State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

November 2, 2023 – Hybrid Meeting

Meeting Minutes

Members attending in person: Mike Weiss, M.D., Licensed Disproportionate Share Hospital Representative; Ken Hempstead, M.D., Pediatrician Representative; William Arroyo, M.D., Mental Health Provider; Jeff Ribordy, M.D., Health Plan Representative; Nancy Netherland, Parent Representative.

Members Attending Virtually: Jovan Salama Jacobs, Ed.D., Education Representative; Elizabeth Stanley Salazar, Substance Abuse Provider Representative; Diana Vega, Parent Representative; Alison Beier, Parent Representative; Karen Lauterbach, Nonprofit Clinic

Members Not Attending: Ron DiLuigi, Business Community Representative.

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

DHCS Staff – In person: Michelle Baass, Joseph Billingsley,

DHCS Staff – Virtually: Brian Fitzgerald, Yingjia Huang, and Cortney Maslyn

External Presenters: Carmen Katzarov, Executive Director, Behavioral Health Integration, CalOptima

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 May 4, 2023, was approved, 10-0.

Opening Remarks from Michelle Baass, Director

Director Baass provided updates on key policy changes to the DHCS managed care plan (MCP) contracts and the MCO Tax for 2026 (Proposition 64).

Schumann: What happens to the 1.2 million members who don't select a new plan. Is there a default option?

Baass: If they don't select a plan, they are placed in a default plan. The default process we use is based on primary care provider (PCP)linkages. To clarify, members always have a choice to change plans. So any time a member is defaulted, the member has the choice to change. For example, people in Los Angeles County who are transitioning from Health Net to Molina Healthcare will have an opportunity to change plans.

Hempstead: Do we have any sense of what proportion of those people have already made a selection?

Baass: They haven't received a choice packet yet. Starting in October, members will get 90-day, 60-day, and 30-day notices.

Salazar: I saw the information notices about the rollout of the MOU and community advisory process. Are plans required to use a single template? Is the template for the plans the same across all 58 counties? Is there uniformity in the contract?

Baass: We do provide a template on our website for each of the different areas, but counties can also change or add more to that template based on their local engagement. We've been working with stakeholders for the last few months on the MOU design. Today we released a new version of the child welfare MOU.

Weiss: Has there been an analysis of the membership in terms of the relationship or linkages with primary care doctors?

Baass: Yes, that was actually one of the requirements from the Centers for Medicare & Medicaid Services (CMS): PCP overlap. I actually believe Health Net and Molina have close to 100% PCP overlap, with the intent of continuity. For those members who don't pick a plan, that is one of the top criteria for default.

Arroyo: Children in foster care are more vulnerable to losing health care because when they are placed in a new home or some other calamity occurs, then suddenly they find themselves in a place where they don't have their primary care doctor. How are we helping to accommodate those children?

Baass: One of the key pieces of the new contract is that every MCP is required to have a foster care liaison who serves as a single point of contact with counties, families, and foster youths themselves to answer managed care questions. We also have a child welfare MOU, which outlined some of the ways to streamline and think through these things. Another thing we've worked hard on is BH-Connect, which is a feature that helps with this. We submitted a waiver on October 20. We are trying to figure out how we incentivize the plans, child welfare, and behavioral health to work together so no one falls through the cracks.

Arroyo: If there were metrics to reassure the general public that these vulnerable populations, in fact, continue to get their health care, that would help.

Baass: Yes, and that was a driving factor in AB 2724 for Kaiser Direct. Kaiser Direct operates in 32 counties, and foster youth are one of the populations that always have a

choice to use Kaiser Direct. There doesn't have to be continuity or any previous relationship with Kaiser. We just need to think about their ability to transfer information that is already available, no matter where the child lives.

Arroyo: What is the data exchange framework with MCPs and Medicaid?

Baass: The plans are required to follow that framework because certain providers are not doing a great job of exchanging information. It's a matter of working through the relationships and trying to demonstrate the need for streamlining information.

