Child Health and Disability Prevention (CHDP) Program Transition Workgroup Meeting

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

May 3, 2023

Agenda

Welcome and Meeting Information	1:00-1:05
Roll Call	1:05-1:15
Policy Updates	1:15-1:25
March Meeting Summary	1:25-1:35
Children's Presumptive Eligibility and Monitoring and Oversight Follow-Up	1:35-1:55
Break	1:55-2:05
Overview of DHCS and CDPH Lead Screening Programs	2:05-3:00
CHDP Activities under the Newborn Hearing Screening Program (NHSP)	3:00-3:20
CHDP Activities Related to Oral Health Screening	3:20-3:40
Public Comment	3:40-3:50
Next Steps	3:50-4:00

Workgroup Meeting Scope

- Senate Bill (SB) 184 requires the Department of Health Care Services (DHCS) to conduct a stakeholder engagement process to inform the development and implementation of a transition plan and defined milestones to guide the transition of the CHDP program to other existing Medi-Cal delivery systems or California state departments, including:
  - Children's presumptive eligibility enrollment activities currently offered through the CHDP Gateway.
  - **Activities under the CHDP-Childhood Lead Poisoning Prevention Program (CLPP).**
  - The Health Care Program for Children in Foster Care (HCPCFC).

Housekeeping & Webex Logistics

Do's and Don'ts of WebEx

- Participants are joining via computer or phone (link/meeting info on CHDP Program Transition website)
- For technical support, email CHDPProgram@dhcs.ca.gov
- CHDP Transition Workgroup members: Use the Q&A box to submit questions
  - To use the "Raise Your Hand" function click on "Participants" in the lower right corner of your chat box and select the raise hand icon
- Other participants: Use the "Raise Your Hand" function to provide public comment during the designated portion of the meeting
- Live closed captioning will be available during the meeting

Note: DHCS is recording the meeting for note-taking purposes

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Workgroup Members

- **Anne Nadler,** Public Health Nurse, Alameda County
- **Beth Malinowski,** Service Employees International Union
- **Cheri Stabell,** CHDP Deputy Director, Los Angeles County
- **Diana Boyer,** County Welfare Directors Association of California
- **Eileen Espejo,** Children Now
- **Erin Thuston,** California Department of Social Services
- **Jack Anderson,** County Health Executives Association of California
- **Kate Ross,** California Association of Health Plans
- **Karen Motus,** HCPCFC Program, LA County
- **Kenzie Hanusiak,** Partnership Health Plan
- **Kim Saruwatari,** Public Health Director, Riverside County
- **Lori Gardner,** Public Health Program Manager, Madera County

Workgroup Members (continued)

- **Mary Giammona, MD,** Molina Healthcare
- **Megan Blanchard,** Public Health Nursing Director, Humboldt County
- **Monica Montano,** California Dental Association
- **Nancy Netherland,** CHDP Program, MCHAP Parent Representative
- **Nancy Shifflet**, Public Health Nurse, Shasta County
- **Rebecca Sullivan,** Local Health Plans of California
- **Shakoora Azimi-Gaylon,** California Department of Public Health (CDPH)
- **Tamica Foots-Rachal,** Family Voices of California
- **Tanesha Castaneda,** Program Manager, Santa Barbara County
- **Yasangi Jayasinha,** American Academy of Pediatrics California

DHCS Team

- **Susan Philip,** Deputy Director, Health Care Delivery Systems
- **Joseph Billingsley,** Assistant Deputy Director, Integrated Systems of Care Division (ISCD)
- **Cortney Maslyn,** Division Chief, ISCD
- **Sabrina Atoyebi,** Branch Chief, ISCD
- **Barbara Sasaki,** Section Chief, ISCD
- **Janeen Newman,** Unit Manager, ISCD
- **Daria Moore,** Nurse Consultant I, ISCD

DHCS Team (continued)

Medi-Cal Eligibility Division (MCED)

- **Daryl Hightower,** Unit Chief

Managed Care Quality and Monitoring Division (MCQMD)

- **Dana Durham,** Division Chief
- **Stacy Nguyen,** Branch Chief
- **Oksana Meyer,** Section Chief, Compliance & Facility Site Review Oversight Section
- **Adrienne McGreevy,** Health Program Specialist II

Medi-Cal Dental Services Division (MDSD)

- **Adrianna Alcala-Beshara,** Division Chief

Sellers Dorsey Team

- **Mari Cantwell,** Managing Director, California Services/Strategic Advisor
- **Sarah Brooks,** Director/Project Director
- **Laurie Weaver,** Senior Strategic Advisor/Subject Matter Expert
- **Jill Hayden,** Director/Subject Matter Expert
- **Felicia Spivack,** Director/Subject Matter Expert
- **Alex Kanemaru,** Senior Consultant/Project Manager
- **Olivia Brown,** Consultant/Project Manager

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Policy Updates

- CHDP Childhood Lead Poisoning Prevention (CLPP) in fiscal year (FY) 2023-24
  - Funding will be available in FY 2023-24
  - Allocation table remains the same as FY 2022-23
  - Activity reporting workbook and submission procedure remain the same
- CHDP Health Assessment Guidelines, Section 6: Blood Lead Testing and Anticipatory Guidance Revision
  - Updated CHDP program letter and provider notice will be released shortly

Workgroup Discussion

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March Meeting Summary

- The CHDP Transition Workgroup convened to discuss the following topics:
  - Current budget allocation overviews for the Health Care Program for Children in Foster Care (HCPCFC), CHDP-CLPP, and California Children's Services (CCS) programs.
  - Considerations related to future budget allocations, including reallocation of CHDP funding to HCPCFC and CCS.
  - Considerations related to the potential transition of current CHDP staff.
- DHCS will consider discussions from the March workgroup meeting as decisions are made related to CHDP resource reallocation. DHCS will share workgroup input with control agencies (e.g., Department of Finance) during the legislative process.

