CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING MINUTES

MEDI-CAL CHILDREN'S HEALTH ADVISORY PANEL (MCHAP)

Date:	Thursday, March 13, 2025
Time:	10 a.m. – 2 p.m.
Type of Meeting:	Hybrid
Members Present:	14
Public Attendees:	94
DHCS Staff Presenters:	Michelle Baass, Director; Palav Babaria, MD, MHS, Chief Quality Officer & Deputy Director, Quality and Population Health Management; Linette Scott, MD, MPH, Deputy Director and Chief Data Officer, Enterprise Data and Information Management; Pamela Riley, MD, MPH, Assistant Deputy Director and Chief Health Equity Officer, Quality and Population Health Management
External Presenters:	Alex Briscoe, Principal, Public Works Alliance
Additional Information	Please refer to the PowerPoint presentation used during the meeting for additional context and details.

Member Attendance:

- Michael Weiss, M.D.; Present; In person
- Ellen Beck, M.D.; Present; Virtual
- Elizabeth Stanley Salazar; Present; In person
- Diana Vega; Present; Virtual
- Nancy Netherland; Present; In person
- Jeff Ribordy, MD, MPH, FAAP; Present
- Karen Lauterbach; Present; In person
- Kenneth Hempstead, M.D.; Present; In person

- William Arroyo, M.D.; Present; In person
- Ron DiLuigi; Not Present
- Lesley Latham, D.D.S., MS; Present; Virtual
- Alison Beier; Present; Virtual
- Jovan Salama Jacobs, Ed.D; Present; Virtual
- Kelly Motadel, M.D.; Present; Virtual
- Jan A. Schumann; Present; In person

10:00 – 10:10	Welcome and Introductions
10:10 – 10:40	Director's Update
10:40 – 11:40	Birthing Care Pathway
11:40 – 12:30	DHCS Pediatric Dashboard
12:30 – 1:00	Break
1:00 – 1:45	Navigating an Unprecedented Reform Landscape: Medicaid and Youth Mental Health Systems Change
1:45 – 1:55	Public Comment
1:55 – 2:00	Final Comments and Adjourn

Welcome and Introductions

Type of Action: Action

Recommendation: Review and approve the November 7, 2024, meeting minutes.

- **Presenter:** Dr. Michael Weiss, Chair, welcomed meeting participants, and Dr. Jeff Ribordy read the legislative charge for the advisory panel.

Materials/Attachments: MCHAP Meeting Minutes - November 7, 2024

Action: Approve the minutes from November 7, 2024

- **Aye:** 8 (Weiss, Hempstead, Arroyo, Netherland, Lauterbach, Motadel, Salazar, Vega)
- **Didn't Vote:** 4 (Latham, Jacobs, Beck, Beier)

- **Members Absent:** 1 (DiLuigi)
- **Abstentions:** 2 (Schumann, Ribordy)

Motion Outcome: Passed

Director's Update

Type of Action: Information

Presenter: Michelle Baass, Director

Discussion Topics:

- DHCS welcomed Dr. Lesley Latham as the newest member of MCHAP, representing the dental provider perspective. DHCS then provided an overview of Governor Newsom's January 2025 proposed budget, which allocates $193 billion in total funds and approximately 4,800 positions for DHCS, with most funding directed toward local assistance programs, such as Medi-Cal. The budget includes continued implementation of CalAIM and the BH-CONNECT 1115 waiver, which supports behavioral health system improvements, including $1.9 billion over five years for workforce development administered by the Department of Health Care Access and Information (HCAI) in partnership with DHCS. Proposition 35's Managed Care Organization (MCO) Tax and Proposition 1's Behavioral Health Transformation, encompassing the Behavioral Health Services Act and Behavioral Health Infrastructure Bond Act, were also highlighted, with updates available online. DHCS plans to sunset 17 federal redetermination flexibilities by June 30, 2025, as eligibility operations return to standard procedures. Caseload estimates project 16.8 million members for FY 2024–25, decreasing to 14.5 million in the following fiscal year, with potential variability depending on federal developments.
- DHCS also provided an update on Medi-Cal Rx, noting that it has been nearly three years since its implementation. While the initial rollout was challenging, DHCS reported that the reinstatement of adult members, which occurred in April 2024, has been operating smoothly with no reported issues. Pediatric reinstatement went live in February 2025, and early indicators show normal claims processing and call volumes within expected ranges. DHCS stated the rollout appears to be progressing well and committed to continued engagement as policy development continues.
- A member asked whether federal funding adjustments or efficiency reductions might affect the estimated 15 million members, in light of the estimated 4,800

positions at DHCS; DHCS responded that there is currently nothing concrete, and the Department cannot speculate while federal discussions are ongoing.

