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

September 11, 2025
10 a.m. - 2 p.m.

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Hybrid Meeting Tips

- Use either a computer or phone for audio connection.
- Mute your line when not speaking.
- 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

MCHAP Governance

Chairperson Responsibilities and Term Limits

» Responsibilities

1. Help lead all MCHAP meetings in an orderly manner, encourage participation from all members, and maintain a respectful, constructive environment.
2. Collaborate with DHCS staff to develop meeting agendas that reflect the panel's purpose and priorities.
3. Serve as the primary point of communication between the panel and DHCS staff.
4. Notify DHCS promptly when a panel seat becomes vacant.

» Term Limits

- Serves a 1-year term and may serve up to 3 consecutive years.
- After 3 consecutive years, the Chairperson must take a 1-year break before running again.

2026 Chairperson Election

- A new MCHAP Chairperson will be elected at the next MCHAP meeting on November 6, 2025, and will begin their term in first quarter 2026.
- A member must be on the panel for one year before being eligible to run for Chairperson.
- How to run for Chairperson:
  - Submit your written statement of interest to MCHAP@dhcs.ca.gov by Tuesday, September 30, 2025.
  - Statements will be posted on the MCHAP webpage before the November meeting.
  - At the meeting, each candidate will have 1-2 minutes to share their statement of interest and why they'd like to serve as MCHAP Chairperson.
  - Members will vote, and the candidate with the most votes will be the incoming Chairperson.

MCHAP Bylaws

- SB 220 and Bagley-Keene guide how MCHAP is structured, how meetings are held, and what our responsibilities are
- Why We're Creating Bylaws
  - Brings together the requirements from SB 220 and Bagley-Keene into one clear reference, instead of being spread across statute and guidance.
  - Fills in gaps where the statute doesn't provide details, such as the process for electing the Chairperson.
- These bylaws don't create new rules but simply organize what's already required and being practiced.

Major Impacts to Medi-Cal of Enacted H.R.1 Reconciliation Legislation

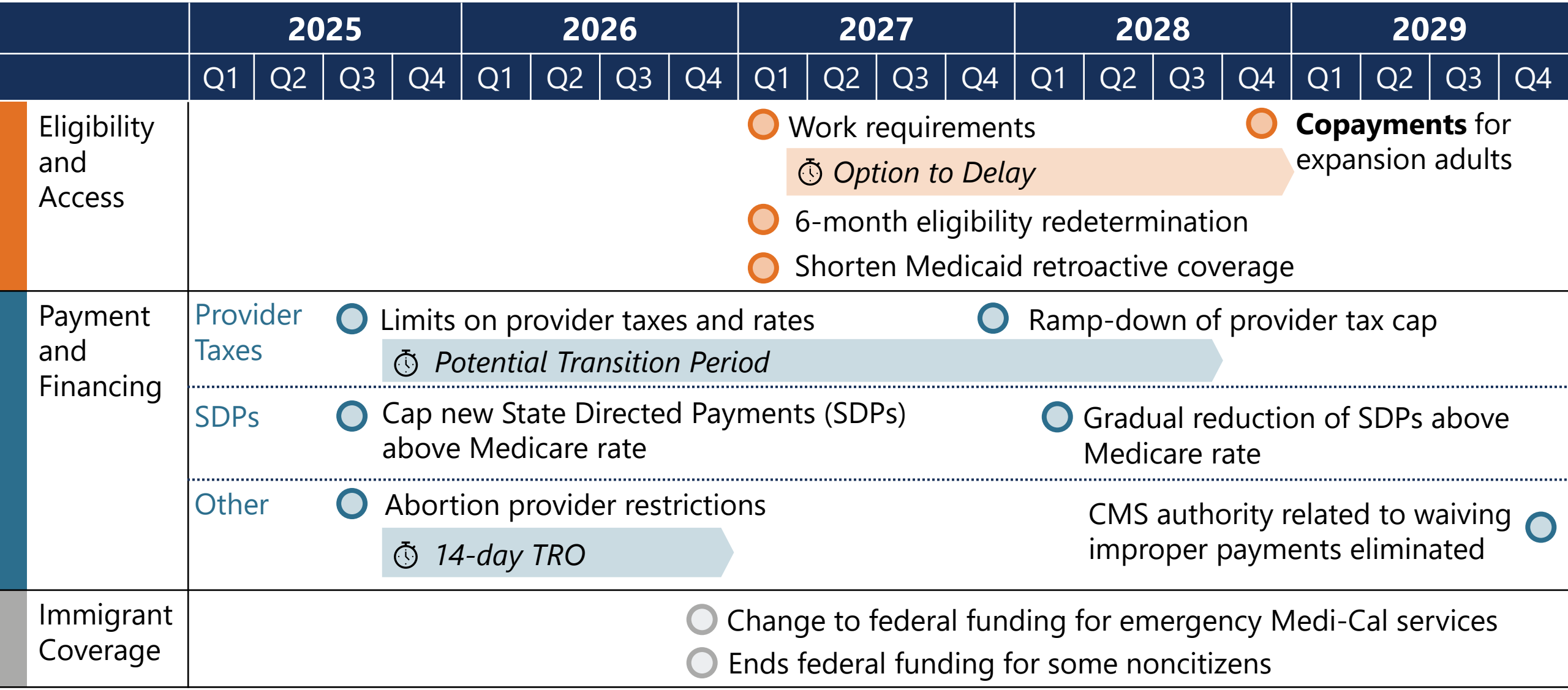
Major Medicaid Provisions of H.R.1

Bottom Line: Up to 3.4 million Medi-Cal members may lose coverage;
$30+ billion in federal funding is at risk annually;
major disruption in Medi-Cal financing structure for safety nets.

Eligibility/Access Requirements	State Financing Restrictions	Immigrant Coverage Limitations	Abortion Providers Ban
» Work requirements » 6-month eligibility checks » Retroactive coverage restrictions » Cost sharing	» Managed Care Organization (MCO) and Provider Tax limitations » State Directed Payment (SDP) restrictions » Federal funding repayment penalties for eligibility-related improper payments	» Reduction in FMAP* for emergency UIS** » Restrictions on lawful immigrant eligibility (increases UIS) ** Federal Medical Assistance Percentage* ***Unsatisfactory immigration status*	» One-year ban on federal Medicaid funding for "prohibited entities" that provide abortion services

All numbers are estimates and subject to change.

Effective Dates for Key Provisions



Q1: Jan–Mar **Q2:** Apr–Jun **Q3:** Jul–Sept **Q4:** Oct–Dec

Effective Dates for Key Provision Eligibility and Access

2025				2026				2027				2028				2029			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- **JANUARY 1, 2027:** Implement **mandatory work requirements** for Medicaid expansion adults ages 19 to 64.

  ⏱ *State option to delay implementation until **December 31, 2028,** with Secretary approval.*

- **JANUARY 1, 2027:** **Redetermine eligibility** for expansion adults once every 6 months.
- **JANUARY 1, 2027:** Shorten Medicaid **retroactive coverage**; provide Children's Health Insurance Program (CHIP) retroactive coverage at state option.
- **OCTOBER 1, 2028:** Impose **copayments** on most services for expansion adults with incomes above 100% of the federal poverty level (FPL).

Q1: Jan–Mar **Q2:** Apr–Jun **Q3:** Jul–Sept **Q4:** Oct–Dec

Effective Dates for Key Provision Payment and Financing (*Provider Taxes*)

2025				2026				2027				2028				2029			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- **JULY 4, 2025:**
  1. Prohibits the implementation of any new Medicaid provider taxes and increasing existing tax rates.
  2. Prohibits any tax that imposes a lower tax rate on providers explicitly defined based on their lower Medicaid volumes compared to providers with higher Medicaid volumes, or taxes Medicaid units of service at a higher rate than non-Medicaid units of service (as well as taxes that have the same effect) – impacts MCO Tax and Hospital Quality Assurance Fee (HQAF).

- **OCTOBER 1, 2027:** Ramp-down of **provider tax** cap begins, with the 6% tax threshold reduced by half a percentage point per year until the threshold hits 3.5% in 2032.

⏱ *CMS may allow for a transition period of up to **3 years***

Q1: Jan–Mar **Q2:** Apr–Jun **Q3:** Jul–Sept **Q4:** Oct–Dec

Effective Dates for Key Provision Payment and Financing (*SDPs and Other)*

2025				2026				2027				2028				2029			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- **JULY 4, 2025:** Caps any future **SDPs** at 100% of Medicare payment levels.
- **January 1, 2028:** Requires states with existing **SDPs** above Medicare rates to reduce payments by 10 percentage points per year until they are no greater than 100% of Medicare.

- **JULY 4, 2025– July 4, 2026:** Bars Medicaid participation by certain **providers of abortion services.**

  ⏱ *14-day TRO*

- **OCTOBER 1, 2029: Eliminates CMS authority to waive states' disallowance of federal funds** associated with "excess" improper payments.

