State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

February 2024 – Hybrid Meeting

Meeting Minutes

Members Attending In-Person: Michael Weiss, William Arroyo, Karen Lauterbach, Jan Schumann, Elizabeth Stanley Salazar, and Jovan Salama Jacobs.

Members Not Attending: Kenneth Hempstead, Nancy Netherland, Diana Vega.

Public Attendees – Virtually: 44 members of the public attended the webinar.

DHCS Staff – In person: Tracy Arnold, Michelle Baass, Sarah Brooks, Autumn Boylan, Joseph Billingsley, Cortney Maslyn, Linette Scott.

DHCS Staff – Virtually: Susan Phillips

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 November 2023 was approved.

Opening Remarks from Michelle Baass, Director

Baass provided an overview of DHCS' Fiscal Year (FY) 2024-25 Governor's Budget Highlights.

Arroyo: Based on your presentation, it seems there's another proposal for a delay. Is this related to a separate funding allocation, or is it connected to the same funding that was delayed last year? Could you provide clarity on how these two pieces are being reconciled?

Baass: We are delaying round six of the BHCIP; 100 million is proposed to go to FY 25. Some of the features are supposed to go out in the current year, but we're moving to the budget year plus one. So, it's Round 6, $480 million, and pushing out the funding.

Arroyo: So it's being proposed to delay for an additional year?

Baass: Potentially, yes.

Beck: The question I have is related to the asset test eliminations. So, for example, if an elderly person applied for Medi-Cal last year and was told that because of their income and Social Security income, they would have to pay an additional amount each month as a spend down. Now that there's asset test elimination, if that same elderly person wants to apply for Medi-Cal, is there still a financial assessment of some sort or limit? Is it that just certain assets are no longer being tested? Can you explain?

Baass: The scenario you present is about share of cost. The individual will need a spend down or pay a share of cost for their care because they meet a certain income threshold. This is the asset test elimination. There are different rules about a person's assets, for example, a house or whatever assets might be. There are two different types of rules in play here.

Beck: To clarify, their income is still assessed, and if they have a steady monthly income, that is still assessed? Asset test is operational assets, like owning a car, owning a house. Is that correct?

Baass: Correct, we have income rules and asset test rules. The asset tests/rules have been eliminated, but the income rules still apply.

Beier: I think you're allowed to have money in the bank as well, when talking about assets. For example, in the past, if someone had money in their bank account that would be held against them. In this new era, they can have money in the bank so they can save for things. Is that accurate?

Baass: Yes, that is correct.

Schuman: So if an elderly person dies and has an estate worth $2 million, is there still an estate recovery that will occur?

Baass: SB 833 significantly reduced the types of services ER can collect on, as well as restricted types of estates to probated estates. It significantly reduced the number of recoverable estate recovery cases and annual collections.

Arroyo: Regarding the newly proposed rate increases, I recall that in the initial round, which is now in effect, there was an increase for non-specialty mental health, primarily in the primary care arena. I'm wondering if similar increases are included for the county mental health plans in the new proposed rate increases.

Baass: The rate increases do not cover specialty mental health. As you recall, these are realigned services. So essentially, the counties provide the non-federal share.

Open Data Portal data by county

Medi-Cal Continuous Coverage Unwinding Dashboard Update

Lauterbach: I noticed that Medi-Cal applications have increased. Is this significant, or is this the normal flow? Is there a reason more people are applying for Medi-Cal?

Baass: I believe these numbers are higher than what we had initially planned for, but it likely reflects the current situation. Additionally, October, November, and December are traditionally our peak enrollment months due to Covered California's open enrollment process, resulting in increased messaging. December typically sees the highest enrollment. It appears to be a significant shift from June.

Weiss: Is there any data on the kids who have been disenrolled in comparison to Covered California?

Baass: We don't have data for children. If I recall correctly, in the first few months, I believe it was approximately about 30% because there's an automated process now. So, if you're disenrolled from Medi-Cal, you are moved to Covered California to select a plan. We can follow up via email and give you the data.

Weiss: The data that would be important for us to know is the number of people who are uninsured.

Baass: It's hard to know because many individuals maybe transition to Medicare or commercial employer-sponsored coverage. We don't necessarily have surveys to follow up with individuals who were disenrolled to understand their coverage. We don't have that as a data point that we can report on.

Schumann: On the ex parte drastic increase, how would I know as a members that an ex parte renewal automatically took place if I already received a yellow packet? Is there a subsequent communication that is sent out?

Baass: I believe you would receive notice that you were pre-redetermined and approved.

Brooks: I don't think you'll receive a yellow packet because the ex parte didn't notice. Let me check on that.

Schumann: I want to make sure that's not confusing for members.

Beier: In LA County, I know an elderly woman who didn't get anything in the mail whatsoever. So she ended up going to the county office and she was told she was approved, but there was not a mailing from the county.

Lauterbach: A follow up question on the ex parte, so the population we deal with most are people experiencing homelessness, do they fall into that ex parte category?

Open Data Portal data by county

Baass: So it's different from what was programmed into the system back in October because we have federal waivers starting in June for individuals with zero income, particularly for the homeless population. We've been considering that they don't even have to complete the paperwork, and this has been in effect since the start of the redetermination process.

Lauterbach: If we continue to see a high number of people being disenrolled during the redetermination process, we need to conduct a deeper analysis to understand why. It seems evident that unstable mailing addresses and other factors such as family changes may contribute to this issue. However, we often only become aware of these issues when they experience significant medical or mental health issues.

