State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

May 4, 2023 – Hybrid Meeting

Meeting Minutes

Members Attending In-Person: Mike Weiss, M.D., Licensed Disproportionate Share Hospital Representative; Ken Hempstead, M.D., Pediatrician Representative; Jovan Salama Jacobs, Ed.D., Education Representative; Karen Lauterbach, Nonprofit Clinic Representative; William Arroyo, M.D., Mental Health Provider; Jeff Ribordy, M.D., Health Plan Representative.

Members Attending Virtually: Ellen Beck, M.D., Family Practice Physician Representative; Diana Vega, Parent Representative; Katrina Eagilen, D.D.S., Licensed Practicing Dentist; Jan Schumann, Subscriber Representative; Kelly Motadel, M.D., County Public Health Provider Representative; Ron DiLuigi, Business Community Representative; Elizabeth Stanley Salazar, Substance Abuse Provider Representative; Alison Beier, Parent Representative.

Members Not Attending: Nancy Netherland, Parent Representative.

Public Attendees – Virtually: 176 members of the public attended the meeting.

DHCS Staff – In person: Michelle Baass, Tracy Arnold, Lindy Harrington, Linette Scott, Autumn Boylan, Jeffrey Callison, Morgan Clair, and Clarissa Sampaga.

DHCS Staff – Virtually: Cortney Maslyn and Joseph Billingsley.

External Presenters: Steve Zimmer, Deputy Superintendent of Public Instruction and Megumi Okumura, M.D., M.A.S., Internal Medicine and Pediatric Specialist, UCSF.

Opening Remarks and Introductions

Mike Weiss, M.D., MCHAP Chair, welcomed meeting participants. The legislative charge for the advisory panel was read aloud by William Arroyo, MD. (See agenda for legislative charge.) The meeting summary from March 2, 2023, was approved, 14-0.

Opening Remarks from Michelle Baass, Director

Baass provided updates on the Governor's Proposal to Modernize California's Behavioral Health System.

Arroyo: The Proposition 63 original structure was a 1 percent tax on income earners of more than $1 million. How can we pay for all the newly expanded services, while maintaining the 1 percent tax? Is a tax expansion a consideration in the development of this new restructuring?

Baass: A tax rate increase is not part of this proposal. Many of the services that counties provide are now part of the Medi-Cal program, such as peer support specialists, community health workers, and dyadic care, and transitional rent will go live with the new 1115 waiver. We're expanding and drawing down additional federal dollars to support these services that were 100 percent Mental Health Services Act (MHSA) or county funded. While it's an expansion, we're also pulling down additional Federal Financial Participation (FFP) to provide these services that weren't part of the conversation years ago.

Arroyo: In the rollout of Prop. 63, 20 percent of the MHSA was for prevention and early intervention (PEI). The original intent of Prop. 63 was to support those with severe mental illnesses, or those with substance use disorders (SUD). In the preliminary restructuring of Prop. 63, I have not seen any discussion about what happens to that PEI. Will there be a de-emphasis on helping young people upstream?

Baass: PEI and upstream intervention are priorities of the Administration, especially regarding the Children and Youth Behavioral Health Initiative (CYBHI). As we think of our comprehensive strategy with one of our clinical focus areas being prevention, we must look at all investments in the entire behavioral health community and in schools. There are opportunities for some of those other services to be funded that were never in place before MHSA originally passed. Prevention services are part of the 30 percent that we're proposing with more flexibility at the local level.

Arroyo: There is a considerable network of narcotic treatment programs statewide. Where do those individuals fall into the restructuring?

Baass: At the local level with the planning process, every county and community will determine how they want to use these dollars.

Arroyo: Is the Department of Managed Health Care (DMHC) playing a larger role in the development process of this proposal?

Baass: We're working with DMHC next year to assess what services will be offered under Medi-Cal, and what commercial mental health services will be offered, and think about utilization controls.

Stanley Salazar: There are a few serious barriers that need to be addressed, such as workforce issues. As we move toward integration, an important issue is the integration and practice of mental health and SUD workforce. Another example is the residency requirements for accessing the Drug Medi-Cal (DMC) system. You must be in the county of residency. Medi-Cal does not follow the client into the DMC system of care. It's been resolved on the mental health side, but not on the substance use side. There are agencies throughout the state who can't accept clients across county borders and can't be Medi-Cal certified.