Homework from March Workgroup

- **CHDP Budget Allocations and Staffing Questions**
  - Feedback requested from workgroup members on key considerations, concerns, and outlooks on future budget allocation and staffing, including:
    - Suggested redistribution of current CHDP allocation toward HCPCFC and CCS monitoring and oversight.
    - Current distribution of administrative time and staff to CCS, CHDP, and HCPCFC programs.
  - Workgroup members also suggested topics for upcoming workgroup meetings, including today's discussion of CLPP activities and the upcoming meeting on HCPCFC as a standalone program.

Summary of Homework from March Workgroup

- Much of the workgroup feedback DHCS received focused on:
  - The importance of working toward a more sustainable HCPCFC staffing ratio.
  - The need for more detail and county-specific understanding of current staffing levels across the state (Note: DHCS will send out a survey to counties to collect relevant information).
  - The types of support needed as managed care plans (MCPs) continue to carry out current CHDP activities, such as provider training, and taking on new responsibilities once the program sunsets.
  - The proposed reallocation of CHDP funds. Most feedback suggested the majority of current CHDP funding should be reallocated to stand up HCPCFC.
  - The difficulty of reallocating existing CHDP staff to CCS and/or HCPCFC because of the distinct skill sets needed for each program.

Alternate Venue to Address

- In previous CHDP Transition Workgroup Meetings, workgroup members have asked questions related to:
  - General Medi-Cal application and eligibility process
    - If you would like to apply for health coverage or have questions regarding eligibility, please contact your local county office.
    - If we are unable to directly answer your question, please visit the Frequently Asked Questions page for answers addressing your specific inquiry.
    - To send an email with questions or comments about the Affordable Care Act/Covered California or Medi-Cal, fill out the security form on the Medi-CalNow page.
  - Presumptive eligibility (PE)
    - Hospital PE: DHCSHospitalPE@dhcs.ca.gov
    - Supports for members/families during and after the PE period: HealthNavigators@dhcs.ca.gov

Alternate Venue to Address (continued)

- In previous CHDP Transition Workgroup Meetings, workgroup members have asked questions related to:
  - PHE unwinding
    - For members
    - For DHCS Coverage Ambassadors
  - Vaccines For Children (VFC) program: MyVFCvaccines@cdph.ca.gov
  - California Advancing and Innovating Medi-Cal (CalAIM): CalAIM@dhcs.ca.gov. For example:
    - Intent of CalAIM
    - Status updates
    - General inquiries
  - Medi-Cal managed care monitoring: pmmp.monitoring@dhcs.ca.gov

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Children's Presumptive Eligibility (CPE) Follow-Up

CPE Follow-Up

The following table outlines additional questions and DHCS responses collected based on feedback received after the January and February CHDP Transition Workgroup meetings:

Question or Feedback	DHCS Response
If dental providers are going to be included as CPE providers, what is the plan for regulation and qualifications?	Our dental providers offer services in both fee-for-service (FFS) and dental managed care (DMC) delivery systems. In DMC, provider activities are monitored by the DMC plan, the Department of Managed Health Care for plan compliance, and our own monitoring, including Audits and Investigation (A&I) audits on an annual (partial) and triennial (full) basis. Dental providers will have to meet the same qualification standards as other Medi-Cal providers wishing to become qualified PE providers. DHCS' contractor's surveillance teams, DHCS' own contract oversight units, and DHCS' A&I teams are all responsible for oversight of Medi-Cal dental providers. Dental providers will have to meet the same qualification standards as other Medi-Cal providers to become qualified PE providers.

CPE Follow-Up (continued)

The following table outlines additional questions and DHCS responses collected based on feedback received after the January and February CHDP Transition Workgroup meetings:

Question or Feedback	DHCS Response
Multiple workgroup members asked about DHCS' plan for provider training and outreach ahead of the transition to CPE?	Initial provider notification has already taken place through a Medi-Cal Provider Bulletin, in addition to CHDP Program: Program & Provider Notices, distributed via email and posted to the CHDP webpage. Additionally, DHCS is reviewing and revising provider training materials for specific CPE provider requirements.
Will board certification be required for CPE?	Board certification is separate from the CPE process and is not a specific requirement for PE providers, though it may be a broader requirement for Medi-Cal providers.

Monitoring and Oversight Follow-Up

Monitoring and Oversight Follow-Up

The following table outlines questions and DHCS responses collected based on feedback received after the February CHDP Transition Workgroup meeting on Managed Care **Provider Enrollment and Credentialing**:

Question or Feedback	DHCS Response
What is the network provider application? Will the provider be responsible for sending the application directly to MCPs?	The network provider application refers to the application that providers complete and submit to MCPs to enroll as in-network Medi-Cal managed care providers, who are responsible for submitting their applications to MCPs. Providers can also choose to enroll through the Department's existing provider enrollment process.
How will DHCS offer support to providers on becoming a MCP-contracted provider?	DHCS directs providers to work directly with MCPs, as each MCP has their enrollment application process for providers to become a part of their provider network.
Post transition, when credentialing, what process will be in place to guarantee the providers are pediatric trained? When provider applications are denied, what process will be in place to document the qualification gaps and deficiencies that need to be addressed prior to reapplication? Who will be reviewing the training offered to guarantee it is as robust as that of current, local CHDP programs?	Please refer to All Plan Letter (APL) 22-013 for MCP screening and enrollment, as well as credentialing and re-credentialing requirements, APL 22-017 for site review requirements, and APL 23-005 for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) training requirements.

