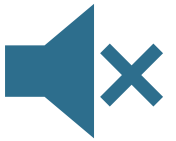
Medi-Cal Children's Health Advisory Panel (MCHAP)

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

March 2025

Webinar Tips

- Please use either a computer or phone for audio connection.
- Please mute your line when not speaking.
- MCHAP members are required to turn on their cameras during the meeting.
- Registered attendees will be able to make oral comments during the public comment period.
- For questions or comments, email MCHAP@dhcs.ca.gov.



Welcome, Roll Call, Today's Agenda

Mike Weiss, M.D., Chair

DHCS

Director’s Update

Michelle Baass, Director

Governor Newsom's 2025-26 Proposed Budget

Governor’s Proposed Budget

- The Governor's proposed fiscal year 2025-26 budget includes $296.1 billion in total funds for all health and human services programs.
- The Governor's proposed budget includes **$193.4 billion in total funds for DHCS** and **4,821.5 positions**. Of this amount, $1.3 billion is state operations (DHCS operations), while $192.1 billion is local assistance (funding for program costs, partners, and administration).
- DHCS budget proposals continue to build on the Administration's previous investments and enable DHCS to continue to transform Medi-Cal and behavioral health care within a responsible budgetary structure.

DHCS Major Budget Issues and Proposals

- Managed Care Organization (MCO) Tax and Proposition 35
- Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration Approval
- Caseload Impacts Related to Redeterminations
- Senate Bill (SB) 525 Health Care Minimum Wage Impacts
- Behavioral Health Transformation Update
- Home and Community-Based Spending Plan Update
- Trailer Bill Language

Medi-Cal Caseload

- Caseload is estimated to remain steady or only slightly decline through 2024-25 (14.8 million members).
- Assumes the end of discretionary pandemic unwinding flexibilities that result in fewer discontinuances after June 2025.
  - Consistent with this assumption, enrollment is expected to fall in 2025-26 (to 14.5 million members).
- Significant variability is possible soon due to potential changes in federal immigration policy.

Additional Information and Resources

- DHCS Website – Governor's Budget Proposal
- Statewide Budget Website – ebudget.ca.gov
- Department of Finance Website – Department of Finance

Medi-Cal Rx Update: Overview

Medi-Cal Rx

- Overview
- Adult Reinstatement
- Pediatric Integration
- Medi-Cal Rx Service Performance
  - Call Center
  - Prior Authorizations

Birthing Care Pathway

Palav Babaria, MD, MHS, Chief Quality Officer & Deputy Director, Quality and Population Health Management

DHCS

Agenda

- Birthing Care Pathway Development and Community Engagement
- Birthing Care Pathway Policy Roadmap
- Looking Ahead
- Transforming Maternal Health (TMaH) Model Update
- Q&A

Birthing Care Pathway Development and Community Engagement

DHCS' Vision for Maternity Care in Medi-Cal

With the launch of the Birthing Care Pathway, DHCS envisions a future in which:

- Medi-Cal members have access to a comprehensive menu of maternity care providers and services, regardless of where they live.
- Members can access risk-appropriate care and are empowered to choose the provider team and birthing location that align with their needs and preferences.
- All members feel respected and heard throughout their pregnancy and postpartum journeys.
- Members are educated about the services available to them and receive the navigational support they need for all aspects of their care.
- Behavioral health services and social supports are accessible to all members, their newborns, and their families.
- Data collection and sharing are improved to strengthen care for pregnant and postpartum members.

Birthing Care Pathway

» Comprehensive **policy and care model roadmap** that will cover the journey of all pregnant and postpartum Medi-Cal members from conception through 12 months postpartum.

» Roadmap includes a series of **policy solutions that address members' physical, behavioral, and health-related social needs.**

» Goals include **reducing maternal morbidity and mortality** and **addressing significant racial and ethnic disparities**.

Birthing Care Pathway Report Overview

DHCS published the Birthing Care Pathway Report in February 2025.

The report:

- Summarizes the current state of maternal health in Medi-Cal.
- Shares findings from Birthing Care Pathway Medi-Cal member engagement.
- Provides an overview of partner engagement conducted to date.
- Discusses the policies DHCS has implemented/is implementing for the Birthing Care Pathway and shares progress to date.
- Identifies strategic opportunities for further exploration.

The Birthing Care Pathway is generously supported by the California Health Care Foundation (CHCF) and the David & Lucile Packard Foundation.

Birthing Care Pathway Report Development

To develop the Birthing Care Pathway, DHCS:

Conducted a landscape assessment to review California's existing maternal health policies and initiatives and identify evidence-based programs, policies, and interventions.

Engaged Medi-Cal members through a Member Voice Workgroup, interviews, and member journaling to ensure their lived experiences shaped the design of the Birthing Care Pathway.

Interviewed more than 25 state leaders, providers, community-based organizations (CBO), associations, health plans, and advocates to inform the design of the Birthing Care Pathway.

Launched the **Clinical Care Workgroup**, **Social Drivers of Health Workgroup**, and **Postpartum Sub-Workgroup** to identify challenges and opportunities in perinatal care and develop and validate policy options for the Birthing Care Pathway.

Birthing Care Pathway
Medi-Cal Member Engagement

- DHCS engaged 30 members who were either currently pregnant or up to 24 months postpartum to share their lived experience.
- Medi-Cal members were selected to represent a diversity of experiences, especially the lived experiences of groups that experience health disparities.

Activity	Description
Interviews	Conducted **1:1 interviews** with **6** members.
Journaling	Invited **6** members to submit five biweekly **journal entries** about their perinatal experience.
Member Voice Workgroup	Launched a **Member Voice Workgroup** with **18** members and held three workgroup meetings.
All members were compensated for their participation.	

Birthing Care Pathway Medi-Cal Member Engagement Key Findings (1 of 2)

Feeling respected and heard by health care providers is critical to a member's perinatal experience in Medi-Cal. Members often feel that their birth plans and breastfeeding choices are not respected. However, members feel like midwives and doulas listen to their needs and preferences.

Some members **experienced discrimination in their health care encounters** during all three perinatal phases. Members felt connected to their health care providers and better supported when they received racially concordant care.

Key moments for trust building with members are often missed, particularly around mindful discussions on behavioral health screening results and referrals to services, trauma-informed approaches to intimate partner violence (IPV) screenings, smooth hospital discharges after birth, and timely access to high-quality breast pumps.

Birthing Care Pathway Medi-Cal Member Engagement Key Findings (2 of 2)

Medi-Cal members often felt like the **onus was on them to independently navigate and coordinate many aspects of their perinatal care** – ranging from coordinating their care across different health care providers to ensuring Medi-Cal coverage for themselves and their newborns.

Finding mental health providers who accept Medi-Cal, are taking new patients, and have perinatal experience is difficult. Medi-Cal members want more frequent and intensive mental health supports.

Medi-Cal members often **do not understand what Medi-Cal benefits and public benefits/social services are available** to them in pregnancy or during the postpartum period (e.g., doula services; Enhanced Care Management (ECM); Women, Infants, and Children (WIC)/CalFresh; and transportation services).

Birthing Care Pathway Key Informant Interviews

DHCS interviewed more than 25 state leaders, perinatal care providers, advocates, and representatives from CBOs, associations, and health plans to inform the development of the Birthing Care Pathway.

Category	Interviewees
Provider Associations	Representatives from the American College of Obstetricians and Gynecologists (ACOG), California Nurse-Midwives Association (CNMA), and California Association of Licensed Midwives (CALM).
Individual Providers	OB/GYNs; family and addiction medicine physicians; certified nurse midwives (CNM); licensed midwives (LM); freestanding birth center (FBC) providers; pediatricians; reproductive psychiatrists; lactation consultants, doulas, and community health workers (CHW).
County Leaders	Representatives from Black Infant Health (BIH), WIC, and Maternal, Child, Adolescent Health (MCAH) programs.
CBO Leaders & Advocates	Individuals focused on LGBTQIA+ health; IPV services; and birth justice and supports for Black, American Indian/Alaska Native, and Pacific Islander individuals.