- A member asked whether funding from other initiatives, such as the Behavioral Health Services Act, might be borrowed to address potential budget gaps related to the Los Angeles fire recovery; DHCS responded that such scenarios are speculative, and while more information will be available in the May Revision, DHCS emphasized that it remains committed to these initiatives and is moving forward with approved waivers.
- A member commended DHCS for quickly clarifying a recent CMS issuance and emphasized the value of DHCS' timely, grounded interpretations for implementation in California; no response was recorded.
- A member asked how the state is protecting undocumented patients who fear accessing Medi-Cal due to concerns about public charge, transportation, and law enforcement presence, and suggested an educational campaign; DHCS responded that outreach is being conducted through the Coverage Ambassadors program, with materials available online and through CalHHS, and noted that non-emergency medical transportation is a covered benefit through managed care plans.
- A member asked how individuals within the Drug Medi-Cal Organized Delivery System (DMC-ODS) substance use disorder (SUD) system can engage with or access Coverage Ambassadors; DHCS responded that ambassadors are volunteers who sign up through the DHCS website and are engaged through webinars and trainings. DHCS also encouraged members to help identify volunteers from the SUD space.
- A member shared concerns about challenges during the transition to managed care for former foster youth, including barriers to Enhanced Care Management (ECM) enrollment and the lack of a mechanism for real-time feedback, and proposed story banking or listening sessions to collect feedback from families experiencing challenges with managed care transitions; DHCS responded that such feedback helps inform oversight and monitoring, emphasized the role of consumer advocates in surfacing systemic issues, welcomed suggestions for improvement, and acknowledged the need for additional feedback mechanisms, noting that DHCS is conducting statewide member advisory meetings to gather such input.

- A member proposed that the state budget account for a potential influx of children relocating from other states to access Medi-Cal due to differing Medicaid eligibility rules; DHCS responded that the governor's budget does not assume such an influx, and there is currently no mechanism in place to track such migration.
- A member asked if DHCS is tracking emergency room utilization trends over time; DHCS responded that this is an area under consideration.
- A member followed up on previous comments about community outreach and asked whether DHCS is doing more to promote privacy protections and enhance safety for vulnerable individuals, and whether additional risks from the federal government are being considered; DHCS responded that health plans are promoting telehealth as an alternative to in-person visits to support access and privacy.
- A member commented that the SUD system is not fully utilizing telehealth due to billing and protocol misunderstandings, and suggested that targeted training could improve access to addiction treatment, particularly within opioid treatment program.

Birthing Care Pathway

Type of Action: Information

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

Discussion Topics:

- DHCS provided an update on the Birthing Care Pathway, which outlines comprehensive maternity care for Medi-Cal members from conception through 12 months postpartum. The pathway aims to improve access to care, reduce maternal morbidity and mortality, address racial and ethnic disparities, and support physical, behavioral, and social health needs. The February 2025 Birthing Care Pathway report summarizes implementation progress, findings, and strategic opportunities. Development of the pathway included a landscape assessment, stakeholder engagement, and workgroups to collect input from diverse Medi-Cal members. DHCS plans to continue stakeholder engagement and, in 2025, will implement the Transforming Maternal Health (TMaH) Model, a

10-year initiative supported by $17 million in federal funding, in five Central Valley counties (Fresno, Kern, Kings, Madera, and Tulare).