Monitoring and Oversight Follow-Up (continued)

The following table outlines questions and DHCS responses collected based on feedback received after the February CHDP Transition Workgroup meeting on Managed Care **Facility Site and Medical Record Reviews**:

Question or Feedback	DHCS Response
Will DHCS advise if they intend to align the CHDP tools to the updated Facility Site Review (FSR) and Medical Record Review (MRR) tools, which were updated in July 2022 to include updates from Bright Futures and USPSTF (US Preventive Services Task Force) A and B recommendations?	The current non-CHDP tools in APL 22-017 already meet current standards for on-site auditing.
Can DHCS better describe the type of reviews that will be happening going forward? Will these reviews be in person or electronic form review? The in-person review is critical for quality care.	All site visits are conducted in person, other than the temporary pause due to the public health emergency. For details on site review requirements, please refer to APL 22-017.
Regarding the periodicity schedule, will provider offices have the capacity to ensure that children will follow the schedule? For example, how many times will a family be contacted to make sure that the child receives their well-child visit, including necessary screenings and immunizations?	MCPs are responsible for ensuring the capacity of their providers through initial site reviews, and then through additional site reviews every three years. MCPs are also required to conduct outreach annually to all families with information about EPSDT.

Monitoring and Oversight Follow-Up (continued)

The following table outlines questions and DHCS responses collected based on feedback received after the February CHDP Transition Workgroup meeting on Managed Care **Facility Site Reviews and Medical Record Reviews**:

Question or Feedback	DHCS Response
Will MCPs do hands-on training, as it is important to assure children are screened correctly?	Certified site reviewers provide hands-on training when needed and appropriate.
How will MCP train provider networks and/or conduct follow-up training/oversight following medical site audits? Are any of these translated into measures that are articulated in MCP contracts?	MCP staff are responsible for conducting facility site reviews and have direct interaction with providers conduct training and oversight of all facility audits. Plans are required to comply with all contract and APL requirements: as part of APL 22-017, providers that do not perform well during the site reviews are placed under a Corrective Action Plan (CAP). MCPs are required to submit information biannually to DHCS of all providers that are under a CAP.

Monitoring and Oversight Follow-Up (continued)

The following table outlines questions and DHCS responses collected based on feedback received after the February CHDP Transition Workgroup meeting on Managed Care **Facility Site Reviews and Medical Record Reviews**:

Question or Feedback	DHCS Response
Please clarify how DHCS "continuously conducts provider site reviews for quality assurance." Can DHCS share the regulatory guidance on this requirement?	DHCS "continuously conducts provider site reviews for quality assurance" through a team of nurse consultants who are solely dedicated to conducting site reviews year-round. DHCS also requires biannual data submission of all provider site reviews as well as documentation of any deficiencies identified by the plan during an onsite audit. State law requires MCPs to have adequate facilities and service site locations available to meet contractual requirements for the delivery of primary care within their service areas. All primary care physician (PCP) sites must have the capacity to support the safe and effective provision of primary care services. For more information about facilities and service sites, see Title 22, California Code of Regulations (CCR), sections 53856 and 53230.

Monitoring and Oversight Follow-Up (continued)

The following table outlines questions and DHCS responses collected based on feedback received after the February CHDP Transition Workgroup meeting on Managed Care **Provider Training**:

Question or Feedback	DHCS Response
Will DHCS provide MCPs with the provider training materials used currently by the CHDP offices?	MCPs and counties are expected to work together during the transition. DHCS plans to standardize EPSDT training at this time.
Will MCPs be required to train providers to do vision, hearing, and anthropometric trainings?	Yes, MCPs must conduct ongoing training for network providers on required preventive health care services, including EPSDT services, such as vision, hearing, and anthropometric screenings.
Add that a MCP must also make a referral to a dental provider per Assembly Bill 2207. Will MCPs now train their provider networks on how to identify and locate available Medi-Cal Dental providers to make this referral (as part of closed-loop referrals)?	This is already a requirement of MCPs per their contract, including having a dental liaison to coordinate such referrals between dental providers and the MCP.

Monitoring and Oversight Follow-Up (continued)

The following table outlines questions and DHCS responses collected based on feedback received after the February CHDP Transition Workgroup meeting on Managed Care **Newborn Hearing Screening**:

Question or Feedback	DHCS Response
If a member does not pass the newborn hearing screening, what protocols do MCPs have in place to ensure the member is receiving follow-up care?	MCPs are required to have policies and procedures in place to refer newborns who fail a hearing screening to the county CCS program for a CCS eligibility determination. If within a Whole Child Model (WCM) county, the MCP would be responsible for ensuring the member receives the necessary follow-up services. MCPs also review medical records during facility site reviews to ensure hearing screenings are conducted and appropriate referrals are made by network providers.
The statement "Provider may send a child/youth through MCP for coordination of non-covered services after a positive screen" for a newborn hearing screening is not correct. Wouldn't any needed services be a covered benefit following a positive screen for a plan member?	Coordination and provision of services depend on whether the county is a WCM county. In WCM counties hearing services are a covered benefit, but in non-WCM counties hearing services are apart of CCS, which are carved out of MCP contracts.

