneficiaries about how they can keep their coverage, including asking beneficiaries to update their contact information with their county of residence. DHCS Coverage Ambassadors include county partners, key stakeholders, managed care plans (MCPs), health enrollment navigators, and clinic and hospital partners and many others. This outreach strategy includes two phases. The first phase is having beneficiaries update their contact information and will launch soon. The second phase is reminding beneficiaries to watch for the arrival of renewal packages in the mail; this phase will launch approximately 60 days prior to the end of the PHE. In prior discussions with our federal partners, it has been discussed that state Medicaid programs would be provided with a 60-day advance notice before the PHE is expected to end. We are anticipating another extension of the PHE, which is currently scheduled to end on April 16, 2022. We will continue to share more information and presentations on the PHE unwinding as things unfold. For individuals who are no longer eligible for Medi-Cal after the renewal process, we are looking at ways to transition them to other coverage. Senate Bill (SB) 260, which will become operational on July 1, 2022, would require Covered California to automatically enroll qualifying individuals who transition from Medi-Cal eligibility into Covered California eligibility. This would require that the consumer be enrolled in the lowest cost Silver Plan, or with their previous MCP if their MCP participates in Covered California. Individuals can choose to be enrolled in the same Medi-Cal health plan after transitioning to Covered California, to the extent that the plan participates.

DHCS Telehealth Policy Developments Update

Mollow: During the PHE, DHCS responded quickly to the revision of telehealth services and supports in our policies. We saw increased utilization of telehealth modalities during the PHE, and DHCS leveraged federal flexibilities surrounding telehealth. Because of Assembly Bill (AB) 133, we were required to convene a Telehealth Advisory Workgroup, and information from that workgroup informed future policies related to telehealth in the Medi-Cal program. We issued a policy paper in February 2021. We are looking at modifiers specific to telephone-only services as well as strengthening policies around patient consent, as well as telephonic evaluation and management. We will also continue to leverage our existing utilization management protocols.

Netherland: Are there thoughts on how the issues with the rollout of Medi-Cal Rx can be a learning opportunity as we look at go-lives for other CalAIM initiatives?

Cooper: Medi-Cal Rx was a massive implementation that touched all 14.5 million lives. Medi-Cal Rx is slightly different from other CalAIM pieces because we brought in a vendor to implement it. Every time we implement a large change, the readiness review is critical. There were some things that we did not anticipate happening, and there were things we planned for and knew would be complicated. A significant number of staff called in sick due to the Omicron variant, which affected our ability to process PAs and meet designated call turnaround times. The biggest lesson learned is ensuring readiness prior to go-live is as comprehensive as can be.

Netherland: Where can I find more information about escalation for CCS and the development of a clinical liaison? I also did not see what fee-for-service (FFS) beneficiaries are supposed to do around address changes.

Cooper: We are regularly working directly with our CCS advocates on the clinical liaison process. Once we are ready to roll this out, there will be an education and outreach engagement effort to make sure the right people are informed. I do not know the details of it yet, but we're happy to bring that back to this group. Updating contact information is the same for FFS as it is for other beneficiaries.

Mollow: Individuals can go directly to their counties to update their contact information, or they can update their information online with the county eligibility system. We are hoping to leverage the DHCS Coverage Ambassadors to remind people of ways they can do this. MCPs can also communicate information back to the counties about changes in contact information that a beneficiary has provided to them.

Netherland: Is it recommended to go through the county of residence or county of origin?

Mollow: The county where their eligibility was established.

Lauterbach: We expect the PHE to extend to July; from there, would the notifications be 60 days prior or after that date?

Mollow: We will be notified 60 days prior that there would be no further extensions of the PHE.

Cooper: There are two 60-day pieces. We are hoping to receive an update from CMS 60 days prior to the end of the PHE that it will not be extended. Then, once the PHE ends, the first redeterminations happen 60 days after.

Lauterbach: As part of the PHE ending, is there a readiness assessment being done at local counties? Some counties are struggling with workforce. Do we have a sense of how many renewals are completed?

Mollow: It is important to us that our county partners are ready. We will be working on an implementation plan of our unwinding and will be doing readiness surveys. We have around 30 percent of our beneficiaries who have renewed through ex parte processes. We will also be sending regular data reports to CMS through the unwinding period.

Cooper: We are looking into flexibilities for how to maintain individuals in coverage including increasing our reasonable compatibility threshold to reduce the number of touches. We are hoping this will simplify the work at the county level. For the 2 to 3 million that may drop off Medi-Cal coverage, we are hoping they remain in coverage through Covered California or other employer-based coverage.

