State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

March 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; Jan Schumann, Subscriber Representative; Jovan Salama Jacobs, Ed.D., Education Representative; Karen Lauterbach, Nonprofit Clinic Representative; William Arroyo, M.D., Mental Health Provider; Stephanie Sonnenshine, Health Plan Representative.

Members Attending Virtually: Ellen Beck, M.D., Family Practice Physician Representative; Diana Vega, Parent Representative; Katrina Eagilen, D.D.S., Licensed Practicing Dentist; Nancy Netherland, Parent Representative.

Members Not Attending: Kelly Motadel, M.D., County Public Health Provider Representative; Ron DiLuigi, Business Community Representative; Elizabeth Stanley Salazar, Substance Abuse Provider Representative; Alison Beier, Parent Representative.

Public Attendees – Virtually: 90 members of the public attended the webinar.

DHCS Staff – In person: Michelle Baass, Palav Babaria, Jeffrey Callison, Morgan Clair, and Clarissa Sampaga.

DHCS Staff – Virtually: René Mollow, MSN, RN, Pamela Riley, M.D., and Cortney Maslyn.

Opening Remarks and Introductions

Mike Weiss, M.D., MCHAP Chair, welcomed webinar participants. The legislative charge for the advisory panel was read aloud by Ken Hempstead. (See agenda for legislative charge.) The meeting summary from December 8, 2022, was approved, 10-0.

Opening Remarks from Michelle Baass, Director

Baass provided updates on the Governor's proposed budget, the Centers for Medicare & Medicaid Services (CMS') approval of the CalAIM Justice-Involved initiative, and the

unwinding of the COVID-19 public health emergency (PHE): Medi-Cal continuous coverage requirement.

Beck: For the Behavioral Health Bridge Housing (BHBH) and the transitional rent, my experience having worked as a physician at times on the street with people who are unhoused, is that transitional rent is a wonderful addition to the Medi-Cal program. How can individuals receive help? Does that fall under BHBH? When will it be implemented?

Baass: The transitional rent will be new. There are two ways we're proposing it. One is a new Community Support under CalAIM delivered via managed care plans (MCPs), separate from BHBH. Then, as part of our California Behavioral Health Community-Based Continuum (CalBH-CBC) waiver as a mental health optional benefit. So, county behavioral health can also offer it as a special mental health service (SMHS) in that delivery system, and we also have it in the managed care delivery system. We still need to submit those waivers to CMS.

Lauterbach: We're getting ready to start all the redeterminations. Will funding be set aside to ensure that the process is smooth? Do we have enough staff?

Baass: In the last two budgets, about an additional $145 million went to county social services departments for eligibility processing. Those dollars are available for counties, and counties are hiring extra staff, paying for overtime, etc.

Arroyo: Regarding the delay of the $480 million in infrastructure money, is it correct that half will go out in the first year and the other half in the second year? Is the funding across the lifespan, or exclusively for children and youth?

Baass: That is across the lifespan. Round four, $480 million, was for children and youth. The rest of the rounds could include children and youth funding, but it is broader.

Arroyo: Can the infrastructure funding be used for capital outlay?

Baass: Yes.

Arroyo: The funding largely targets higher intensity services. If you're going to expand a short-term residential program or establish the crisis residential unit that might be attached to it, these services tend to be much more intensive as opposed to funding for outpatient services. There are recent reports that some of the short-term residential treatment programs have been shutting down in part due to the imposition of the Institution for Mental Disease (IMD) criteria. I'm worried that this delay will prolong the suffering of these young people who really need these intensive level of services. I'm

wondering if there's any possibility that this delay, with respect to children, would not be implemented.

Baass: We have a Behavioral Health Continuum Infrastructure Program dashboard in which you can see by county and by facility types what has been allocated. For round four, which is the children and youth focus round, there are 54 awards. For the delay in round six, not all those dollars will be for children; we will fund needs or gaps with the remaining dollars. The California Department of Social Services will have annual funding that the state can allocate for complex youth care.