Monitoring and Oversight Follow-Up (continued)

The following table outlines questions and DHCS responses collected based on feedback received after the February CHDP Transition Workgroup meeting on Managed Care **Monitoring and Oversight:**

Question or Feedback	DHCS Response
How will provider and clinic staff competency to perform screenings as recommended by Bright Futures, be assessed? Currently, CHDP staff provide onsite skills assessments and trainings to all new provider clinic staff on Bright Futures requirements, including vision/ hearing screening, developmental screening, Adverse Childhood Experiences (ACEs) screening, among others.	MCPs will continue to assess providers on if they are performing well-child visits adequately using the same method and frequency in which the CHDP program currently assesses CHDP providers. DHCS uses a scoring rubric for review of provider medical records, and providers identified as not providing the required screenings will be scored as deficient, placed under a CAP, and provided additional training and/or resources. The provider CAP is closed once the provider is found compliant with all requirements.
What reporting requirements will accompany the closed-loop referral process? How will DHCS conduct oversight and monitoring of these referrals? Additionally, should a referral be made to county social services to assist with filling out the Medi-Cal application and MCP enrollment?	DHCS currently requires MCPs to track their providers' referrals for follow-up services, and to ensure providers coordinate needed services for members. Referrals can be made to county social services if the family needs assistance with the application for continuing health coverage.

Monitoring and Oversight Follow-Up (continued)

The following table outlines questions and DHCS responses collected based on feedback received after the February CHDP Transition Workgroup meeting on Managed Care **Monitoring and Oversight:**

Question or Feedback	DHCS Response
How will DHCS monitor these expectations in order to ensure guidelines are adhered to, and how will DHCS hold MCPs accountable?	DHCS' existing process consists of ongoing provider site reviews, as outlined in APL 22-017, which also includes a scoring process that outlines the threshold of provider site review failure and necessitation of CAPs and activities by the plan and the provider to remedy any deficiency found. In early 2024, DHCS will begin receiving member level data gleaned from medical records obtained during site reviews, which will allow the Department to data mine for trends and analyze areas of AAP/Bright Futures that may be lacking; DHCS will work with MCPs if trends of deficiencies are identified to drive improvement.

Monitoring and Oversight Follow-Up (continued)

The following table outlines questions and DHCS responses collected based on feedback received after the February CHDP Transition Workgroup meeting on Managed Care **Monitoring and Oversight:**

Question or Feedback	DHCS Response
How have MCPs responded to their capacity to conduct outreach and/or to establish the necessary partnerships with community-based organizations, local health departments, local educational agencies, etc. (perhaps through the closed-referral services)?	MCPs are currently undergoing operational readiness in preparation for the new 2024 contract implementation, which includes establishing the necessary partnerships with community-based organizations, local health departments, local educational agencies, etc. that are required for the many different services and programs in the contract.
What will be the obligation of sites to report changes in their provider capacity? Specifically, will MCPs be replicating the notification processes that currently exist between local CHDP offices and providers/sites?	MCPs are responsible for establishing the capacity of their providers when they enter into agreements with them, and are then responsible for tracking the number of members it assigns to their providers based on their agreed upon capacity to serve the MCP's network. Changes in provider capacity is between MCPs and their providers to determine how to best communicate. Counties should share their best practices regarding notification if they believe it could benefit CPE providers moving forward.

Monitoring and Oversight Follow-Up (continued)

The following table outlines questions and DHCS responses collected based on feedback received after the February CHDP Transition Workgroup meeting on Managed Care's role in **Vaccination Rates**:

Question or Feedback	DHCS Response
In addition to contractual obligations, what other commitments will MCP carry forward to guarantee increased vaccination rates? What will DHCS be doing to enforce planning in this area?	Immunizations are a part of the core set of children's measures for Managed Care Accountability Set (MCAS), which means all MCPs will be required to meet a minimum performance level for vaccinations. To enforce minimum vaccination rates, DHCS will place MCPs on a CAP until addressed or take other enforcement actions, such as monetary sanctions.
Will DHCS create a transition-related immunization baseline? What will be the expected percentage of children to be up-to date on their well-child visits and immunizations? How will this be tracked post-transition?	DHCS already has minimum performance levels for vaccination rates that are monitored quarterly and trended regularly, so no measures need to be set specifically for the transition.

Monitoring and Oversight Follow-Up (continued)

The following table outlines questions and DHCS responses collected based on feedback received after the February CHDP Transition Workgroup meeting on **other** Managed Care considerations:

Question or Feedback	DHCS Response
Counties are eager to find ways to better partner with MCP plans today and well into the future. This is critical to this transition as well as the broader vision of CalAIM. How can the state play an additional role in supporting MCPs and counties in learning how to engage together to maintain the health of their communities?	Community engagement is one of the key areas of focus added to the 2024 contract, specifically regarding collaborating with community stakeholders on population health management strategies and adding more required elements to memorandums of understanding so that MCP relationships with third-party entities, such as counties, would be more impactful.
An area of concern is how critical, timely public health updates will be transmitted to MCP plans and from MCP plans to their provider network, especially those serving CHDP populations.	Counties should share their best practices regarding communicating public health updates if they believe it could benefit CPE providers moving forward.
It would be helpful to understand how MCPs are providing Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) services as well.	Please refer to APL 22-008 for specific MCP requirements regarding the provision of NMT and NEMT services, and APL 23-005 for EPSDT NMT/NEMT requirements.

DHCS Site Review Unit: Oversight and Monitoring Activities

- DHCS/MCQMD adheres to PCP site review requirements outlined in APL 22-017.
- Each MCP is assigned a DHCS Nurse Evaluator as their primary contact.
  - MCPs submit data for all PCP sites reviewed on a biannual cycle.
  - Data are reviewed by DHCS to identify providers with low or failed scores.
- As part of the mandatory biannual data submissions, plans also submit information for all providers that were issued a CAP during the review period.
  - This includes documentation and proof of successful remediation of deficiency and overall CAP status.
- DHCS conducts independent site reviews to audit plans and their network provider sites.
- Any failed reviews require the MCP to issue a CAP and work with site to remedy.