Birthing Care Pathway Workgroups

Workgroup	Participant Charges	Composition
Clinical Care	Identify what needs to happen in the hospital, birthing center, provider office, and other community settings from a Medi-Cal member's perspective.	Physicians; midwives; lactation consultants; doulas; Tribal health providers; FBC, behavioral health, and federally qualified health center (FQHC) providers; managed care plans (MCP); and local public health.
Social Drivers of Health	Identify best practices and needs from programs and providers that currently work to address perinatal health-related social needs.	CHWs; doulas; violence prevention organization representatives; local public health and social service program representatives; home visitors; and providers with Black birthing expertise.
Postpartum Sub-Workgroup	Design a clinical pathway for what providers can do during the postpartum period to achieve positive health outcomes.	Cross-representation from the Clinical Care and Social Drivers of Health Workgroups, as well as additional physicians.

All three workgroups met throughout 2023 and 2024 to discuss key challenges with the Medi-Cal birthing experience and provide feedback on proposed policy solutions. Workgroup members who indicated financial barriers to participation were compensated for each meeting they attended.

Birthing Care Pathway Partner Engagement Key Findings (1 of 2)

Access to maternity hospitals in rural communities is **rapidly diminishing**.

Midwives and lactation consultants face **barriers to Medi-Cal provider enrollment and reimbursement**, impeding member access.

Limited qualified providers and long appointment wait times hinder access to **perinatal behavioral health care**.

Improved collaboration, integration, and data sharing among perinatal providers and health systems are needed to deliver **coordinated care** to pregnant and postpartum Medi-Cal members.

The **group care model** provides a team-based, whole-person approach to birthing care and builds community.

Birthing Care Pathway Partner Engagement Key Findings (2 of 2)

The Comprehensive Perinatal Services Program (CPSP) should be modernized to bolster access to comprehensive perinatal services to all pregnant and postpartum members.

Pregnant members are not consistently being connected to **providers and facilities that meet their risk level**. Screenings should be updated and streamlined to better assess a member's risk level, connect members to services, and prevent screening fatigue.

There are **limited housing programs** available to pregnant Medi-Cal members.

Medi-Cal members would benefit from additional educational resources on how to navigate the perinatal period.

Additional Input for the Birthing Care Pathway

DHCS received additional input on the Birthing Care Pathway from maternity care and social services providers, state leaders, MCP representatives, Tribal health providers, local public health, and birth equity advocates.

Birthing Care Pathway Policy Roadmap

Birthing Care Pathway Policy Roadmap

Policies DHCS Has Implemented/Is Implementing

10 completed

23 in progress

9 not started

The Birthing Care Pathway report also includes **Strategic Opportunities for Further Exploration** which **require additional assessment and planning to determine if implementation is feasible and would be contingent on external factors** (e.g., additional state budget resources).

Focus Areas of Policies DHCS Has Implemented/Is Implementing (1/2)

Provider Access and MCP Oversight. Expanding access to a range of maternity providers, including doctors, midwives, and doulas; enhancing oversight of maternity services delivered through Medi-Cal MCPs; and improving communication to Medi-Cal members on available benefits and provider types.

Behavioral Health. Enhancing trauma-informed care and increasing access to mental health and substance use disorder services.

Risk Assessment. Identifying pregnant and postpartum Medi-Cal members who are high risk and connecting them to needed services and supports; and strengthening intimate partner violence screening.

Care Management and Social Drivers of Health. Delivering whole-person care; addressing social needs, including housing and nutrition; and strengthening partnerships with community providers that have perinatal expertise.

Focus Areas of Policies DHCS Has Implemented/Is Implementing (2/2)

Justice-Involved Care. Facilitating enrollment in Medi-Cal and ensuring access to services before and after release from prison or jail.

Payment Redesign. Increasing reimbursement rates for a range of maternity care providers and supporting value-based maternity care.

Data and Quality. Building integrated systems for data sharing; supporting cross-enrollment of Medi-Cal members into crucial safety net supports; and creating new performance metrics to improve the quality of Medi-Cal maternity care.

State Agency Partnerships. Coordinating across different California programs for maternal health, such as home visiting and Paid Family Leave, to boost member awareness and access.

Focus Areas of Strategic Opportunities for Further Exploration

The opportunities for future discussion for the Birthing Care Pathway are in the following six focus areas:

- Provider Access and MCP Oversight and Monitoring
- Behavioral Health
- Maternal Care Models and Access
- Provider Resources
- Data and Quality
- State Agency Partnerships

Looking Ahead

Continued Community Engagement on the Birthing Care Pathway

- The Birthing Care Pathway is **a multi-year initiative.**
- **DHCS aims to continue engaging a diverse set of partners** to implement and further develop the Birthing Care Pathway.

Transforming Maternal Health (TMaH) Model Update

TMaH Model Overview

In January 2025, the federal Centers for Medicare & Medicaid Services (CMS) announced California as one of 15 states selected to implement the **TMaH Model**.

- TMaH is a **10-year delivery and payment model** designed to test whether evidence-informed interventions, sustained by a **value-based payment (VBP) model**, can improve maternal outcomes and reduce Medicaid and Children's Health Insurance Program (CHIP) program expenditures.
- DHCS will implement TMaH in five Central Valley counties: **Fresno, Kern, Kings, Madera, and Tulare.**
- DHCS will receive **$17 million in federal funding** and targeted technical assistance.

TMaH Model Partners

DHCS will partner with providers, care delivery locations, and other partner organizations, including MCPs and the California Department of Public Health (CDPH), to implement various TMaH elements in the model test region. DHCS has already been engaging with many of these partners through the Birthing Care Pathway.

Partner Providers

- OB/GYNs, midwives, physicians, maternal-fetal medicine specialists, nurses, and other clinical and support staff, such as doulas, lactation consultants, and perinatal CHWs.

Partner Care Delivery Locations

- Hospitals, OB/GYN and family medicine practices, safety net providers (FQHCs and RHCs), Tribal sites, birth centers, and other care sites.

Partner Organizations

- MCPs, CDPH, California Maternal Quality Care Collaborative (CMQCC), California Perinatal Quality Care Collaborative (CPQCC), Pregnancy-Associated Review Committee (PARC), universities, CBOs, and other non-clinical partners.

TMaH Model Timeline

Pre-Implementation Period: Model Years 1-3

January 2025-December 2027

- **Model Years 1-3:** DHCS receives technical assistance to develop the TMaH Model and achieve pre-implementation milestones.
- **Model Year 3:** Infrastructure payments are made to providers.

Implementation Period: Model Years 4-10

January 2028-December 2034

- **Model Years 4-10:** DHCS implements the TMaH Model
- **Model Year 4:** Quality and Performance Incentive Payments are made to eligible providers.
- **Model Year 5:** DHCS will transition to a VBP model

Questions?

Contact us at BirthingCarePathway@dhcs.ca.gov with any questions.

DHCS Pediatric Dashboard

Linette Scott, M.D., MPH, Deputy Director and Chief Data Officer, Enterprise Data and Information Management

DHCS

Take a deeper dive into the DHCS Pediatric Dashboard

Questions?