Netherland: I share your concerns about vulnerable child populations. Ultimately, we know that foster youth have a higher level of mobility, so there is a real concern about interrupting continuity of care with trusted primary providers. Can we get the materials from the last Foster Youth Health Task Force meeting? There are specific summaries of data, specifically on some of those transitions. I saw that there was guidance related to continuity with providers. For example, recommendations for warm handoffs between TCM providers.

Salazar: We have a committee on child welfare at the state level. Do we have a committee dedicated to juvenile justice? Who are the partners and how are you ensuring youth in the juvenile justice system are part of this transition? The linkage between health and behavioral health needs some attention.

Baass: Juvenile Justice youth are a big part of our CalAIM Justice-Involved Initiative, which will be going live in 2024 in phases. So that in reach in-reach services, the pre-enrollment, connections with ECM and Community Supports, as appropriate, are all part of our CalAIM Justice-Involved Initiative, which includes juvenile justice populations.

Baass: Next, I want to provide an update on a big piece of our budget that was passed in June with the reauthorization of the Managed Care Organization (MCO) tax. The tax is effective from April 1, 2023, through December 31, 2026, bringing in $19 billion in MCO tax revenue. For the first time, we are using the majority of those funds, about $11 billion, to increase Medi-Cal rates for providers and investments in the Medi-Cal health srvices. Previously, MCO tax revenues were just used to support the existing Medi-Cal program. Revenues from the current MCO tax will additionally be used to support rate increases and investments in the Medi-Cal program.

This will happen in two phases: January 1, 2024, we will be moving primary care, obstetrician-gynecologist, and non-specialty mental health provider rates to 87.5% of Medicare.

Effective in 2025, there will be additional rate increases and investments for a broader range of services, including specialty care, community and hospital outpatient procedures, abortion emergency room facility and physician services, designated public hospitals, ground emergency transportation, and behavioral health, as well as additional rate increases for primary, maternal, and non-specialty mental health care.

All of this information will be released in January with the Governor's budget. Our term sheet is posted on the website. We will build base rates to a certain level and then augment those rates with an enhancement based on geographical shortages of providers, the Healthy Places index for children, and additional bumps based on where we need to build more capacity.

Arroyo: What happens after 2026?

Baass: Every MCO tax has been for a 3-4 year period for the last 20 years because tools change at the federal, commercial, and program levels.

Weiss: My understanding is this is an adjustment to Medi-Cal fee-for-service? How would this relate to capitated medical groups?

Baass: As part of this, we will require plans to pass through this base rate plan. So we are working through the mechanism to do that, but it is not supplemental or anything that would have to be reconciled. The intent is for that full rate to go to the provider.

Ribordy: Was 2025 ground emergency transportation wrapped?

Baass: Correct.

Ribordy: For the MCO tax, wasn't there a discussion about proposed legislation because the MCO affects permanent evaluation?

Baass: It was a ballot initiative.

Netherland: I am curious to know if we are looking at the implementation and rollout of MCPs in different parts of the state. I have been hearing about inconsistencies around MCPs. Can we get more information about the type of data you are collecting and when you think that might be available for review. I'm looking at enrollment data for child populations. I've heard there is a carve out or special considerations for young people impacted by juvenile justice and foster care. I'm curious what enrollment looks like and the number of people who are referred by providers or are contacted to initiate onboarding. How many are completed with matches? The intent of the program was to look at locally based, concordant, and perhaps smaller organizations. I'm hearing from the plans references to working with larger entities that were more prepared to bill and partner with out of state telehealth support. Just curious if we could get a "state of the union" if you will.

Baass: Sure, we have a lot of information from 2022 because we don't have the July information yet. But we can come back to that. Yesterday we announced part two of PATH CITED grants to build capacity with some of our CBOs, and it will take years to build the runway. Fortunately, some of our counties and clinics have this stuff in place. Those are going to be the first ones providing this service. The goal with our TA Marketplace and PATH dollars is to provide some of our smaller providers with the help

they need to become Medi-Cal providers. We also still have PATH round 3 and 4 dollars.