Q1: Jan–Mar **Q2:** Apr–Jun **Q3:** Jul–Sept **Q4:** Oct–Dec

Effective Dates for Key Provision Immigrant Coverage

2025				2026				2027				2028				2029			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- **OCTOBER 1, 2026:**
  Provides regular **FMAP for emergency Medi-Cal.**

- **OCTOBER 1, 2026:**
  Ends the availability of federal Medicaid and CHIP funding for **refugees, asylees, and certain other noncitizens.**

Q1: Jan–Mar **Q2:** Apr–Jun **Q3:** Jul–Sept **Q4:** Oct–Dec

Eligibility/Access Requirements

Eligibility: Work Requirements

Section 71119: Requires states to condition Medicaid eligibility on compliance with work requirements (called "community engagement requirements") for adults ages 19 through 64. The provision applies to individuals enrolled through Medicaid expansion or a section 1115 demonstration providing minimum essential coverage.

Exemptions must be verified every 6 months

Effective *Parents, guardians, caretaker relatives, or family caregivers of a dependent child age 13 and under or a disabled individual; medically frail individuals; pregnant/receiving Medicaid postpartum coverage; foster/former foster youth under age 26; American Indian and Alaska Native individuals; veterans with a disability rated as total; incarcerated or recently released within 90 days, Medicare Part A/Part B; meet Temporary Assistance for Needy Family or Supplemental Nutrition Assistance Program work requirements; drug addition/alcohol treatment program*

Date: January 1, 2027

Impact:

An estimated **up to 3 million Medi-Cal members may lose coverage**, which will significantly drive up the uninsured rate and raise costs for hospitals and clinics treating uninsured patients.

All numbers are estimates and subject to change.

Eligibility: 6-Month Eligibility Checks

Section 71107: Requires states to redetermine eligibility for adults enrolled through Medicaid expansion or an expansion-like section 1115 waiver once every six months.

Effective Date: January 1, 2027

Impact:

An estimated **400,000 Medi-Cal members may lose coverage**, which will drive up the uninsured rate and raise costs for hospitals and clinics treating uninsured patients.

All numbers are estimates and subject to change.

Eligibility: Retroactive Coverage

Section 71112: Shortens Medicaid retroactive coverage from three months to one month for expansion adults and two months for all other Medicaid applicants. This provision also allows states to provide two months of CHIP retroactive coverage. (Currently, CHIP does not have retroactive coverage, and services may only be paid in the month of the application.)

Effective Date: January 1, 2027

Impact:

An estimated **86,000 Medi-Cal members/ year would be affected** by this policy and receive 1 month of retroactive coverage, rather than 3 months.

All numbers are estimates and subject to change.

Eligibility: Cost Sharing

Section 71120: Requires states to impose cost sharing for services provided to Medicaid expansion adults with incomes above 100% of the FPL ($15,560 per year). States would decide the amount, not exceed $35 per service and subject to an aggregate limit of 5% of family income.* Cost sharing must not apply to exemptions under current law or to primary care services, behavioral health services, federally qualified health center services, rural health clinic services, and certified community behavioral health clinic services.

Effective Date: October 1, 2028

*Note: For drugs, cost sharing must be $4 (preferred) and $8 (non-preferred); for non-emergent services received in the hospital emergency department, cost sharing must be no more than $8. (This is as of 2015 and adjusted for inflation over time.)

Impact:

- The cost sharing requirement will limit access (e.g., due to members delaying or forgoing care, confusion about new requirements) among the Medicaid expansion population.
- Providers will likely see an increase in uncompensated care.

All numbers are estimates and subject to change.

State Financing Restrictions

Provider Tax Limitations

Section 71115 and 71117:

- Prohibits any new Medicaid provider tax or increases to existing tax rates (for both local- and state-imposed taxes).
- Prohibits any tax that either (1) imposes a lower tax rate on providers explicitly defined based on their lower Medicaid volumes compared to those providers with higher Medicaid volumes, or (2) taxes Medicaid units of service (e.g., discharges, bed days, revenue, or member months) at a higher rate than non-Medicaid units of service. Also prohibits taxes that have the "same effect" as in (1) or (2) above.
- Modifies the provider tax cap whereby the 6% tax threshold must be reduced by half a percentage point per year until the threshold hits 3.5%.

Effective Date: Moratorium effective immediately; phase-down beginning October 1, 2027.

Impact:

- CA's current MCO tax structure is non-compliant under these new parameters and will need to be modified to align with the new federal standards (though it may be challenging to do so without decreasing the revenue from the tax).
- The new constraints jeopardize other major provider taxes, including the Hospital Quality Assurance Fee, threatening revenue streams.
- Going forward, these limitations may undermine CA longstanding strategy to finance the non-federal share of Medi-Cal.

All numbers are estimates and subject to change.

State Directed Payment Restrictions

Section 71116: Caps any future SDPs at 100% of Medicare payment levels. Requires payments with existing SDPs above Medicare rates to be reduced by 10 percentage points per year until the SDPs are no greater than 100% of Medicare payment levels.

Effective Date: Immediately for new SDPs; reduction in existing SDPs starting January 1, 2028

Impact:

- Limits CA's ability to use SDPs to increase provider payment rates above Medicare levels, which may reduce provider participation and access in Medicaid.
- Constrains CA's ability to raise the non-federal share of Medicaid funding, potentially pressuring other areas of the budget.
- Limits future SDP increases, including for public hospitals and private hospitals, all of which have inpatient and/or outpatient rates exceeding Medicare.

All numbers are estimates and subject to change.

Mitigation: Rural Health Transformation Fund

Section 71401: Establishes $50 billion funding program to mitigate federal funding cuts on rural health providers.

Funding Disbursement: CMS will allocate $10 billion each FY for FY 2026-2030.

Funding Distribution:

- 50% distributed equally across states with approved applications
- 50% distributed to states per CMS discretion, pursuant to specific rural impact factors (e.g. state's % of rural residents; share of rural health facilities in the state compared to nationwide), with at least 25% of states with an approved application included.

Allowable Uses: CMS and states have flexibility to decide (1) allowable uses, and (2) eligible recipients (recipients and benefitting providers are not limited to rural health care facilities used in the funding distribution criteria). States must implement at least three activities specified (e.g., prevention and disease management; training and technical assistance; recruitment; etc.).

Limitations: Cannot be used as non-federal share of Medicaid payments. Admin cap 10%.

Next Steps:

- State to submit application (including a detailed rural health transformation plan) by TBD deadline, no later than December 31, 2025.
- CMS required to approve by December 31, 2025.

All numbers are estimates and subject to change.

Federal Funding Repayment Penalties

Section 71106: Except in limited cases involving the Medicaid "spend down" group and when there is insufficient documentation to confirm eligibility, the law eliminates CMS' ability to waive federal penalties associated with improper payments related to eligibility even when states are making a good faith effort to address them. CMS is also required to issue disallowances upon identifying improper payments under federal audits beyond Payment Error Rate Measurement (PERM), as well as, at the option of the Secretary, state audits.

Effective Date: October 1, 2029

Impact:

CMS may claw back federal funds from CA, even if the state is implementing a corrective action plan to reduce errors, increasing financial risk.

All numbers are estimates and subject to change.

Immigrant Coverage Limitations

Reduction in FMAP for Emergency Medi-Cal

Section 71110: Prohibits states from receiving the 90% enhanced matching rate for emergency services provided to individuals who, but for their immigration status, would have qualified for the ACA optional adult expansion group. Also applies to emergency care provided to refugees, asylees, and other lawfully residing individuals.

Effective Date: October 1, 2026

Impact:

- CA will lose the 90% federal match for emergency Medicaid services, requiring increased General Fund spending and/or a rollback of services covered under the emergency Medicaid benefit.
- May increase financial pressure on safety-net providers, particularly hospitals that deliver high volumes of emergency care to noncitizens.

All numbers are estimates and subject to change.

Restrictions on Lawful Immigrant Eligibility for Medi-Cal

Section 71109: Ends the availability of full-scope federal Medicaid and CHIP funding for most refugees, asylees, victims of human trafficking, certain individuals whose deportation is being withheld or who were granted conditional entry, or individuals who received humanitarian parole, such as certain Afghans who aided U.S. operations in Afghanistan or people fleeing violence in the Ukrainian war.

Effective Date: October 1, 2026

Impact:

Approximately **200,000 immigrant Medi-Cal members** will shift from satisfactory immigration status (SIS), which is eligible for full Federal Financial Participation (FFP), to unsatisfactory immigration status (UIS), which is only eligible for emergency and pregnancy-related FFP – at the newly reduced rates noted in prior slide.

All numbers are estimates and subject to change.