Brooks: So, if ex parte occurs, you wouldn't receive a yellow packet in the mail that would only occur if ex parte had failed. And so then you need to go through the process. But you would receive notification in the mail that ex parte had occurred. So you would receive notification that you had been approved.

Arroyo: But I was wondering if we are tracking the new enrollees who now qualify for Medicaid, that previously did not qualify for federally supported Medicaid due to their citizenship status.

Baass: In last year's budget, our estimate indicated that approximately 700,000 individuals would be eligible for expansion within the 26 to 49 age range. This estimate was part of last year's governor's plan. The enrollment figure for the FY 23-budget act was based on this estimate, as it represented the number of limited-scope individuals we had at the time. We are currently in the process of confirming our numbers since this is a recent development, and we will continue to monitor the situation.

Arnold: There are about 1.33 million in the total expansions right now enrolled and we do put up by population; you have the initial expansion with youth (0 to 12). Then we go from there. So all of those different expansion populations are posted online in the open data portals. If you add them all up, it’s about 1.33 million as of October 2023.

Election of Chairperson for 2024

Baass: We have the election of our chairperson for 2024. And we'd like to present Dr. Weiss as the candidate for this position. Do I have a motion to elect?

Salazar: I'd like to put the motion on the table to Dr. Michael Weiss as our chairperson.

Arroyo: Second.

Bobbie: Now we have a roll call vote as required by the hybrid rule.

Weiss: Yes

Arroyo: Yes

Diluigi: Yes

Open Data Portal data by county

Eagilen: Yes

Lauterbach: Yes

Jacobs: Yes

Motadel: Yes

*Schuman***:** Yes

Beck: Yes

Salazar: Yes

Beier: Yes

Ribordy: Yes

Dr. Weiss is elected chairperson of the board for 2024

Weiss: I've learned more in the last year of being on this committee, from the members of the committee as well as from DHCS staff. I think it's such a great opportunity for us to share what frontline experiences are and for you to share what the challenges are at the highest levels. And to figure out what we can all do collectively, that benefits the kids. That's really what we're all here for. So, I appreciate the opportunity and I look forward to continuing to learn.

Sarah Brooks provides overview and updates to the DHCS Pediatric Dashboard

Salazar: We rely heavily on counties in California to collect specific data, and investing in data infrastructure has been challenging. However, CalAIM appears to be making significant efforts to level the playing field in many aspects. While I'm not sure if you're prepared to give a presentation on this topic, I'd like to revisit it. I represent substance use delivery providers and systems, and we are typically a silent partner in the healthcare ecosystem. However, given the current overdose epidemic and the mental health and substance use needs in our communities, it's essential to integrate substance use disorder (SUD) data into our decision-making practices.

Brooks: I know there is recent, new federal 42 CFR that is allowing new sharing of information that we're looking at. And maybe Dr. Scott can speak to that a little bit more.

Dr. Scott: We have to appropriately de-identify and protect confidentiality in public information we share. Also, Department of Public Health has an opioid dashboard that brings in data from a number of different data sources and is broken down by county I think it includes inpatient, mortality, and a variety of different components. We're continuing to look at how we expand both the public reporting we're doing and how we create visualizations to make it more useful. In terms of the data we have related to claims associated with SUD treatment, we have the ability to do that. In the same way that Sarah mentioned, doing standard demographics, we do things by county, so we have a lot of data that we've published by county. Again, we suppress

Open Data Portal data by county

accounts that are small, so if there are some counties with small counts, we're not going to be able to show the data for them. There's more that we will be working on doing.

Michelle: And one thing to highlight under CalAIM is the change to move to CPT codes for Specialty Mental Health and Drug Medi-Cal, including the Drug Medi-Cal ODS, Behavioral Health Payment Reform. We will learn more with that change in terms of the refined reporting of services that are being provided. Particularly in specialty mental health, we categorize services at a very high level. With this CPT code level of information, we'll have a better understanding for the specialty mental health services that will be consistent detail with services provided under Medi-Cal outside of specialty mental health.

Weiss: Understanding that the implementation of this dashboard was four years ago. So I acknowledge that. And also acknowledging the importance that dental care plays in overall health. I'm wondering if we have an opportunity to look at the topical fluoride metric to align it with what we're seeing in the MCAS. The new metrics that are going to be held to the minimum performance level, it's a different metric. And I wonder if we have an opportunity to look at that, on the dashboard to be able to have a comparator.

Dr. Scott: I believe that as part of the CalAIM dashboard and our population health management goals, there's a focus on several measures, including those from the MCAS. For instance, the fluoride measure might be included, although I'm uncertain if it will be available soon. However, it's important to note that reporting to the MCAS already exists. In addition to the managed care plans reporting, we submit various other reports, such as those related to the Core Set Measures and the CMS-416. While some specifications overlap, others differ slightly. For instance, the CMS-416 is the required reporting for EPSDT to CMS, while the Core Set Measures are also required to report starting in 2024 for children and behavioral health adult measures. This creates some complexity as the measures may sound similar but have subtle differences. We're actively discussing strategies to avoid confusion in this regard.