Break

Navigating an Unprecedented Reform Landscape: Medicaid and Youth Mental Health Systems Change

Alex Briscoe, Principal, Public Works Alliance

DHCS

Acronym Definitions

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Adverse Childhood Experiences (ACEs)
- California Advancing and Innovating Medi-Cal (CalAIM)
- Children and Youth Behavioral Health Initiative (CYBHI)
- Local Education Agencies (LEA)
- Special Education Loan Plan Areas (SELPAs)
- Prospective Payment Systems (PPS)
- Managed Care Organizations (MCO)
- Certified Public Expenditures (CPE)
- Local Government Agency (LG)
- University of California (UC)
- Public Hospital / Member of California Association of Public Hospitals (PH)
- Intergovernmental Transfers (IGT)

Youth are in Crisis

Consider the facts before COVID:

104 percent ▲

increase in inpatient visits for suicide, suicidal ideation, and self-injury among children aged 1-17.

151 percent increase for youth aged 10-14.

61 percent ▲

increase in the rate of self-reported mental health needs since 2005.

50 percent ▲

increase in mental health hospital days for children since 2006.

Post-COVID: ▲▲▲

- Suicide has surpassed cancer as a cause of death for young people in America.
- 42 percent of young people experience persistent sadness and hopelessness.
- 1 in 4 young adults have seriously considered suicide.

The Price is Higher for Black and Brown Children

Many receive the wrong services at the wrong time and in restrictive or punitive settings.

70 percent of children on Medi-Cal are children of color.

2x is the suicide rate for Black children ages 5-12, versus their white peers.

70 percent of youth in the juvenile justice system have unmet behavioral health needs.

Making Healing-Centered Systems

Requires acknowledgment of how **racism** and **poverty** impact the social and emotional health and well-being of children and families—and how traditional medical model services are limited to address them.

The Problem

The U.S. incarcerates a larger proportion of its adolescents than any other developed nation

The rate of incarcerated youth in the U.S. is more than 3 times that of South Africa, the developed nation with the next highest rate.

Black and Brown youth are disproportionately sentenced and impacted by criminal legal systems.

- Relative to White youth, in 2019, Black and Brown youth were 4.4 times as likely to be incarcerated.
- Tribal youth were 3.2 times as likely.
- Latinx youth were 27% more likely (92 per 100,000).

Incarcerated youth in the U.S. have disproportionately high physical and mental health morbidity compared to non-incarcerated peers.

Taking Action

There is a real opportunity to address a crisis in the lives and experiences of vulnerable youth. Public opinion and policymaker agendas are **currently aligned**.

Political Will

State and federal administrations have established a focus on child and family well-being driven by COVID, the youth mental health crisis, and decades of evidence from the social drivers of health movement

Community Support

Half (52 percent) of all Californians address mental health needs as “extremely important” and list it among the most critical issues for the state to address.

Emerging Consensus and Consciousness

Exploring the impact of adversity, structural racism, and the pandemic on the social and emotional health of children and families

Unprecedented Reform and Investment

A reform landscape with an unprecedented level of investment ($10+ billion) and a shifting payor landscape.

To Take Advantage of This Moment, We Must:

1. **Develop** new and expanded partnerships with MCPs (commercial and Medi-Cal).

2. **Embrace** the critical need to reform our financing and delivery models so they are team-based, healing, and relationship-centered.

3. **Focus** on building a health care system for people, by people, through new provider types and community networks.

4. **Adopt** a paradigm shift that reimagines mental health as a support for healthy development, not a response to pathology.

Overview: What is the Justice Serving Network (JSN)?

Capacity building initiative for 28 California CBOs focused on the well-being and economic mobility of young people impacted by criminal legal systems.

Strengthens program delivery and revenue models.

The JSN is a Public Works Alliance (PWA) three-year initiative designed to **support and scale CBOs** focused on the **well-being and economic mobility of young people** impacted by criminal legal systems.

We partner with grassroots organizations to **increase their capacity to deliver ECM and CHW benefits, facilitate connections between CBOs, and create ongoing revenue** for services that reflect the needs and life experiences of their community's youth.

Why JSN?

Poverty and incarceration are Social Drivers of Health.

JSN is creating a network of culturally aligned CBOs that employ staff with relevant lived experience.

Our primary concern is for young people of color in California who have endured systemic inequities, adverse childhood experiences (ACEs), and disproportionate apprehension by criminal legal systems.

We Believe:

- Relevant lived experience is essential to support youth impacted by criminal legal systems.
- Unprecedented changes to Medi-Cal have created new opportunities for the growth of community care networks.
- Existing child-serving systems have underserved, excluded, and, in some cases, harmed populations of children and families.

Our Work is Built On:

- Community-based solutions
- The credible messenger model
- Cultural humility
- Healing-centered engagement
- Transformative mentoring
- Reimagining how California defines, finances, administers and delivers children's mental health supports and services

CBOs **Can** and **Must** Be Essential Actors in Our Response

CBOs led by **credible messengers** are essential in supporting youth involved in criminal legal systems. Our collective failure to support them has contributed to the marginalization and criminalization of vulnerable children.

We can and must do more.

In Partnership with the Office of Youth and Community Restoration (OYCR), PWA is:

1

Completing an **organizational capacity analysis and identifying youth justice organizations** currently serving justice-involved youth.

2024 Q1-Q4

2

Analyzing the managed care benefit, MCPs, and opportunity in the context of new benefits and funding sources.

2024 Q1-Q4

3

Creating a network of CBOs in partnership with Full Circle Health Network to develop contracts with MCPs for ECM. CS, CHW, and NSMHS

2025 Q1-Q4

4

Leading an effort to reimagine service delivery through best practices, certified provider networks, and communities of practice.

2025 Q1-Q4

JSN Three-Year Model (1 of 2)

- Needs assessment based on staff interviews, budget, and logic model review
- Executive Director coaching
- Staff training
- Facilitated team workshops
- Resource sharing and network connections among Medicaid stakeholders
- Capacity building stipend
- Identification of new financing opportunities

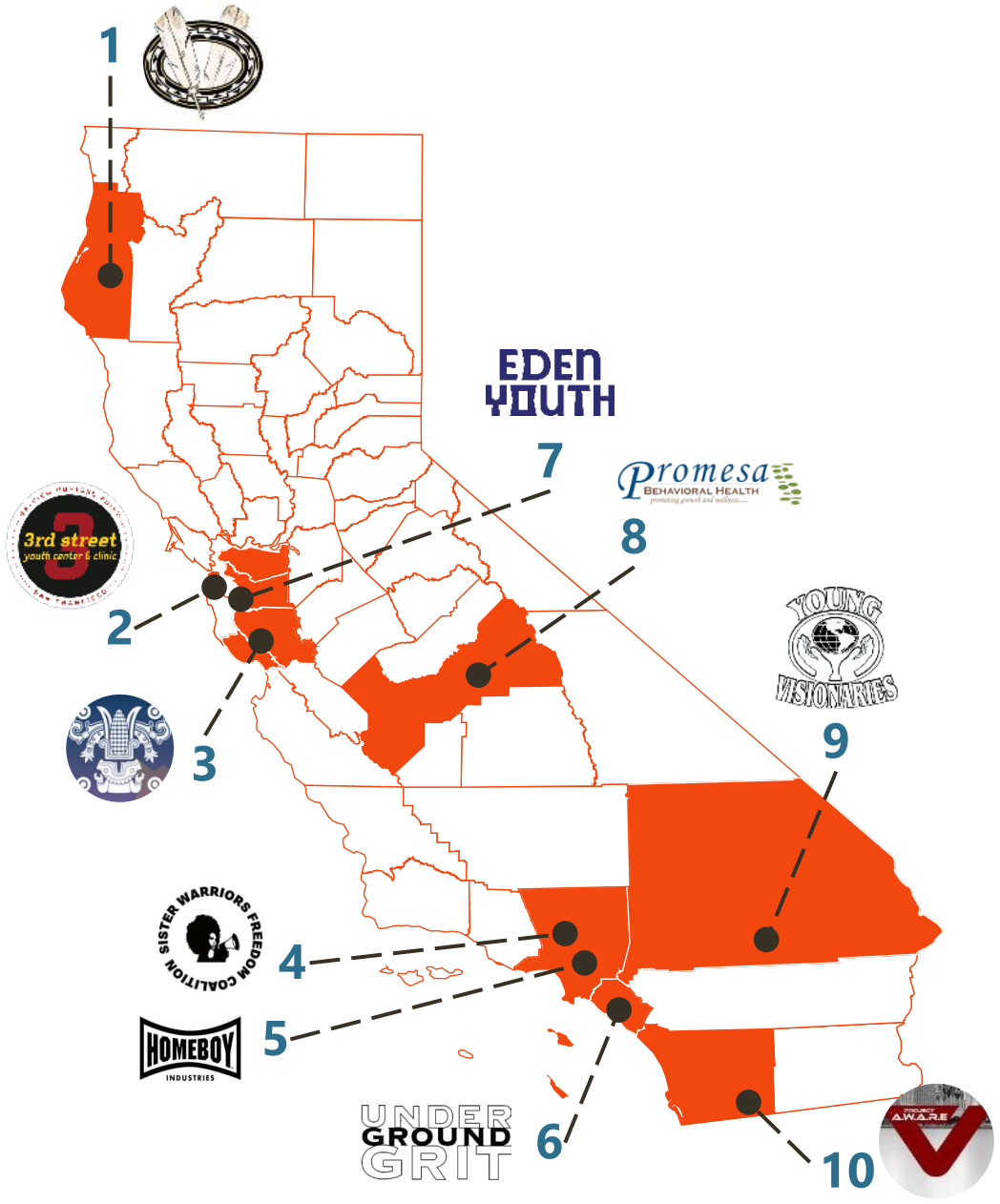
JSN Three-Year Model (2 of 2)