DHCS Site Review Unit: Oversight and Monitoring Activities (continued)

- DHCS Nurse Evaluators conduct a side-by-side audit and certify MCP Master Trainers.
- DHCS conducts a triennial Inter-Rater Review (IRR) process to recertify the MCP Master Trainers.
- In early 2024, DHCS will begin collecting medical record data that will allow DHCS to better track and trend the provision of core preventive services.
  - Data will allow for stronger gaps analysis, as well as regional and MCP-specific performance analysis for the provision of critical preventive services.

Site Review Process and Training Overview

Krista Riganti, RN, DHCS-MT

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Site Review Program Overview

- Facility & Medical Record Review
  - Based on FSR assessment tool and MRR guidance
- Management of PCP poor performance and noncompliance
  - Based on results of FSR and MRR
- Technical training and resources for providers
  - Focus is guided by FSR and MRR
- Current collaboration efforts with CHDP

Facility and Medical Record Reviews

	FSR		MRR	
	Old	*New*	*Old*	*New*
Total questions	150	190*	77	147
% increase	≈25%		≈90%	

*20 new questions ± 20 revised questions which includes additional content, moved to CEs, etc.

Facility Site Review

1. Access & Safety
2. Personnel
3. Office Management
4. Clinical Services
   - Pharmaceutical services—meds on hand
   - Laboratory services—testing availability and that tools are correct, not on competency of tests done by staff
   - Radiology services—same as for lab services
5. Preventive Services
6. Infection Control

Medical Record Review

1. Format
2. Access & Safety
3. Coordination of Care
4. Pediatric Preventive
   - AAP/Bright Futures—have the correct tests been marked as done? Are the tools in place?
   - ACIP guidelines
5. Adult Preventive
6. OB/CPSP

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Management of Provider Poor Performance and Accountability for Non-Compliance

MCP Actions per APL 22-017

1. Established scoring and pass/fail rates
   - 79% is considered a Fail and CAP mandatory
2. Established CAP requirements and timelines
3. Panel closure due to failed score/noncompliance with CAP
4. Removal from network for 3 strike/noncompliance with CAP

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Technical Training and Resources for Providers

Current Examples of Training

1. Provide technical assistance and resources
   - Regarding information on what items are required to pass FSR, Bright Futures, etc.

2. Provide training on regulatory and health plan requirements
   - Technical training and resources

3. Removal from network for 3 strike/noncompliance with CAP

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Current Collaboration Efforts with CHDP

Riverside and San Bernardino counties

- Tandem reviews
- Blood-lead collaboration

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Workgroup Discussion

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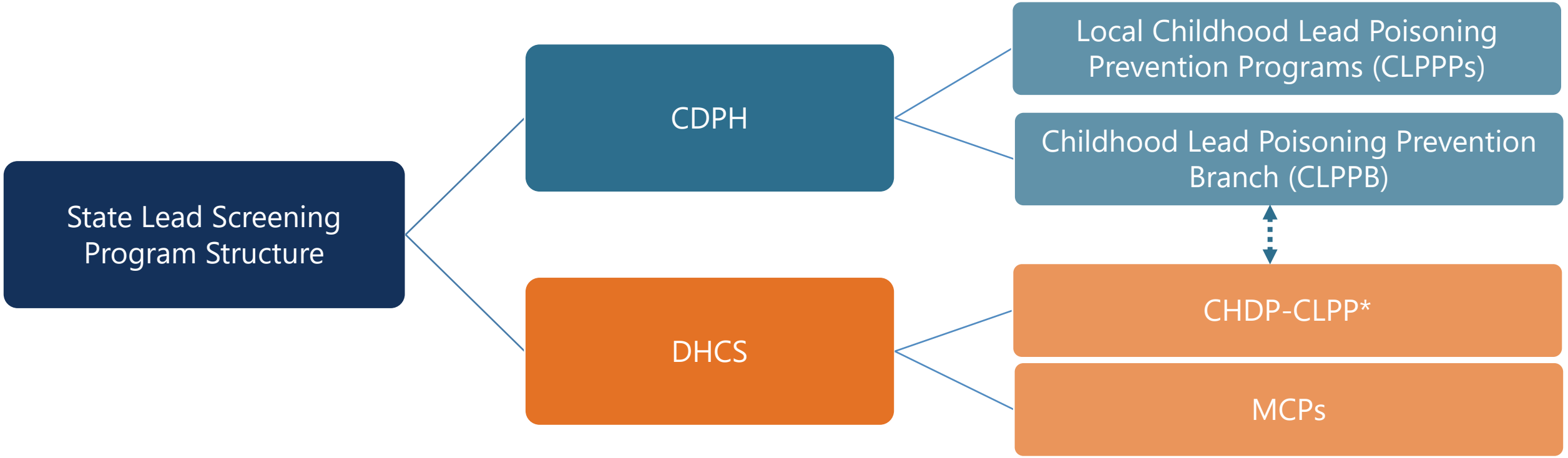
Overview of DHCS and CDPH Lead Screening Programs

Overview of State Lead Screening Program Structure



* CHDP-CLPP is responsible for medical record reviews (MRRs)
CDPH and DHCS partner to combine data from the databases of both departments' to identify Medi-Cal members in order to obtain a more accurate estimate of blood lead screening rates among children under age 6 receiving Medi-Cal services.