Arroyo: I would like to address Liz Stanley's remarks regarding data andSUD among youth. As some of you may be aware, this group has previously made recommendations directly to the state legislature. I'm wondering if data collection and analysis pose challenges given the infrastructure within DHCS. As we have done before, we could advocate on behalf of DHCS to the state legislature to strengthen the infrastructure for better data collection. This is crucial, especially considering the opioid crisis, the significant settlements with drug companies, and federal funding allocated to states for addressing the opioid crisis. Without accurate data, it's impossible for us to advocate effectively with the state legislature for any assistance DHCS may require. It's vital for informing both us and the general public on efforts to prevent substance use problems among youth. I urge you to prioritize the provision of this data as soon as possible. While I understand it exists, unless we can utilize it in our actions and communications with our constituencies, it's challenging to improve SUD treatment for youth.

Dr. Scott: What are two or three metric that would make a difference in your advocacy?

Open Data Portal data by county

Arroyo: Well, at the very least, I would like to understand the utilization of services among youth aged between 10 and 21, or perhaps up to 24, in county SUD programs. Whether it's outpatient services or any other offerings, we lack this information. Despite our longstanding requests over the years, some of us who have been here for quite some time have consistently asked to see this data. Given the magnitude of the opioid crisis and other substance use issues, it would be invaluable to know the extent of youth engagement with these services. We are aware of the prevalence rate of substance use problems in the US through federal surveys conducted biennially, along with similar surveys in California. However, without specific data on the youth being served, it's challenging for us to advocate effectively for additional support.

Salazar: When you mentioned 'public-facing data,' I understand the importance of having a defined set of information available on dashboards. However, what I've been hearing, and I share this frustration myself, is that obtaining basic utilization data, even at the county level, is incredibly challenging. This difficulty extends beyond legislative circles; it affects referral systems, especially as we collaborate more closely with them in healthcare and mental health. Identifying gaps in services and matching them with the needs of individuals is a formidable task when data is lacking. It sometimes feels like the 'Wild West' at the county level, where some counties excel in their efforts while others struggle due to resource constraints.

My primary concern is that SUD often doesn't receive adequate attention due to longstanding barriers like the 42 CFR regulation. While there are ways to navigate around this, such as safeguarding client information, we're still not fully informed about various aspects, such as the number of physicians willing to prescribe buprenorphine for adolescents or the accessibility of evaluation services for them.

Brooks: Certainly, your request is noted. I think Linette and I will go back and talk about if there are other specific metrics that would be helpful for you to see. If there are, certainly communicate them to us so we can talk further about them. The more specific we are the more helpful it will be.

Jacobs: I had a clarifying question. With the dataset, does that include all the services that are provided to students at LEA or school sites?

Scott: No, this does not include LEA data.

Jacobs: Do you have a different data set for that?

Scott: So, the key thing in terms of the data that we're able to publish is, it depends on how it's claimed and paid. If it comes in on an individual person level, on a claim, then we've got it independent of whether it's paid by developmental services or social services, or county or what have you. But if there's some sort of aggregate information that's done at the facility level, then we're not able to do this kind of compilation. Does that help?

Open Data Portal data by county

Jacobs: A little bit. I was wondering, how are we looking at that data? Because I know like speaking from a school site level or district level, there are many kids that we are servicing through Medi-Cal. I just wonder where does that information go? What dashboard will that land at? Because I know each individual district vis collecting it.

Scott: If we have claims data, we can look at it as a provider base. and such. So, there's ways we can stratify the data. But if you could send it in writing more specifically, that would be helpful, just because that way we can double check and give you a clear answer. Okay?

Jovan: Yeah, because some of the services are directly at a school site by a provider. And I just want to make sure we are capturing all the data. Okay, I'll send that in writing. Thank you.

Eagilen: I just wanted to mention that in the dental field, one of the most valuable tools that we have, since 2014, is silver diamine fluoride, and it was approved for use in 2014 by the FDA. And the reason I mentioned this one is because silver diamine fluoride as a caries arrestor. It keeps dental caries from forming and spreading in the teeth. It essentially marries the antibacterial action of silver and the preventive action of fluoride. So, it would be wonderful on the dashboard if there was a breakout for silver diamine fluoride. I know that it falls within the category of those preventive codes that were looked at. However, a special breakout for this would be beneficial because it's lightyears ahead of the traditional prevention techniques that we have been using in the past. That code is D 1354.

Dr. Scott: We'll need to revisit that code specifically unless you already have insights. One significant consideration, particularly when discussing dashboards, is their broad applicability. It’s crucial to consider whether they address overarching needs or specific one-time inquiries. Given our efforts to create interactive dashboards, we must prioritize our initiatives. The Children's Health Dashboard, for instance, compiles various reports developed over time, but there's room for advancement and refinement. The question arises: where should we strike the balance between detail and summary? We must ensure that our dashboards offer valuable insights without overwhelming users. Therefore, it's crucial to identify the top two or three metrics that truly drive decision-making. This prioritization not only guides our work but also ensures that the information presented effectively communicates the story of the program and addresses stakeholders' needs.

Salazar: In this case, the compilation has drawn threads from the data and dashboards we've collected, highlighting both strengths and areas for improvement. Our current landscape is vastly different, raising questions about how best to proceed. What are the essential components we should prioritize? As we consider investing in a new dashboard, should we focus on incorporating additional Healthcare Effectiveness Data and Information Set (HEDIS) measures, or are there alternative approaches worth exploring? Looking ahead, as managed care plans prepare for future initiatives, such as memorandums of understanding and data exchanges with behavioral health services, what implications will these have for data management and analysis? While we often mention 'data' in the context of dashboards, there are likely numerous

avenues we can explore to achieve our objectives. It's an important conversation to have as we navigate this evolving landscape.