The JSN partners with CBOs to provide financial support for capacity building, technical assistance for billing medical, and ecosystem expansion opportunities.

- Technical Assistance
- Financial Support
- Ecosystem Building
- Youth Advisory Council

JSN Cohort 1 Map

1. TWO FEATHERS NATIVE AMERICAN FAMILY SERVICES
2. 3RD STREET YOUTH CENTER & CLINIC
3. MILPA
4. SISTER WARRIORS FREEDOM COALITION (2)
5. HOMEBOY INDUSTRIES
6. UNDERGROUND GRIT
7. EDEN YOUTH
8. PROMESA
9. YOUNG VISIONARIES YOUTH LEADERSHIP ACADEMY
10. PROJECT AWARE



There is hope, and it comes from an unlikely place – Medicaid

By making a few essential changes to Medicaid, we can

break the medical model and transform the experience of children and families, often preventing them from ever entering the juvenile justice system.

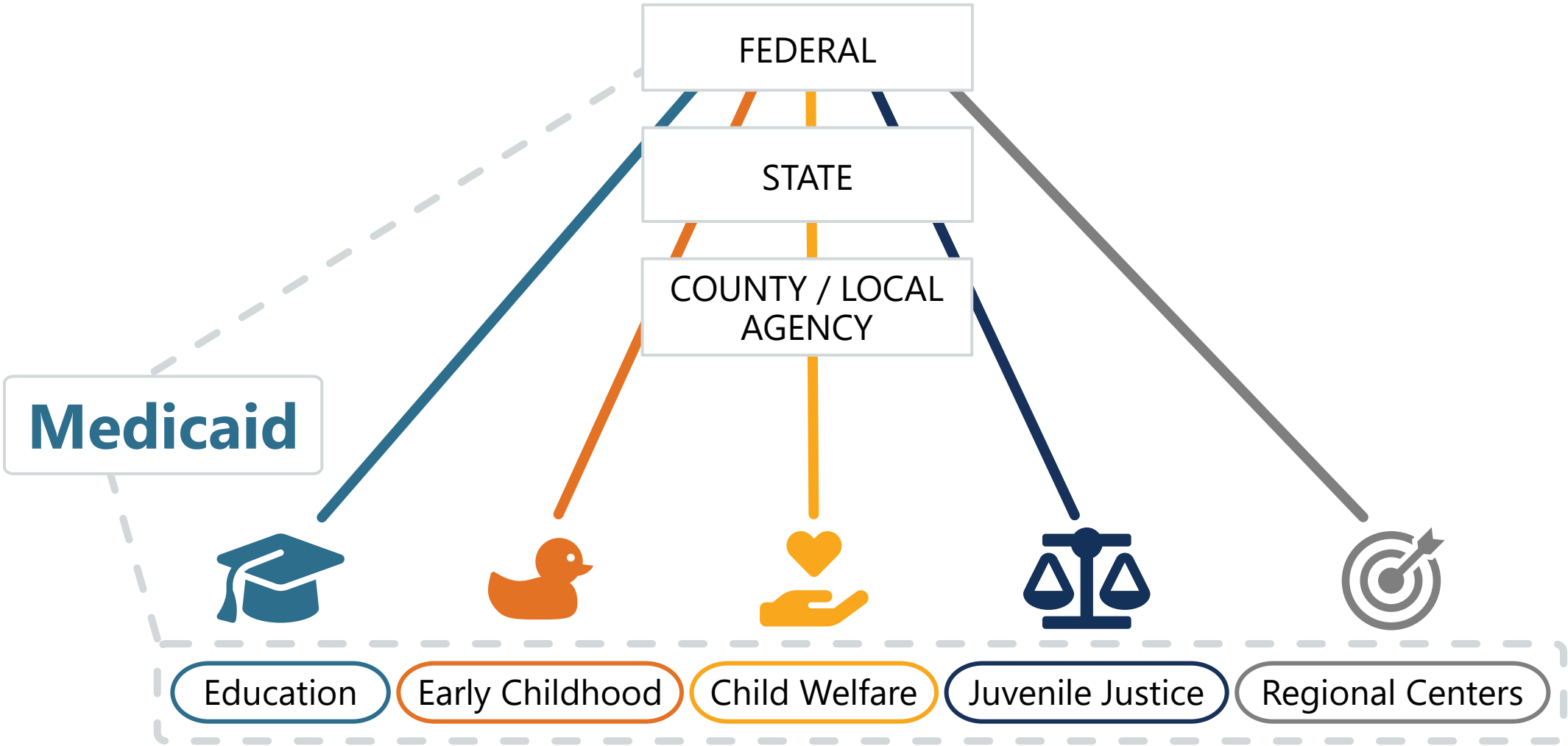
Call to Action:
5 Essential Medicaid Strategies

- **Remove diagnosis.**
  Remove diagnosis as a prerequisite for treatment. Expand medical necessity criteria in the context of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and ACES).
- **Reimagine the workforce and the model.**
  Add new provider types to the Medicaid State Plan, and reimagine the behavioral health workforce. Leverage lived experiences, and shift the economic benefit of safety systems to the people they were intended to serve.
- **Treat parents with their kids.**
  Low-income Americans interact with the health care system 12 to 15 times, on average, in the first three years of their child's life. Center schools and primary care as healing and anti-racist centers of support.
- **Make schools automatically in-network for all health plans.**
  Reach kids where they spend most of their time. Leveraging essential community provider status and health plan portability requirements make schools equivalent to emergency departments. Health plans must reimburse for services provided there, regardless of network.
- **Hustle: Get federal matching dollars.**
  Medicaid's unique entitlement for kids is an opportunity to fund the needs of the child welfare system. Pursuing this funding requires grit and determination.

From Promise to Practice: Implementation Measures for CalAIM and CYBHI

- Remove diagnosis—are penetration and access rates improving?
- Workforce—how many of each new provider types have been credentialed, and how much access are they creating?
- Treat parents with their kids—how many dyadic services have been billed?
- Make schools automatically in network—how is the state promoting partnerships and ensuring expanded access?