DHCS Lead Screening Program

Overview of Current CHDP-CLPP Program

- The CHDP-CLPP Program is administratively tied to DHCS' CHDP through an interagency agreement (IA) with CDPH. The IA between CDPH and DHCS outlines several responsibilities of the CHDP-CLPP Program, including, but not limited to:
  - Identifying and reviewing Medi-Cal lead records.
  - Providing CLPP educational materials and trainings to Medi-Cal providers.
  - Sharing Medi-Cal data and information with CDPH.
  - Working collaboratively to update policy guidance regarding lead assessments, blood lead screening, follow-up for lead testing, and appropriate interventions.
  - Ensuring that in counties without contracts with CDPH's CLPPB to manage lead poisoned children, such children will be assisted to the greatest extent possible.

CDPH and DHCS
CHDP-CLPP Program Responsibilities and Activities

Current Scope of Work: IA 19-10498/ DHCS 19-96093
Goal 1: Provide Medi-Cal Lead Services to the Local Health Jurisdictions*
A. Objective 1: Review and identify Medi-Cal lead records. Deliverables: On a quarterly basis, county CHDP program staff will provide to CDPH/CLPP Branch electronic reports of medical records reviewed and findings related to lead as specified above.
B. Objective 2: Provide educational materials to provider offices when necessary. Deliverables: County CHDP programs will provide CDPH/CLPP Branch electronic quarterly reports of educational materials distributed to provider offices. The reports include provider site information, description of materials, and the number of materials provided.
C. Objective 3: Local Health Jurisdiction provider training. Deliverables: County CHDP programs will provide CDPH/CLPP Branch electronic quarterly reports of trainings provided. The reports, include training date(s), provider lab information, and findings.

CDPH and DHCS
CHDP-CLPP Program Responsibilities and Activities

Current Scope of Work: IA 19-10498/ DHCS 19-96093
Goal 2: Provide Medi-Cal Lead Data Analyses Deliverables: DHCS/Integrated Systems of Care Division (ISCD) will provide CDPH/CLPP Branch with specified data extractions and Management Information System (MIS)/Decision Support System (DSS) technical assistance training.
Goal 3: Improve Program Measures and Program Policies Deliverables: DHCS/CHDP will provide CDPH/CLPP Branch with electronic copies of Medi-Cal lead-related information notices, and the number of new Medi-Cal lead members enrolled, and the resources provided in the non-contracted counties.

* All goals and objectives follow the same timeline (quarterly until agreement is revised or terminated).

DHCS Lead Screening Program

DHCS currently conducts activities around blood lead screening through CHDP and MCPs.

CHDP

- Annual budget allocations to local CHDP programs to perform MRRs, training, and care coordination to supplement CDPH CLPPB activities utilizing CHDP statewide presence

MCPs

- Responsible for conducting blood lead screening for MCP members
- MCPs conduct chart audits as part of regular FSRs and MRRs, which include lead screening reviews and provider training

MCP Lead Screening Activities

Current CHDP Program Activity	Current Managed Care Process
CHDP providers offer lead anticipatory guidance, order screenings, and document results. Requirements include: • California regulations require testing at ages 12 and 24 months. • If not tested at 12 months, catch-up testing is required between ages 12 and 24 months, and up to age 72 months if not tested at 24 months. CHDP programs verify these activities are completed using the CHDP Medical Record Review, as detailed in DHCS 4492. CHDP-CLPP verify these activities using the medical record review of the CHDP-CLPP Activity Reporting workbook	MCPs must verify that children receiving health services through publicly funded programs receive anticipatory guidance on lead poisoning prevention at each periodic health assessment, starting from 6 months of age and continuing until 72 months. MCPs' performance on the National Committee for Quality Assurance (NCQA) Lead Screening in Children is being measured for the current calendar year. MCPs ensure their network providers conduct blood lead screening in accordance with APL 20-016. MCPs verify these activities are completed using the PCP – MRR Standards detailed in APL 22-017.

CHDP-CLPP Roles and Responsibilities for MCPs

Current CHDP Program Activity	Current Managed Care Process
Local CHDP programs conduct reviews of medical records and targeted provider outreach and education activities for the CHDP-CLPP Program.	MCPs must comply with CHDP-CLPP Program requirements in APL 20-016. Requirements include: • MCPs must ensure their network providers who perform PHAs on children between the ages of 6 months to 6 years (i.e., 72 months) follow the current federal and state laws and industry guidelines for providers issued by CDPH-CLPPB. • Screenings are provided in compliance with EPSDT requirements, including arranging for transportation to Medi-Cal appointments. • MCPs are required to quarterly identify all child members under age 6 years (i.e., 72 months) who have no record of receiving a blood lead screening test and notify the network provider who is responsible for the care of an identified child member of their obligation to fulfill regulatory requirements on testing and noticing.

CHDP-CLPP Roles and Responsibilities for MCPs (continued)

Current CHDP Program Activity	Current Managed Care Process
Local CHDP programs conduct medical records review and targeted provider outreach and education activities for the CHDP-CLPP Program.	MCPs are responsible for conducting chart audits as a part of regular FSRs and MRRs. For more information, see APL 22-017 where blood lead screening is a part of the MRR. MCPs conduct provider training per their contract with DHCS, which includes blood lead screening training. MCPs provide initial Medi-Cal program training within 30 working days of being an active MCP provider. MCPs also provide direct training and/or education materials to providers upon request or upon identification of need and must document biannual provider training that includes EPSDT-specific training.

CHDP-CLPP Roles and Responsibilities for MCPs (continued)

Current CHDP Program Activity	Current Managed Care Process
Inclusion of CDPH CLPPB in DHCS blood lead related activities.	DHCS to continue current data exchange protocols, as outlined in inter-departmental data sharing agreement. Transition the publication of CDPH CLPPB blood lead guidelines to the Medi-Cal Provider Manual. Added child blood lead screening measure to annual managed care performance reporting.