Baass: Please send specific examples on those regulatory pieces. As part of our California Behavioral Health Community-Based Continuum (CBH-CBC) waiver proposal (our 1115 waiver proposal), we will be releasing more information on the workforce initiative. While not directly related to what I just discussed, I recognize there is a significant need for workforce capacity development.

CYBHI within Schools

Boylan and Zimmer gave a presentation on CYBHI and its integration into schools.

Jacobs: I want to go over the fee schedule implementation. I have worked in three school districts, and each district has done the Local Educational Agency (LEA) Medi-Cal billing quite differently. It is an enormous amount of paperwork, and it takes a lot of organization and expertise to make sure that the billing is done correctly. I'd like to streamline it and make it more user-friendly. I appreciate all the investments that the state has done to address youth mental health needs. How are we going to get these service providers? We are investing a lot of money and need to think about how we're going to attract individuals into the field and retain them. There are shortages everywhere, and the need is quite high.

Boylan: As part of CYBHI, our colleagues at the Department of Health Care Access and Information (HCAI) have different workforce initiatives to strengthen and bolster the behavioral health workforce. In addition to expanding their existing programs, HCAI is providing stipends and reimbursement for tuition and other investments in workforce strategies. They're also standing up a new classification of workers - Wellness Coaches - to supplement and add to the workforce and the continuum of care available to support students in school and school-linked settings. Last year, we implemented the

Community Health Workers (CHW) benefit, which provides reimbursement for Medi-Cal services provided by individuals with lived experience and expertise in community settings and schools. We are launching the virtual services platform to provide coaching support for daily interaction. We spoke with more than 300 youth, and they repeatedly highlighted two things. First, they just needed somebody to talk to, and the Wellness Coaches will fill that gap. Secondly, they really want peer-driven programs with young people and near-peers providing support. There are several CYBHI programs focused on improving access to peers and near-peers to support the workforce, take some of the pressure off of our licensed workforce, and reduce some of the stresses on our crisis continuum of care, our inpatient hospital and emergency department infrastructure by bringing those preventative upstream touches and supports to students.

Ribordy: Can behavioral health providers bill any insurance without being contracted?

Boylan: Yes, under the CYBHI fee schedule. Health plans are required to reimburse schools and school-linked providers for delivery of services to students at a school site, without requiring the school and school-linked providers to be in the health plans' provider networks. The school site definition is for services that are provided or arranged by the school or the district at an onsite or offsite location, including through community partners. Some schools have community partners that deliver those services in the school or near the school, and those providers will, if arranged for by the school/district, be included in school-linked provider network for the fee schedule.

Ribordy: At the health plan level, we're prohibited from contracting or paying providers that are not Medi-Cal-enrolled. There is a way around that, which is called a letter of agreement, but it's very labor intensive on both sides, and for an agency that doesn't really bill Medi-Cal, it would be very difficult. If we get a claim from a provider that's not contracted or credentialed with us, we couldn't pay it. The reason we contract with providers is to ensure quality and that they have the appropriate credentials. In rare instances we've had to de-credential providers for poor quality or inappropriate behavior. If nobody is credentialing or contracting these providers, who is monitoring quality and credentialing?

Boylan: We work closely with the Local Health Plans of California (LHPC), California Association of Health Plans (CAHP), and County Behavioral Health Directors Association (CBHDA) to make sure we have a clear oversight and monitoring framework that includes credentialing and quality monitoring. Schools and school-linked providers will have to be enrolled in Medi-Cal. There is a process for how that's done for the Local Educational Agency Medi-Cal Billing Option Program (LEA BOP) that we're looking at

mirroring. We want to reduce the administrative burden and not require each school to undergo credentialing from multiple plans. We're working through how to centralize and delegate some of those functions in a way that makes sense and that feels comfortable for the health plans and counties. While still doing our due diligence, there will be monitoring protocols and mechanisms in place to protect the integrity of the Medi-Cal program and to ensure that medically necessary services are delivered to students by qualified and eligible providers.

Ribordy: For the sites that you're using as early adopters, can you include rural areas? A lot of these pilots are done in large urban areas, and they don't replicate well into the rural regions.