Schumann: Regarding the Medi-Cal Rx implementation, is there a process for advanced communications to guardians, caregivers, or parents regarding expirations of the PAs? For telehealth, we need to ensure access to technology by constituents. I have found potential resources through the FCC Affordable Connectivity Program that offer full covered internet and taxpayer-subsidized computers for individuals who can apply for that program. Is there encouragement by DHCS for that program? I am happy to share that information. Regarding the PHE unwinding, I love the idea of the ambassador program. Can this email address be shared yet? Is it possible to use USPS national change of address database to further reach out to individuals who do not directly update their address to DHCS? It would be advantageous to have a future meeting for the panel to see data related to renewals and disenrollment data.

Cooper: For the PA changes, we are discussing what the best practices of communication are. We are also considering extending PA time periods. On the telehealth technology information you have, please share that with Rene. On the PHE unwinding, we will track the reporting very closely as we will be required by CMS to have a public dashboard for tracking renewals and disenrollment. The full unwinding plan will be released in mid-April.

Beck: Undocumented individuals ages 50 and older are moving into full Medi-Cal on May 1, 2022. Once the PHE ends, will they immediately get information that they now must apply? Ambassadors need to work closely with that population.

Mollow: Currently, enrolled individuals do not need to reapply. They are getting notices that will tell them about this. As we are doing the unwinding, we will be relying on the existing renewal dates.

Beck: We are concerned about people who will not be eligible for anything, such as those ages 26-49 and undocumented, who will not be eligible until the new budget.

Mollow: They will still be eligible under restricted scope Medi-Cal. If they are undocumented, unfortunately, they are ineligible to purchase coverage through the state-based exchange.

Beck: Who is working specifically with that population? Can we have ambassadors who recognize the limitation and help with transition?

Mollow: We will take that back as we look at our toolkits and messaging.

Beck: If I can be of service, feel free to reach out. For the newly introduced bills on pupil wellness, it should be recognized that some of the services would be for parents. Does anyone have knowledge on that? I will find the bill number and get back.

Medi-Cal's Strategy to Support Health and Opportunity for Children and Families

Babaria provided an update on Medi-Cal's Strategy to Support Health and Opportunity for Children and Families. Slides are available here: https://www.dhcs.ca.gov/services/Documents/031722-MCHAP-presentation.pdf.

Weiss: One area that may permeate all of this is data. What gets to DHCS may not be what is really happening at the front line. We know there is a data disconnect. Is there any renewed energy around making sure data is captured, integrated, and aggregated?

Babaria: We are looking at what we can do to bolster data exchange and accuracy of data. The PHM service is looking to aggregate data at the state level. The PHM service intends to bring in all of the data streams outside of Medi-Cal, in addition to what we have within Medi-Cal.

Cooper: Our Equity and Practice Transformation Grants currently proposed in the budget will help us get the provider-level gathering of information. We are hoping with practice transformation grants, providers can use that to update their electronic medical record to better capture exactly what they are doing.

Sonnenshine: For implementing these strategies, what is the state's approach for aligned activity? When considering that equity requires moving barriers, how will the statewide population approach balance at the state-level compared to the national level? As we are expanding the breadth and depth of services offered to children across the state, how are we going to support the provider pipeline and workforce?

Baass: Concerning the workforce, there is $1.7 billion in the budget for the Department of Health Care Access and Information (HCAI). Some of that is going toward the

workforce we know we need to develop. We are researching which professions can help deliver these services.

Babaria: We clearly have workforce shortages in certain areas. There is a lot we can do on the ground in terms of how care is delivered. We have intentionally, through our CalAIM efforts, pulled in representatives from other departments. We want the standard to be the same across the state, and to think through what are the local needs and community barriers. We are thinking about what the rubric needs to be to measure social needs for children.

Motadel: I did not see any mention of battling misinformation. I think this will be a critical initiative. Can you talk about how that will play into this program?

Babaria: I think there is clearly a component for member education. As part of the COVID-19 Vaccination Incentive Program, our health plans and providers have a deliverable on how to combat misinformation. There are many lessons to learn from this as to what worked and what did not. We are looking forward to analyzing the outcomes from that program.

Motadel: I think we have to recognize that the vaccination efforts worked much better in adults than in children, so we should continue to look at other options.

Babaria: I agree. Please feel free to send any strategies my way.

Netherland: There is a gap between policy on paper and what happens in practice. Is there room to increase the role of the parent or caregiver? Are there thoughts on how to include beneficiaries (since we are talking about children, we would include the parent or caregiver) and their experiences of the benefits? It is important to have very robust representation of beneficiary voice.

Babaria: A pillar of the quality strategy focuses around elevating the member voice and experience. We envision this at the state-level through advisory councils as well as at the plan level for the new consumer counsels as part of the managed care plan procurement. For all of these initiatives, we are trying to reach out more to bring in the member voice in an intentional way, such as through focus groups or sitting on committees. The practice transformation payments look at local transformation in alignment with all of these initiatives.