Abortion Providers Ban

One-year Ban on Federal Funding for "Prohibited Entities" that Provide Abortion Services

Section 71113: Bars Medicaid participation by certain providers of abortion services, including Planned Parenthood, for the one-year period following enactment (through July 2026).

Effective Date: Effective immediately.

***Note: At the end of July, two preliminary injunctions were issued that blocks the Trump Administration from implementing this provision nationwide for certain providers.*

Impact:

- In CA, roughly 80% of Planned Parenthood patients rely on Medi-Cal, meaning this proposal would effectively strip $305 million in federal funding from one of the state's largest providers of reproductive health care.
- Loss of federal Medicaid funding may force Planned Parenthood to reduce services, limit appointments, or close centers—particularly in underserved areas.

All numbers are estimates and subject to change.

California Population Health Management Service: Medi-Cal Connect

Laura Miller, M.D., Medical Consultant, Quality and Population Health Management

DHCS

Agenda

- **Objectives**
  - Discuss Medi-Cal Connect Vision and Goals
  - Provide an update on recent milestones
  - Explore key Medi-Cal Connect features, especially those related to children's health
- **Topics**
  - Medi-Cal Connect Vision and Goals
  - Release Schedule and Priorities
  - Medi-Cal Connect Features for Current Users
  - Longitudinal Member Record (LMR) Preview
  - Dashboard Preview
  - Questions

Population Health Management (PHM)

PHM is a core initiative of DHCS' California Advancing and Innovating Medi-Cal (CalAIM) transformation.

Medi-Cal Connect will enable DHCS and our partners to accelerate progress in improving health outcomes for the people we serve.

CalAIM Initiatives:

- Behavioral Health Initiative
- Community Supports
- Dental Initiative
- Enhanced Care Management (ECM)
- Incentive Payment Program
- Integrated Care for Dual Eligible Members
- Justice Involved Initiative
- **Population Health Management (PHM)**
- Providing Access and Transforming Health
- Statewide Managed Long-term Care
- Supporting Health and Opportunity for Children and Families

Medi-Cal Connect Vision

- **Improve the health of Medi-Cal members and reduce disparities** by providing a data-driven solution that supports whole-person care and population health functions.
- **Integrate information** from diverse sources, enabling multi-party data access and sharing to inform policy and enhance the member care experience.

Medi-Cal Connect Has Four Primary Goals Supported by Ten Core Objectives

Member Experience

1. Empower cross-sector collaboration
2. Anticipate member needs
3. Provide proactive, personalized care

Whole-Person Care

4. View member risks and unmet needs
5. Utilize statewide Risk Stratification, Segmentation, and Tiering (RSST)* algorithm
6. Reduce gaps in services

Population Level Insights

7. Facilitate data aggregation and integration
8. Act on population-level health trends

Informed Policymaking

9. Strengthen Medi-Cal oversight and monitoring
10. Leverage analytics and insights

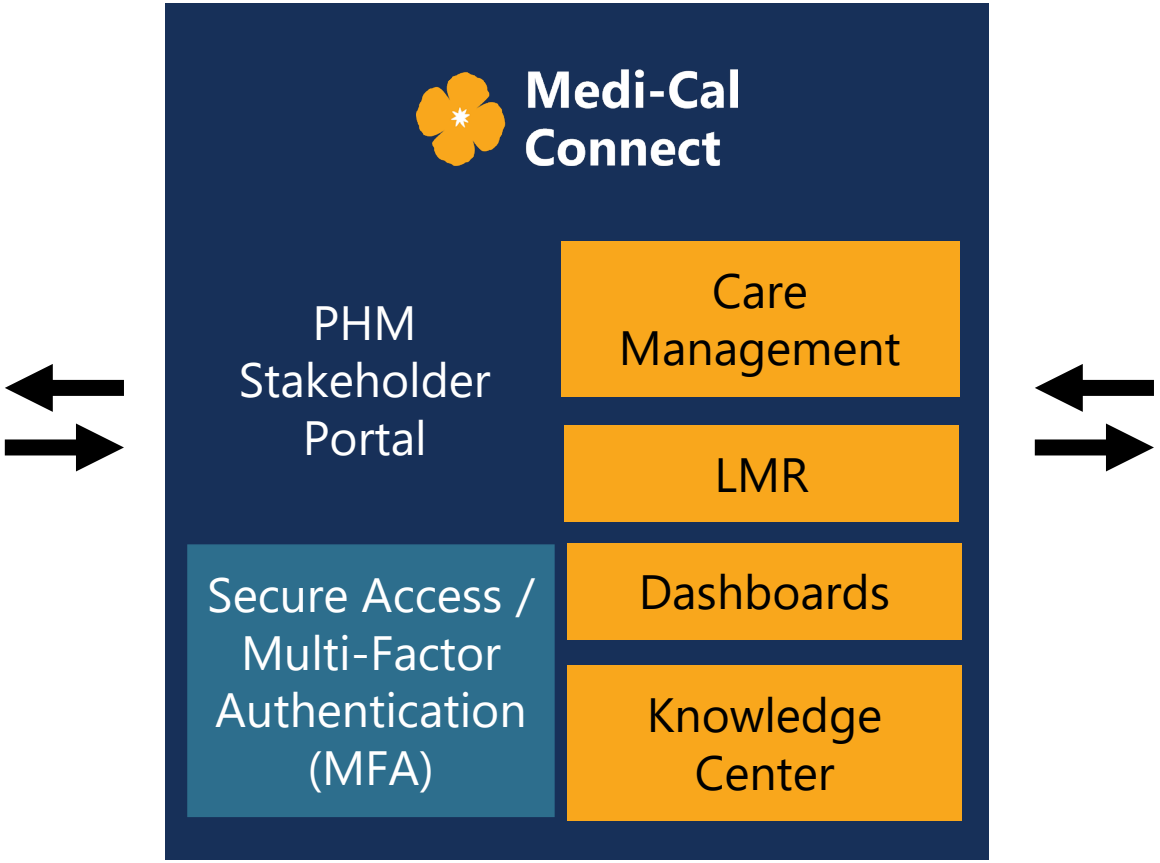
*Risk Stratification Segmentation and Tiering

Data-Driven Solution from Trusted Sources

Medi-Cal Connect will aggregate health and social information from many sources to support members and communities.

Example Sources

- Housing Agencies
- Department of Social Services
- Medi-Cal Health Plans
- Department of Public Health



Outputs

1. Data to support member care.

2. Data to improve policy and programs for communities.

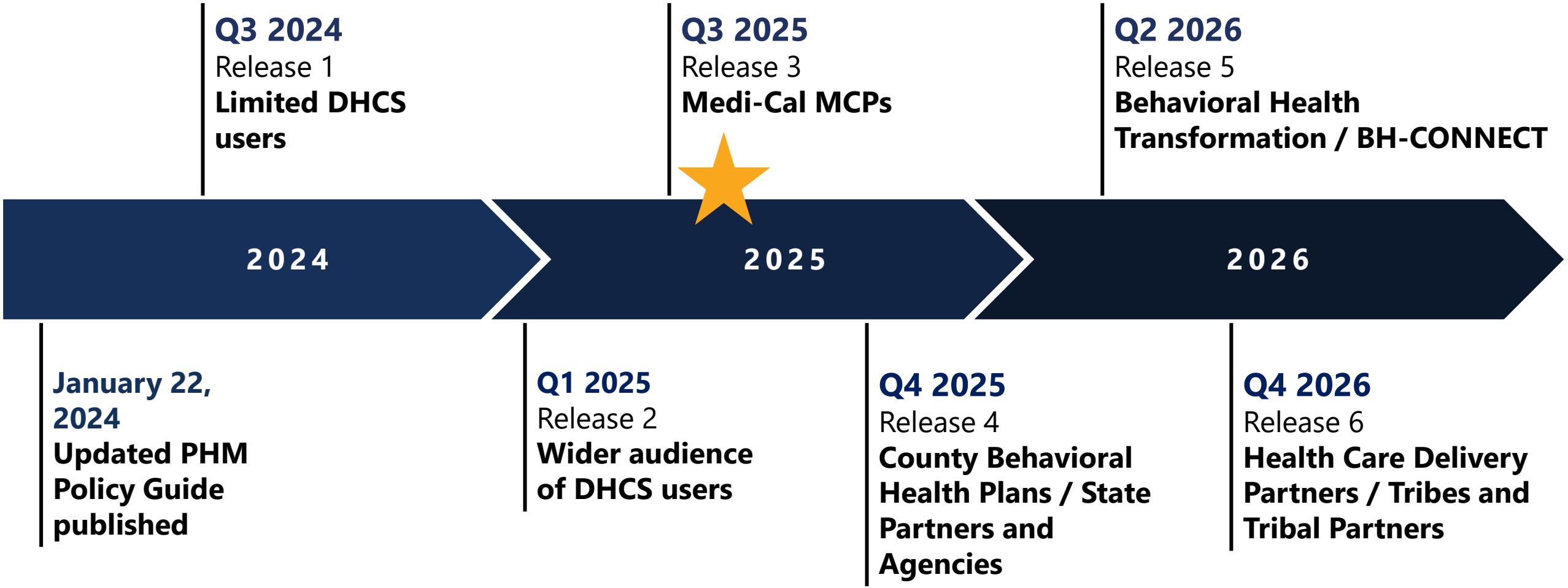
Medi-Cal Connect Stakeholder Release Timeline

The PHM Service "**Medi-Cal Connect**" will be rolled out in six releases to allow feedback, refinement, and implementation of capabilities.