California Department of Public Health (CDPH)
CLPP Program

CDPH
California Department of
PublicHealth

CLPP Program Overview

Mission: Eliminate childhood lead poisoning by identifying and caring for children who are lead poisoned and preventing environmental exposures to lead.

How we do it: The state provides lead poisoning prevention and case management services to 12 local health jurisdictions and funds 49 local health departments to provide these services.

CDPH California Department of PublicHealth

CLPP Program Functions

Primary Prevention

- **Outreach and education** to parents, health care providers, child care providers, and businesses/organizations.
- **Reducing lead hazards** by certifying lead professionals to safely identify and remove lead in buildings.

CDPH California Department of PublicHealth

CLPP Program Functions

Case Management

- **Home visits and ongoing case management services** by public health nurses and environmental professionals to children with blood lead levels meeting the state case definition.
- **Manage blood lead data** and perform data surveillance.

Services Provided

To all children under age 21 with case-making blood lead levels (BLLs), regardless of income or documentation

<u>Case Management of Lead Poisoning:</u>

- Public health nurse home visits – outreach and education
- Coordination with health care provider
- Environmental investigations - residence, other
- Correction/remediation of lead exposures
- Follow-up and monitoring

CDPH California Department of PublicHealth

Discussion Questions

- Would it be beneficial to continue the current CHDP-CLPP allocation, under a different program name, after the CHDP transition?
  - Why or why not?
  - Is the allocation enough to allow for participation in the absence of CHDP?
  - Is the allocation enough to bolster staff retention?
  - What potential alternatives should DHCS consider for the allocation?

Workgroup Discussion

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Welcome and Meeting Information	1:00-1:05
Roll Call	1:05-1:15
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Public Comment	3:40-3:50
Next Steps	3:50-4:00

CHDP Activities Under the Newborn Hearing Screening Program (NHSP)

NHSP Overview

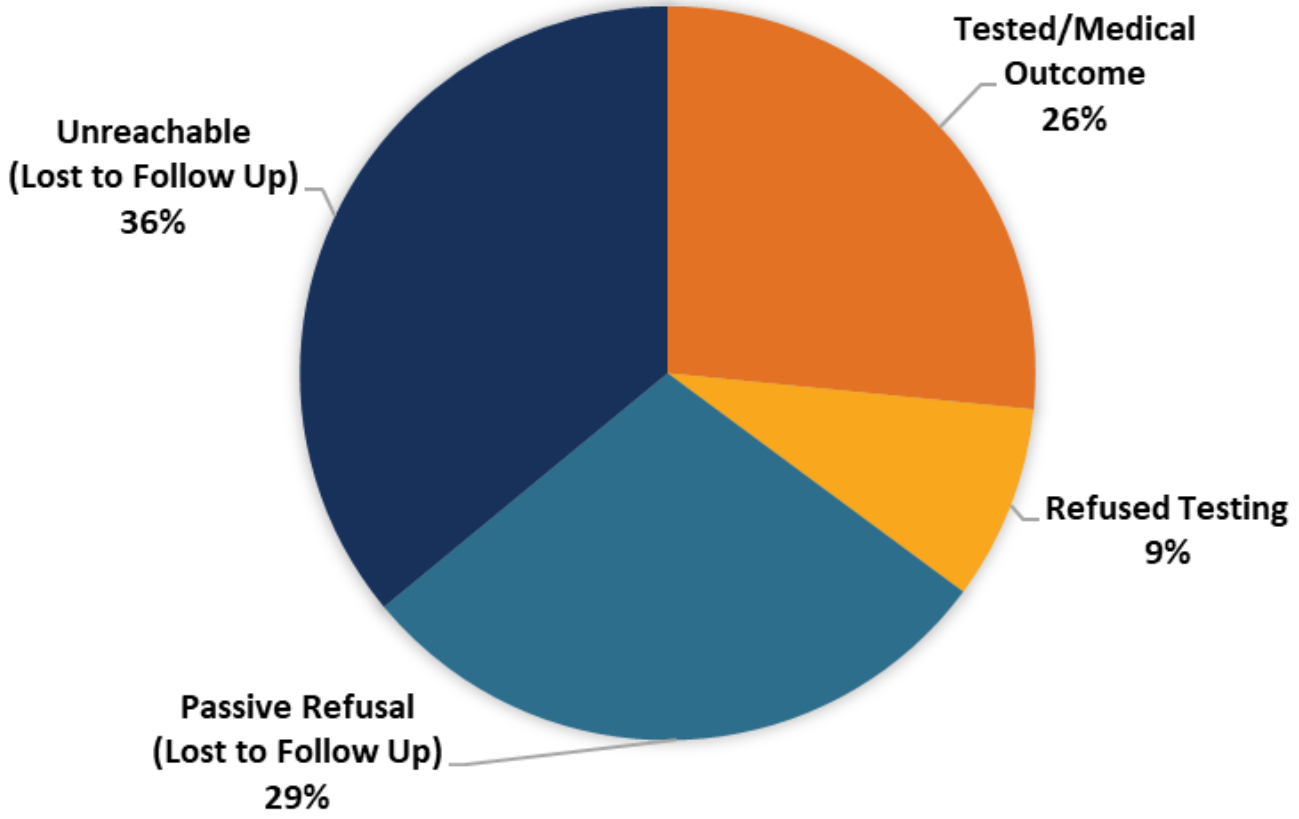
- **Goal:** Screen all babies by 1 month of age, identify infants with a hearing loss prior to 3 months of age, and link infants to early intervention services by 6 months of age. Babies are screened for hearing loss in the hospital at the time of birth. The NHSP tracks and monitors all infants who need follow-up testing and diagnostic evaluation and provides access to medical treatment and appropriate educational and support services.
- NHSP requires every general acute care hospital in California with licensed perinatal services to offer a hearing screening to every newborn.
- NHSP uses two regional contracted Hearing Coordination Centers (HCCs) to assist hospitals in developing their newborn hearing screening programs, certify and monitor the hearing screening programs, in addition to tracking those infants who require further diagnostic testing and intervention to assure they are linked to appropriate services.