Boylan: Absolutely. We've had conversations with the superintendents and our LEA partners. How do we make sure we have our representative group of schools and districts participating to test different models? Some schools bring in community partners, while other schools manage it on their own. Many work closely with their county behavioral health departments, while some have closer relationships with health plans. We want to understand how it works in different models of service delivery, as well as different geographic locations. It's something that we need to figure out for small school districts and for Los Angeles. We want to make sure that we have representation in the first cohort and expanding into the second cohort to figure out what some of the complexities are for the different types of schools that might participate. We will work through these issues before we release statewide guidance.

Beier: My concern is oversight. For parents and families of the students, it would be a great value to have those family advisory or user councils filled from different zip codes, districts, and small school sites. Regarding the peer and wellness behavioral prevention, the kids just want to be able to talk to someone.

Stanley Salazar: The departments are being very thoughtful about how to lift up the schools and their capacity to become Medi-Cal certified and to access Medi-Cal funds in an appropriate way. I encourage looking at those same models when trying to uplift Community Supports services and substance use delivery agencies in small communities. What kind of principles can be transferred from how we support the schools in this Medi-Cal billing world to those smaller essential agencies in the community? Also, what is your approach to equity and social justice in the school environment? Schools are not created equally. There are enormous social driver disparities in many communities.

Boylan: We recognize the need to continue capacity-building efforts and build out our network of SUD providers. Work is being done both at HCAI and DHCS to support and strengthen the SUD workforce. There is an equity framework that has been developed through the California Health & Human Services Agency (CalHHS), and there was a process and workgroup established to define the equity standards, which is available on the CalHHS CYBHI website. DHCS is also focusing on implementing the fee schedule and wellness programming. There is an implementation strategy around the operational readiness criteria that we are going to establish, how we provide technical assistance, and the scope and provision of services to students, including CHW services through the new Medi-Cal benefit in the fee schedule. It ensures that schools have the option to deploy CHWs, Wellness Coaches, as well as the provision of psychoeducation services and parent/family resources for children and families. In our contract with the Sacramento County Office of Education (SCOE) to implement wellness and mindfulness programs in schools, DHCS included specific strategies to address equity issues and identify specific populations of focus, such as school districts working with tribal partners, to ensure wellness programs are available to students from tribal communities. We're also including a focus on equity in our Evidence-Based Practices and Community-Defined Evidence Practices grants, making sure that they're intentional about serving populations of focus. We're also thinking about how to deploy services and ensure that the virtual services platform works for diverse populations.

Arroyo: Steve Zimmer did not define what community schools are, which I believe is critical to this discussion. Community schools in Los Angeles were primarily designed for those students who could not make it in regular classrooms and who had severe behavioral problems, such as SUD.

Boylan: Are those non-public schools?

Arroyo: Yes, they're operated by the Los Angeles County Office of Education. I don't know if that's what Steve was referring to or not.

Boylan: No, that was not what he was referring to. It's my understanding that community schools, particularly Title 1 and low-income schools in the state, are public schools that meet certain criteria. They're implementing a framework that is devoted to the whole person care approach, recognizing that students and families need extra support, including mental health support and parent and family programs that create a community environment within the school setting. Dr. Jacobs might be able to provide more information.

Arroyo: Is that different from a regular K-12 school?

Jacobs: Typically, they are K-12 schools. In Pasadena, eight of our schools are Title 1 schools in areas with lower socioeconomic status. They're traditional public schools in local neighborhoods, but they're targeted to provide these additional services. One of the schools in my district has the Families in Transition Department located on the campus. Many families are suffering from homelessness. There is a washer and dryer onsite so families in transition can wash their clothes. Unfortunately, these are some of our lower-performing schools, so there are additional coaches provided by our district. They have reading and math coaches for elementary schools. Their classes are smaller, and there is much more curriculum. There's more collaboration time built into that, as well as more social and emotional support, and additional counselors provided. It looks at the whole child. Parenting classes are offered, and food banks and health clinics provide additional food for families.

Arroyo: Is it fair to say less than 10 percent of the general K-12 population are enrolled in community schools?

Jacobs: Yes, less than 10 percent.

Weiss: How many community schools are there?

Jacobs: It's by grant.

Arroyo: A very small subset is what we're describing. A $4.1 billion program is a hefty investment. That is what Steve Zimmer said was funded. What is the role of Employee Retirement Income Security Act (ERISA)-governed plans?