Release 1 7/24/2024*	Release 2 3/3/2025*	Release 3 7/18/2025	Release 4 Q4 2025	Release 5 Q2 2026**	Release 6 Q4 2026
DHCS (limited user group)	DHCS (full user group)	Medi-Cal managed care plans (MCPs)	» County Behavioral Health Plans » State Partners and Agencies	Develop and deliver Behavioral Health Measures	» Local County Partners » PHM Program Services and Supports » Health Care Delivery Partners » Tribal Partners

*Go-Live Complete
** Contract amendment under CMS review

Medi-Cal Connect Timeline



Medi-Cal Connect

User Success Story

Medi-Cal Connect Success Story

Post-Release 1: Leveraging Dashboards and Taking Action

The Challenge

Dr. Leland Soiefer, who works in the Quality and Health Equity Division at DHCS, wants to review quality measures by county.

He uses **Medi-Cal Connect** to view dashboards and explore current member screenings and immunization rates in California.

The Findings

Dr. Soiefer notices Imperial County is performing much better than neighboring counties in lead screening and childhood immunizations.

He contacts Imperial County to identify county-led efforts that might be improving outcomes.

The Impact

Dr. Soiefer again uses Medi-Cal Connect to identify counties with lower childhood vaccination rates among Black/African American members.

He follows up with MCPs in a regional collaborative meeting to discuss how to close this gap.

Key Features and Future Capabilities

LMR and Care Management Capabilities

Key care management features are available to MCPs. These features benefit **parents and children by helping care team members be aware of the broader care ecosystem.** Enhanced feat ures may be included in future releases as prioritized by DHCS (e.g., additional programs and services flags).

Member Summary	» Overview of member's health history
Member Information	» Contact and demographic information » Health plan enrollment
Risk Profile	» Risk tiers by subdomain
Quality Measures	» Centers for Medicare and Medicaid Services (CMS) Core Set » Medi-Cal Managed Care Accountability Sets (MCAS) Measures
Programs and Services	» Eligibility and Enrollment
Care Team Information	» Primary Care Physician (PCP) information » ECM or Complex Care Management (CCM) care manager information
Diagnoses	» Record of conditions, including chronic conditions » Provider visits associated with a condition
Claims	» Inpatient, outpatient, pharmacy, dental, and behavioral health

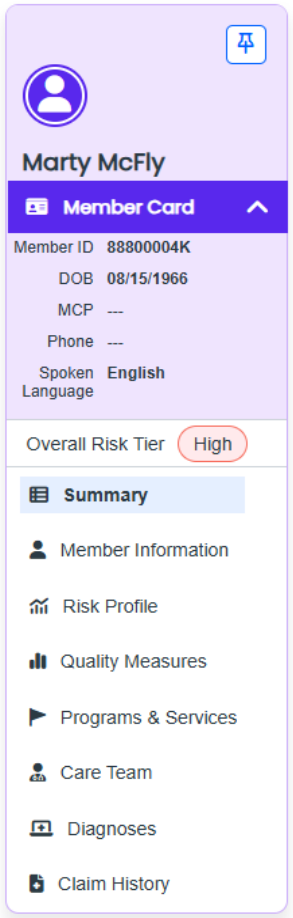
Medi-Cal Connect Key Features

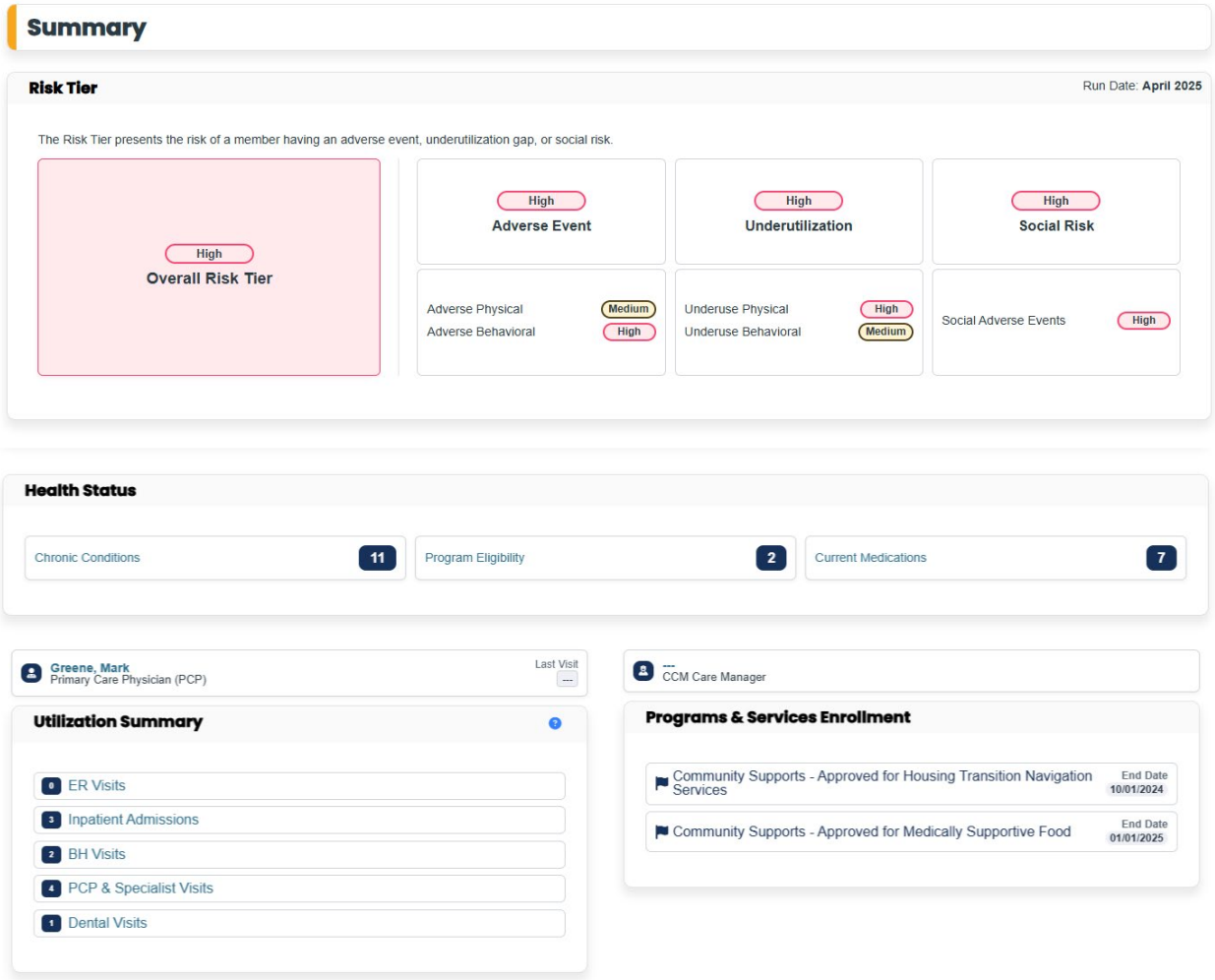
MCP users will gain access to additional capabilities in mid-September

