State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

March 16, 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; 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; Katrina Eagilen, D.D.S., Licensed Practicing Dentist.

Members Not Attending: Ron DiLuigi, Business Community Representative.

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

DHCS Staff: Will Lightbourne, Rene Mollow, Brian Hansen, Mike Dutra, Nathan Nau, Norman Williams, Jeffrey Callison, and Morgan Clair.

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 January 26, 2021, was approved, 14-0.

Opening Remarks from Will Lightbourne, Director

Director Lightbourne provided DHCS updates. The Centers for Medicare & Medicaid Services (CMS) approved California's waiver application to make testing available in schools for students covered by Medi-Cal. The approval was retroactive to February 1, 2021, and will continue for 60 days after the end of the federal public health emergency (PHE).

The state developed an equity formula for vaccination distribution. CMS increased the Medicare reimbursement for vaccinations, and the American Rescue Plan Act of 2021 aligns Medicaid reimbursement with Medicare reimbursement.

Medi-Cal Rx was scheduled to go live on April 1, but we are delaying implementation to review new conflict avoidance protocols submitted by Magellan Health, the project's contracted vendor. The systems were ready, but Magellan is potentially being acquired by the Centene Corporation, and we had to ensure there is a strong conflict avoidance plan in place to protect the sharing of data given the fact that Centene owns and operates health plans and specialty pharmacies that participate in the Medi-Cal program. We don't have a new go-live date, but we expect to know in early May if this issue can be resolved. If not, we'll set a new go-live date and work with the managed care plans (MCPs) to determine how much lead time is needed. In the meantime, a small number of offices haven't enrolled in the state's system. There was some interest among the California Children's Services (CCS) community for a specific liaison function between the third party administrator and their networks. We'll use the intervening time to create the liaison functions.

There may be additional hearings for the May Revision related to the American Rescue Plan Act of 2021, which has provisions related to DHCS' service areas. Among the provisions: full Medicaid benefits to pregnant and postpartum care for a full year, and additional support for Home and Community-Based Services.

DHCS is working with consultants (Sellers Dorsey) on our health care disparities work and expects to have a completed product by April, in time to link with the CalAIM and MCP procurement efforts. We have been working with the California Department of Public Health (CDPH) on bridging health equity and behavioral health.

Jan Schumann: Is it public record which pharmacies are not on board for Medi-Cal Rx, and do you see advocacy work in this space?

Lightbourne: I'm not sure if it's public record, but there is not a need at this point for external pressure.

Arroyo: Can you speak to any relevant budget hearings directly related to the Governor's proposed allocation of $400 million to expand mental health services in schools? Would it be a bill or included as budget trailer language?

Lightbourne: The schools proposal was introduced in the Assembly. We've been working with advocates, the Department of Education (CDE), and the County Behavioral Health Directors Association to refine this proposal. Budget trailer bill language is expected.

Arroyo: A federal initiative is soliciting applications from states and will fund up to five states to have a collaborative learning community, learning to implement school-based mental health services. Has California submitted an application?

Lightbourne: No. Please send a copy of the application.

Arroyo: Can you elaborate on the maternal health provisions in the American Rescue Plan Act of 2021?

Lightbourne: The provision created the option for a five-year period in which states can extend Medicaid eligibility for pregnant or postpartum persons for 12 months. Currently, California has a two-month extension that can be extended to 12 months if there is a behavioral health issue.

Sonnenshine: I appreciate DHCS contemplating the ramp-up time that health plans would need to implement Medi-Cal Rx. Could implementation push out to 2022?

Lightbourne: We want to be realistic and reasonable, but there are potentially budget savings with the implementation of Medi-Cal Rx, so there's a fiscal dimension for not wanting to delay.

Sonnenshine: For the behavioral health funding in schools, is it for technical assistance? And can health plans preview that work as it's being discussed with school districts?

Lightbourne: Strictly technical assistance, and yes, we will work with the associations.