Brooks: As I mentioned earlier, there's indeed an abundance of information and data available. Linette and her team have published a wealth of accessible information and data. Perhaps our focus should be on identifying the specific information you're seeking and ensuring that it's easily accessible to you. If there are additional questions or considerations to enhance the narrative or make improvements, let's engage in those discussions. We need to ensure that any additions or adjustments align with the broader context, rather than creating isolated elements. There's more to discuss, but I believe this serves as a solid foundation to build upon.

Weiss: Data for the sake of data is of no value. The challenge that we face is that we're trying to put something forward that is actionable. And we have the challenge of the fact that it's so delayed. Are the metric going to lead to some kind of change? And it's a rhetorical question right now, but I think that's really where we need to go.

Scott: Most of our dashboards include stratification for children, alongside adults and other demographics. When evaluating their usefulness and actionability, we have over 100 datasets on the open data portal, it’s a lot of work to do that. We're considering whether to streamline these datasets, keeping those that are most valuable and relevant. In the mental health space, we have numerous dashboards and managed care plans. Our focus is on how we stratify data by various demographics, such as the CCS population, and how we can present standard utilization and outcome quality measures by the population of interest, be it age group or service. Currently, these views are fragmented, posing a workload challenge and making it difficult for users to navigate. With the rollout of our CalAIM dashboards, we aim to provide a more cohesive experience, ensuring that each initiative includes relevant age group stratification and addresses the diverse interests of stakeholder groups.

Salazar: have you landed on implementing any equity metric that will work across the systems? Have you decided what those are?

Baass: I don't know that we've decided, but for decades, we've been stratifying data by age, sex, race, ethnicity, and geography, all of which are ways to address equity and disparity concerns. Just last week, we released our managed care quality, accountability, and sanctions dashboards, where we presented metrics statewide as well as stratified by race and ethnicity. This aligns with our goals for 2025 and underscores our commitment to progress. Our comprehensive quality strategy outlines our primary focus areas, including primary care, maternal care, and the integration of behavioral health. These areas serve as our guiding principles, informing everything we do across the department.

DiLuigi: We're really getting into the micro data and it's a good discussion I wanted to go back to what Bill raised earlier, just to reinforce that what I really appreciate is the question of data particularly around substance services.

Open Data Portal data by county

Beck: To me when I look at dashboards, I hope for two things. One is that we can identify gaps, for example, we know that in areas around the state, there is an insufficient amount of specialty psychiatric services. And, I was glad to hear about primary care because I do think there is an important role that needs to be addressed. One is gaps. And I'm so glad that one of the speakers in the last couple of minutes mentioned outcomes. It's always hard for me to look at data like this. And what I really want to know is if people are receiving adequate care? What does specialty care mean? Was it one visit? Is it ongoing? Did their health improve? There are ways to look at outcomes. I realized that is part of our long-term strategy. But I wonder, in terms of mental health and these kinds of dashboards, how can we start identifying outcomes that we would like to see. And then so it's not only utilization, it's not only did a person have a visit, but what is the outcome? What happened to this person?

Salazar: We're doing what we should be doing, which is investing in infrastructure, and investing in workforce to work with the infrastructure. And we will count the utilization. I hope when we give money, we expect outcomes. Right now, we're not paying for value or outcomes but for infrastructure. We're paying for possible utilization at this point. And I really hope I'm still in the game when we're doing outcomes.

Linette Scott gives Update to Data Exchange Framework, CMS Interoperability Rule, and CalAIM Data Sharing Authorization Guidance as it relates to the Youth Populations.

Weiss: As I examine the roadmap, one significant opportunity stands out to me: involving schools in the data exchange framework. Given the emphasis on mental health, particularly with initiatives like BCHIP, understanding the intersection of The Health Insurance Portability and Accountability Act (HIPAA) and The Family Educational Rights and Privacy Act (FERPA) is crucial. I believe there's immense potential in including schools in this framework, but I'm uncertain if this is already part of the roadmap.

Scott: In terms of how the statute was passed, certain groups of providers are mandated to sign the data exchange framework, but anyone can sign up. While some providers must comply, others have the option to do so, broadening the scope. For instance, counties with behavioral health services are not required to sign the framework yet, but they still need to exchange data with health plans due to interoperability rules. These different pieces are interconnected, creating opportunities and varying requirements across different areas. However, it's important to note that our agency leadership and Secretary have emphasized that the framework encompasses not just health but also human and social services. Our data sharing authorization guidance addresses where FERPA fits into this framework, highlighting the holistic approach we're taking. It's essential to consider how these elements come together.

Salazar: In the spaces where I work, I collaborate with consultants and county-level collaborators, engage with providers, and maintain memberships in several provider associations to stay informed. However, I've noticed that this critical information isn't filtering down to the community as effectively as it should. Understanding how to appropriately

exchange information is vital for the success of the changes we seek. My question to you is: Can we initiate an educational campaign? While I appreciate the resources available on your website regarding CITED and PATH and how to access technical assistance, we must prioritize data exchange, which serves as the backbone of communication and partnership—key components of our objectives. I'm eager to support such a campaign, but I'd like to understand what assistance you need from us. We need to disseminate this valuable information throughout the field at every level and can't solely rely on counties to do so. In my experience at the county level, data personnel are often the least involved or informed. Therefore, we must spotlight this issue and equip stakeholders with the tools they need for success.