Netherland: County collaboratives are worried about the accessibility of data sharing and the capacity to access some of the data necessary to be a meaningful ECM provider. What are recommendations that can be shared across regions?

Baass: PATH dollars can be used for those needs.

Netherland; I would love if we could have regular updates during our meetings on highs and lows of the implementation of those programs.

Baass: Over the last year, Jacey and I did a listening tour throughout the state. We met with 11 plans, their providers, and their community groups about CalAIM. Some feedback we got was that we gave lots of flexibility to our plans in terms of criteria for Community Supports. But we heard that that flexibility was not helpful. They wanted us to standardize Community Supports across the state, so that's what we are doing. We are trying to hear everyone's perspectives on the ground.

Netherland: Those are amazing innovations. Let us know how we can contribute and support the efforts that are being made by all stakeholders.

Arroyo: I appreciate you going around the state and agreeing to create standard supports. I am concerned about the small counties that don't have resources that large counties have. How do you plan to assist them?

Baass: That is the intent of PATH dollars. We used those dollars in round two to focus on small local areas. To infuse dollars at the local level to build out Medi-Cal providers, ECM, and Community Supports.

Salazar: Providers have a "hidden network" of providers that they've cultivated with their juvenile justice funding and grants. I don't know if the information is trickling to them. It would be interesting if there was a campaign to reach providers who were affiliated with target population, but not necessarily affiliated with a plan. It would help if we could reach them so they could be involved in the transformations.

Baass: Do you have any suggestions on how to do that?

Salazar: I would want to speak with someone. There are a lot of great ideas coming out of the Council on Criminal Justice and Behavioral Health. I think we would work through the chiefs at the Chief Probation Officers of California (CPOC) because they have developed a network over 20-30 years. I am not sure they know there is an onramp they should take advantage of. If I were a chief, I would be talking to all of my providers to get their insights.

Arroyo: For example, there is a large group of awardees of Proposition 64 funds, which is the Adult Use of Marijuana Act. A lot of those funds are for preventing the use of illicit substances. Those CBOS that have been awarded grants are not in Medicaid space. I

recommend DHCS work with Proposition 64 administration to become familiar with those CBOs they have engaged with in the grant awardee process because the intent of the awards is to reach the same populations.

Election of Chairperson for 2024

Director Baass reminded members that at the upcoming February 2024 MCHAAP meeting, members will have the opportunity to elect a new chair. Any member is encouraged to run.

Student Behavioral Health Incentive Program (SBHIP) Overview

Brian Fitzgerald gave a high-level overview of the SBHIP program, and Carmen Katzarov detailed Orange County's efforts to implement the program.

Ribordy: Our behavioral health team has been involved with most of the County Boards of Education. Our challenge is that we currently have 14 counties and will have 24 counties. Having agreement among all of those counties is hard. Workforce issues are even more challenging in rural areas. We can't even get our clinics to do the billing correctly, so it is hard to imagine how tricky billing will be for school districts that have no experience doing billing. But this is a great program. We only have two universities in our area – Cal Poly Humboldt and Chico State. So we are leveraging resources we have. We are used to dealing with having low resources.

Jacobs: Over the last couple of years, we have seen more intense social emotional needs and higher rates of substance use than ever before. Teachers, social workers, and public safety personnel are struggling. We've had an increase in funding, but it's hard to find people to support students. In special education specifically, we are finding higher rates of students in crisis and who need more restrictive environments than ever before. We appreciate all of the work and collaboration that Orange County has done. In Los Angeles County, we have more than 60 school districts, one of which is the second largest school district in the country. I haven't seen this kind of collaboration in Los Angeles County, but I'm going to follow up with our folks to see what is going on. We are relying on telehealth access in my community in Pasadena, but families are not accessing it as much as we would like. They want to be in person. Some of our community members need us to walk them through the telehealth process. I'm looking forward to seeing what other school districts and counties are doing to tackle that issue. I also have a question about the presentation. Can you point me in the direction of someone to talk to about how Orange County is engaging with students with autism? How are they working with special education plans?