Arroyo: Regarding the Children and Youth Behavioral Health Initiative (CYBHI), the virtual platform doesn't draw down any federal dollars?

Baass: We have not made that assumption.

Jacobs: I want to acknowledge the $429 million in grant opportunities for school districts starting in April. Just to put a plug out there for this funding, as another way for people to get access to resources. This is going to be a valuable resource, especially since, some of the intense emotional needs that our students have faced due to the pandemic and continue to face as we transition back to school.

Baass: We've been doing a statewide listening tour on all the recent and upcoming initiatives. For the last two sessions that we held, the County Superintendents of Education attended. These are small groups, 20 people in the meetings, bringing together Medi-Cal and our schools to weave together all the support and services that youth, individuals, or families might need.

Director Baass gave an update on the CalBH-CBC

Sonnenshine: Are those benefits that would be offered through the county SMHS and not managed care benefits?

Baass: Correct; they are opt-in and it's not a statewide requirement. It's similar to how we do Drug Medi-Cal, where the counties opt in to provide those services, but if they opt in to the IMD piece, they must provide all the services in the program. We want to build out the continuum. We don't want the push toward institutional care.

Arroyo: Are these services part of the waiver that was recently approved by CMS?

Baass: No. In November we released a draft concept paper. We have the proposal in the Governor's Budget, and we'll be going back for public comment before submitting it to CMS this summer.

Eagilen: Could you elaborate on the statewide incentive plan and the Centers of Excellence expansion?

Baass: We'll have defined metrics for the statewide incentive program for each of those three different populations of focus. The Centers of Excellence is new, and not currently in our SMHS space. It will be technical assistance (TA) for counties and providers as we implement these new programs.

Director Baass gave an update on the Justice-Involved initiative

Lauterbach: One of the issues we see with juvenile justice is integrating the child when they're released back into the family care. It can be extremely messy and challenging. I'm happy to give you any details. It doesn't happen a lot, but it can be disruptive to the family.

Baass: I don't know if that's ever come up.

Arroyo: I sit on a state prison commission rehabilitation oversight board, and we look at the rehabilitation services, including mental health and substance use services. All these individuals have very complex needs. Will Enhanced Care Management (ECM) kick in during this 90-day period, or after they are discharged?

Babaria: There are two distinct phases largely related to the CMS processes and approvals. First are the pre-release services, which are s kick in during that period when they're still in custody, and then, secondly, at the time of release is when ECM kicks in and they can get the ECM benefit. From a logistical perspective, they're both designed to do the same thing, which is care coordination, preparation for discharge, navigation, and getting them linked into Medi-Cal. As we design the policy, the vision and goal is, wherever possible, whoever that pre-release service provider is, is the same ECM provider post-release.

Arroyo: Would that ECM be from the MCP or SMHS?

Babaria: The ECM providers will be contracted through the MCPs, but we are actively working to ensure county behavioral health partners and others are part of that network. So we are working very closely with the County Behavioral Health Director's Association (CBHDA) and the counties to make sure that wherever possible, the counties are participating in ECM.

Arroyo: This would include every single county as opposed to an opt in?

Baass: Correct.

Schumann: Going back to Karen and Dr. Arroyo's comments, this is 90 days before they're released. My concern would be for a juvenile who may be incarcerated for periods of six months. Is there any form of continuity of care that can continue while they're in prison if they've already had services beforehand?

Baass: The MCP would be privy to that information. I think it would depend on how it gets operationalized and the length of time the person is incarcerated. I don't know if we have a specific standard on that.

Babaria: I think at both the MCP level and the provider level, there's always member choice. I think the provider level is a little more complicated. Providers have different roles, depending on the length of time, and if that person is a new patient versus an existing patient. If in the interim they closed the practice to new patients, they may not be able to accept them for primary care. From what I've seen, Stephanie might have more input at the MCP level. Many of our MCPs try to ensure that continuity as much as they can.