LMR

Purpose:
Access to member-level data

Example Users:
MCP Care Managers





Medi-Cal Connect Key Features

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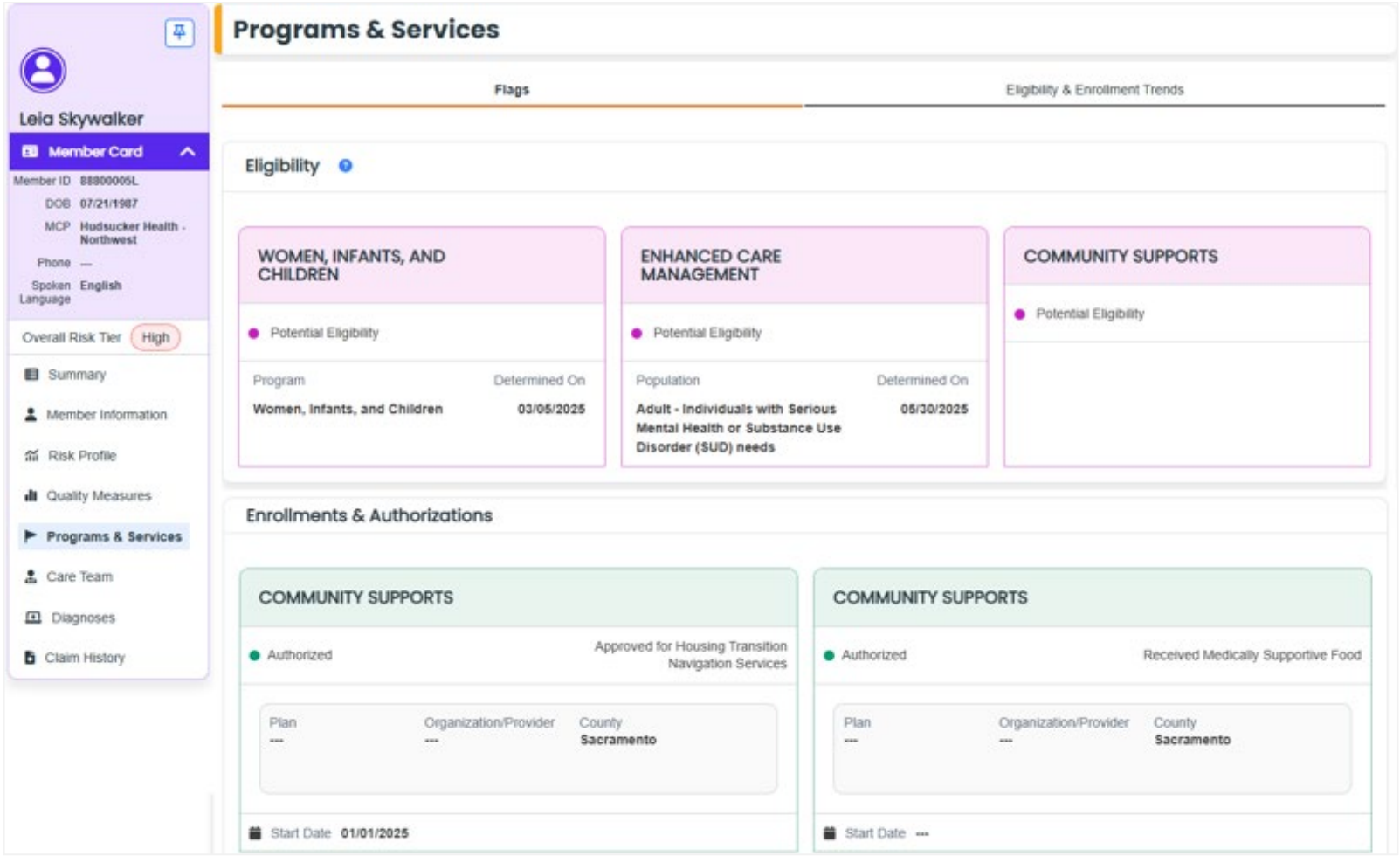
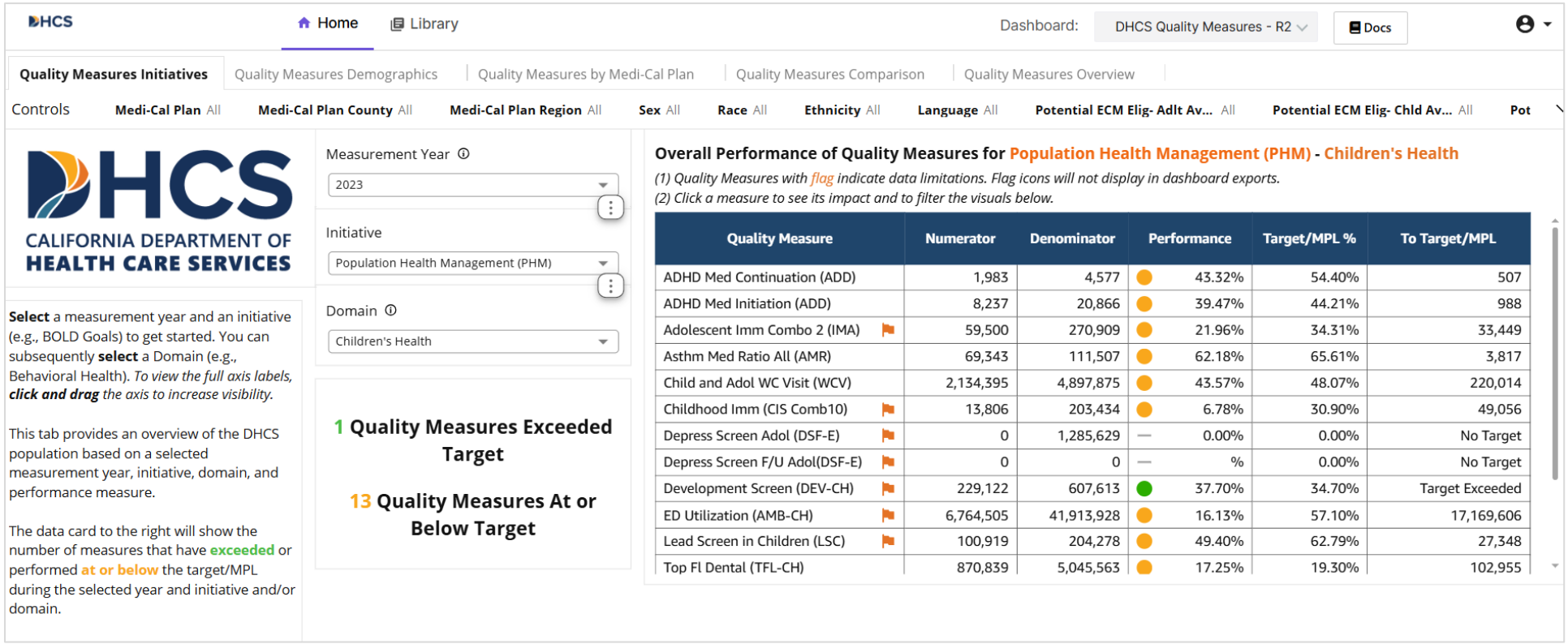


Quality Measure Dashboard

MCP users will gain access to additional capabilities in mid-September

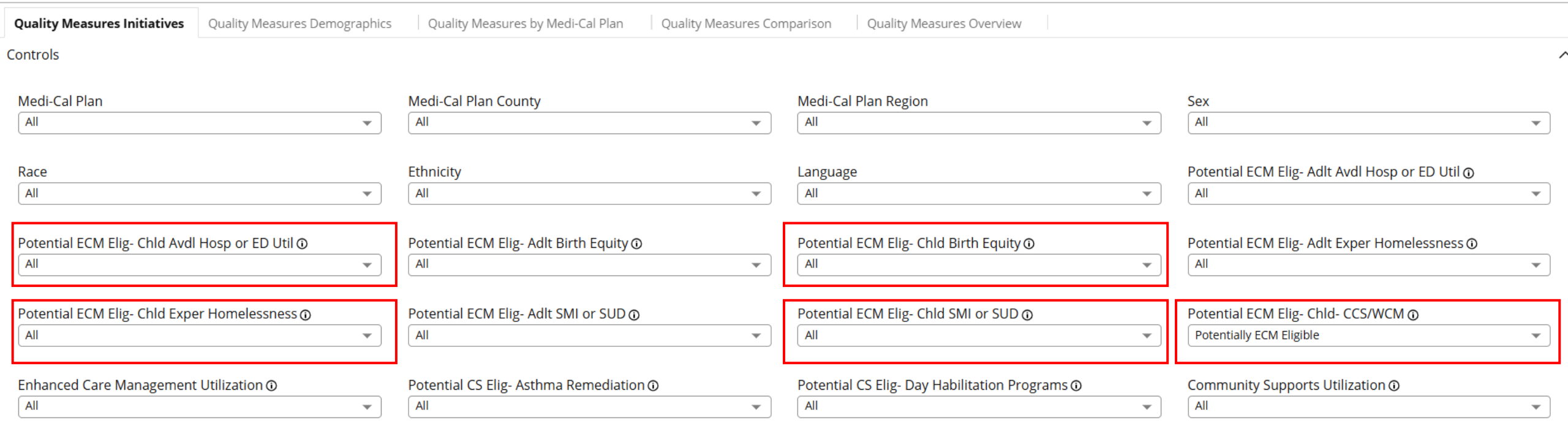
Purpose:
Analyzes quality performance for a given calendar year and initiative

Example Users:
MCP Quality Analysts



Children's Health-Related Eligibility Filters

- Available on the Quality Measures, Condition Prevalence, and Health Equity Dashboards