Katsarov: From the perspective of managed care, those issues came up in our needs assessment. It's going to require ongoing collaboration. This work is an iterative process that must continue past 2024. With the autism program, we must work with schools so we aren't duplicating. We are able to lean in and support. For students going through regular Individualized Education Plans (IEP) and have a gap, the MCP can come in and

provide support. For example, we are building our IT infrastructure. Our ADA providers are talking to the schools to make sure they have the IEP plans in place. We are still learning, but we are in it together.

Fitzgerald: This is an iterative, collaborative approach. This is just step 1. In terms of workforce shortages, we have several long-term initiatives through the California Department of Health Care Access and Information (HCAI). Through Student Behavioral Health Incentive Program (SBHIP) and the Children and Youth Behavioral Health Initiative (CYBHI), we are trying to train the lowest level staff at schools to render early intervention services to bridge the gap in a two-step process. I would like to learn more about collaboration in Los Angeles.

Weiss: Adding to what Jovan said, one of the things we've done to reduce redundancy is provide consented HIPPA/FERPA compliant records to our nurses. So when our nurses are creating IEPs and 5014s, they don't have to be doing that blindly. They can be incorporating information from the medical team that is providing that service. We are one children's hospital in a county, but it has been worth the effort. The nurses and students love it. We are also looking at bidirectional data to look into the clinical medical records of attendance, disciplinary action, grade progression, etc. I don't know about the physicians in the room, but when you ask a family how school is going, the answer is always "great". That is arguable a social determinant we should all be focused on.

Vega: How are you planning to do the IEP assessments? According to the IDEA (Individuals with Disabilities Education Act, school districts can't do any assessments without written approval with the parent's consent. It is concerning that you are planning on assessing these kids without parental consent. How will you protect student privacy? Any time I want to share information about my students, I need a signed ROI. I wonder how you are protecting privacy, especially because there will be so many agencies collaborating. What kind of support will be available for families of students who qualify for mental health supports at home? You mentioned training. How do you ensure equity? I imagine lots of families will want to move districts based on the services that are provided because their current schools are not participating. Who will receive the training? Counselors at school districts? As far as the behavioral health curriculum, who mandates which curriculum would be appropriate?

Katzarov: In Orange County, all of the schools are participating in the curriculum. It was customized from the needs assessment. Western Services is in the process of working with every district and school to decide what trainings are needed. They will be available for any personnel working with students with mental or behavioral health needs. During our needs assessment, we keep hearing, "I need more support and training around core competencies." We are not circumventing anything that has to do with HIPPA. We must go through the proper channels. As far as IEPs, we would not circumvent any regulatory processes. What we are trying to do is create good operational practices so that when there is consent in place, we can get the kids to care. For example, a child with autism

will have an IEP, and if there is a family who needs or wants more behavioral health treatment or services, they are the ones making decisions.

Fitzgerald: Those are complex questions to which we may not have exact answers. These are all local decisions done by the plans and communities with broad oversight from the state, so it varies. Anecdotally, having worked with all of the counties and plans, I can attest that much of what Carmen said is universal. Everyone wants more training and to reach as many students as possible, but they are not going to circumvent laws, regulations, or current practices. Privacy is still a high priority, if not the highest priority. Getting buy-in from parents is a challenge. It's an operational lift to not get parental consent. In reference to your comment about disparities, we want to focus on have and have-nots. We didn't want funding to be proportional to school size. For example, we don't want all of the money to go to LAUSD and none of the money going to Anderson Union High School just because they have fewer students. We don't want all money going to one school over another. SBHIP has tried to tackle those disparities. Its not perfect, and there is room for improvement, but it was built out in a way that could address disparities from step one. From a training perspective, we know we can't hire every practitioner we would like for all spectrums at school sites, so we are providing that broad training to schools and so the resources they have there already are prepared. The Surgeon General provided evidence-based trainings on signs of early intervention and how to get students into treatment or someone more specialized within the school district.