Sonnenshine: Thinking about data-sharing, particularly as it relates to kids, I would want us to just test that assumption that the health plan would be aware at the point that a child entered the system. We may or may not know, and so, if that's something that we would want to build into the system we need to be very intentional about that because that would require new communication patterns that I think we're going to be developing toward 2024 and beyond. We would want to make sure that the system partners were working together on that infrastructure to get those notifications. So, that is something I'll note and carry back with my peers.

Weiss: Along the lines of data, just wondering if you've gotten far enough to think about what the recidivism or clinical outcome metrics will look like.

Babaria: This being the first waiver that CMS has approved of its kind, there were a lot of caveats. If you look through the Special Terms and Conditions, the monitoring and evaluation sections are denser. Within the next six months, we will add our own additional layer on top of CMS', which will include clinical health outcomes, mortality within that first 14-to-30-day period post-release, and recidivism, as well as employment and housing. We can bring back the specific details because there's a lot in there that we are required to monitor and report on in terms of outcomes. In addition, in the justice-involved initiative, every single facility will be screening members for ECM eligibility. We will be keeping track of those screenings, who's eligible and who ends up being enrolled, and who doesn't. We're also thinking about more proactive ways of data monitoring at the state level through the Population Health Management (PHM) service,

especially. We already have California Department of Corrections and Rehabilitation (CDCR) data on who is in custody at state facilities. For jail and juvenile facilities, that data infrastructure has not been set up, but the vision and goal is to have as close to real-time information about who is in custody today.

Arroyo: Given this interest in the data-sharing element of this program, can anyone speak to how the data exchange framework fits into this?

Baass: The data exchange framework are the rules of engagement to which everybody agrees.

Arroyo: Are these data exchange systems going to become an administrative burden for providers in terms of entry? As the data exchange framework is moving forward, hopefully providers aren't overwhelmed with the data entry tasks. Just raising it as a real issue.

Baass: That's a goal of the framework, that it is not double entry. You enter it once.

Babaria: I just want to remind everyone that the data exchange framework is really around health care data exchange, so it is for provider entities that are also covered under HIPAA and have obligations under the federal interoperability rules. We should refer to the statute, but my understanding is that educational facilities, jails, and prisons (outside of health care services) are exempt from that data exchange framework. So as we think about non-health care linkages with public health, schools, and correctional facilities, there are limitations because the data exchange framework doesn't go that far.

Arroyo: If the MCP is going to start working on the justice piece 90 days before, there's no exemption for that. It's my understanding that all the social service agencies will be part of the data exchange framework.

Baass: We can take this back. I think their timeline is two years later than the health side of it. This is not our area.

Babaria: On the ECM side, we have been having conversations, and we continue to evolve our policy.

Director Baass gave an update on the unwinding of the PHE.

Hempstead: Is there any projection of how many will be disenrolled?

Baass: We are estimating two to three million, almost going back to pre-pandemic levels. There's going to be a smooth transition to Covered California. We anticipate

many individuals will be eligible for Medicare and that many individuals also already have other health coverage, but they've been maintained on Medi-Cal.

Hempstead: What is the plan for data reporting?

Baass: We'll post monthly dashboards with state- and county-level data with regard to application processing. This is going to be a significant workload at the county level.

Hempstead: Can you provide more information on the Covered California transitions?

Baass: If an individual or family is no longer eligible for Medi-Cal, they will essentially move over to Covered California, and they will have to take action to ensure that they select their plan. They don't have to apply to Covered California. [As a reminder, it is possible that an individual or family might have a premium due to Covered California based on their income and family size.]

Hempstead: Your Coverage Ambassadors can help with that transition?

Baass: Yes, it's all automatic. There's no action to do that transition.