Boylan: They are not included.

Arroyo: What happens to those children who are under ERISA-governed plans in the schools, as this effort moves forward?

Boylan: The statute covers and requires plans that are regulated by DMHC, the Department of Insurance (DOI), and the Medi-Cal delivery system. That's the limitation around what we can influence, in terms of the children in CYBHI and the fee schedule. That still brings in a lot more funding for schools.

Arroyo: You're coming in with great services, but you're not going to provide them to kids who have ERISA-governed health plans. I don't know if that discussion has taken place, but it really was significant when I was trying to work with schools and implementing services on campus.

Boylan: The schools are not prohibited from delivering services to those students, but they won't receive reimbursement from the health plans through CYBHI. Schools are

delivering services and have an obligation to do so under many different state and federal regulations. Those will continue. Through community schools, they are delivering an array of services that are necessary to meet all student needs. Those are all funded through the California Department of Education (CDE) and the community schools' grants. There's also the LEA BOP program for Medi-Cal kids. These pieces come together to provide that larger landscape. Even if the reimbursement is not available for 100 percent of the population, a lot of kids in schools are covered by the Medi-Cal program and are under commercial insurance, as regulated by DOI and DMHC. Even if the rate is only $10, they get $10 for every kid to whom they're delivering services. That's a lot more funding for behavioral health services than schools are getting today, and they can use these resources to support the school.

Arroyo: I understand that. I would just urge you to systemically look at the population and consider what are we going to do for them if our statute does not affect those members? The next item here relates to the incredibly low reimbursement rate for Medi-Cal providers. In concert with UCSF, one of the conclusions is that we cannot get providers because the reimbursement rate is so low, and one of their final recommendations was to increase the Medi-Cal reimbursement rate. Otherwise, it's impossible to provide services. The California Medical Association says there won't be any providers if these reimbursement rates continue to be low. While we have plans that are innovative and promising, if the reimbursement doesn't pay the bills for providers, they will not serve Medi-Cal members. On paper, the array of Medi-Cal children's behavioral health services is the best in the country, but are all of the other health plans going to pay for intensive care coordination, integrated behavioral health care services, therapeutic behavioral services, and therapeutic foster care services?

Boylan: Thank you for your comment about provider reimbursement rates.

Arroyo: Plans can't provide services offsite. Are the outcast dollars that schools get being mobilized in any way to support this effort, given that this is all school based?

Boylan: Schools are required to use their Local Control Funding Formula allocations to provide services to students. This would supplement what schools are already providing under the multi-tiered systems of support and the positive behavioral health interventions in schools.

Arroyo: My understanding is that schools can do whatever they want with the Local Control and Accountability Plan dollars.

Boylan: There is some measure of local control.

Arroyo: Can a school district, as Los Angeles Unified was, be a county Medi-Cal provider and a LEA BOP provider?

Boylan: Yes, and many of the school districts and school sites participate in both with the counties, especially mental health services providers and LEA BOP. They cannot submit a claim for the same service to multiple payers. The same would be true under the fee schedule, and they couldn't bill for the same service to the same student under all three, but they can participate in multiple programs.

Arroyo: Since this effort is going to include SUD services, are Prop. 64 dollars included?

Boylan: No. There are a lot of programs for youth that are being funded by Prop. 64, and DHCS recently released information about some of the grants and initiatives that are being launched with Prop. 64 dollars for youth SUD prevention.

Arroyo: Is there systematic coordination with the Prop. 64 effort, given that there's going to be an overlap in service array?

Baass: When we talked about the behavioral health modernization and the local regional planning, that was the intent. There are so many funding streams and programs that are all addressing these same matters, and only at the local level is there that kind of understanding. The intent with the proposal that we talked about at the beginning is to do that at the local level.

Arroyo: Where are teachers unions with this whole effort?

Boylan: We engage regularly with education labor unions, the California Teachers Association, as well as the labor organizations representing school psychologists, counselors, and nurses. We have an education coalition of many members that we meet with on a regular basis to get input about the CYBHI, LEA BOP, and others.

Arroyo: I'm glad there are infrastructure grants to help schools, and I hope it's sufficient. Credentialing is also very important. I'm heartened to hear that you were engaged in a conversation where there were monolingual Spanish-speaking parents. Because that voice is missing at all levels in our government, especially the state level.