Vega: It worries me that there aren't assessments at school. Would this be replacing those? The special education assessment is to assess what a special education impact might be in order to provide services. Its very hard for schools and parents to assess what the students' special needs might be. How are you making a distinction that mental health services are related to education, or are they the same?

Katzarov: In Orange County, we look at the screening and referrals intervention that we took on, not the assessments related to the IEP. The screening and referral we are talking about is to reach more children and youth that might need mental health services at school. Our schools in Orange County are already doing those screenings. But what we found in our needs assessment is that they vary in so many ways. So what we are trying to do is bring in different professionals to look at different screeners and put a process in place to make sure that schools have a better way to identify which students need access to help faster. Those screening are done with consent; we wouldn't circumvent any of that.

Vega: Schools already have an individualized education plan. Are you taking that away from schools?

Katzarov: No. We are just looking at what is already in place and trying to improve it. In Orange County, the schools themselves wanted a more standardized approach to get

the kids the right services. We don't just want to screen kids; we want to get kids the care they need.

Fitzgerald: We must look at these systems – the juvenile justice system, the health care system, the education system, the housing system – holistically to give individuals whole person care. Government is starting to cross-collaborate.

Beck: In my school district, UCSD, we've partnered with the Lemon Grove School District to do this kind of work. We looked at health care for kids and parents, as well as the staff and the physical space. Related to your comment on training, I encourage you to involve the Youth Advisory Group in the training of the teachers and staff. We created a middle school curriculum to help young people in the school become youth health promoters. They were involved school-wide in the process of change. A young man diagnosed with schizophrenia gave a talk on schizophrenia. A young woman who was in foster care also led trainings. They were some of the best trainings we've ever had.

Katzarov: Thank you. It's great to work across districts.

Netherland: It is great to see this program rolled out in rural communities. In my son's school, they are learning tenants of best practices around how to be healthy. I wonder if there is a missed opportunity in engaging caregivers. For example, privacy is not the intent of the school – it is a part of state and federal statute. Many times, caregivers don't know that. I often train fellow caregivers on laws to explain that these programs are not a threat, and they are not creating access points to kids who don't already exist. They are really resourcing gaps in care. In future iterations of this program, it would be great to engage caregivers and replicate the strong work with the lived experiences of young people. It would also be great if we could collect data of our successes and present them to the end user. I am always taking data to families to educate about some of the impacts to evidence-based practices, and why they are crucial to the health and wellness of our kids on an individual and a societal level.

Fitzgerald: You are right. It is outside the scope of this project, but it is important. Kids are heavily influenced by their caregivers.

Salazar: Echoing Nancy's sentiment, caregivers and parents are the partners and stakeholders. I am excited that Carmen is using the allcove model, because it is built around wellness and is essentially a youth-driven system of decision making. The California Health Care Foundation has several briefs on how to compensate volunteers. This is the first time there is a true effort to impact these silos. I always want to make sure the state knows what a heavy and long-term lift this is. We've used 42 CFR, which is a regulation around privacy in substance use disorders, as a wedge to keep us siloed. The siloing of substance use disorders or substance misuse discussions and support has resulted in a system of stigma. I don't hear in these discussions the word "substance use" or "misuse". I don't see where you are pulling the thread into the school environment funding stream. The specialty substance use plan is called the DMC-ODS. It is absent from many of the discussions, except the documentation and billing

initiatives. But I don't hear that thread being pulled in. Inside of the DMC-ODS plan, there is a block grant. Twenty percent of the block grant is for prevention, most of which is done in schools. So why is the discussion of substance use disorders an afterthought in these discussions?