Medicaid: The Tie That Binds Fragmented Systems



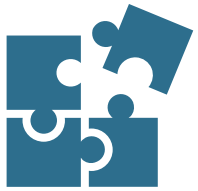
Medicaid and System-Involved Youth Impact Areas

Upstream Prevention

Provide children, youth, and families in the community with access to services and supports to meet emerging needs.

Intensive Evidence-Based Services

Broker access to services to prevent the need for a family to formally enter care.



Tailored Services for Children in Foster Care

Proactively address trauma and mental and behavioral health challenges for children and youth in foster care.

PRIMARY ← — — — — — — — — — — — — — — — → **SECONDARY**

Young People (Up to Age 21) in Medicaid are Unique

Broad Eligibility

Children don’t have to be sick to get care: they have broad eligibility for a range of supports.

Unique Financial Standing

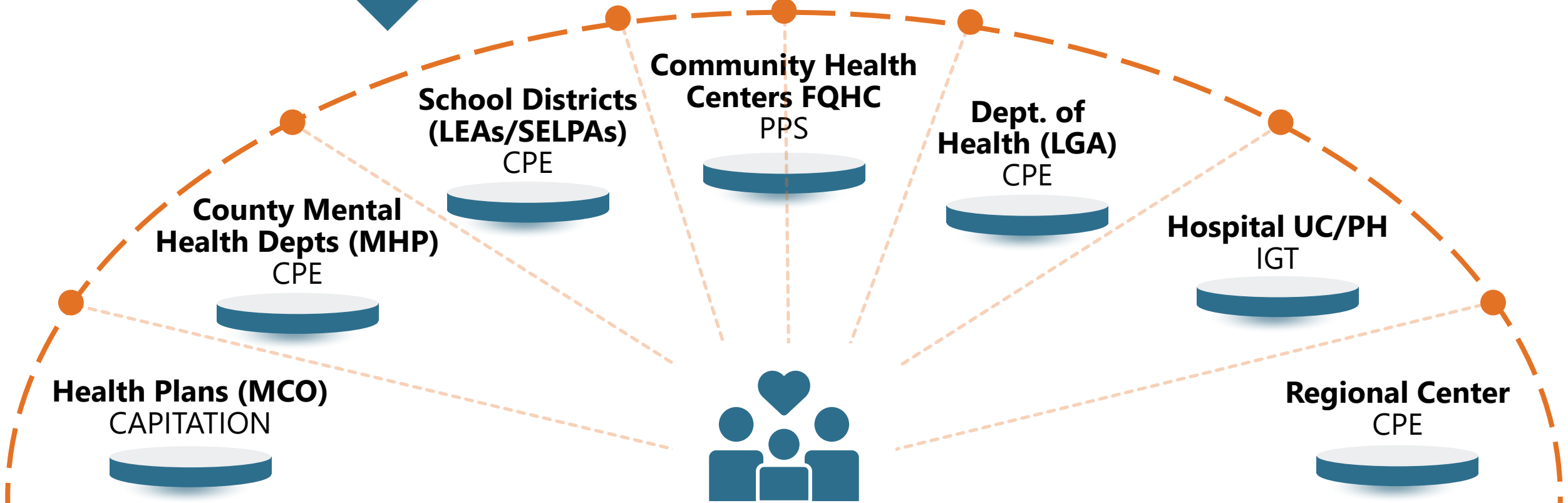
The federal government must match all eligible expenditures without a cap.

The Medicaid Map

Who Pays for Federally Entitled Services to **Children and Families**

Federal Government
Distributed through federal departments with funding authorized by Congress (Federal Financial Participation (FFP)/Match)

State of California
Acting as pass-through, enhancer, or reconciler of funding—sometimes providing it, sometimes certifying (Certified Public Expenditures (CPE))



JSN Managed Care Opportunity Map

1

Integrating New Non-Clinical Benefits ECM and Community Supports

2

Accessing New Mental Health Benefits
Dyadic and Family Therapy Benefits

3

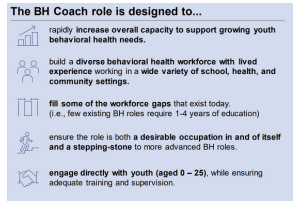
Integrating New Provider Classes
CHW, Doula, Peers, Wellness Coaches

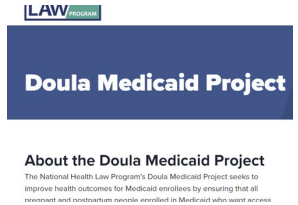
4

Partnering with Schools on Fee Schedules
Becoming designated providers and billing case management and psycho education codes

Expanding Provider Class

Doulas, CHWs, Peers, and Behavioral Health Coaches





Provider Expansion Guidelines

Scope

What can the provider do, in what setting, under what supervision and articulation, and what codes will they bill? Are community-defined and culturally concordant practices specifically named and included?

Credentialing

Who is responsible for curriculum development, certifying the content and quality of training, defining the core competencies, and certifying attainment?

Paneling

How does the new class sign up with the payor? What is the required process and documentation?

Payor

Who pays claims: MCPs or MHPs? Under what authority and what process?

Rates

What is the time, frequency, duration, and reimbursement level of all eligible services? Does it reflect a living wage?

□ = Existed Before CalAIM/CYBHI
* = NEW

NEW Medicaid Reimbursable Career Pathways to Support ACEs Networks of Care

Leveraging and Integrating the Wisdom and Experience of Culturally Concordant Providers

	TITLE	DEGREE	FUNDING
Ages 12-17	*Peer-to-Peer in-school	Middle or High School student	HHS demo grants, SBHIP, CSPP, MHSA, ELOP, HRTP & WIOA potential, CTE Pathway
Ages 18+	*Peer Specialists	SB 803: CA MHSA/county certified	County MHP/SMHS
	*Community Health Workers	CA certified and work experience pathways	MCP rate schedule, & CPSP perinatal option for FQHCs
	*Doulas	CA certified and work experience pathways	MCP/FFS bundled payment
	*Wellness Coach I	AA degree	MCP reimbursed starting in 2024
	*Wellness Coach II	BA degree	MCP reimbursed starting in 2024
	OQP/Rehab Specialist/Parent Partner	County Option	County MHP/SMHS
	*Intern or ASW/AMFT	Master's degree BBS Registry	MCP/PPS SB 966
	Licensed Therapist	3,000 Post Masters intern hours	MHP/SMHS and MCP/NSMHS

The Statewide All Payor Fee Schedule

Defining the Statewide All-Payer School-Linked Fee Schedule

Non-Exhaustive as of May 22, 2023.

Authorizing Statute, California Welfare & Institutions Code section 5961.4:
The State Department of Health Care Services shall develop and maintain a school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment provided to a student 25 years of age or younger at a school site.

Scope of Services

- Services included in the fee schedule when it launched on January 1, 2024:
  - Psychoeducation
  - Screening and Assessment
  - Therapy
  - Case Management

Providers Included

- A Local Edudcational Authority (LEA) or public institution of higher education enrolling in the network will enable their "**designated providers**" to offer services (including employed, contracted, or affiliated providers an individual school deems part of their provider network and possesses the credentials required by the Department of Managed Health Care (DMHC)/DHCS.

Who is Eligible to Participate?