Netherland: I think it is important that consumers are fully integrated into all workgroups and not siloed. There needs to be assessment of how successful things like community advisory councils execution is, especially the parent or stakeholder strategies. What would the details of accountability measures look like to ensure the robustly implemented initiatives?

Cooper: We tried to put new requirements in the procurement. For example, health plans historically did not have to report out what their recommendations were and how they implemented them. This is a new requirement we will have moving forward. Maybe

we can discuss offline on what training opportunities families use or need to be successful in informing the work we do.

Baass: We are in the process of designing what our state-level consumer advisory committee will look like and how to implement best practices.

Netherland: I would love to support the work in any way I can. We should also think about how we make these accessible. Some language in the contract is not readily accessible to some.

Stanley Salazar: What are all of the steps before the administrative integration that can enhance and move us incrementally through integration? The carve-out of mental health and behavioral health are destructive. The way in which they are administered creates silos. I know we are rolling out a No Wrong Door policy for mental health and substance use disorders (MHSUD) this year; how do we incrementally bring providers and counties into a practice of integration now? That way when we get to integration, we are not looking at agencies and providers who are starting at the beginning of integration, as opposed to having practiced.

Cooper: I think you are referencing two or three different levels of integration. One level is between our physical care system and our counties. Within CalAIM, we have a proposal to have full integration by 2027; some integration has started this year. This includes a five-year road map and milestones. For a future presentation, we could bring back the MHSUD integration, administrative and clinical, and how we are thinking about that road map to get to 2027. The end goal is to have one plan, rather than two. On the provider side, we are hoping when the payment reform goes live in July 2023, it simplifies our ability to work with clinical integration.

Stanley Salazar: Just as important as dispensing information to consumers is how we can get messages to providers and operators so they can prepare for the changes.

Cooper: We will take that back and make sure to think about a communication strategy specifically for providers.

MCP Request for Proposal (RFP) Procurement Update

Cisneros provided an update on the MCP RFP procurement. Slides are available here: https://www.dhcs.ca.gov/services/Documents/031722-MCHAP-presentation.pdf.

DiLuigi: I would like to hear more about how this approach might disparage carve-outs. Carve-outs create problems in coordination and quality of care by reinforcing silos. I think we need to push back on the provider community as well. Many times, you see this avenue taken of avoiding lower margin services. The larger MHSUD health systems do not have this capability and could not put together coordinative services. I want to emphasize the importance of oversight and creating the right kind of environment for quality and coordinated services.

Cooper: This procurement is not changing which benefits are carved in or out of MCPs' responsibilities. Those types of decisions would be larger through the budget process and maybe even voting. Historically, we have had more collaboration with mental health plans. In this new RFP, we are extending that to the SUD side. While we can't include everything in the MCP contract, we can look at how we can increase integration without making one entity fully responsible for everything. We increased the amount and types of relationships we require our MCPs to have, such as who they should have a Memorandum of Understanding with and how data sharing should be done across our delivery systems. One of the pieces in our new procurement is closed-loop referral requirements, which has never been required before.

DiLuigi: We need to focus on this and look for ways to bring about integration of care.

Baass: For the first time, our comprehensive quality strategy includes metrics related to specialty mental health and substance use disorder. We are recognizing all the different delivery systems that support Medi-Cal beneficiaries.

DiLuigi: Would you agree that DHCS and county health plans have to set the tone?

Baass: We are continuing with a quality perspective and data reporting. Some is payment reforms, and some is the behavioral health codes to get information that is more refined on what mental health services provide.

Weiss: In reference to the delegated model, can you walk through how you see this playing out? A concern is that sometimes the terms managed care plan and health network are used interchangeably. Will there be requirements passed down to health networks to make those changes?

Cisneros: The Delegation Reporting and Compliance Plan is a new requirement that we will have to work with plans on. The ultimate goal of the delegation reporting plan is for the Department to have a full view of the members' access and how the Prime plans are providing access through their delegated model. The Plan will need to justify the need for subcontractors and show that delegation is to the members' benefit. We have defined in the contract to delineate the primary plans, the subcontractor, and downstream subcontractors so that reporting requirements on the Delegation Reporting and Compliance Plan would be more clear.

CalAIM Enhanced Care Management (ECM) and Community Supports Update

Cisneros provided an update the CalAIM ECM and Community Supports. Slides are available here: https://www.dhcs.ca.gov/services/Documents/031722-MCHAP-presentation.pdf.

Stanley Salazar: What is the plan for a justice-involved youth stakeholder group?

Cisneros: We do not have a specific timeframe yet. All updates will be provided on the ECM and justice-involved webpages.