Fitzgerald: It's a good question. Behavioral and mental health need to go through lots of different delivery systems. There are financial disparities between the two systems. Through CalAIM, we are putting substance use delivery on par with mental health delivery. Treating students is a two-fold process. Students use substances to self-medicate. It's something that clinicians at the local level should be looking at in aggregate. For example, in Los Angeles County, the substance use group is different from the mental health group.

Salazar: Yes, and not every young person is addicted, with a diagnosable disorder. But they are exposed and experimenting with drugs. There is a rich opportunity to bring early intervention into this discussion.

Katzarov: At the local level, SBHIP is giving the opportunity of discussion. In our county, having our mental health plan there means both. It's mental health and the DMC-ODS. We don't see that as separate.

Arroyo: This initiative is way overdue. Fifteen years ago we tried to do this and failed 100 times in Los Angeles County. That being said, there are still many problems. I want to highlight behavioral health staffing shortages. In your presentation, you did not mention something. In one county I am working with, there are a lot of trainings, but they leave the moment their training ends because they can't afford to live in that coastal county. Finding affordable housing for young professional staff is hard across the state. But as long as we have property values that are so high, there will be a shortage. I want to underscore Diane's comment about IEP responsibility and mental health responsibility. This will come up in lawsuits.

In Los Angeles County, we were taken to task repeatedly by attorneys on the educational side, who said that certain services had to be delivered not by schools, but by other agencies. The auditors of the various systems (particularly fiscal services) drilled us about use of state fiscal money. They wanted to know why we were using state money when we had access to local money. There needs to be fiscal audit trails that the auditor understands. I also want to bring up the homeless student population. There are 200,000 homeless students. Are we focusing on this population? Is there a way to map where these students are in the state with where these services are being made available to try to ensure that some of these populations can take advantage of these services? Brian mentioned quality metrics that might be used to see how well this initiative is rolling out. We heard from the California Community Schools program, but we have not heard how that might interface with this initiative.

Fitzgerald: We agree that housing is an issue. We are talking to counties to try to figure this out. Under other initiatives, we have included increases in wages to address labor

demand. As far as metrics go, the California Health & Human Services Agency (CalHHS) is working on developing outcome measurements CYBHI for delivery of care.

Baass: SBHIP is one of the early stages of efforts by the CYBHI, and it is linked with schools and engagement with the California Department of Education (CDE). These connections aren't necessarily happening through SBHIP, but through CYHBI.

Schumann: I was a part of a youth advisory group as a youth, and it was great. I would like to see a breakdown of the 1.4 million people that are being served broken down by county. There is a juvenile justice program in Orange County called Pepperdine Resource Youth Diversion and Education (PRYDE) . I also noticed that Carmen mentioned a partnership with UC Irvine, and I would love to see that move to northern Orange County, where there is more social and economic diversity through CSU Fullerton. If a school provider bills for a service and that same student has an appointment for the same service with a community provider on the same day, is there a conflict with the billing?

Baass: That depends on the type of service and the delivery system. If the service is medically necessary, then there should be no conflict.

Hempstead: I would consider that an utter nightmare, not from a billing standpoint, but from a psychological standpoint. We can't have two therapists working with the same child on the same day. We don't have the workforce to duplicate services. I think that trying to leverage telehealth services in rural areas would be the solution, rather than placing so many psychologists in the school that the child has a school therapist and a community-based therapist.

Medi-Cal Redetermination Overview

Yingjia Huang gave an overview of the Medi-Cal Redetermination process.

Hempstead: I was surprised that the monthly enrollment total isn't dropping quicker.

Huang: We are not seeing immediate dips in the caseload. Because of the incoming new applications and the number of people coming back on coverage, we are seeing a smaller decrease. With more months of data, we can have a better understanding of trends.

Schumann: Is "newly enrolled for the first time" somebody who has never had Medi-Cal?

Huang: Correct.

Schumann: Is "new applications" someone who hasn't had a coverage in a certain period of time?