LEAs

- School districts
- County offices of education
- Charter schools
- California Schools for the Deaf and Schools for the Blind

Public Institutions of Higher Education

- California Community Colleges
- California State Universities
- University of California campuses

1. CYBHI Fee Schedule - Outstanding Policy and Operational Questions meeting (April 18, 2023) Source: California Welfare & Institutions Code 5961.4 (link); Section 1374.722 of the Health and Safety Code

Review

- Most families and almost all children interacting with the child welfare and juvenile justice systems are eligible for Medicaid.
- Children in Medicaid are unique, with broad eligibility and no cap on federal funds.
- MCPs increasingly are the center of the Medicaid universe.
- Behavioral health is changing.
- Medi-Cal pays for SDOH services it previously did not pay for.
- Medi-Cal pays for new provider types.

Why It Matters

- Medicaid can and should fund and drive child welfare/juvenile justice transformation across the entire continuum.
- It can prevent entrance in the child welfare system.
- It can support and sustain families when they do come into contact with these systems.
- Fundamentally and dramatically expand access to care and support in new, more relevant models of care.

Sources

- 104 percent increase inpatient, 50 percent increase in MH hospitalizations, 61 percent increase in self reported MH needs (CA Healthy Kids Survey).
- California Health Report - fewer than 6 percent utilize care; fewer than 3 percent receive ongoing care.
- 70 percent of children with Medi-Cal are non-White.
- 2x suicide rate for black children, aged 5-12 than that of their White peers.
- 70 percent of youth in juvenile justice have a mental health disorder.
- Centers for Disease Control and Prevention – suicide as the second leading cause of death.
- 1 in 4 youth ages 18 to 24 said they had "seriously considered" suicide in the past 30 days.
- The pandemic has taken a big toll on the mental health of children.

Contact:

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Questions?

Public Comment

Final Comments and Adjourn

Upcoming 2025 Meeting Dates

- July 10, 2025
- September 11, 2025
- November 6, 2025

Thank You!

Appendix: Birthing Care Pathway

Policies DHCS Has Implemented/ Is Implementing

Provider Access and MCP Oversight and Monitoring (1 of 4)

Problem Statements

- **Limited racial and ethnic diversity of maternity care providers** in Medi-Cal today.
- Members face **delays in obtaining breast pumps.**
- **Smoother hospital discharges are needed after birth.**

Policy Solutions	Status
Leverage CalHealthCares education **loan repayment program** to build pipeline and increase diversity of OB/GYN and family medicine workforce.	In Progress
Streamline requirements and improve access to a range of **high-quality breast pumps**.	In Progress
Create guidance and/or technical assistance for MCPs on supporting pregnant and postpartum members **transferring to different care settings and levels of care**.	In Progress

Provider Access and MCP Oversight and Monitoring (2 of 4)

Problem Statements

- Members and providers are often **unaware of the full array of available maternity care services.**

Policy Solutions	Status
Create and enhance **member-facing communications materials** and outreach strategies on perinatal Medi-Cal benefits and provider types to bolster awareness during and after pregnancy.	In Progress
Issue a **standing recommendation for doula services** for all pregnant and postpartum Medi-Cal members to increase access to doula services and launch a **Doula Directory** for use by Medi-Cal members, providers, and MCPs to identify doulas in their community/network.	Completed
Establish a **Doula Implementation Stakeholder Workgroup** comprised of doulas, Black birthing justice experts, Tribal representatives, local health departments, advocates, and provider associations to inform DHCS' doula benefit design and reimbursement approach.	In Progress

Member-Facing Fact Sheets

Doctors, Midwives, and Doulas:

Finding the Right Care Team for Your Pregnancy

Medi-Cal

Do you think you might be pregnant? Choose your care team early to help you navigate your pregnancy and birthing journey. Medi-Cal pays for medical professionals (like doctors and midwives), doulas, and other care providers to help with your needs.

	Who They Are:	What They Do:
	DOCTORS, like OB-GYNS and some Family Doctors Medical professionals who help with every part of pregnancy, including prenatal checkups, childbirth, and postpartum care.	» Specialize in maternal health, providing checkups, tests, and prescriptions » Monitor high-risk pregnancies » Usually deliver babies in hospitals » Can perform surgeries (like C-sections)
	MIDWIVES Specially trained health professionals who care for people with healthy, low-risk pregnancies—including prenatal checkups, childbirth, and postpartum care. Some midwives are also nurses.	» Provide prenatal checkups, advice, and emotional support » Support personalized approaches to pregnancy and childbirth » Can deliver babies in hospitals, birth centers, or at home » Do not perform surgeries (like C-sections)
	DOULAS Birth workers who help with physical, emotional, and non-medical support before, during, and after birth. They do not provide medical treatment or deliver babies.	» Teach you about pregnancy, childbirth, and caring for a newborn » Empower you and help you speak up for what you want during pregnancy and childbirth » Provide breathing, relaxation, and other support during childbirth

Ready to support a healthy pregnancy and start your baby's journey off strong?

Scan the QR code or visit **https://www.dhcs.ca.gov/services/Pages/Maternal-Perinatal.aspx** to learn more about picking the right care team for you and your family.

Services for Pregnant People and New Parents

Medi-Cal

If you have Medi-Cal and are pregnant or just had a baby, you have access to free health care and services to keep you and your baby healthy and safe.

Medi-Cal Programs and Services

Health Care
Medi-Cal covers health care for you and your baby—from pregnancy until at least one year postpartum. That includes labor and delivery, doctor visits, hospital stays, emergency care, medical supplies, medications, family planning, dental, vision, and more.

Care Coordination
Get help managing your health care before and after your baby is born, including follow up doctor's visits, rides to the doctor, and specialty care referrals.

Mental Health & Addiction
Talk to a therapist and get help for common issues like postpartum depression or anxiety, mental health needs, or alcohol and drug treatment.

Classes for Health, Childbirth & Parenting
Learn how to stay healthy during pregnancy, make a birth plan, and take care of your new baby.

Breastfeeding & Nutrition
Get help with breastfeeding coaching, free breast pumps, nutrition counseling, and vitamins.

Community Supports
If you qualify, you can get help with housing, healthy food, and other needs along with your health care.

American Indian Maternal Support Services
American Indian mothers can get health care, education, emotional support, and home visits before and after having a baby.

Other Programs and Services

Paid Family Leave
Get up to eight weeks of paid leave for each parent to care for your family within a 12-month period.

Women, Infants, and Children
Get healthy foods, breastfeeding help, and checkups for you and your baby.

CalFresh
For members who want to add to their budget to put healthy and nutritious food on the table.

Black Infant Health
Black pregnant and postpartum people can get both one-on-one and group help.

Ready to support a healthy pregnancy and start your baby's journey off strong?

Scan the QR code or visit **www.dhcs.ca.gov/services/Pages/Maternal-Perinatal.aspx** to explore these free services and find the right support for you and your family.

Provider Access and MCP Oversight and Monitoring (3 of 4)

Problem Statements

- Members and providers are often **unaware of the full array of available maternity care services.**

Policy Solutions	Status
Survey MCPs on promising practices to promote covered perinatal benefits among members and providers and reduce administrative burden for providers.	In Progress
Consolidate and update Medi-Cal perinatal policies through a single All Plan Letter (APL) and update provider manuals **to clearly define perinatal benefits and provider enrollment requirements** for midwives, birth centers, and doulas. Encourage MCPs to incentivize network providers to offer group perinatal care models to members.	Not Started

Provider Access and MCP Oversight and Monitoring (4 of 4)

Problem Statements

- Medi-Cal provider enrollment requirements created **potential barriers for midwives participating in Medi-Cal.**
- **Downstream subcontracting arrangements** can create barriers to perinatal services.