Boylan: Agreed. We're making sure that we're talking to youth, parents, and caregivers, representing all the diverse populations in the state, including non-English speaking parents and caregivers. We want to ensure their voices are centered in the work that we do, listening to their needs, and designing this work with their families and students in mind.

Weiss: I'd like to see the quality metrics that will be reported. The clinical quality outcomes are going to be important.

Boylan: Agreed. CalHHS issued a Request for Proposal last year and selected an evaluation partner, Mathematica, that will be doing some evaluation work across all of the 20 various workstreams. DHCS is working closely with them to identify those metrics and the evaluation strategies. We are also thinking about the interplay between the CYBHI, the larger work at DHCS around Population Health Management strategies, quality monitoring and oversight. There will be more to come on this.

Baass: As we designed CYBHI a couple of years ago, evaluation was up front as we were thinking about it, and it's included in the original proposal.

Weiss: It's also a great opportunity to marry academic and clinical data to really prove efficacy. We, as physicians, sometimes think that because we're curing the disease, that we're knocking it out of the park. However, if we're curing the disease and the kid is missing seven days of school a month, then we're not knocking it out of the park.

Boylan: We've heard that from Los Angeles partners and from the health side. We're also doing some work to dig into and understand the intersections between the Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act, and how that plays out. These are all things that we're working through and are absolutely part of the conversation.

The County Perspective on Medi-Cal Redeterminations presentation was rescheduled for another meeting.

Break – 30 minutes.

California Children's Services (CCS) Update

Billingsley, Okumura, Maslyn, and Scott gave a presentation on the Whole Child Model final evaluation report

Weiss: Were there any measures of cost of care included?

Billingsley: Yes. From a cost of care perspective, there was work done, but it wasn't included in the final report. From the research standpoint, there were questions in identifying what the key pieces are when looking to verify the quality of care being provided within the Whole Child Model (WCM). The evaluation was focusing on the access of quality of care received in the WCM versus the classic CCS counties.

Beck: Were there any specialty services where there were gaps? If you have hypotheses, or if the data showed you any ideas of both the increased use of the emergency room, was that because there was a greater awareness of certain things being a problem, or was there a lack of access?

Okumura: To answer your first question, we conducted a subgroup analysis for the 10 percent who thought the WCM was worse. Those who reported worse care tended to be those with higher subspecialist use, those who reported worse general health status and those who had difficulty accessing DME. We identified potential opportunities for complex case management which could potentially mitigate these issues. We examined the entire CCS population, smaller subgroups, limiting our ability for a deep dive into analyzing those children with medical complexity. As for your second question, determining whether lack of access led to emergency department (ED) visits was difficult. No notable differences were found between the WCM and CCS in primary or subspeciality provider access, suggesting other factors were involved. There may be unmeasured factors that contributed to this, such as county in services and differential access to after-hour clinics, but we were unable to test this. With Phase One and Phase Two, in more rural areas, there may be difference in provider ability that we couldn't control for. For diagnoses, that brought children to the ED, the groups were similar, with the predominate reasons being going to the ED being upper respiratory infections and gastroenteritis and the typical things that would bring a child to an ED.

Maslyn and Scott gave a presentation on CCS quality metrics workgroup, and CCS performance by selected measures.

DiLuigi: Regarding the classic CCS program, I recall that the advocacy groups had been very reluctant to make changes. Have we included them in the surveys? Do we see any judgment on their part that things have gone positively?

Billingsley: Yes, tying back to the WCM evaluation process, and those stakeholders were included in the evaluation process, which had multiple components, including informational interviews between families, providers, and key advocacy groups. This has been an ongoing topic at our regular quarterly CCS Advisory Group meetings. We're doing a more in-depth meeting with stakeholder groups later this month to address specific questions regarding the evaluation now that they've had more time to dig into it and develop questions.

Ribordy: You said this was Healthcare Effectiveness Data and Information Set (HEDIS) data?

Scott: This is based on the analysis we're doing on claims and encounters. The core set measures are very similar to the HEDIS measures, but they do sometimes include measures that are not HEDIS.

Ribordy: For some of the immunizations, I suggest having a minimum performance level for an overall measure. Is there going to be an accountable measure set?