Quality Measures by Demographic

Children's Preventative Health – Quality Measures Dashboard

Quality Measures Initiatives | **Quality Measures Demographics** | Quality Measures by Medi-Cal Plan | Quality Measures Comparison | Quality Measures Overview

Controls | **Medi-Cal Plan** All | **Medi-Cal Plan County** All | **Medi-Cal Plan Region** All | **Sex** All | **Race** All | **Ethnicity** All | **Language** All | **Potential ECM Elig- Adlt Av...** All | **Potential ECM Elig- Chld Av...** All | **Pot**

DHCS
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Measurement Year: 2023

Initiative: Population Health Management (PHM)

Domain: Children's Health

1 Quality Measures Exceeded Target

13 Quality Measures At or Below Target

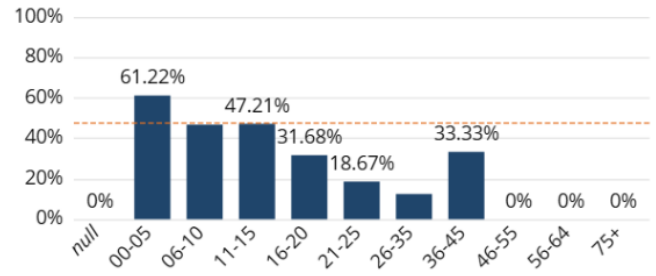
Overall Performance of Quality Measures for Population Health Management (PHM) - Children's Health

Click on a measure in the table below to filter the visuals.

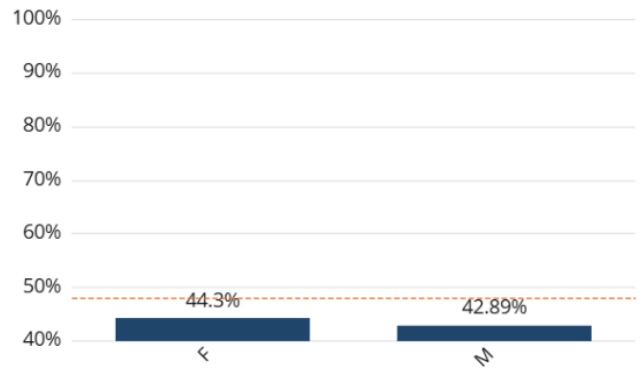
Quality Measure	Numerator	Denominator	Performance	Target/MPL %	To Target/MPL
ADHD Med Continuation (ADD)	1,983	4,577	43.32%	54.40%	507
ADHD Med Initiation (ADD)	8,237	20,866	39.47%	44.21%	988
Adolescent Imm Combo 2 (IMA)	59,500	270,909	21.96%	34.31%	33,449
Asthm Med Ratio All (AMR)	69,343	111,507	62.18%	65.61%	3,817
Child and Adol WC Visit (WCV)	2,134,395	4,897,875	43.57%	48.07%	220,014
Childhood Imm (CIS Comb10)	13,806	203,434	6.78%	30.90%	49,056
Depress Screen Adol (DSF-E)	0	1,285,629	0.00%	0.00%	No Target
Depress Screen F/U Adol(DSF-E)	0	0	%	0.00%	No Target

Performance for Child and Adol WC Visit (WCV) by Age Category

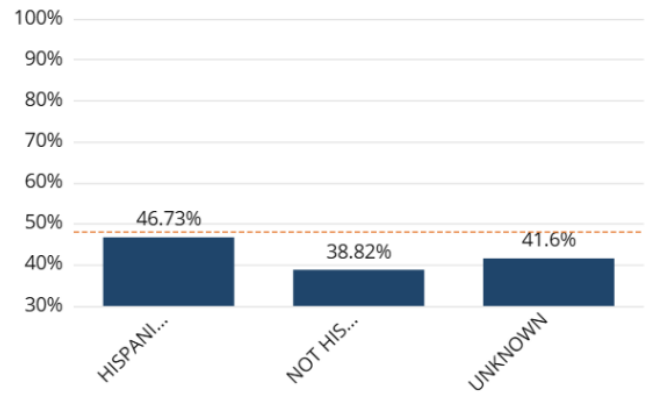
The age categories are standard increments and do not align to a specific measure stratification.



Performance for Child and Adol WC Visit (WCV) by Sex



Performance for Child and Adol WC Visit (WCV) by Ethnicity



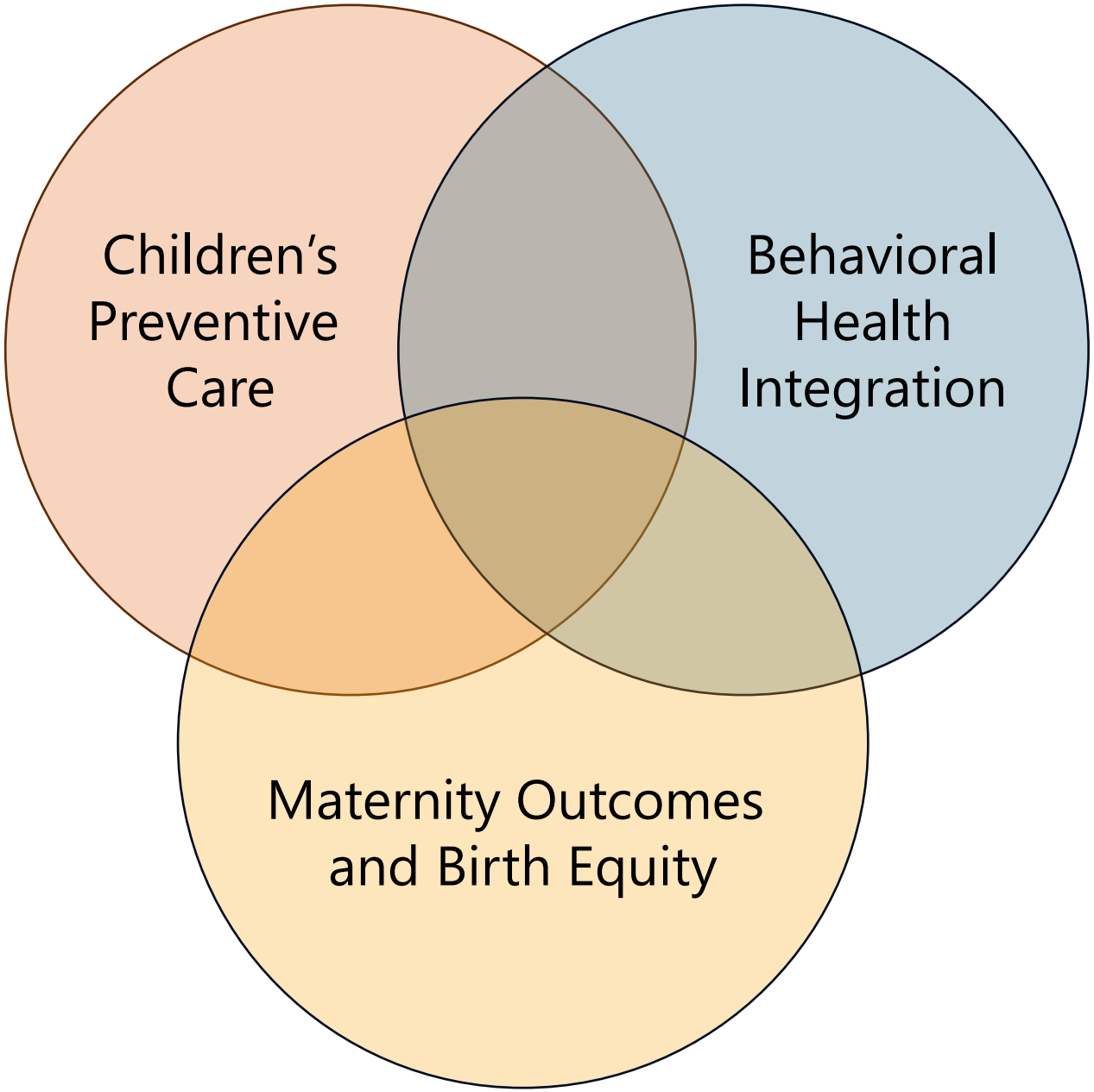
Questions?