Policy Solutions	Status
Remove administrative barriers to Medi-Cal provider enrollment and reimbursement requirements **for midwives** by ensuring alignment with state licensing and scope of practice requirements.	Completed
Clarify MCP **network adequacy requirements for CNMs, LMs, and FBCs** as mandatory provider types and strengthen thresholds that must be met.	In Progress
Enhance oversight of network agreements and/or delegated arrangements for maternity/perinatal care services to ensure covered benefits are clearly outlined.	In Progress

Behavioral Health and Trauma-Informed Care (1 of 2)

Problem Statements

- Members face **challenges accessing timely behavioral health care** with limited mental health providers who accept Medi-Cal, are taking new patients, and have perinatal experience.

Policy Solutions	Status
Raise awareness of the Children and Youth Behavioral Health Initiative's (CYBHI) ongoing investments to **provide behavioral health services to children and their parents**.	Completed
Review MCP and behavioral health contracts to identify opportunities for **strengthening existing language to ensure pregnant and postpartum members have access to qualified behavioral health providers**.	Not Started

Behavioral Health and Trauma-Informed Care (2 of 2)

Problem Statements

- Some providers are **confused around how long a pregnant or postpartum member can receive residential substance use disorder (SUD) treatment.**
- **Trauma can negatively impact a member's physical and mental health outcomes,** relationships with health care providers, and adherence to treatment.

Policy Solutions	Status
Reinforce communication of **existing Medi-Cal coverage policy of no maximum stay** (e.g., 60 days) **for members**, including pregnant and postpartum members, **receiving residential SUD treatment**.	Completed
Update and disseminate SUD Perinatal Practice Guidelines for providers that deliver SUD treatment to pregnant and parenting women.	Completed
Reframe services in a trauma-informed context, acknowledging how care needs to be delivered to pregnant and postpartum members who are experiencing or have experienced ACEs, IPV, community violence, and racism.	Not Started

Risk Stratification and Assessment

Problem Statements

- **Lack of standardization for how MCPs use risk stratification algorithms**, employ risk tiers, and connect members to services.
- **IPV screening is inconsistent** with limited follow-up care or support.

Policy Solutions	Status
Develop a risk stratification, segmentation, and tiering (RSST) process in Medi-Cal Connect to identify pregnant and postpartum members who are high risk. The RSST will identify members who may benefit from connections to additional social support and clinical care.	In Progress
Incorporate IPV screening as part of Medi-Cal assessments performed by providers and clinical care managers.	Not Started

Medi-Cal Maternity Care Payment Redesign (1 of 2)

Problem Statements

- Partners explained that **Medi-Cal's reimbursement rates for licensed and non-licensed maternity care providers are not high enough** to incentivize participation in Medi-Cal.
- The existing FQHC and RHC reimbursement methodology **does not incentivize clinics to provide dyadic services.**

Policy Solutions	Status
Increase rates for maternity care providers and enhance supplemental payments for Labor-and-Delivery (L&D) and hospital-based birthing center services.	In Progress
Expand Quality Incentive Pool (QIP) for Designated Public Hospitals (DPH) and District and Municipal Public Hospitals (DMPH).	Completed
Strengthen implementation of dyadic services by establishing an alternative payment methodology (APM) allowing FQHCs, RHCs, and Tribal Health Programs (THP) to be reimbursed for dyadic services at the Medi-Cal fee-for-service (FFS) reimbursement rate in addition to the FQHC/RHCs' PPS reimbursement rate and THPs' All-Inclusive Rate (AIR) for an eligible visit.	In Progress

Medi-Cal Maternity Care Payment Redesign (2 of 2)

Problem Statements

- FBCs and midwives providing home births face **challenges being recognized and reimbursed for their birthing approaches**.
- Providers are not incentivized to **appropriately transfer a patient to a higher level of care** based on their needs.

Policy Solutions	Status
Redesign how Medi-Cal pays for maternity care services to create a new birthing care payment model that rewards value-based care, incentivizes best practices for pregnant and postpartum members, and supports the goals of the Birthing Care Pathway.	In Progress
Develop billing/reimbursement guidance for Medi-Cal providers as well as MCPs and their subcontractors on LM services, including home births, and FBC services.	Not Started

Care Management and SDOH (1 of 3)

Problem Statements

- **Homelessness and housing insecurity** contribute to adverse maternal and infant outcomes.

Policy Solutions	Status
Encourage utilization of Transitional Rent under the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 waiver demonstration as a Community Supports service **for eligible Medi-Cal members** – i.e., those who (1) meet one or more of the qualifying clinical risk factors (e.g., pregnancy and up to 12 months postpartum), are (2) experiencing or at risk of homelessness, and (3) fall within one or more of the transitioning populations (e.g., transitioning out of a hospital after giving birth).	In Progress
Encourage **MCPs to consider working with facilities that offer rooming in with short-term post-hospitalization stays** to provide Recuperative Care (medical respite) or Short-Term Post-Hospitalization Housing to members experiencing homelessness and who meet clinical criteria.	Not Started

Care Management and SDOH (2 of 3)

Problem Statements

- **ECM and Community Supports providers** serving pregnant and postpartum members **need perinatal expertise.**
- Some **members are unaware of what ECM and Community Supports cover** and how they can find out if they are eligible.

Policy Solutions	Status
Conduct outreach to **WIC**, **home visitors, CBOs, and county behavioral health and nutrition services providers with perinatal expertise** to become ECM providers.	In Progress
Encourage **MCPs to build partnerships with IPV CBOs** to serve as ECM and Community Supports providers.	Not Started
Encourage **MCPs to partner with housing providers that meet the needs of perinatal populations** from pregnancy through 12 months postpartum **to serve as ECM and Community Supports providers**.	Not Started

Care Management and SDOH (3 of 3)

Problem Statements

- Providers need **technical assistance, support, and educational materials around the ECM Birth Equity Population of Focus** as well as **education about which Community Supports can best support** their patients.

Policy Solutions	Status
Expand ECM referral pathways, particularly from social services and behavioral health providers, for pregnant and postpartum members.	In Progress
Leverage **Providing Access and Transforming Health (PATH)** to support ECM Birth Equity providers by providing technical assistance and prioritize ECM Birth Equity providers for **Capacity and Infrastructure, Transition, Expansion, and Development (CITED) Initiative awards**.	Completed

Perinatal Care for Justice-Involved Individuals

Problem Statements

- While some jails provide medications for opioid use disorder (MOUD) during pregnancy, many individuals are **abruptly discontinued** from these medications postpartum.

Policy Solutions	Status
Ensure pregnant and postpartum individuals are **enrolled in Medi-Cal pre-release**.	Completed
Ensure eligible pregnant and postpartum individuals **receive 90-day pre-release services**.	In Progress
Encourage **connection to ECM upon release**.	In Progress

Data and Quality (1 of 2)

Problem Statements

- California **does not have a statewide technology platform for maternity care providers, programs, and MCPs to easily and safely share patient data** and help members manage their medical, behavioral, and social needs.
- Eligibility and enrollment **data sharing across public benefits and programs are inconsistent** in California causing gaps in care and service delivery.

Policy Solutions	Status
Leverage Medi-Cal Connect to support whole person care and provide population insights by **safely sharing integrated health care and social data and insights about members among providers, delivery systems, programs, and state agencies** that support Medi-Cal members.	In Progress
Leverage learnings from pilot programs aimed at **cross-enrolling Medi-Cal members into crucial safety net supports** upon pregnancy through 12 months postpartum to inform strategies to facilitate cross-enrollment and the ongoing rollout of Medi-Cal Connect.	In Progress

Data and Quality (2 of 2)

Problem Statements

- **Maternity care quality metrics** that are used for MCP quality improvement and accountability processes **are limited**.