- A member shared their experience of opening one of the first women's and children's recovery homes in California within the substance use delivery system in Los Angeles, stating this issue has been a long-standing passion throughout their career. They expressed strong support for the Birthing Care Pathway, commending the overview presented and highlighting the challenge of enacting not just system-wide change, but also organizational change, such as shifting behavior within hospitals and agencies. The member emphasized that such transformations, from patient behavior to agency and hospital systems, are critical and require ongoing effort. They noted that many excellent programs in California have not scaled, particularly those focused on women who are transitioning out of the criminal justice system and dealing with substance use and mental health issues. The member pointed out that while many of these programs were evaluated and funded through federal grants, they often go dormant. The member also raised concern that women with substance use disorder and mental health challenges often do not seek prenatal care early enough, showing up only when delivery is imminent, and stressed the need for more work in this area. Additionally, the member shared their experience of working with counties to implement the Family First Prevention Act, pointing out the resistance from hospitals in implementing safe care plans. They recommended reaching out to Riverside County, which has made significant progress in working with its hospital system, and they also highlighted the successful efforts of First 5 Orange County, particularly their work with safe care plans. DHCS responded by noting that CMS launched a nationwide learning collaborative focused on perinatal substance use, in which DHCS is participating. DHCS highlighted the importance of bringing these successful entities on board as CalAIM and Medi-Cal providers to help scale their impact. DHCS acknowledged the challenge of relying solely on grant funding and emphasized the opportunity to scale these initiatives through the integration of these providers into the Medi-Cal system.
- A member shared their experience of managing the early childhood system of care in Los Angeles County for 15 years, initially launched with support from First 5 California through federal funding. They emphasized the crucial role of federal dollars and state collaboration with the California Department of Public Health (CDPH) in securing funding to support these perinatal programs. The member

mentioned programs like Nurse-Family Partnership, an evidence-based model with more than 30 years of proven outcomes. They highlighted a major challenge: while there are evidence-based programs with strong research backing, there is no single funding stream to sustain them. They noted that counties often had to use multiple financing sources to support these programs, creating logistical challenges, particularly in replication efforts across counties. The member also discussed the difficulties faced by pregnant women in Los Angeles who were too ill, due to substance use or mental health issues, to leave their homes and access care. As a result, care had to be delivered at home. They raised the point that these women often do not seek out care, such as appointments with OB-GYNs or prenatal care providers, and emphasized that finding and serving these women requires proactive efforts. The member stressed that coordination at the state level and streamlined financing are key to addressing these challenges. DHCS responded by acknowledging the member's comments and context, noting that ECM has significant potential to tailor its services for pregnant and postpartum members, including in-home services. DHCS also mentioned that adding evidence-based home visiting as a Medi-Cal benefit is a priority, contingent on future funding availability.

- A member praised the community-based approach, including in-depth interviews and compensating participants, and suggested it be adopted across the care system as a standard, budgeted practice, not just foundation-funded. The member asked whether this kind of member engagement would be ongoing and appreciated the inclusion of goals around telehealth, transportation, outreach, and trust-building. They recommended involving doulas or other care partners in clinical visits to strengthen trust with patients. DHCS responded that they are revising and consolidating fragmented maternity care policies and developing measurement strategies to track service delivery. They confirmed plans for continued member engagement under the TMaH Model and highlighted the Medi-Cal Member Advisory Committee, which advises leadership, sets its own agenda, and is compensated. Engagement extends beyond quarterly meetings to include regular check-ins. The member followed up to ask if DHCS collaborates with members on solutions, emphasizing the value of community-driven input. DHCS confirmed that solution development is built into the model. They noted that members co-created and tested fact sheets on provider choice and available services, now posted on the Birthing Care Pathway webpage and translated into all threshold languages.