Scott: As part of the Affordable Care Act (ACA), the requirement was for the Centers for Medicare & Medicaid Services (CMS) to establish a set of measures that could be used to compare state Medicaid programs and which are called the "core set measures". There's a child set and an adult set and there are different categories of primary care access and preventive care, maternal and perinatal health, care of acute and chronic conditions, behavioral health care, dental and oral health services, experience of care, and long-term services and supports measures with about 30 to 40 for children and adults. Some measures are for both, but it's the age group that makes them different. We report those annually to CMS.

Ribordy: DHCS recently levied sanctions to the health plans over quality measures. Is that a plan for this?

Scott: In the context of the health plans and the quality measures that relate to sanctions, that speaks to the Managed Care Accountability Sets (MCAS). The MCAS is the subset of measures to which health plans are held accountable. Most of them are also CMS core set measures. The MCAS measures report financial and performance accountability to CMS. The core set is a bigger set, while the MCAS is a smaller set.

Ribordy: Are there plans to levy sanctions for CCS measures?

Scott: I'm just explaining the difference between the CMS core set versus the MCAS. The MCAS is used for accountability with health plans. In terms of accountability for particular health plans or populations, that was a different part of the team, so I can't speak to that.

Ribordy: On the ED visit measure, it's okay to use that to compare CCS classic with CCS WCM, but you can't really compare that to non-CCS kids because it's a different population. It's not a fair comparison.

Scott: To your point, it's not being compared from a performance perspective. We shared it because it gives you the context of what the differences are. Absolutely, it's a completely different population and we expect there to be a difference. That's an expected difference, not a performance issue.

Weiss: I just had a comment about the ED data. I would be cautious about looking at 2022 and 2023 ED data in the future, I'm sure you are all aware of it. We had no ED visits in 2021 – or maybe it was 2020 - because the kids weren't in school. We must be careful with what we do with this going forward.

Scott: We have been tracking. We have other reports online that are just simply utilization reports from 2020 through current, and you can see the drop that happened in 2020. It's slowly coming back up as people get more engaged in all those things that usually result in ED visits.

Arroyo: I read that there was a major uptick in ED visits due to behavioral health issues during the pandemic. Is there some thought about pairing those out and looking at them separately?

Scott: We have done some analysis on reporting in terms of teasing out behavioral health diagnoses versus not, and we've got that utilization reporting that we do on the public website that looks at various measures. That might be interesting to look at. In terms of diving in specifically to the different components of ED visits, we don't have that on hand.

Eagilen: What marketing was done for this program versus the prior one? Were there specific marketing efforts for members, or did you use standard mailers or a text campaign?

Billingsley: There is work to do around extensive messaging around the rollout implementation of the WCM process. The actual implementation happened around 2018 or 2019, and over the course of three phases, in terms of the different participating counties and health plans that were implementing as WCM plans.

Ribordy: I'm the WCM Medical Director for Partnership HealthPlan. We had extensive meetings and conversations with the CCS counties. We discussed transition planning and MOUs, and we had meetings to go over their highest risk kids and discuss them on a care coordination basis. We went throughout our counties and had stakeholder meetings with parents and families to answer questions. Most of them were already Medi-Cal members, so they were familiar with us. We explained how the process would work with CCS transportation, etc. It was an extensive transition.

Weiss: Yes, similarly, the only difference for us was we're in a delegated model county. Our health plan, a County Organized Health System (COHS) health plan, , did a lot of outreach. We, at the health network level, also did individual outreach. It was through our provider relations teams working with our primary care and specialty care offices,

but also through mailings and informational meetings. We also spent a lot of time, particularly with our subspecialty faculty who had been part of team care centers, to better understand what that all meant and how to navigate it.

Eagilen: That was helpful. A lot of work was expended to move the needle, and there was a lot of success. I think part of these results we're seeing has to do with the time coming right after COVID, and we'll see how things will play out in future years when the PHE has been unwound.

Public Comments:

Doug Major, O.D., California Children's Vision Now Coalition: I just want to remind you about the unmet need that affects too many of our children, which is vision care. Why is vision care still so invisible since it's the number one disabling condition of children? DHCS hasn't been able to treat over a million children. That passes onto CDE, which must pay for extra special education and academic rescue, which then passes on to the California Department of Corrections and Rehabilitation, which benefits, by job security, to have these individuals go into their facilities. Can we break this cycle and get a seat at the MCHAP table? We're asking for an agenda item. We have some of the best researchers in the state willing to be at your service to let you know the scope of this public health need.