Policy Solutions	Status
Identify opportunities to **leverage and integrate existing California maternity data centers with Medi-Cal data** to more comprehensively measure and monitor birth outcomes.	In Progress
Create **key performance indicators to track the efficacy of maternity care** and monitor adherence to Birthing Care Pathway policies.	Not Started

State Agency Partnerships (1 of 2)

Problem Statements

- California's **home visiting programs** are not coordinated across state agencies, causing a **lack of member awareness and underutilization.**
- Low-income individuals in California are less likely to take advantage of the state's **Paid Family Leave (PFL) program.**

Policy Solutions	Status
Collaborate with CDPH, the California Department of Social Services (CDSS), and MCPs to **promote home visiting for Medi-Cal members** and ensure eligible members can access home visiting programs.	In Progress
Partner with the Employment Development Department (EDD) and Legal Aid at Work (LAAW) to **develop a resource guide for perinatal providers** on how their pregnant and postpartum patients can **access the state's PFL and State Disability Insurance (SDI) programs**.	In Progress

State Agency Partnerships (2 of 2)

Problem Statements

- Lack of **access** and links to **risk-appropriate care.**
- **Siloed** services, programs, and interventions.

Policy Solutions	Status
Partner with CDPH, Office of the California Surgeon General (OSG), and CMQCC to develop the **statewide Maternal Health Strategic Plan.**	In Progress
Leverage the Family First Prevention Services Act (FFPSA) to **support SUD and mental health treatment** services for pregnant and postpartum individuals at risk of child welfare involvement.	In Progress
Continue to support the OSG Strong Start & Beyond movement through participation in the **Perinatal Advisory Group (PAG)**.	In Progress

Strategic Opportunities for Further Exploration

Provider Access and MCP Oversight and Monitoring (1 of 2)

Problem Statements

- **Access issues persist** despite MCPs meeting existing Medi-Cal network adequacy standards.
- **Significant racial and ethnic disparities** in maternal health outcomes persist.

Potential Opportunities

- **Strengthen oversight and monitoring of network adequacy standards for maternal providers**, including adopting an appropriate threshold for accepting Alternative Access Standards (AAS) requests.
- Require MCPs to participate in a **joint performance improvement project (PIP)** in which all MCPs are required to participate, focused on **reducing disparities for Black, American Indian/Alaska Native, and Pacific Islander** pregnant and postpartum members.

Provider Access and MCP Oversight and Monitoring (2 of 2)

Problem Statements

- Many perinatal providers **lack the training to conduct IPV screening.**
- Only physicians, registered nurses, and dieticians working under the supervision of a physician can provide **lactation services** in Medi-Cal today.

Potential Opportunities

- Require MCPs to **incorporate IPV training into required network provider training** and **promote universal IPV education** in health care settings.
- Update lactation policy to **recognize International Board Certified Lactation Consultants (IBCLC) and Certified Lactation Counselors (CLC) as a provider type** that can bill Medi-Cal.

Behavioral Health (1 of 2)

Problem Statements

- Members face **challenges accessing behavioral health providers** that have perinatal training and appointment availability.

Potential Opportunities

- Develop **statewide perinatal behavioral health consultation line** for maternal providers and therapists without perinatal training to receive consultations from qualified mental health and SUD providers with perinatal expertise for pregnant and postpartum members living with behavioral health needs.
- Support the implementation of **perinatal workforce training on trauma-informed, culturally relevant crisis care** and integration of county behavioral health services into obstetric provider practices for pregnant members living with SUD or serious mental health needs.
- Support CBOs serving pregnant and postpartum individuals living with behavioral health needs by providing counties with a **list of proposed uses for Behavioral Health Services Act (BHSA) funds** that address gaps identified for this population.

Behavioral Health (2 of 2)

Problem Statements

- Parents must be allowed to **stay with their infants** while undergoing **treatment for neonatal abstinence syndrome (NAS).**

Potential Opportunities

- Support postpartum members to **stay in the hospital with their newborns (e.g., rooming in) while the newborn is being treated for NAS/Neonatal Opioid Withdrawal Syndrome (NOWS)** and not be discharged until their newborn is discharged.

Maternal Care Models and Access (1 of 2)

Problem Statements

- **Limited oversight of** the **CPSP and insufficient data to track utilization** of CPSP services.
- **Separate CPSP provider enrollment process** with CDPH is burdensome.
- Existing CPSP payment structure for FQHCs/RHCs **encourages clinics to maximize service volume** over reducing member burden.

Potential Opportunities

- **Enhance the delivery of comprehensive perinatal services** across the FFS delivery system and Medi-Cal MCPs, including:
  - Aligning with the most recent clinical guidelines.
  - Updating benefit delivery structure.
  - Improving state oversight with data-driven monitoring.
  - Modernizing the payment and billing code structure.

Maternal Care Models and Access (2 of 2)

Problem Statements

- There is **no perinatal specialization for CHWs.**
- **More racially concordant providers**, including midwives, are needed.
- **Short-term housing solutions** are needed for high-risk pregnant members to be closer to risk-appropriate care.

Potential Opportunities

- Develop **perinatal specialization for CHWs.**
- Develop **loan repayment program** to increase diversity and rural representation of **midwives**.
- Provide **short-term housing for high-risk pregnant members** who live in remote counties that is near hospitals equipped to care for complex maternal and fetal medical conditions and obstetric complications.

Provider Resources

Problem Statements

- **Additional Medi-Cal provider education is needed on the programs and services for which** pregnant and postpartum members may be eligible.

Potential Opportunities

- Require MCPs to **augment provider training requirements to include a focus on Medi-Cal perinatal benefits, perinatal mental health, and SUD.**

Data and Quality

Problem Statements

- There is a **need for additional maternity care quality metrics** beyond those currently tracked.
- DHCS does not currently require reporting on **patient-reported measures around access and patient experience** for perinatal care and services.

Potential Opportunities

- Develop **technical workgroup to advise** on perinatal health and birth outcome **quality measures.**
- Identify quality metrics and require reporting **on patient-reported outcome measures (PROM)** around access and patient experience for perinatal care and services.

State Agency Partnerships (1 of 3)

Problem Statements

- **Members and providers may be unaware of which birth setting would be best suited** based on their level of risk during pregnancy.
- Members are also often **unaware of the impact their current health has on pregnancy outcomes** until they attend their first prenatal appointment.

Potential Opportunities

- Partner with CDPH to **require birthing hospitals to have a verified ACOG Levels of Maternal Care designation.**
- Partner with OSG to promote community education and **pregnancy risk awareness.**

State Agency Partnerships (2 of 3)

Problem Statements

- Low-income individuals in California are **less likely to take advantage** of the state's **PFL program.**
- California faces **maternal health care workforce shortages** across multiple provider types.
- **None** of California's **home visiting programs** are available **statewide**, and each has **differing eligibility criteria.**

Potential Opportunities

- Explore options to **obtain data from EDD to improve outreach** to pregnant and postpartum Medi-Cal members **about the state's PFL and SDI programs**.
- Coordinate with the California Department of Health Care Access and Information (HCAI) to fund **workforce development strategies for perinatal providers**.
- Collaborate with CDPH, CDSS, and MCPs to **provide at least one voluntary home visit to every newly pregnant Medi-Cal member** and develop a standard to identify members who would benefit from more than one home visit in the prenatal and postpartum periods.

State Agency Partnerships (3 of 3)

Problem Statements

- **Stigma around SUD treatment** results in many members **forgoing necessary care for fear of prosecution or child protective services involvement.**

Potential Opportunities

- Examine opportunities to partner with state agencies to **protect pregnant and postpartum individuals from prosecution** for drug-related offenses that may be initiated after they seek SUD treatment.
- Partner with CDSS to **educate health care partners on child welfare policy nuances** that may inadvertently require or permit revoking custody from the parent due to use of medications for SUD treatment and consider modifications to the policies.
- Collaborate with CDSS on **training for labor and delivery clinical care teams and child welfare case managers about perinatal SUDs** to reduce stigma, misinformation, and barriers to treatment.