Scott: Thank you. I think it's a fair observation, for many of us that work in this space. It's not a new observation. To the extent that you have suggestions of how we can do that, effectively, it would be helpful. I've been working with the Electronic Health Record (EHR) incentive program since 2009, but it's inherently been one of the challenges all the way through is how to get enough attention from that kind of policy piece to bring the data piece along with it, right? And have people understand. It kind of goes back to our dashboard conversation, if it's actionable, and it affects what you're doing on a day-to-day basis, then people care. How do we message it to help get it into that space? So that it's, it becomes part of that evolution.

Salazar: Again, this is so nuanced. All this work is so nuanced, and so detailed, and so granular, when you get out there. I'm working with some counties on plans of safe care implementation under the Family First Prevention Services Act (FFPSA). Not that it's your job to talk to county council, but if we don't get the information to the leadership and to the middle managers, and to the people that can get it done, they can't push it back up through their chain of command.

Arroyo: The potential for all *this* is enormous, but the path to get there is challenging as you know, better than most. To dovetail Liz's comments, I would argue that many policymakers have introduced bills currently in legislature and I won't name them, but you probably know which bills they are, is asking to get accomplished with the data exchange framework is supposed to accomplish. And so, what I see is that, as reported, the counties are not the only ones who have informational gaps. But the state legislature, in my opinion, also has a need to hear about the data exchange framework. You know, there's a slew of new legislators in the state legislature this year. They are clueless about what you're doing. And I don't know when the last time it was that you presented it to them. If the information can be streamlined to the right people, you may reach your goals sooner. Again, the potential is phenomenal.

Beck: I appreciate the point made about many young people receiving care within the educational system, such as at school-based health care sites. It's crucial to include and share this kind of data more extensively. There's often apprehension about overstepping boundaries in the educational system and inadvertently sharing confidential information. I'm curious, though you may already be addressing this, if there are discussions with large healthcare systems statewide. It ultimately boils down to what individual providers feel comfortable sharing for the benefit of their clients. I've been part of meetings where groups grapple with how to

communicate effectively, both technically and in terms of overcoming barriers to sharing social and medical information. While I imagine such discussions are already happening, I wonder about engaging with different healthcare systems across the state and facilitating conversations with their chief information and communication officers to ensure this understanding trickles down to clinicians and practitioners.

Linette: Thank you for that suggestion.

Joseph Billingsley and Cortney Maslyn Present Overview on CCS Compliance, Monitoring and Oversight Program.

No comments or questions were made.

Autumn Boylan Provides Overview of Youth Platform Launch and Children and Youth Behavioral Health Initiative (CYBHI) Fee Schedule Program Update.

Arroyo: I tried one of these the other day. And I had to be registered. Has there been any feedback about having to register?

Boylan: In the BrightLife Kids, you do have to register and create a complete profile in order to use that app. However, they are building out some guest access pathways that will come online later so that people can access the content library without creating an account. They can access wellness activities along with various other features but for the things like coaching and peer communities, those would require the account to be created. For Soluna there's already a guest access pathway for users to explore the app and to checkout kind of what's happening within the context of the app without committing to creating an account. It does not allow them to access the coaching support without creating an account.

Boylan plays demonstration videos for BrightLife Kids and Soluna.

Salazar: So you know, the initiatives under the entire CYBHI initiative is huge, *and* you're going to talk about the school-based access to behavioral health services in a second. Where do you see this piece actually really fitting together? But I'm also going to say with the two distinct specialty units of mental health, and especially *planned* and substance use. I see there's going to be an easier way to plan but how do you envision these puzzle pieces fitting together?

Boylan: So, for the virtual services platform, I think, you know, part of the way that we envision it is that it becomes a part of the overall landscape of services. But I'll tell you, when we were talking to kids, as we're doing this stakeholder engagement across the state, we would get in a room with young people and ask the question, do you know where to turn for help? And no hands ever went up Every time we asked that question, they don't know where to go. And so part of the answer to your question is, where do we see these fitting in, it’s a front door. it's a place for kids to go where when they don't know where else to turn, they don't want to talk to their doctor, they don't want to tell their parents, they don't want to disclose to somebody at school, they can get started on their wellness journey and pass through these apps. Now, if

they're already in care, they can also use these apps, right? We've talked a lot about kind of what that looks like. We don't want somebody getting clinical services from two different providers. However, there are lots of kids including my own, who is in clinical treatment for a mental health condition. And sometimes things happen in life that make you stress out a little bit that's not related to your mental health disorder or condition. So like my own child is going through all sorts of things and dealing with that in a clinical therapeutic environment. But you know, then a breakup happens in a relationship, or they get in a fight with a sibling or they're stressed out about homework that's due at school the next day. They can use these apps as a tool to get support, guidance, direction. The coaching is really meant to be short term solutions, goal oriented to address specific problems. Now, you might come up with a plan to utilize these tools for the next 3-4 sessions and then go about your life but if something happens down the road you are able to come back. Users can come back multiple times, but it's really meant to be a front door. However, if the person's needs are really escalated and they need additional support or clinical intervention, clinicians are trained to identify that. They're trained to help navigate a person to community resources and specifically to do a warm handoff. So, when a person needs that level of support, they're connecting the user with a known and trusted partner in the community that can help meet their needs in a more appropriate way.