J.T. Tassinari, O.D., Western University of Health Sciences College of Optometry, Pomona: Yesterday I saw some twins, second graders from a great family who are well-behaved children. Both have complicated levels of astigmatism. They lost their glasses a week ago. The earliest their parents could bring them in to see me was yesterday because not everybody accepts Medi-Cal. Now these girls must wait another four to six weeks to function in second grade. I'm grateful that the state has vision care benefits for poor children, but I just hope we can improve that system.

Mike Odeh, Children Now: I appreciate the discussion today. I hope that at a future meeting this year, we can talk about the continuous coverage policy for young kids that was approved in last year's budget. I'm really excited to see that come to fruition.

Member Updates and Follow Up

Beier: I know that with the PHE ending, redeterminations are coming up, and if we wait until August, I don't know if that's the best move. I request that we look into the continuous coverage for kids ages 0 to 5 years old with the Medi-Cal redetermination before people start to lose coverage.

Beck: I'd like to follow up on further steps, not only around behavioral health, but just how best to partner with CDE to really achieve health care for children and families, and prevention and education in the classroom. I'm glad that it was already on the agenda for future meetings to continuing exploring that partner.

Schumann: Something we might want to add as a future agenda item is advanced directives. They're important for younger people or students before they turn 18 years old and head off into the real world, to get their advanced directives and HIPAA forms in place, in the event they can't make decisions for themselves in medical emergencies.

Stanley Salazar: May is Children's Mental Health Awareness Month, and there are wonderful resources online to have providers and agencies engage their community participants. I would also further like to discuss capacity building and uplifting the systems going forward. I want to recognize the California Department of Social Services (CDSS), which has issued new regulations to add SUD access to children in foster care system under their client and patient rights sections. Because of continuum of care reform (CCR) and Institution for Mental Disease (IMD) regulations, we've lost a tremendous amount of residential capacity in the foster care system in California in the last few months. It may adequately meet the capacity that's left in the foster care system, but there is a huge cry for residential SUD treatment programs. All residential SUD treatment programs for youth must have community care licenses. One of the major reasons that those providers do not engage in SUD treatment themselves (certification, licensure, etc.) is because of the barrier for out-of-county youth to secure payment for Medi-Cal in those counties. That would be one thing that could change the face of residential treatment for youth in the state.

Beck: Something that came to mind are some recent cases where youth, who were nonverbal, especially teens, had issues in the ED in being heard. It would be interesting to learn what resources we provide for folks who are nonverbal, especially in the ED situation for youth.

Arroyo: I'm trying to remember when we last addressed a state audit, and I think it had to do with prevention services. I know that there have been other state audits on health plans. One more recently, for example, on CalOptima, which demonstrated an enormous surplus due to monies that should have been spent on health care but were not. Prior to that, there was a major finding related to L.A. Care, where they fell short with respect to many of standards. I think that it's this panel's charge to review those, take notice of such reports, and chime in on recommendations because some of them conclude that there have been major shortfalls in compliance with state contracts.

Hempstead: My interest is the workforce issue, and we're already seeing a system that's totally taxed. We're going to need people to fill these positions. I liked hearing about leveraging unlicensed or less highly skilled qualified folks, wellness educators, etc., to try to fill some of those gaps. I'm still looking at the app-based, virtual scalable options. Nothing substitutes talking to someone. We must keep looking at more scalable solutions than simply hiring more therapists in schools.

Upcoming MCHAP Meeting - August 17, 2023, and Next Steps

Weiss: We will add the redetermination and budget updates to the next meeting agenda. Regarding CYBHI, I'd like to dig deeper into the workforce issue. We mentioned there are a lot of initiatives around that, but it might be worth hearing more to see how we can help with that, locally. WCM outcomes will be an ongoing discussion to dig deeper in some of the other metrics. We discussed cost of care, which is high on the list, given quality maintenance or improvement. We also talked about continuous coverage, advanced directives, care for nonverbal patients, especially in the ED, and health plans. We have plenty of topics to discuss for upcoming meetings.