- A member commended DHCS for the collaborative development of the Birthing Care Pathway and asked which outcome measures would be used to assess its success over time, specifically in three, five, or seven years. DHCS responded that they are developing a comprehensive maternity care measurement strategy, which includes current metrics like prenatal and postpartum visits and c-section rates, while also exploring ways to link Medi-Cal and public health data. The primary focus is on reducing morbidity and mortality and connecting those outcomes to specific health care services. DHCS is working with the National Quality Forum on fast-tracking maternity measures, including a hypertension control measure, the first of its kind, given the impact of cardiovascular disease, particularly on African American and postpartum individuals. Success will be measured by improved outcomes, closing disparities, and integrating data sources to support informed care.
- A member commented that workforce shortages and insufficient monitoring hinder progress, and suggested DHCS consider incentivizing outcomes to drive adoption at the organizational level. The member noted that without integration into the business model, such goals may not be prioritized, especially by executive leadership. DHCS responded that while policy implementation and research are often treated separately, they are actively working to integrate outcome measures into the business model. DHCS highlighted that their Health Care Financing team manages the state's value-based payment strategy, which includes the Quality Incentive Program for district and public hospitals. This program includes maternity measures, such as prenatal and postnatal visits, c-sections, baby-friendly designation, breastfeeding, and the hemorrhage bundle. These measures are also tied to auto-assignment, the Quality Withhold program, and plan sanctions for underperformance. DHCS emphasized that they are leveraging all available tools while continuing to refine and identify the most impactful measures for incentivization.
- A member asked for clarification on the closure of rural maternity wards, acknowledging the complexity of the issue. The member noted that rural areas lack the economies of scale of their urban counterparts and expressed concern about sustaining access without simply keeping facilities open without sufficient demand. DHCS agreed that the issue is complex and involves shared accountability among DHCS, HCAI, and CDPH. DHCS explained that low patient volume can pose safety risks, especially when high-risk individuals receive care at facilities not equipped to manage complications. They emphasized the

importance of appropriate risk assessment and matching care settings to individual risk levels. DHCS shared that stakeholder engagement highlighted members' desire for birthing options, including home births, birthing centers, and midwifery care for low-risk individuals. For high-risk cases, care must be delivered in appropriately equipped facilities, which may require travel, especially in rural areas. The state is working to map out risk-based care pathways and expand access accordingly.

- A member asked whether DHCS has considered leveraging programs like Cal-MAPS to address workforce shortages, emphasizing the need for innovative solutions. DHCS responded that the policy guide includes CalHealthCares, a loan repayment program prioritizing OB/GYNs and family physicians in rural areas. DHCS acknowledged the need for broader partnerships and noted some complexities around funding and authority, but affirmed the potential for expansion.
- A member commended the collaborative process and asked about other multi-stakeholder design efforts DHCS sees as promising. DHCS highlighted a peer-to-peer perinatal behavioral health initiative in Los Angeles County, where experts support both primary care and behavioral health providers. The program is in early stages, and DHCS is monitoring its impact with an eye toward potential statewide scaling.
- A member asked if the Birthing Care Pathway specifically addresses unplanned pregnancies among adolescents and young adults aged 14–20, who often delay prenatal care. DHCS responded that this subgroup is part of their population health strategy and will be supported through Medi-Cal Connect, a forthcoming analytics platform. They are developing a risk prediction model and plan to consult experts to refine identification. The Office of the California Surgeon General is also working on complementary risk assessment tools to help create a system that reliably identifies and connects individuals to needed care.
- A member shared an example from Los Angeles, where peer graduates of a perinatal program became community advocates and even lobbied at the federal level. Another group of trained women taught others to administer developmental screenings in community settings.
- A member reflected on the declining involvement of family medicine residents in obstetric care, noting excitement among trainees about doula coverage and the Birthing Care Pathway. The member suggested investing in OB-focused

fellowships or intensive training to strengthen comfort and competency in maternity care.

- A member from a rural health plan emphasized the difficulty of attracting OB providers to rural areas. They described efforts to support family medicine residencies with OB training, update hospital bylaws to allow midwives, and track provider placement data though rural data remains lacking. The member noted a large disparity in physician placements between Northern California and Los Angeles. They shared that they plan to sponsor a state bill to allow standby birthing centers at facilities that have closed or never had them, and asked for DHCS support.