NHSP Referrals to CHDP

Current CHDP Program Activity	Future/Proposed Process
If a family has not kept any appointments and/or the provider has made three attempts to contact the family, the Hearing Coordination Center (HCC) refers the family to the CHDP program for further tracking and follow up.	DHCS will create a dedicated inbox for the HCC staff to submit requests for updated beneficiary information. DHCS staff will use the Medi-Cal Eligibility Data System to retrieve the updated information and report back to the HCC's weekly. Additionally, DHCS and the HCC's with work together to ensure as few babies as possible are lost to follow up.
CHDP county staff contacts the referred family to determine if they need assistance with scheduling an appointment or transportation to an appointment for hearing screening or diagnostic evaluation.	DHCS and the HCC's will work collaboratively together to contact the family to see if they need assistance in scheduling the appointment or transportation.

2022 NHSP Referral Data

- 411,596 infants screened in California in CY 2022
- 507 babies were referred to CHDP in CY 2022
- Outcomes were received for 482 cases (95%)
- 314 babies (65%) were lost to follow up (unreachable or passive refusal)
- 168 babies (35%) were not lost (tested, had a medical outcome or family refused testing)



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CHDP Activities Related to Oral Health Screening

Oral Health Screening

- In accordance with the AAP Bright Futures Periodicity Schedule, risk assessments are to be performed at ages 6 and 9 months. Additionally, for ages 1 through 6 years old, a risk assessment is to be performed and accompanied by necessary follow up for positive screens.
- Currently, a dental screening/oral assessment is required at every CHDP health assessment regardless of age.
- Local CHDP Programs refer children to a dentist as follows:
  - At any age if a problem is suspected or detected.
  - Every six months for maintenance or oral health.
  - Every three months for children with documented special health care needs when medical or oral condition can be affected, and for other children at high risk for dental caries.
- Local CHDP Programs receive referrals for dental care coordination (CHDP Program Letter & Provider Notice 12-01)

Oral Health Screening | EPSDT Requirement

Current CHDP Program Activity	Anticipated Process for July 1, 2024
Dental Periodicity • A dental screening/oral assessment is required at every EPSDT/CHDP health assessment, regardless of age. Screenings and risk assessments are to be provided in accordance with the AAP Bright Futures Periodicity Schedule outlined on slide 74. • Children and youth should be referred to a dentist based on the criteria outlined on slide 74.	• Dental Periodicity requirements including assessments and referrals already and will continue to exist under EPSDT and are available in both the fee-for-service (FFS) and managed care delivery systems. • As to managed care, DHCS reviews and approves MCP policies and procedures for providing required dental services and dental-related services that includes the duties of the MCP's required dental liaison. MCPs must track referrals from well child visits to dental services as part of EPSDT case management. DHCS monitors the provision of topical fluoride to children quarterly, which requires MCPs to meet a minimum performance level. Notably, in 2025, DHCS will be requiring MCPs to maintain Closed-Loop Referral systems, so that DHCS can begin monitoring MCPs' ability to provide care coordination for services, such as dental.

Oral Health Screening | DMC Requirement

Current Program Activity	Current Process
DMC Contractors are required to develop and implement an initial health screening policy, and conduct an initial screening of each new member using an oral health information form (OHIF), in accordance with 42 CFR § 438.208 (b) and any related APLs issued by DHCS.	• The process may vary slightly by DMC Plan, but for most plans, there is a letter and, at times, additional outreach (e.g., phone calls, text campaigns) to the member to conduct this assessment. • Once the DMC can understand the needs of the member they work to ensure there is case management with the appropriate supports. • This outreach is in addition and separate from the outreach the providers are also responsible for their assigned members as well.

Oral Health Screening | MCP Requirement

Current CHDP Program Activity	Anticipated Process for July 1, 2024

Dental Periodicity
• A dental screening/oral assessment is required at every EPSDT/CHDP health assessment, regardless of age. Screenings and risk assessments are to be provided in accordance with the AAP Bright Futures Periodicity Schedule outlined on slide 74.
• Children and youth should be referred to a dentist based on the criteria outlined on slide 74.
	• MCP are also required to conduct the following:
	  • Ensure that dental screenings/oral health assessments for all members are included as a part of the Initial Health Assessment
	  • For members under age 21, MCPs are responsible for ensuring that a dental screening/oral health assessment is performed as part of every periodic assessment, with annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first.
	  • Ensure that members are referred to appropriate Medi-Cal dental providers.
	  • MCP dental liaison coordinates non-covered services after a positive screen.

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Next Steps

- Meeting summary
- **Following this meeting, DHCS will request feedback on the following:**
  - CHDP-CLPP Transition Activities
  - NHSP
  - Oral Health Screening

Workgroup Meeting Logistics

Meeting notices and materials to be posted on the CHDP Program Transition website.

2023 Workgroup Meeting Dates*

- June 14

* Dates and meeting content are subject to change

Contact Information

- For more information, questions, or feedback regarding the CHDP Transition Workgroup, please email Sarah Brooks at SBrooks@sellersdorsey.com and Olivia Brown at OBrown@sellersdorsey.com
- For assistance in joining the CHDP Transition Workgroup meetings, including information about meeting details and obtaining assistive services, please email chdpprogram@dhcs.ca.gov

Thank you!

DHCS