Huang: The number of new applications is all the new applications regardless of whether you had Medi-Cal coverage beforehand. Newly enrolled is a subset of applications who never had previous history of Medi-Cal.

Netherland: Does “lists” refer to the CBOs or to counties?

Huang: Both. We don’t need to give them counties because it comes from them. But we source the information from our county system and provide it to the CBOs.

Netherland: The new grants are coming out. Will those same lists be provided directly to the CSAC SAQC?

Huang: That’s part of the allocation agreement we have with navigators. CBC is modeling the construct of what we have. They will have something similar, which includes privacy clauses that allows us to share this information.

Baass: We also shared the lists of who will be up for redetermination proactively.

Netherland: We have redetermination happening and counties switching plans. Is there a map of those changes? There are significant changes to how consumers access that information for children.

Baass: That’s gets to the 90-, 60-, and 30-day notices to let members know of the transitions. You’re suggesting incorporating redetermination and that plan information together?

Netherland: Its confusing to know what information we need. It may be helpful to let consumers know that they may have one or the other or both. They may need to do redetermination and then switch plans. It wasn’t clear to the providers either.

Huang: There are so many things happening at the same time. We just completed an MCP transition training webinar for our coverage ambassadors to advise our members on the ground. We also recognize that many of our members will touch county doors because of this redetermination process. Our counties also have been trained to understand this transition.

California Children’s Services (CCS) Quality Metrics and New Whole Child Model Implementation Overview

Joseph Billingsley and Cortney Maslyn gave an overview of the CCS Quality Metrics and New Whole Child Model Implementation.

Netherland: Can you talk about how the two advisory committees will work together?

Billingsley: The CCS Monitoring and Oversight Workgroup was put in place last year to oversee the implementation of the CCS program. As part of that process, we’ve worked closely with stakeholders to identify different processes that are being monitored. There is a difference between the measurements used by that committee versus this workgroup, which is looking at the quality of how individuals are accessing their services

and outcomes measures. There is a relationship, but the measure set we are looking to set are different.

Maslyn: Yes. The CCS committee is about overseeing the CCS program and the counties responsibility, while this quality metrics committee is about the care being delivered by both the counties and providers. The CCS Advisory Group provides an opportunity to discuss the subcommittee's outcomes.

Weiss: Assuming the risk profile for CCS and Whole Child are both the same, do we have the ability to get granular data where we can accurately compare data on emergency department (ED) utilization, inpatient bed days per thousand member months, and readmission rates? The data are coming from a number of different places. The real coup de gras is knowing whether the classic model or the Whole Child Model is performing better in those arenas.

Billingsley: One of our goals for this committee was to define attainable measures from a data collection standpoint. Part of our process is knowing what data is available to us immediately to meet the intent of the requirement. We are also looking at measures that *would be good* to be able to look at and compare across programs. Then we want to create the necessary dashboard so we can start that process.

Maslyn: We do already have some of this information on the DHCS website, showing comparisons between the Whole Child Model patients and the general population. We want to know "what are the metrics and the minimum performance levels?"

Ribordy: The new single plan counties are not a part of the Whole Child Model at this point, correct?

Billingsley: Correct.

Ribordy: After 2022, are there plans to do more Whole Child Model expansion?

Billingsley: There is nothing established yet.

Ribordy: Do you see any delays for the 2025 implementation date?

Billingsley: So far, no.

Netherland: Is there a place to involve people with lived experiences not just at the plan level, but also at the Department level? Is there a place at the Department level to talk about the changes at CCS? I run a group of parents who are at CCS and there isn't one person you can call. It is hard to get information from the county. With the transition to the Whole Child Model, there has been great confusion about who to contact about barriers to care? How will those types of concerns be handled with the Kaiser transition? What support will be given? We know MCP has a series of checks and balances for the contracts. How did that work with Kaiser because I know the procurement process was different than the other MCPs.

Baass: The goal of AB 27 was to make Kaiser the same as every other plan.