DHCS Pediatric Dashboard

Type of Action: Information

Presenter: Linette Scott, MD, MPH, Deputy Director and Chief Data Officer, Enterprise Data and Information Management; Pamela Riley, MD, MPH, Assistant Deputy Director and Chief Health Equity Officer, Quality and Population Health Management

Discussion Topics:

- DHCS provided an overview of the Pediatric Dashboard and conducted a live demonstration of the CalAIM landing page. The presentation highlighted efforts to advance and innovate Medi-Cal, with an emphasis on data-driven improvement, transparency, and accountability. The dashboard is regularly updated and will continue to expand as new data become available.
- A member commented on the need to integrate behavioral health care delivery across systems, noting that the current siloed approach (between specialty mental health, substance use services, and mild to moderate services from managed care plans) creates confusion and barriers to access. The member emphasized the importance of involving plans in integration efforts and expressed hope for achieving holistic care, despite the complexity involved.
- A member asked about the typical data lag associated with the dashboard and how it affects the ability to take timely action. DHCS responded that claims lag has improved and is now generally around three months, although this varies by service type. Utilization data are updated monthly and may go up to the current calendar year (e.g., early 2024). However, for quality measures, annual reporting is still standard due to the need for full-year data. DHCS highlighted Medi-Cal Connect as a promising tool to support more real-time data access and

emphasized the importance of balancing reporting effort with data utility, especially when utilization trends remain stable over time.

- A member asked about potential workarounds to improve data timeliness, particularly for specialty mental health. DHCS responded that claims and encounter data have become timely, due in part to incentives linked to quality measures that require data within three months. However, the 2023 payment reform introduced some delays. DHCS noted that counties technically have up to a year to submit claims, but that waiting risks exclusion from quality reporting. They added that the current state is improved compared to the past.
- A member noted that the specialty mental health claim data shown in the dashboard was from 2022 and asked when newer data would be available, given concerns about outdated trends and worsening youth mental health needs. DHCS responded that updated data would be added soon and can be accessed via the Behavioral Payment Reporting section on the DHCS website. They acknowledged that reporting lags are due in part to the 2023 payment reform and historical use of the state fiscal year for behavioral health data. Updates are in progress to revise the dashboard with more current data.
- A member asked when 2023 data might become available and whether there has been any analysis to determine if children are transitioning from specialty to mild to moderate mental health services. DHCS responded that no such analysis has been completed, but the question is important. DHCS noted a prior assessment that examined service utilization across systems and would consider revisiting this issue to ensure that children's needs are being appropriately met.
- A member commented that they appreciated the update and noted a return to pre-pandemic enrollment levels. They observed an increase in well-child visits but noted a decline in immunizations, particularly flu vaccines, which may be tied to lingering vaccine hesitancy post-COVID. They suggested renewed outreach through ambassadors to promote immunizations.
- A member referenced a utilization report from the early days of non-specialty mental health expansion, which showed relatively stable specialty mental health numbers despite increases in proportional use. They reiterated concern about stagnant immunization rates and highlighted the need for local partnerships and feedback from communities to develop effective solutions.
- A member asked whether data are available on provider performance, specifically turnaround times for receiving equipment, such as glasses or

wheelchairs. The member noted that while user numbers are available, there is interest in metrics that reflect provider delivery timelines. DHCS responded that these type of data are not currently available. Claims data captures when a service or item is paid for, not when it was ordered or delivered. Similarly, referral-to-appointment timelines are not available through claims. While proxies are sometimes used to estimate delays, there is no consistent or reliable metric available to track those service delivery intervals. The member followed up by asking how DHCS holds providers accountable for delays in delivering care or equipment. DHCS responded that accountability is assessed through several mechanisms, including quality measures, managed care plan access standards, network adequacy reviews, consumer surveys, and onsite audits and investigations conducted by a dedicated DHCS arm. They also emphasized growing efforts to focus on member experience and timely access to care, which may help address some of the concerns raised.

- A member commented on the decline in school-based mental health services following the end of COVID-era funding. They shared their experience working in school districts where temporary funding had supported hiring mental health professionals, many of whom are now being laid off. The member expressed concern about unmet student needs and called for stronger data to evaluate whether services, such as mental health, diabetes care, and weight management, are improving and being delivered in a timely manner. They also questioned how existing dashboards can be used to track such outcomes and suggested a collective learning approach to better understand and display meaningful results. DHCS responded that efforts like Medi-Cal Connect are being developed to improve data visibility through dashboards and interactive tools. These tools are intended to help bring data to life and support public reporting. DHCS emphasized that they are prioritizing children's health outcomes and working to align care delivery transformation with those goals. This includes setting accountability targets with managed care plans, promoting best practices, and improving data collection and reporting. Collaboration with providers and community-based organizations (CBO) is central to these efforts.
- A member asked about the use of Medi-Cal mental health screening tools developed to guide referrals to managed care or specialty mental health providers. They noted the absence of related data in current dashboards and asked if statewide information is being collected on the frequency or effectiveness of these tools. The member also referenced anecdotal feedback