Lauterbach: As part of the readiness for the counties, are they giving information about call center times? In Los Angeles County, call center wait times are at a minimum an hour or more, and often we're getting people who can't resolve the issue. We're having to start all over again because there's not a way to escalate an issue to a supervisor. I'm hoping that this is part of the readiness plan. Regarding updating addresses, often people should go to BenefitsCal, but those updates don't happen right away. We've had updates take almost a month, unless we call in, but then we get stuck in the call center wait loop. I don't know if there's a disconnect on how that's happening. I'm happy to provide any details about that.

Baass: We will be monitoring these metrics, including call centers. Counties are facing extreme workforce challenges, but it is something we will be monitoring.

Mollow: DHCS is addressing concerns regarding call center wait times by working with county partners, recognizing that call center operations vary . DHCS will monitor and follow up on any delay in address changes, especially if they occur within the same county. DHCS is collaborating closely with a small subset of county directors to address these issues and ensure that issues are raised in a timely fashion. DHCS is also emphasizing the importance of updating information and will raise any concerns with our county partners to address any issues.

Lauterbach: I can forward you the cases that we've had.

Mollow: Please send those to me.

Vega: I moved in October. I reached out to the Department by phone and electronically. It took 2.5 months to change my address. I was getting mail at the old address, and I missed a lot of information that was relevant. I went online and updated the information and spoke with my medical case manager.

Mollow: Thank you so much for sharing that information, Diana. I will be taking this back to further discuss.

Medi-Cal's Strategies to Enhance Quality and Care for Children and Families

Riley and Mollow gave a presentation on EPSDT Medi-Cal for Kids and Teens Toolkit.

Arroyo: I'm impressed with this effort. I thought that MCPs were required to develop their own messaging. I urge you to create an educational form. I also appreciate the due diligence about acknowledging the behavioral health description challenges. It's particularly challenging for families because we have a bifurcated benefit with the county and with the health plans. Hopefully, that can be addressed in a revised effort. In the brochure for kids, there was no mention of behavioral health services. I look forward to that revision.

Schumann: Awesome job on that brochure. I would like to see it available at physicians' offices.

Baass: That is something we are looking into.

Weiss: I applaud the content, but also the change in semantics. If it's not already being done, I suggest collaborating with the American Academy of Pediatrics (AAP) chapters and the state AAP.

Mollow: They were part of the small groups that we reached out to for feedback and on the materials. We'll also be working with folks on how we can get the materials in doctors' offices and encouraging our MCPs to help support their providers in that effort.

Eagilen: Retitling it makes it much more provider friendly. I especially enjoyed that you spoke about the periodicity because that is something that is very important that most of the parents just don't really get. As many avenues as we can disseminate this information, even if it's duplicitous, the better, because they really need to have this.

Salama Jacobs: How are you going to outreach with school districts? Do you plan on including brochures in nurse's offices?

Mollow: When the materials are translated, we will have targeted discussions with individuals for how we can help to support them in getting this information out. To your point, we also want to look at more than one way in which we put this information out.

Hempstead: Rather than creating thousands of pamphlets for doctor's offices, creating a one-pager with a QR code is an extraordinarily efficient way to do this.

Mollow: That's a great idea.

Maslyn presented about the Child Health and Disability Prevention (CHDP) program transition.

Netherland: Are there specific metrics that DHCS plans to use to monitor the transition, such as utilization of services? How are MCPs implementing the dental provisions of AB 2207? There was a workgroup meeting that recommended DHCS make a formal request to counties about the funding allocation to support functions of CHDP, California Children's Services, and Health Care Program for Children in Foster Care; has that request been made? How is DHCS going to be both providing that support and assessing the progress of that transition? I'm also wondering about the knowledge transfer between CHDP and MCPs. Finally, given the existence of the community advisory councils that are part of the contracts for the MCPs, what is their role? I've seen some other advisory groups that have been engaging in a bi-directional approach with other stakeholder workgroups to co-create some of the agendas, and I wonder if that can be done with the CHDP transition workgroup.