Weiss: If someone between the age of 18-25 goes away to college, what is the licensure of the supervising provider? Can they engage in the app if they're out of state?

Boylan: It's a non-clinical workforce. But the supervising providers do have to be licensed in the state of California. It's also not clinical treatment so they could still use the app while they're in school. But I think we're trying to just monitor usage and kind of see what those patterns look like.

Weiss: Are you utilizing the find health closed loop component? How do we know if a referral occurred?

Boylan: For the warm hand off component, it is a closed loop process, but some of that is being built out. Part of the contract requirements for both vendors is that they have a robust network of community-based organizations that they partner with in every county, so that they have that known and trusted allies that they can go to. The idea is that they've developed a network, which they're working on doing, they have some of those pieces in place, but that'll be become more robust over time.

Weiss: So, you alluded to these kids having an existing mental health provider, primary care doctor, etc. Is there any feedback, Are the kids asked to indicate if they have an existing care team, primary care, doctor, whatever? So that provider can be in the loop on what's happening, if desired?

Boylan: That would come out as part of that coaching session. They're not asked about their specific care history as part of the account creation, but it's disclosed by the user. If the information isn't disclosed by the user, there's no way for us to extract or obtain that

information. So there wouldn't be a sharing necessarily between the app provider and the PCP or a clinical provider in community. However, what we've been thinking about is how do we create the functionality, which we don't have within app to allow the user to extract their own information. So, I took an assessment within the app, here's my chat history, and then share that information with their provider. That's not functionality that we have in place yet. But it's part of the discussion around the product roadmap to kind of see what we can build in into the future.

Beck: Is there a plan for helping young people who are interested in being peer coaches, or developing coaching skills to be trained to peer communities? And I think I'll go through the questions and then you can respond to whichever you'd like. The second thing is feedback and evaluation. Young people that go to the site and don't have the best experience or have a good experience. How is that being captured and communicated? And then thirdly, I just want to clarify this is for all young people, you don't have to be a Medi-Cal enrollee to use the platforms. And then finally, in terms of outreach, I do think that the schools, like my daughter works in an afterschool tutoring program in one of the indigenous communities in California. I could just see her telling the kids she works with about this and creating space and time to sign on and see what happens. I There could be actual time devoted in schools or in other settings to young people exploring these platforms.

Boylan: Okay, so I'll try to go in order. Thank you for your question. For the peer communities and for the peers approach, I would say it's part of the CYBHI, there are a couple of different work streams that DHCS is not lead on, but our colleagues at the Department of Health Care Access and Information(HCAI) are doing some work in this space to develop career pathways and options for people to become wellness coaches, as part of this new classification of workforce called wellness coaches. And then the certification process is ongoing to recruit people to enter that certification program. There's also separately a small contract through HCAI and some of their work around a Youth Health Academy to get high school students involved in some of these career pathways. And then another piece that we are leading specifically is a $10 million pilot demonstration project, *where* we're partnering with a Children's Partnership to establish eight high school sites to study peer-to-peer learning in school-based settings, where the peers are actually the high school students providing peer support to other students in the high school setting. *O*ne of the culminations of that project, when it concludes in the next couple of years will be that the Children's Partnership will produce a document that is statewide standards for high school peer-to-peer administration.

There are feedback loops built into the evaluation within the app so that users can directly give input there. Those are also things that the apps, you know that the two companies are building in more robustly to be able to get specific feedback on coaching sessions on content on other activities within the app, that we're also looking at data to identify like what's resonating within the app? What are the modules that folks are spending the most time on? How much time are they spending? are they return users? So we're looking at all of those things, and kind of poring

through that and we'll be sharing out some of those resources and a dashboard after you know, on a quarterly basis going forward?

The platforms are for all children. In California It's not just for Medi-Cal members, it's for every kid in California, ages 0 to 25. It also for all parents and caregivers for young children, ages 0 to 12. No insurance needed. We want everybody to get access to the support that they need, and then get navigation support when they need it.

And then absolutely, we agree that schools are a primary audience for this outreach and engagement effort. Both of our vendors are working with schools and counties. We are also doing a ton of work around school-based services, which we hopefully will get to a little bit about today. And we are also sharing this resource. So, we've done webinars for all of the county offices of education, we're including outreach materials, such as the slides that we've shared, we created these videos, including a five-minute video specifically to help tell the story with educators about what these opportunities are. We're leveraging that countless communities of practice for the school's module. We're also talking to people about it on a regular basis. Earlier this week the vendors and my team did a meeting where there were 250 educators participating in a statewide convening from the California Department of Public Health in their school's initiative. We are focused on getting the word out and sharing these with our colleagues, both in K -12, childcare, and in college universities settings.

Arroyo: So I actually met with a state organization of psychiatrists, mostly child and adolescent psychiatrist and there were two areas of concerns and reservations. First one, the evidence base for the strategies used in these two commercial apps. The second concerning reservation is security features of these two apps. It is well known that electronic medical records have been hacked all across the country. Large datasets have been shared, unfortunately. And so it's that kind of mindset, and particularly in the social media world, youth data is being shared among various commercial entities. *H*ow do you convey to a potential user that certain security measures are foolproof?