from providers who felt the tools were ineffective. DHCS responded that although the screening tools were developed, DHCS does not currently have data on their usage or outcomes. The primary data source—claims—does not capture the use of screening tools unless a billing code is associated with the activity. At present, DHCS does not collect or report screening tool results. However, DHCS is aware of this gap and is working to address such limitations through Medi-Cal Connect, which aims to support more responsive and useful data infrastructure.

- A member asked how DHCS is working to capture and share true outcomes, beyond what is available through claims data. They acknowledged the launch of Medi-Cal Connect and emphasized the need for deeper analysis of screening, treatment, follow-up, and long-term outcomes. The member suggested that piloting new methods for measuring outcomes could help identify both progress and shortcomings across the state. DHCS responded by highlighting the CalAIM Dashboard, which compiles reporting across multiple initiatives and includes outcome measures where feasible. They noted that while the dashboard does not capture every potential data point, it is tied to specific areas of active work. DHCS invited members to share specific outcome measures they believe are missing so DHCS can evaluate their feasibility. The dashboard is updated regularly, with new data and measures added on a three- to four-month cycle. They reiterated that Medi-Cal Connect is already live internally and will expand externally. This platform is being designed to integrate a wide range of data sources, including claims, housing, justice-involved populations, Women, Infants, and Children (WIC), and CalFresh, to generate more actionable and near-real-time insights for system improvement.

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

Type of Action: Information

Presenter: Alex Briscoe, Principal, Public Works Alliance

Discussion Topics:

- Alex Briscoe from Public Works Alliance discussed the importance of creating healing-centered systems that address the impacts of racism and poverty on the social and emotional well-being of children and families. He emphasized the high incarceration rate of adolescents in the U.S., particularly Black and Brown youth, who are disproportionately affected by the criminal justice system.

Incarcerated youth also face greater physical and mental health challenges compared to their non-incarcerated peers. Briscoe identified an opportunity to address this issue, noting alignment between public opinion and policymakers. He introduced the Justice Serving Network (JSN), a three-year initiative focused on supporting and scaling CBOs working with youth impacted by the criminal justice system. The initiative aims to enhance the well-being and economic mobility of youth, especially in communities of color in California, by increasing CBO capacity to provide services like ECM and Community Health Worker (CHW) benefits. Additionally, it fosters connections among CBOs and works toward sustainable funding for local services. The JSN model prioritizes employing staff with lived experience to support youth facing systemic inequities, adverse childhood experiences (ACEs), and the criminal justice system. The discussion also covered five key Medicaid strategies and their potential impact on Medicaid and system-involved youth, including the Multi-Payer Fee, which covers outpatient mental health and SUD treatment for students aged 25 or younger at California school sites, detailing the scope of services and participant eligibility.

- The member asked about online safety, specifically regarding cyberbullying, the risks posed by strangers contacting children, and how these factors affect the mental health of younger children and teenagers. They suggested incorporating these concerns into the presentation, recognizing their growing impact on youth mental health. The member pointed out that cyberbullying and online harassment contribute significantly to anxiety, depression, and other mental health challenges among youth. Alex responded that while the presentation didn't address root causes, the rise of mobile platforms in 2009 marked a shift, allowing harmful cultural messages to directly reach young people. He emphasized that the issue isn't the platform but the culture it reflects. Alex explained that digital media now enables young people to access disturbing content alone, often late at night, creating a sense of isolation and despair. He further noted that the messages being transmitted are not new, but have been part of societal culture for centuries, such as gender inequality, racism, and wealth disparity. However, these messages are now delivered unfiltered and directly to youth. While acknowledging the negative impact of digital media on mental health, Alex stated that society must take responsibility for the harmful messages being transmitted.
- A member commented on the difficulties in managing partnerships between school systems and mental health service providers, particularly due to