Cooper: We have a specific children and youth ECM advisory group. We are adding more justice stakeholders to that group to help inform our efforts. Right now, we are covering eligibility and benefits, and we plan to get to reentry, which will include ECM connection, especially in youth correctional settings.

Schumann: Is there coverage or Community Support available to cover an A0998? The city bills separately, stating it is a non-covered benefit from state. We received a bill for $300 that is not covered by Medi-Cal.

Cooper: Typically, in Medi-Cal there is no cost-sharing. If you could send us an offline message of the code you are referencing, we will look into that for you. At this time, we're not adding new Community Supports, as it would take extensive negotiation and review with CMS.

Netherland: I wonder about an adult model and how this has been for children and families. I want to support looking at inclusivity of risk versus utilization patterns. How does high-touch work for families that have a lot of medical complexity? Will there be a rule on what beneficiaries perceive their needs to be? How do we know what will be enhanced? From whose perspective are we gathering that data? Has there been a discussion about minimum spending per child? Do we have know what percentage of the budget or what allocation we are looking at in terms of per child expenditure?

Cooper: One of the things in the standardized ECM contact requirements is that an enhanced care manager must be willing to work across delivery systems to take on the care coordination of all services and be the main point of contact for the family or individual, rather than having multiple case managers. The intent behind ECM is meeting people where they are. These are the most vulnerable who need an additional level of touch. They are not necessarily providing the medical services, although we encourage that if they can. In our MCP procurement, we will require MCPs to report on children utilization separately so we can understand the types of services, or lack thereof. We'll need to take that back and think about how MCPs can survey individuals who receive ECM services so we can know it is doing what we designed it to do.

Beck: I appreciate the effort on accountability outcomes. In the creation of the community health centers, are we giving guidance to the plans of how to do this, monitoring how they do this and whom they are selecting? Having more providers in school is a very successful model for children and families.

Cisneros: We thought a lot about that when building these requirements. All plans will have to show they can meet these requirements initially. We are building more into our monitoring program to address these requirements at various intervals. The new 2024 MCP contract is very exciting because of these new established intervals.

Cooper: The benefit for schools is not just for behavioral health. For Medi-Cal MCPs, there is a different requirement in the procurement contract. Starting January 1, 2024,

they will be required to provide Medi-Cal services in schools, near schools, or at school-linked community centers.

Beck: How do the families or parents fit into the requirement of providing services in or near schools?

Cooper: I do not have an answer right now. There are conversations on these pieces between DHCS and the California Department of Education.

Baass: We are going to require more public posting of this data and the actions that plans are taking, particularly concerning equity metrics, for greater transparency.

Member Updates and Follow-Up

Arroyo: We should include an update on the Governor's new Community Assistance, Recovery, and Empowerment (CARE) Court proposal, and how that would apply to children. We should discuss the new contingency management program for SUD and how that might benefit children.

Netherland: I would like to hear more about ECM and the thinking around that for children. Also, an update on the Whole Child Model evaluation. Another item is financing around behavioral health initiatives being rolled out for children in school-based and community settings. Are there thoughts at the system and policy levels on how this will be integrated into medical health? How is it tied with pediatricians?

DiLuigi: We are dealing with the breadth of new programs and enhancements. If it is possible, I would like to have the intended discussion items sent to us as far in advance as possible to give us time to think about it in preparation for the meeting.

Weiss: We should start seeing some quality outcomes in the Whole-Child Model. I would like to explore emergency department visits, hospitalizations at a population level, and maybe some clinical metrics.

Eagilen: I would like an update on the doula services benefit.

Public Comment

Damian Carroll, Vision to Learn: I am commenting today to advocate for increasing access to vision care for California's schoolchildren. About 35 percent of children at the Title I schools we visit fail the vision screening; about 80 percent need glasses; and the vast majority have gone without any vision care during COVID-19. The vast majority of these children are covered by Medi-Cal.

Cheri Stabell, *Child Health and Disability Prevention Program, Los Angeles County*: Regarding the proposal to sunset the Child Health and Disability Prevention (CHDP) program on July 1, 2023, the CHDP is currently the gold standard in pediatric care. CHDP can be an asset to the CalAIM initiative moving forward.

Susan McLearan: Dental carries are the most pervasive and preventable childhood disease. My organization would appreciate a bulleted list in areas where inequities in the utilization of preventive dental service is addressed, as well as strategies to address children and adult utilization and enrollment of state programs providing preventive dental services.

Monica Montano, California Dental Association: I would like to echo the comment made on the elimination of the CHDP program. The local CHDP programs provide essential training and care coordination for children. Tooth decay is one of the main areas evaluated during the CHDP assessments among children. There is little to no information on how many children have dental referrals.