Improving Preventive Care Outcomes in Early Childhood

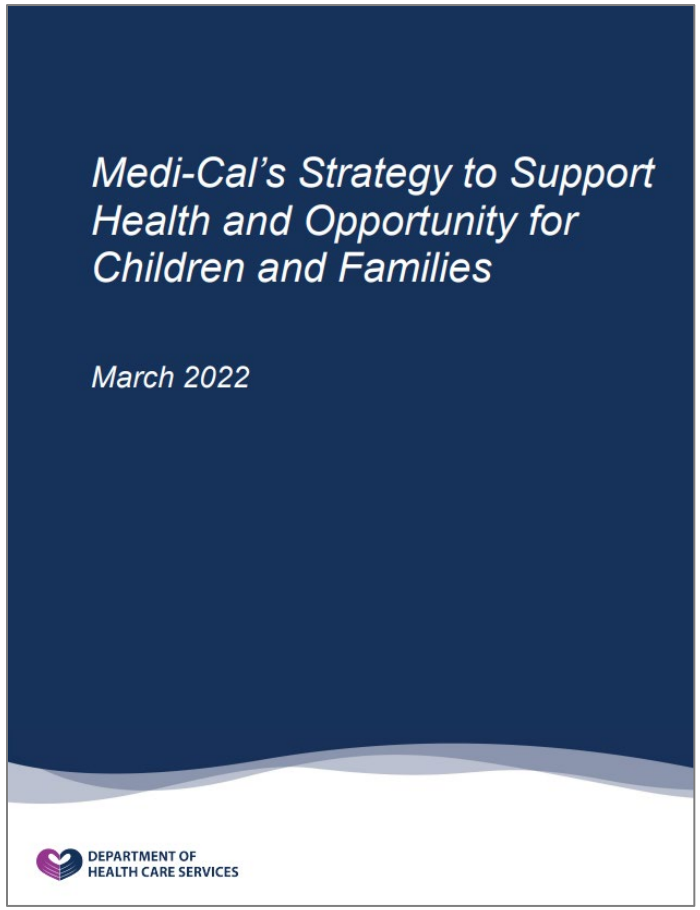
Pamela Riley, MD, MPH, Assistant Deputy Director and Chief Health Equity Officer, Quality and Population Health Management

DHCS

Children's preventive care is a priority clinical focus area in DHCS' Comprehensive Quality Strategy



Medi-Cal's Strategy to Support Health and Opportunity for Children and Families



- **Forward-looking policy agenda** for children and families enrolled in Medi-Cal that unifies the common threads of **existing and newly proposed child and family health initiatives.**
- **Eight action areas** with detailed key initiatives that are designed to:
  - Solidify **coverage** for children.
  - Promote **whole-child and family-based care**.
  - Strengthen **leadership and accountability**.
  - Implement evidence-based initiatives.

Access Medi-Cal's Strategy to Support Health and Opportunity for Children and Families

Medi-Cal Strategy to Improve Health and Opportunity for Children and Families

1. Implement a new **leadership structure** and **engagement** approach.
2. Strengthen the **coverage** base for California's children.
3. Fortify the pediatric **preventive and primary care** foundation.
4. Strengthen access to pediatric **vaccinations**.
5. Enhance **accountability** for high-quality and equitable care.
6. Apply a **family-centered** approach.
7. Address the child and adolescent **behavioral health** crisis.
8. Next steps on the **foster care** model of care.

Enhanced Accountability for Children's Preventive Care Outcomes

Domains	Managed Care Accountability Set Measures
Children's Health	» Child and Adolescent **Well-Care Visits** » Childhood **Immunization** Status » **Developmental Screening** in the First Three Years of Life » Immunizations for Adolescents » **Lead Screening** in Children » **Topical Fluoride** for Children » Well-Child Visits in the First **15 Months (Six or More)** » Well-Child Visits for Age **15 Months to 30 Months (Two or More Visits)**
Reproductive Health	» Breast Cancer Screening » Cervical Cancer Screening » Chlamydia Screening in Women » Prenatal and Postpartum Care: **Postpartum Care** » Prenatal and Postpartum Care: Timeliness of **Prenatal Care**

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022-23 Rate Difference
Children's Health Domain				
Child and Adolescent Well-Care Visits (WCV) – Total	47.51%	**47.02%** ↓	49.50%	2. 48▲
Childhood Immunization Status – Combination 10	**36.63%** ↓	**34.69%** ↓	**30.64** ↓	- 4.05 ▽
*Developmental Screening in the First Three Years of Life – Total**	——	32.33%	40.34%	8.01 ▲
Immunizations for Adolescents – Combination 2	39.23%	39.97%	41.36%	1.39 ▲
Lead Screening in Children	——	54.57%	**58.46%** ↓	3.89 ▲

Measure	Measurement Year 2021 Rate	Measurement Year 2022 Rate	Measurement Year 2023 Rate	Measurement Years 2022-23 Rate Difference
Children's Health Domain				
*Topical Fluoride for Children – Dental or Oral Health Services – Total**	——	9.75%	**18.17%** ↓	8.42▲
WCV in the First 30 Months of Life – WCV in the First 15 Months – Six or More WCV	**40.23%** ↓	**49.56%** ↓	**53.56%** ↓	4.00 ▲
WCV in the First 30 Months of Life – WCV for Age 15 Months to 30 Months – Two or More WCV	**60.28 %** ↓	**64.33%** ↓	**66.65%** ↓	2.32 ▲

California Faces Performance Challenges in Early Childhood Preventive Care

Well-Child Visits in the First 30 Months of Life, By State (2023)

- California's Rate: About 46% of children received 6 or more well-child visits in the first 15 months of life
- National Comparison: This is below the national median of 59%, indicating room for improvement.
- Opportunity: Improving access, transforming primary care, improving data collection and reporting, and collaborating with key partners can help ensure that more California children receive timely well-child visits.

Source: Mathematica analysis of Quality Measure Reporting (QMR) system reports for the 2023 Core Set as of May 16, 2024.

Best Practices for Improving Children's Preventive Care Outcomes

Improving Access	Primary Care Transformation	Improved Data Collection and Reporting	Collaboration with Key Partners
» **Expanding weekend/evening access** to improve availability. » **Incentives and targeted outreach** for members not utilizing care	» Practice transformation using **dedicated staff, data analytics, and incentive structures** to improve performance. » Addressing **care gaps through education and outreach**, with a focus on **community engagement**.	» Addressing **gaps in data completeness and reporting delays** in DHCS data sources. » Expanding **electronic data-sharing agreements** for improved tracking.	» Strengthening health plan partnerships with **Women, Infants, and Children (WIC), First 5, schools, and health navigators**.

Opportunity Areas to Improve Children's Preventive Care Outcomes

Data & Reporting

- Improve **real-time provider access** to well-child visit tracking portals.
- Address **data inconsistencies** and reporting gaps.
- Strengthen health plan **collaboration with DHCS** on timely and complete data.

Provider & Member Engagement

- Increase **community-based outreach** to engage hard-to-reach populations.
- Address **outdated contact information** through state partnerships.

Policy & Collaboration

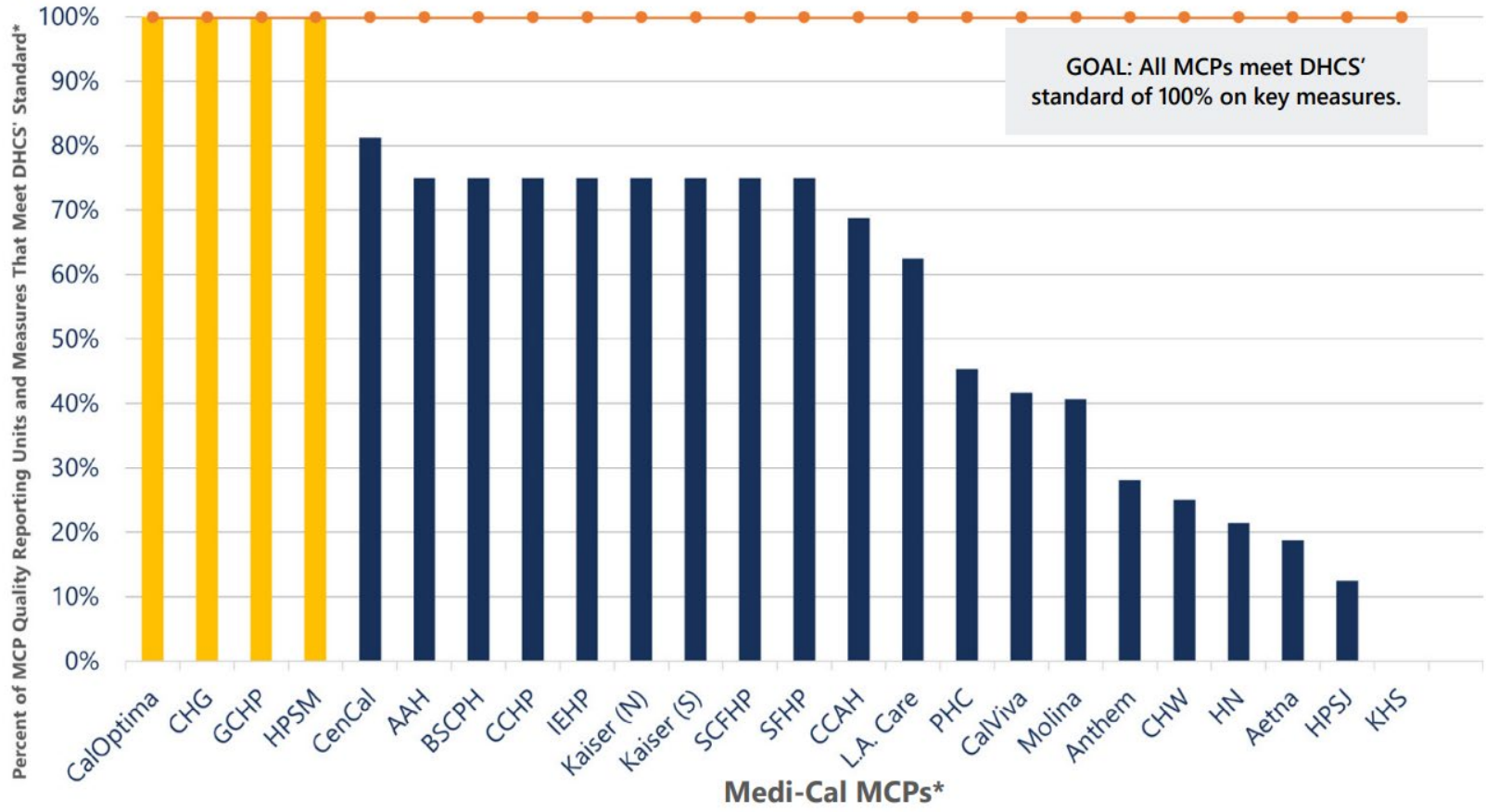
- Identify **scalable interventions** for challenging issues (e.g., lead screening; vaccine hesitancy).
- Support capacity building to implement best practice interventions.
- Support partnerships and **regional and local collaboration** to improve outcomes.