Weiss: For Medi-Cal Rx, will continued work on the contract drug list continue so we can have input on the pediatric components?

Lightbourne: Yes. We will use the intervening time to encourage prescribers.

Status of DHCS Telehealth Policy

Rene Mollow provided an update on DHCS' telehealth policy. Slides are available here: https://www.dhcs.ca.gov/services/Documents/031621-MCHAP-presentation.pdf

Hempstead: Can you explain how these guiding principles and allowances will interact with the typical managed care organization? We focus on payment parity, but are patients also getting parity? What is the engagement of stakeholders at the parent and patient levels?

Mollow: Our expectation is if you have a set arrangement with a MCP for a visit, you'll be paid the same amount for a synchronous visit if you're doing it via a telehealth modality. For telephonic audio-only services, we'll be establishing a lower reimbursement structure. Our expectation is that MCPs will similarly follow suit. Accountability and transparency are extremely important to us. To the extent that providers are accurately capturing and reporting the use of telehealth modalities, then we can start to measure the pre-and-post PHE trends.

Lightbourne: There was a dimension to Dr. Hempstead's question regarding whether the quality of care is improving. We'll need to measure this closely. Quality of care and patient choice are critical.

Hempstead: Particularly looking past the PHE, there's a temptation that telehealth is more convenient. But there needs to be checks and balances to make sure that quality of care isn't lost.

Schumann: Is there a way to add wording for reimbursement for parity that the patient voluntarily consents to that form of delivery?

Mollow: We do indicate that in our policies. We will make sure that it's clearly indicated.

Netherland: I'm interested in looking at quality measures and equity. For working families, telehealth has the potential to increase equity for care. I'm also interested in outcome data and metrics that could compare performance between different MCPs and payers to ensure telehealth services do have high quality and are supporting measures that increase equity.

Mollow: We will consider this information. With the work that we're doing for CalAIM and Medi-Cal procurements, there are opportunities to further refine the work we're doing with an equity lens.

Lightbourne: We are very pleased with the appointment of DHCS' new Deputy Director for Quality and Population Health Management and Chief Quality Officer. As we pull together all quality functions, we will have a structure focused on accountability and quality.

Weiss: The quality metrics are important. There's work being done by the American Academy of Pediatrics on objective quality metrics. It would be incumbent upon us to gather objective data, not only on clinical quality outcomes, but also the cost of care. Is telehealth also a modality to help us achieve triple aim outcomes? Will relaxation around care being delivered across state lines be included in the policy? We saw an uptick in college students using telehealth.

Mollow: To the extent that these providers are enrolled in Medi-Cal that would not change in their ability to render services to our beneficiaries. We will need to monitor this to ensure providers participating in Medi-Cal are enrolled and vetted for program integrity.

Arroyo: When is the last date for feedback prior to sending these recommendations to CMS?

Mollow: For the policies, we'll work with stakeholders to see if there's additional feedback. There is also an opportunity for public feedback when we submit the State Plan Amendment. If there is a particular area that you have a concern about, please let us know.

Arroyo: In the telehealth policy recommendations, there is nothing related to working toward achieving or attempting to eliminate obvious health inequities in the state. We must look at the metrics that will be identified.

Mollow: The new Deputy Director for Quality and Population Health Management will look at quality metrics and outcomes. There's a lot of work to be done to eliminate health inequities and disparities in Medi-Cal.

Beck: I'm thrilled that video platforms will still be usable. From an equity point of view, it would be helpful if there were funds or resources to assist families where you can speak or work with someone, much like with promotoras. Similarly, when people apply for Medi-Cal, like the Federally Qualified Health Centers (FQHCs) that allow virtual applications, it would be helpful to have a section on the website instructing people how to apply. It also seems like you'll set up a separate billing stream for telephonic visits. We've encountered a subset of our patients who don't have a smart phone or computer or who have limited literacy. In some situations, we've provided a tablet to a patient through a health plan or subsidized program to allow the person to meet the requirements. We've found that Zoom televisits can allow a specialist, primary care physician, and translator on the line at the same time. How can we make this happen across Medi-Cal systems?