Maslyn: I appreciate your recommendation about the Community Advisory Committee, and we'll take that under consideration. Ultimately, we want the co-creating agenda process and identifying where those gaps are. That can also be for the public during the public comment period. We've discussed internally some of the things you mentioned with knowledge transfer as well as monitoring oversight activities, and we hope to put that on the agenda. This is a cross-divisional project, so we've worked with our divisions to present all items in one stakeholder engagement process.

Weiss: We're going to adjust the agenda to move on to Dr. Babaria and her presentation.

Babaria presented on the Comprehensive Quality Strategy, PHM, and ECM.

Arroyo: Is complex care management (CCM) a standard MCP benefit?

Babaria: It is a program that is offered by most MCPs. It is a National Committee for Quality Assurance (NCQA) requirement. As all our plans become NCQA accredited, they

are required to provide that. In my experience, even those plans that aren't NCQA accredited tend to have care management programs in-house.

Arroyo: Do we have utilization data on these specific benefits?

Babaria: I don't know that we've collected that data previously, but we will be as a part of the PHM monitoring approach, which we can present to you all on once it's finalized. We will be collecting that data, both to look at how many people are eligible for CCM programs and how many are enrolled. Eventually, we want to know the efficacy of those programs because not all of them are designed equally, and if they're not achieving the outcomes we want, that's something we want to look into. Also, with the launch of PHM, we did create a statewide standard on some of these things that all MCPs must have including robust plans within these four domains: cardiovascular disease, depression, diabetes, and asthma. Many MCPs go above and beyond that, but we are trying to standardize some of those approaches.

Sonnenshine: I think the difference from a plan perspective is that the CCM services that health plan staff deliver are done within health plan walls. We're not all brick and mortar these days, but it's different from the ECM, where you're contracting with the provider in the field who's meeting the member where they're at in the community. It's not a billable service. We're not part of the provider network health plan staff delivering that service. Previously it wasn't something that was tracked and reported in the same way because it was coordinating care and navigating patients with primary care providers and SMHS in the counties.

Netherland: I appreciate the commitment to continuity of care. Most young people in foster care, or the adoption assistance program (AAP), are enrolled in fee-for-service (FFS) and not managed care. How are we thinking about ECM for that population, given that it looks like there's more than 90,000 AAP or foster care youth enrolled in FFS versus 79,000 in managed care? I want to see how ECM is implemented and maybe having an update on some of the details on what this is going to look like for that very vulnerable population, especially with some of the delays in enrollment from county to county.

Babaria: For the benefit of others who may not have read the ECM policy guide, there is an entire population of focus for foster youth that is expansive. It includes those who are eligible for other programs to qualify that will address the care management gaps and needs for those who are in managed care and qualify as foster youth.

Baass: We are working through the numbers and will provide shortly. I think the benefit of managed care is that it has an opportunity to do this type of care coordination, and FFS is about a member managing their own services. We'll take this back and continue to think through it.

Beck: True accountability is for whoever is providing care – plans or individuals – so I ask that maybe at some point you come back and talk about the 20 items that you mentioned and then how they link to these various outcomes, particularly the child morbidity and mortality you say is heightened as a future ECM category. So, in the example that you shared, let's say tragically there wasn't such a good outcome. How would accountability be acted on?

Babaria: DHCS has been working to strengthen accountability as one of the major guiding principles in our Comprehensive Quality Strategy. DHCS has implemented comprehensive sanctions for the first time based on MCPs failure to meet the minimum performance levels (MPL) for quality measures in measurement year 2021. Plans that had deficiencies in meeting the MPL in more than one measure or domain faced sanctions and were classified into green, orange, and red tiers. The children's domain had the most measures that were missing the MPL, indicating the need to improve children's preventive care. Plans in the red tier are under a corrective action plan for their deficiencies in quality, and monetary accountability has been levied. My team and I are meeting with every MCP every three to four months to review what their strategic plan is to address those deficiencies. DHCS is still developing monitoring strategies for PHM.