Boylan: So first of all, both of the companies that we've selected have tons of experience in this space, they've been providing digital behavioral health support to children, youth, and families for many years. Kooth has been active for over 20 years, Brightline also has over a decade of experience doing this work in the digital space for this exact type of programming. They both have done a ton of research and studying of their methodologies and refined them over the years. They have also both been published in peer reviewed journals. So there is a growing body of evidence around digital behavioral health tools that's not specific to our vendor programs. It is a growing body and field of work that has taken off. They definitely do use evidence-based modalities for how they deliver treatment, they have very clear safety protocols around how they train their coaches. So they do employ evidence-based strategies that have been documented, peer reviewed, and we could share some of those resources in terms of materials.

Open Data Portal data by county

Arroyo: Published peer-reviewed sources would go a long way, for my constituency. For example, a recent LA Times article detailed that in a child abuse allegation, courts and judges always order parents to attend parenting classes as part of the process of getting their children back. In many instances, those parents training classes have no evidence base and the parents then continue to abuse the kid again. In one instance the parents killed the kid. But it's that kind of sense that, you know, people are wondering, you know, we have lots of protocols for children, but are they ever safe? It was unclear to me that there was any evidence or strategies being used in the app that I was looking at. So just something you should be aware of.

Boylan: Totally agree with you. And it's part of what we vetted in process and happy to share some of those particular resources, but *usage and safety are* something that we will be monitoring very closely Moving into your second question security protocol. You know, as a business associate of the DHCS and state Medicaid agency, we have tight protocols in our contract with both of these vendors around security and privacy provisions. They have to comply with all of the state law and federal requirements around security and privacy and submit extensive documentation demonstrating that they've met these protocols, even prior to the launch. Our Information Security Office is very involved in the review of *these* deliverables. It's an ongoing process, it wasn't a one and done thing. But it's a regular process where we are verifying that they are maintaining all of the appropriate certifications and level of security and adhering to all of the privacy requirements that are required of the state Medicaid agency and as the state healthcare agency as well. DHCS also owns the data. The apps do not. They're commercial companies true. But they do not have permission to use data in a commercial way. We own the data, they are not allowed to use it without our permission. They're not allowed to sell it*,* share it*, or* use it for research, without our explicit permission.

Arroyo: Is the reader informed that it is unlawful to ABC and D? *Boylan*: Yes, there are privacy disclosures and notice of privacy practices, both within apps and on the websites for both of the programs.

Schumann: I use an app called Messenger Kids with my nine-year-old son. Occasionally, he may experience anxiety or encounter other issues. While I'm not a clinical psychologist, I find comfort in knowing that through this app, we can communicate, and then his mom can review the conversation through the parent portal where trained professionals are involved. My question is whether parents using the Brightline and Soluna apps have similar access and support.

Boylan: I'm not sure if there is visibility into the chat history on BrightLife Kids. However, it would only be on BrightLife Kids. The Soluna app would not have any parent view of chat history or any other activity because that app is explicitly for youth and young adults. The BrightLife Kids is a dyadic model in which the parent consents to the child having a solo appointment with a coach. The parents are aware and are able to bring it back into the group session with the family. But I don't know, specifically about being able to see the chat transcript or history. I can ask that question, but I don't actually know. It's part of the model that the parent is informed

and they're all working on something together. So, the kids are not doing things on their own that the parent isn't aware of.

Schumann: It would just be nice for the parents to be able to download that data for an actual clinical psychologist or professional to review so that they can make sure they're given the right direction and guidance for their particular disorder.

Boylan: Yes, we're working on app functionality to allow the users to be able to download their own activities within these apps to be able to share them with their providers, but we do not have that functionality yet.

Lauterbach: I wanted to circle back to users needing more services and referrals. Can you tell me a little bit more about that? I'm assuming that they're screening them for the different health insurance status? Because we see that people get really lost in that. For example, if you have Medi-Cal it can be really hard to get behavioral health services. So how are they keeping their list up to date?

Boylan: Regarding insurance information, Brightline Kids includes a pathway during account creation for users to input their insurance details. Brightline serves not only Californians but also other commercial clients, such as Amazon, providing therapy services to their employees. Therefore, they require insurance information to facilitate billing. However, users can bypass this step or select "no insurance" and still access the app's free services, covered by CalHOPE. On the other hand, the Soluna app does not request insurance information upfront. Users can add this information later if they choose. We prioritize user anonymity and allow them to explore services without divulging personal details like insurance information or identifying information about themselves or their families. If a teenager or young adult requires community-based support, they can choose to share their information directly with the organization or with the Soluna care navigation team for assistance. Regarding the provider list, while Find Health has a process for updating it, it's not real-time. However, the care navigation component ensures that the network of providers available on the app is actively vetted and up-to-date for seamless handoffs.
Lauterbach: So I'm imagining you're going to get people that are uninsured, and they're going to be a referral to information on Medi-Cal on how to apply?

Boylan: I think that we can figure out how to make that available to them. But it is not their role to get them enrolled in Medi-Cal. However, the community-based organizations that are part of that affiliate network can help them.

Lauterbach: Sometimes people stop care because they think they can't pay for it. They don't realize that Medi-Cal is actually a program that can help them. So that would be a great connection.

Boylan: We heard costs as being a barrier pretty much across the board. Even if there's no cost to, they think that there is a cost.