workforce shortages. They emphasized that mental health professionals are often stretched across multiple schools, making it challenging to meet the needs of all students. The member highlighted specific schools in urgent need of mental health services, but only able to access a few agencies, exacerbating the issue. They also noted that as funding for mental health services has declined, districts struggle to hire enough social workers, school psychologists, and other mental health professionals. Additionally, integrating outside service providers into schools requires coordination and trust-building, which can be difficult. Alex responded that addressing the youth mental health crisis requires recognizing schools as essential partners in the mental health system, on par with hospitals. He stressed the importance of collaboration with CBOs, as schools alone cannot meet the mental health needs of all students. Alex provided recommendations for schools: collect student health information for billing purposes, partner with one of the available platforms that streamline billing and claims submission, and explore using designated providers, allowing CBOs to register and bill on behalf of schools.

- A member asked about the allocation of funds from California's Opioid Settlement Agreement and Proposition 14, as well as other federal and state resources for mental health, noting that these funds are often spread across various agencies. They expressed concern that there isn't a clear, coordinated plan to leverage these resources in a way that would benefit children and families effectively. Specifically, the member questioned where these funds are being directed within the Medicaid system, especially given the large sums available through the Opioid Settlement Agreement and Proposition 14. They also mentioned the need for a more integrated approach to funding, especially as it relates to mental health services, and emphasized that these resources should be utilized more strategically to address the mental health needs of youth and families. Alex responded that this issue highlights a broader challenge in ensuring resources are being utilized effectively, and that while there are multiple sources of funding, coordination is often lacking. He acknowledged the importance of addressing these gaps and ensuring that local systems can act on the opportunities created by the state's policy changes. Alex encouraged MCHAP leadership to track these changes and ensure that the promises made by these policy shifts are implemented in practice.
- A member expressed mixed views on the presentation, stating that while the state has a vision for youth mental health, it has yet to be fully realized. They

acknowledged that the vision is progressive, but emphasized that there are significant barriers to putting this vision into practice, particularly within the existing Medicaid structure and regulations. The member expressed concern that SUD issues continue to be sidelined due to numerous challenges, including the complexity of Medicaid regulations, which often make it difficult to integrate these issues into the broader mental health system. They pointed out that while the state has a progressive vision for addressing youth mental health, Medicaid regulations and the medical system's limitations hinder the ability to implement that vision effectively. The member also discussed the importance of simplifying medical billing and reducing regulatory barriers to improve access to care. They emphasized that once an issue like SUDis included in the Medicaid system, it becomes entangled in the complexities of the broader medical system, which can make it harder to address effectively. Alex responded that he appreciated the points raised, acknowledging the challenges in navigating the system. He agreed that there is a need for reform, but emphasized that everyone involved is doing their best to overcome these obstacles. The member followed up by agreeing that significant work remains to be done to address bureaucratic barriers and simplify the process of delivering care to youth with mental health and SUDs.

Public Comment

Type of Action: Public Comment

Discussion Topics:

- Doug Major, from the California Children's Vision Now Coalition, mentioned that he recently returned from Washington, D.C., where he advocated for children's vision care in California. Doug noted that California has one of the lowest rates of access to children's vision care in the nation, with some metrics showing worse outcomes than national graduation rates. He emphasized that without adequate vision care, children may struggle to succeed in school. Doug suggested that a vision care metric be added to the dashboard, as the issue is currently not represented. He highlighted his role as a member of a local managed care group for the past five or six years and pointed out that with access to data, local managed care groups could work to improve the situation. He noted that the absence of data prevents the identification of gaps in vision care and thus limits the ability to address the issue. Doug submitted a fact sheet to all attendees and mentioned that a group from UC Davis is available to

discuss the matter further. He concluded by urging the inclusion of vision care in efforts to improve children's health outcomes.

Upcoming MCHAP Meeting and Next Steps

Type of Action: Information

Presenter: Mike Weiss, M.D., Chair

Discussion Topics:

- The next meeting has been changed to July 10, 2025.
- MCHAP will continue to be a hybrid meeting until further notice.

Adjournment of Meeting

Name of person who adjourned the meeting: Michael Weiss, M.D.

Time Adjourned: 2 p.m.