Beck: Thank you for making those changes. I'm thrilled that there are ways to streamline the provider category. There are very high expectations of how they would function, but maybe don't have to meet every single criterion because it's not relevant for that particular group and who they're serving.

Babaria: As we launch the community health worker and doula benefits, we have a non-licensed workforce joining Medi-Cal or serving in these capacities as Community Supports or ECM providers. In order to reduce onerous requirements that are unnecessary, we are soliciting feedback to determine what that middle ground is where we can still gather data without requiring the entities to stand up a full health care infrastructure.

Sonnenshine: DHCS is proposing a massive Medi-Cal transformation. There needs to be a discussion about accountability and how it should be approached punitively or with a willingness to collaborate to improve performance? Currently, three different counties

are being monitored, with one underperforming and engaged in the sanction process with the state. The delivery system needs to expand provider capacity to address disparities in under-resourced communities where there's one physician for 2,200 patients. It's important to set targets and measure performance to encourage addressing root causes and expand the number of providers.

Baass: How do we think about our investments regarding quality and outcomes? We clearly learned our lessons through the COVID PHE, and how we used that information to direct resources.

Eagilen: Regarding the doula benefits, are those non-licensed providers going to be only hired by the managed care organizations (MCOs) or will they be working independently with Medi-Cal?

Babaria: Rene will cover doulas more this afternoon, but they'll be enrolled as Medi-Cal provider type. For CHWs, we're working out what that enrollment pathway looks like. ECM providers contract with the MCP and are not employed by the plan; they just contract with the plan for reimbursement.

Eagilen: Outside of ECM, are they just independent contractors?

Babaria: Yes. There are different ECM provider types, but all of them need a contract with the MCP to provide those services.

Arroyo: Are the standards of accountability applied equally for MCPs and FFS?

Arroyo: Why are these standards imposed on the MCPs and not in the FFS system?

Baass: By 2024, 99 percent of Medi-Cal members will be in managed care. That is the delivery system.

Babaria: The federal managed care final rule provides guidelines for accountability infrastructure. Monitoring for fraud, waste, and abuse exists in both managed care and FFS systems, but the expectations for clinical quality and outcomes are different. In terms of the behavioral health system, county behavioral health systems are considered in the eyes of CMS as MCPs, and quality monitoring and accountability infrastructure are being set up for county behavioral health. The Comprehensive Quality Strategy includes measures, and behavioral health plans will be held accountable, with 2022 as a baseline year, and 2023 is when we'll start monitoring and expecting certain targets based on national benchmarks.

Arroyo: It would be great to hear about what those developing standards are for county behavioral health.

Babaria: The CalBH-CBC waiver is also another opportunity because there are robust quality components building up capacity and infrastructure, especially in some of the smaller behavioral health counties.

Beck: I'd like to know more about the Alternative Payment Methodology (APM) for FQHCs.

Babaria: We can provide a full presentation on APM, but briefly, each participating FQHC would receive monthly payments equivalent to their total, projected Prospective Payment System (PPS) payment entitlement in the form of an APM per-member per-month rate, paid across all assigned members attributable to each MCP with whom the participating FQHC has contracted. The APM would incentivize delivery system and practice transformation through the flexibilities available under a fully capitated reimbursement model. For example, a patient could do remote blood pressure monitoring and have a quick two-minute phone call with a nurse, which would count under the APM model, but not under traditional FQHC rules. This allows FQHCs to maximize access for patients who need to see a provider and serve those who don't with an expanded health care workforce.

Break – 30 minutes.

Rene Mollow gave a presentation on the doula benefit and new stakeholder workgroup**.**

Weiss: Is the workgroup looking at quality metrics, such as patient or provider satisfaction, or pregnancy outcomes? Is that on the roadmap?

Mollow: It will be. We'll be working with the team to identify metrics and welcome all input through our workgroup meetings.

Eagilen: What was the rationale for the referral process for doulas because patients typically self-refer? The referral process may be a roadblock for Medi-Cal members because many physicians may not see the need for doulas and may not inform patients of the option.