Mollow: For telephonic visits, it would still be an allowable modality that can be billed, but not at the same payment rate as face to face.

Lauterbach: Will telephonic care be part of the Alternative Payment Methodology (APM) model discussion?

Mollow: The APM model is intended to launch in January 2023. We are having discussions with our clinic partners for the APM to incorporate telephonic and other modalities.

Lightbourne: The APM schedule is intended to develop an entirely different reimbursement system.

Lauterbach: I'd advocate for a quicker schedule. FQHCs are huge providers for Medi-Cal patients. For telephonic behavioral health visits, we've seen great things happen for teens in terms of flexibility to do things over the phone. There's stigma associated with them going into the school's counseling centers. They have more anonymity when accessing telephonic services.

Mollow: Behavioral health telephonic visits are included. As a reminder, we have a "cheat sheet" in the telehealth proposal that takes you through different modalities pre-and-post PHE.

Beier: These MCHAP meetings have a tendency to run technical, and it's difficult to keep up. Since these meetings are open to the public, it would be helpful to explain things. It's great that there are new patient appointments on telehealth as it opens up access to specialists. There was mention of federally designated service areas and an opportunity that diminished. Could you explain what that is?

Mollow: We will make note of the technical terms that we use and work to do a better job. Federally designated service areas are requirements set forth by the Health Resources and Services Administration (HRSA). HRSA is a federal entity that oversees FQHCs and Rural Health Centers (RHC). They have a designated service area to serve their population. Within that service area is how they can operate under those federal

requirements. Other provider types do not have the same types of limitations from a federal perspective. Providers must meet federal requirements to receive the federal designation and receive allowable funding.

Schumann: Regarding access to technology, would there be an option for a provider to order internet-enabled devices to connect with their patients through a durable medical equipment (DME) provider, similar to how a physician orders glucose monitoring devices?

Mollow: I do not have knowledge as to whether or not DME providers would carry such devices. For purposes of devices deemed DME, such a designation comes from the Food and Drug Administration (FDA). Not clear how such a device would meet the requirements to be classified as DME.

Arroyo: Can you speak to the federal change to the public charge rule?

Lightbourne: We recently issued a joint press release celebrating the fact that this racist policy has been effectively undone. The public charge provisions that were established by rule a few years ago no longer exist. We'll have a heavy lift communicating with people who have been intimidated out of seeking services. We must rebuild their trust in government.

Beck: Do you have any thoughts about the mechanisms for rebuilding trust?

Lightbourne: Not yet, partly because so much energy has been going into the vaccine strategy. I suspect it will be through the same channels. When we look at enrollments over the past year and a half, we notice the reduction of new enrollments in Medicaid by people who self-identified as Hispanic or Latino. The PHE started essentially when the public charge rule went into effect.

Beck: You may want to link it to the vaccine work that's being done, and encourage people that they're safe.

Hempstead: The point about technical difficulties for telehealth visits is very well taken. Even under the best circumstances, it can be difficult, so we can imagine where some of the barriers would be in terms of health inequities. Lastly, we have to be very careful about keeping the medical home intact. The idea of having remote services that are so geographically remote where one loses the ability to see the provider in person is a conversation we must have.

California Advancing and Innovating Medi-Cal (CalAIM) Update

Brian Hansen and Mike Dutra provided an update on two initiatives for CalAIM: Enhanced Care Management (ECM) and Population Health Management related to children. Slides are available here: https://www.dhcs.ca.gov/services/Documents/031621-MCHAP-presentation.pdf

Arroyo: What extent do you envision the mental health plans (MHP) managing either ECM or In Lieu of Services (ILOS?

Dutra: We envision MHPs taking on the role as ECM providers. The qualifier is that the MHP should manage ECM, and they must be willing to provide those additional core services.