Netherland: That's great. So it sounds like it could be a shared mechanism for all Whole Child Model MCPs. But I don't think it was ever reconciled because sometimes the MCPs would get calls and there was confusion. There is an opportunity to educate the consumer.

Ribordy: Kaiser is required to have a clear Whole Child Model grievance processes for its members. That's a key part of the post transitional monitoring process. Also, there have been pre-existing grievance process requirements for MCPs, but we are also implementing that for the counties and CCS because there hasn't been a clear process for people to report grievances at that level. Part of what we've been working on with the workgroup and stakeholders is issuing that grievance policy letter and figuring out how that works in CCS Classic versus Whole Child Model counties. We also want to make sure we communicate the rights that parents and their members have. We require our MCPs to communicate with members about their rights. We are also working to determine the best way for counties and DHCS to communicate that information.

Netherland: I just think there might be an information gap, and it's worth investigating. I appreciate the Department doing a mindful evaluation of the races and ethnicities of those who filed or did not file grievances.

Public Comment

Dr. Doug Major, California Childrens' Vision Now Coalition: Thank you Director Baass, Chairman Weiss, and all of my friends at MCHAP. We are very excited about the California first of juvenile justice Medi-Cal coverage, as well as the alcove model between the school and public health. Something we would be very excited about would be Austin Beutner, the former school superintendent of LA Unified, who worked very hard to get health care into the local community schools and found that the main problem students faced was a lack of access to vision care. We just want to remind you that vision care is a high leverage activity. Austin formed "vision to learn", an outreach that is now across the nation. It has had a hard time getting to California; we must ask for donations in California. So, I am asking that we have a coalition ready to serve and help you, including people from Harvard, former school nurses' associations, PDIG – the eye disease group – all set up to help you make correct decisions regarding vision care, which is the invisible part of this equation. We were asking for a place on the agenda to let you know our concerns, as well as to understand the metrics behind this. Thank you so much for all of your work.

Kelly Hardy, Children Now: There is a lot going on in Medi-Cal managed care regarding Enhanced Care Management (ECM), and I know that children in foster care is a specific population of focus. There was a lot of discussion about foster children being an important vulnerable population today. I wanted to ask how DHCS envisioning that care will be coordinated on behalf of foster youth that have been under fee-for-service, and there have not been any plans at this point to move them into managed care? Those

children in foster youth are not eligible to get ECM benefits because they are on fee-for-service. Thank you.

Member Updates

Schumann: I would like to re-emphasize my previous comments to advocate that we have more meetings. When we first started the MCHAP board, we were meeting every few weeks. It's been six months since we last met. It is easier to put time on the calendar than it is to take them off. Once they are off, it is hard to put them back on. I would love the August date to be changed to include a June and September meeting so we can meet during the budget decisions and again when people get back from Labor Day.

Unknown member: I want to compliment another fantastic meeting and agenda, and I am sure we would all look forward to continued updates, particularly on the redetermination process. I know it's already been noted, but just adding my thoughts.

Beck: I'd love to see a map of the counties and the state to see who has "well child", who have "Single Plan", who don't have any, and who have the Kaiser arrangement. We looked at academic outcomes, and they improved in settings where health care and education collaborated, and we encourage you to continue looking at outcomes.

Vega: I have an observation about the student behavioral health initiative. Will students not be able to receive mental health support when school is out of session or during breaks? Does that mean there is going to be collaboration between current therapies, or that they would stop services, specifically to children who get Medi-Cal? That is something we probably need to think about.

Motadel: I'd also like a breakdown by age. We focus so much on middle school and high school, but those of us in practice know that there is a lot of anxiety and depression starting in elementary school, including reaching the level of hospitalization and suicidal ideation by age 7. I want to make sure we aren't forgetting about the younger kids.

Weiss: We believe that these meetings will continue through 2024. As soon as we hear more, we will let you know. It was great to see everyone today.

Wunsch: The 2024 meeting dates are on the screen, and we will send out calendar invites.