Mollow: That is a valid point. The rules for providing Medicaid preventive services are based on medical necessity and the recommendation or referral by a licensed practitioner within the program. We're also working on making available tools to help support our providers that participate in our program, and MCPs will have an obligation to educate both their providers and members about the availability of this benefit. If a requested covered benefit is denied, the provider must give the member a notice of

action explaining why they cannot receive that benefit. The goal is to increase awareness and access to doula services and to address any challenges encountered by the doula community.

Eagilen: Can you expand on the information dissemination plan for the doula program?

Mollow: We have information in our Medi-Cal provider manual that covers information on services and how to bill for those services. We have done trainings with the doula community in terms of provider enrollment. The training and that information sharing is also on the doula webpage. We've also been working with MCPs, and they have been doing trainings and educational series to educate their communities.

Arroyo: Has the development of the doula program been informed by research? Is California the first state to have Medicaid-supported doula services? If not, are we being informed by those other states?

Mollow: Yes to both questions. Evidence shows that having doulas can help to reduce inequities and disparities and birth outcomes, especially among populations of color. We've also looked at work that's been done by other states. California is one of a few states that has state law to support the implementation of the benefit.

Beck: For residency programs across the state, both in primary care and family medicine, I think this would have a ripple effect for trainees now and into the future. It would be helpful if there was a workshop or one pager that could be integrated into their curricula.

Mollow: That is exactly what we want to do and part of what I presume will come out in terms of recommendations for the doula implementation work. Please continue to flow those good thoughts and questions to us.

Lauterbach: I understood there were some issues with FQHCs accessing doula benefits?

Mollow: The doulas are not reimbursed for these services on a per-visit basis, but it doesn't preclude the clinic from procuring doulas to work on their staff. Through the rate setting process, their costs can be incorporated and then reflected in future rate changes that they may have.

Lauterbach: Would they be able to access them through managed care almost like a specialty referral? I'm thinking of our providers referring somebody who would benefit from a doula.

Mollow: We're working to develop a doula registry and we'll also be making available information on the doulas that are enrolled in the program. That information can also

be provided to the MCPs. It doesn't preclude the MCPs from also working with doulas within their communities.

Public Comments:

Doug Major, O.D., California Children's Vision Now Coalition: I'm still concerned about making vision care visible in the spectrum of what you do. We need actual metrics to make this a part of the system. I'm surprised that there are no current metrics on vision care. This is a small penny in the $140 billion pie. Vision is a tool for academic success. What we're asking for is an agenda item, so that this community can understand the depth of this problem. We have a coalition representing every single major university in the state of California waiting to serve you. We feel it is so important to sync your questions with the children of this state.

Member Updates and Follow Up

Weiss: Let's go around the room. Stephanie, on behalf of everybody, we appreciate all your efforts.

Sonnenshine: I appreciate and thank this forum. I appreciated the opportunity to learn and listen to each of the participants in the panel. I've worked in the Medi-Cal delivery system for 17 years. I'm a mom of a kid who has Medi-Cal coverage as a former foster youth. The work done here is personally important to me.

Beck: Grateful for all the efforts that are being made. I just wanted to call attention to something the Director said at the beginning, which I thought was great - to work toward more steps to integrate the work of health care and education.

Eagilen: Thank you, Mike, for stepping up to the helm. I wish you all the best leading our group for the current year.

Vega: I am very grateful for this group. I have seen progress. I feel like you have heard the concerns that I've raised.

Upcoming MCHAP Meeting – May 4, 2023, and Next Steps

Weiss: I just want to thank Director Baass, Dr. Hempstead, and the group for prepping me and welcoming me to this position. I've been practicing pediatrics for 40 years, and one of the most profound moments of my career was when we convened a group of 20 Medi-Cal families at the Orange County Boys & Girls Club. The theme we overwhelmingly heard is they want to be heard; it was about navigating through the challenges that we are all leading to try to improve. Our next meeting is May 4.