Hansen: The intent of ECM is to provide coordination across the full spectrum of care – social services, medical, behavioral health, etc. It may be appropriate to have the MHP or specialty mental health services (SMHS) provider be that coordinator.

Stanley Salazar: My concern is the capacity in the SUD field to make the transition to this standard of care. Have you anticipated the challenges that provider organizations will face in delivering these standards of care? There will be readiness and capacity issues. How do we make sure that the capacity to provide these services is available, and how do we get the plans ready?

Hansen: We will consider your comments. Capacity building is part of the thinking behind the staging of implementation. Capacity has already been developed for target populations that are launching earlier. There are additional focused target populations for ECMs that weren't present, particularly focused on children and youth.

Weiss: My understanding is that this is designed to migrate away from Health Homes and Whole Person Care (WPC) programs. How does this integrate with the Whole Child Model (WCM)/CCS and the seniors and persons with disabilities program? For a lot of these care management programs, the model of care currently exists. I worry about the redundancy of work and families getting to their health assessments/health plans for care. In counties where there might be a delegated model, how does that fit in?

Hansen: We will ensure that all MCP requirements flow down through to the delegation. For CCS and WCM, the ECM services with their new and enhanced focus on children and youth, require a different level of depth and thinking of these interactions with ECM services. We don't want to have duplication, but we want to fill any gaps. There's deep thinking about what you've mentioned happening right now.

Dutra: When we released these documents for comment more than a year ago, we received questions about needing more criteria around these target populations. The comment period just closed on the other documents, and we've heard these same comments. We've been exploring with local CCS leaders and trying to refine how these all fit together. To your point, we don't want to have a child with two case managers. We expect that around May we will release final contract language with refined target populations.

Eagilen: Is ILOS tied into the ECM program, or is it independent?

Hansen: It's both. They're separate programs and services, but we expect a large portion of ECM to connect together the systems and services and ILOS to fill gaps in direct services.

Eagilen: You mentioned that it was optional to provide this care for members, so how is it going to be monitored?

Hansen: Part of that is the process prior to implementation whereby we're receiving a model of care document from a MCP that details how it plans to do these things, what ILOS they'll implement, and how it's integrated into their system of care.

Dutra: Once a new initiative like this is implemented, we'll do immediate, interim supplemental reporting, and it extends to quarterly reporting to the MCPs. We will compile data points in the first year until the encounter data are sufficient. Because we're releasing coding guidance, all of the ILOS encounters must be coded and reported to us.

Eagilen: For ILOS compensation, is it patient dependent or per patient level that only so much can be allocated per given year?

Dutra: In general, we don't have limits on that, and we haven't issued limits for MCPs to cap ILOS. There are inherent parameters because it's supposed to be ILOS, so it's at the MCPs discretion. They will report those costs to us over a period of time that gets factored in.

Hansen: Many of the MCPs are providing some of these services because it's the right thing to do, but this will allow them to get credit in their rate development processes.

Beck: Related to social determinants of health (SDOH), this could occur within the coding that you mentioned. For the individual risk assessment (IRA) survey, will you provide a template or requirements? There has been an issue with the mental health carve outs. Things would fall through the cracks for a child with serious SUD because the communication between the systems doesn't always work well. How would this program change that to allow for fluid communication and support?

Hansen: Broadly, CalAIM is focused on filling the gaps. For ECM, we'll have one care manager to ensure providers are communicating with each other. DHCS is standardizing the IRA survey tool. The SDOH gives you a few tools; if it's coded, MCPs can find and identify that data.

Beck: I propose to elevate SDOH by recommending that they're included in the care plan.

Sonnenshine: I want to echo comments in terms of the standard of care through this implementation of the delivery system, and in some instances, the complete development of a delivery system to provide a new benefit. The plans are concerned about the additional detail that's needed to ensure we can put forth the best transition plan for a complete model of care. We understand the urgency to implement ECM and

ILOS, but how do we do so while ensuring capacity is available? For ILOS, to the extent that revenue made available, plans won't be able to provide those services initially because we must offset costs in other categories.