Open Data Portal data by county

Salazar: Two-part question -- The first is, I'm assuming that the associated agencies provide their target population for their funding. What funding is required and when can they provide that information to the care navigator to navigate?

Boylan: So the ideal pathway would be if you're enrolled in Kaiser or anthem or whatever that you go to like that they, that they connect you with a provider in your network. But absent that they would be connected to the community-based organizations in their area.

Salazar: I'm curious about the screening and assessment tools. What are they how are they decided on?

Boylan: BrightLife kids uses a pediatric Symptoms Checklist. Soluna uses the PHQ for self-administer tests, and then they use that session one wants and needs outcome measure as well as the mental wellbeing scale.

Autumn, the speaker, provided updates on the implementation progress of a fee schedule program for local education agencies (LEAs)

Salazar: What comes to my mind, representing the substance use treatment provider sector is that historically, they have outpatient services throughout the state. It was previously known as the Block Grant program and is now the Medi-Cal system. Their primary source of service was through the school system, and they were on campus providing services. So have you tackled this interface? You can be a counselor and build through the system, but it seems duplicate now because now under drug Medi-Cal state agencies are doing field based services.

Boylan: I can provide a broad overview, and then we can discuss further offline. Our focus regarding fee schedule programs and substance use disorder services is rooted in transparency and truthfulness. This encompasses psychoeducation, screening, referrals, and brief interventions as integral components of our model. However, it's a nuanced situation. During our interactions with youth across the state, and feedback from county stakeholders, uncertainty surrounds school-based services due to varying approaches and opinions across counties. So we've adopted a cautious approach with plans to reassess as needed. Regarding the overlap question, there are distinctions in funding between SACB and Medi-Cal, as well as differences in what can be accessed and the responsibilities of existing plans. Considering the involvement of multiple payers, including commercial health plans regulated by Department of Managed Health Care and disability insurance, access to services provided by doctors may vary among them.

Salazar: It's a disruptive innovation to the substance use provider business. They're going to have to change their business model in multiple ways in the counties. I get the feedback from the constituents of the providers, that they're very concerned about this disruption.

Autumn: We've heard that across the board.

Open Data Portal data by county

Arroyo: So this piece of CYBHI, is maybe the most revolutionary of all the facets of CYBHI. I was speaking to some people at national organization that I'm active in, and they couldn't believe that this was underway. That being said, tell me about some barriers that DHCS has encountered in terms of including the Employee Retirement Income Security Act (ERISA) plans.

Boylan: They're not named in the statute. So there's no statutory authority for the ERISA plan. If there is a statutory change, we will certainly work to incorporate them into the program model. But the statute specifically obligates disability insurance regulated by the department of insurance, healthcare service plans regulated by CMHC, and the *Medi-Cal* delivery system. AB 133 was the original bill.

Beck: First of all, I think this is excellent to as someone who's done this work in schools over the years without reimbursement. What is the role of Carelon Behavioral Health? Will every provider who's involved have to register with them? Or are they just monitoring?

Boylan: Carelon Behaviroal Health will be the third-party administrator that DHS is contracting with to serve as a statewide infrastructure. So they will be the claims clearinghouse which means that all of the claims for this program will go through Carelon. Now outside of this program is managed care plans or contracts with LEAs they can pay those contracts separately, but in order to be considered a part of this program, all of the claims will have to go through Carelon's system and Carelon will get the payment from the plan and then remit the payment back to the provider. They're not taking cut of the payment.

Beck: If a provider is providing care in the system and is not a part of a large group already, will they have to become a Carelon provider to be able to work in a school and provide care?

Autum: They don't have to be a Carelon provider but they will have to be credentialed by Carelon. And they will have to be listed on the provider roster by the LEA that they are working with. They must be designated by the LEA or they don't get in.

Public Comments:

Doug Major, O.D., California Children's Vision Now Coalition: There is no vision care metrics in the dashboard. Vision care is the most common childhood disability that is treatable. If you look at the Children's Now report card, we are ranked last in the nation now for access to vision care. If you didn't get a chance, please look at the Imperial College of London's needs assessment they did for you. Ironically, the only data that flows to the Department of Health Care Services comes from Department of Corrections. The Department of Corrections are the drivers of children's vision care in the state of California. We're asking for, again, after four years an agenda item on this committee. We have groups from Stanford, UCSF, UCLA and Harvard. We'd loved it to be a part of that. We are also looking for a champion. If one of you committee members wants to be a champion and really make a difference, preventative care for the million children who don't have glasses Please contact me we'll work together. Let's fix this problem

and put the metrics so that we can change the behavior. Let's help the leadership who needs your direction to change that mid management status quo. Thank you so much.

Member Updates and Follow Up

Arroyo: The California State Auditor issued a report on access to children's mental health services late last year. And having read a 60-page document, there's a lot of finger pointing at the counties, managed care plans at DHCS, and The Department of Managed Care. It is illuminating and very disconcerting. Anyway, I wish that we would take a look at that. Both DHCS and Department of Managed Care chair provided feedback that was incorporated into this document. The last thing, we had a subgroup that helped develop the dashboard. and maybe it's time to consider this group helping if permitted.

Ellen: The two areas I want to focus on is identifying gaps and resources. And then the other is focus look at outcomes, not only mental health, medical, dental, but how are we really looking at outcomes, measuring outcomes and then acting based on those.

Weiss: Our next meeting is Wednesday, May 1 and will continue to be hybrid.

Open Data Portal data by county