Arroyo: How much state general fund is being used to support this? What would incentivize me to provide temporary or permanent housing?

Hansen: ECM, ILOS, and PHM are not 1115 waiver programs; they will be covered under the State Plan. They are different than WPC where you have cost neutrality with federal funding. There are budget items in the proposed Governor's budget related to CalAIM initiatives, ECM being one, and these services will be matched. This package of CalAIM proposals would address problems that were raised. MCPs were asking for flexibilities to solve the problems. For ECM and ILOS, we're not talking about the entire homeless population, but rather medically appropriate, cost-effective ILOS for people who are having complex issues. It's a smaller subset and is designed to fill gaps. These services will not pay for housing; ILOS will be for temporary recuperative care or housing navigation transition services.

Lightbourne: $750 million was included in the Governor's proposed budget for a behavioral health infrastructure (outpatient placement and residential settings). ILOS will help support local providers in providing case management and services.

Arroyo: I just hope we have commitment from local housing authorities.

Hansen: There are efforts underway to ensure that these programs are connected with the entry pathways of local housing providers and authorities.

Weiss: We want to leverage the current infrastructure and don't want to lose these providers. MCPs in ECM/ILOS must contract with these providers. We anticipate capturing many of these housing providers already being used in the WPC sphere and build upon it.

Member Updates and Follow Up

Beck: We talked about the extended budgetary coverage for undocumented elders was not going to happen in this budget, but there was a bill introduced by Assemblymember Arambula looking at extended coverage. Are there any updates?

Lightbourne: There's a great deal of interest in the Legislature in extending coverage.

Beck: Is the Legislature working on longer term solutions for when someone falls out of coverage?

Lightbourne: Not that I have heard.

Stanley Salazar: Our regulatory system is based on silos. This project begins to realize and define integration and collaboration at the practice and case management levels. Are we looking at data dashboards across these silos at the state level?

Lightbourne: Yes, but not to anyone's satisfaction yet. We've consolidated our data and analytics sections to try to address this. CHHS is also trying to link across state data dashboards.

Stanley Salazar : We may want to consider an update on the Family First Prevention Services Act and how it will change the practice of social work and the delivery of child welfare services across the state.

Nancy Netherland: I'd like to revisit the Medi-Cal Children's Health Dashboard, specifically related to the conversations we had today about some of the metrics to be collected for accessing quality and equity of care. I'm interested in getting more information on how comparative performance data between MCPs can become available to consumers.

Hempstead: I want to put in a personal plug to get vaccinated this spring.

Eagilen: I would like to see the Dental Transformation Initiative (DTI) on the agenda and the problems concerning the funding lapse that Kelly Hardy mentioned. There were specific funds in Proposition 56 that were allocated for DTI.

Lightbourne: In the 1115 waiver renewal that CMS approved, one of the areas they did not approve was continued federal participation. The goal is certainly to not let the DTI end. We'll adjust budgets to make up for the fact that CMS discontinued DSHP funding that could have extended the DTI for another year. We are spending down what was left over, hence why the DTI is being moved up in CalAIM.

Schumann: The next meeting agenda should include how reimbursements for COVID-19 vaccines will be implemented at the state level for Medi-Cal providers.

Arroyo: For the next agenda, how will the American Rescue Plan Act of 2021 impact California's budget?

Beck: We should look at how key state departments - CDE, Housing and Community Development, and DHCS - collaborate, including barriers to collaboration.

Public Comment

Kelly Hardy, *Children Now*: I'm passing along a question from a colleague regarding the DTI. Funds to support the DTI will run out in mid-June. They'll need to figure out how to start the dental proposal in CalAIM early to avoid lapses in benefits and provider payments. Can you provide any information on this?