Children's Health: How do MCPs Compare in Quality?

To assess overall quality, DHCS evaluates if MCP Quality Reporting Units for each plan meets or exceeds the established standard for each key measure. Figure 2 shows the percentage of Quality Reporting Units within each plan that successfully meet these standards across all key measures for Children's Health.

*DHCS' standard is based on national averages or median benchmarks for Medicaid plans. See Appendix for a list of Quality Reporting Units.

Figure 2: Children's Health Quality



Source: [MY23 MCAS Fact Sheet]

Successful MCP Interventions – Improving Access

- **Kearn Health Systems – Systemic Interventions**
  - **Well Child Visits** – partnered with 5 mobile unit providers
  - Engaged and completed mobile units with more than 15 school districts across the county.
  - Demonstrated improvement in **15 of 18 measures for MY2024 compared to MY2023**.

- **ABC Tulare – Mobile van and School-based Health Center's Outreach Interventions**
  - **Well Child Visits and Immunizations** – supported the school's administrative needs, such as a refrigerator to store vaccines, parent outreach with Federally Qualified Health Centers (FQHC), member incentives, mobile van maintenance, needed equipment, and supplies.

Successful MCP Practice Transformation Interventions to Improve Well Child Visits

MCP	Intervention	Result
Molina	» Use of Practice Transformation Specialists (PTS) to supply provider offices with their member outreach lists each month	10.5 percentage point increased over baseline rate
Kaiser	» Care gap alerts during office visits, panel management tools to support outreach efforts, and expansion of online personal action plan reminders to include 18–21-year-old	9 percentage point increased over baseline
Blue Shield Promise	» Telehealth, in-home and community clinic days in 90 days	680 well visits completed in 90 days

Promising Practices Supporting Improvement in Children's Preventive Care

Member Engagement

Practices:

- Targeted member outreach by the health education team to build vaccine confidence.
- Assist members with scheduling direct appointments.

Provider Engagement

Practices:

- Active MCP engagement with provider/clinic sites and one-on-one educational coaching.
- Provider educational forums about MCP resources and benefits, coding, and sharing effective peer practices.
- Incentives on extended clinic hours.

Community Engagement

Practices:

- Active work with school-based health services, mobile vans, and public health partnerships.
- Active presence in community events, such as picnics, health fairs, and social media.

Fortifying the Pediatric Preventive and Primary Care Foundation: Strengthening EPSDT Benefits

- Federal law enacted in 1967 established the **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** requirement, which requires comprehensive age-appropriate health care services be provided to all Medi-Cal-enrolled children and youth up to age 21.
- Requires preventive screening, diagnostic services, and treatment services.
- Screenings, coverage requirements, and definition of medical necessity for children enrolled in Medi-Cal are more robust than they are for adult care.

Goal of EPSDT

Ensure that children get the

Right Care

at the

Right Time

in the

Right Place

Medi-Cal for Kids and Teens (EPSDT) Outreach & Education

- DHCS refers to the EPSDT benefit as **Medi-Cal for Kids & Teens**
- DHCS developed resources to **support family and providers' understanding of benefits:**
  - Child & Teen/Young Adult Brochures
  - Know Your Medi-Cal Rights Letter
  - Provider Training

CMS Affinity Group: Improving Preventive Care in Early Childhood

- Beginning in fall 2025, DHCS will participate in a 21-month CMS state affinity group to improve utilization of preventive services in early childhood, including advancing preventive care through well-child visits
- Pre-implementation phase (3 months): understanding opportunities for improvement and developing a quality improvement project
- Implementation phase (18 months): Work with quality improvement partners to implement, test, and improve quality improvement intervention.

Discussion – Considerations for Improving Early Childhood Preventive Care Outcomes

- Eligibility and enrollment
- Access improvement
- Primary care transformation
- Improved data collection
- Utilization of expanded workforce
- Member and community engagement

Questions?

Break

Medi-Cal Rx

Lori Bradley, Division Chief, Pharmacy Benefits Division

DHCS

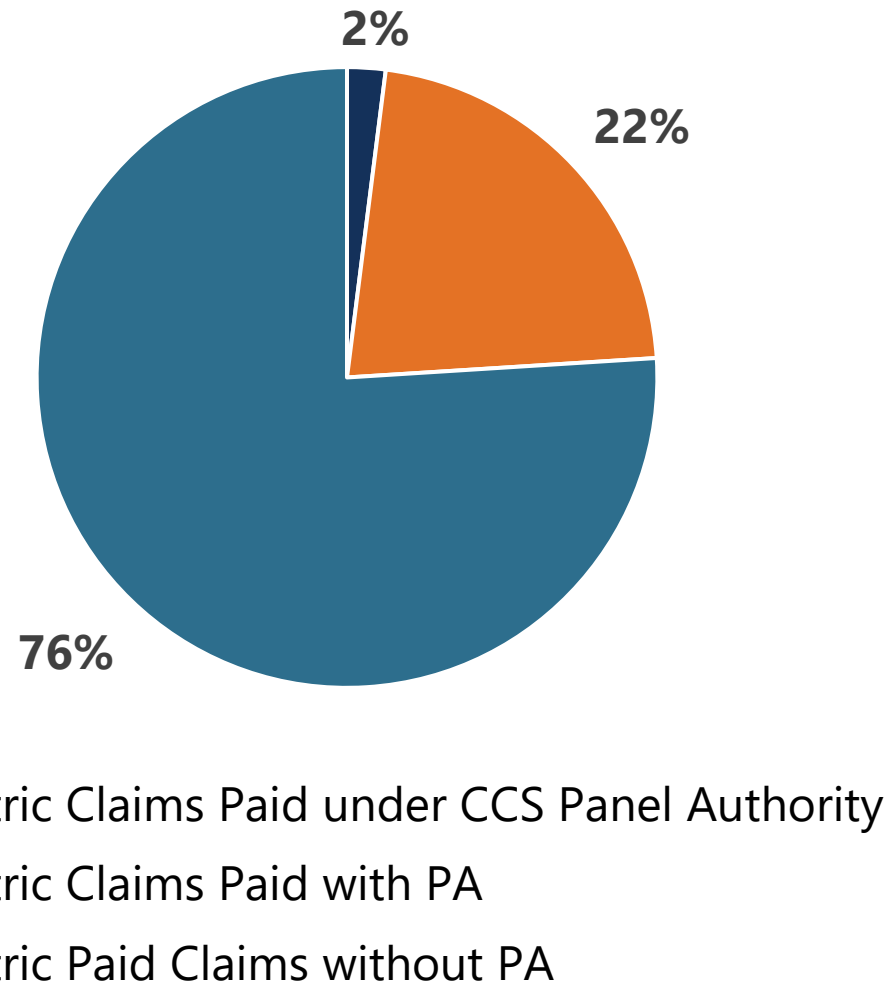
Agenda

- Pediatric Integration Update – Overview of Claims and Prior Authorization Data
- Impact of Budget Changes to Pediatric Pharmacy Benefits
- Medi-Cal Rx Activity Update – Efforts to Improve Access and Reduce Administrative Barriers

Week 20 Post Implementation: Claims

6/13-6/19/25

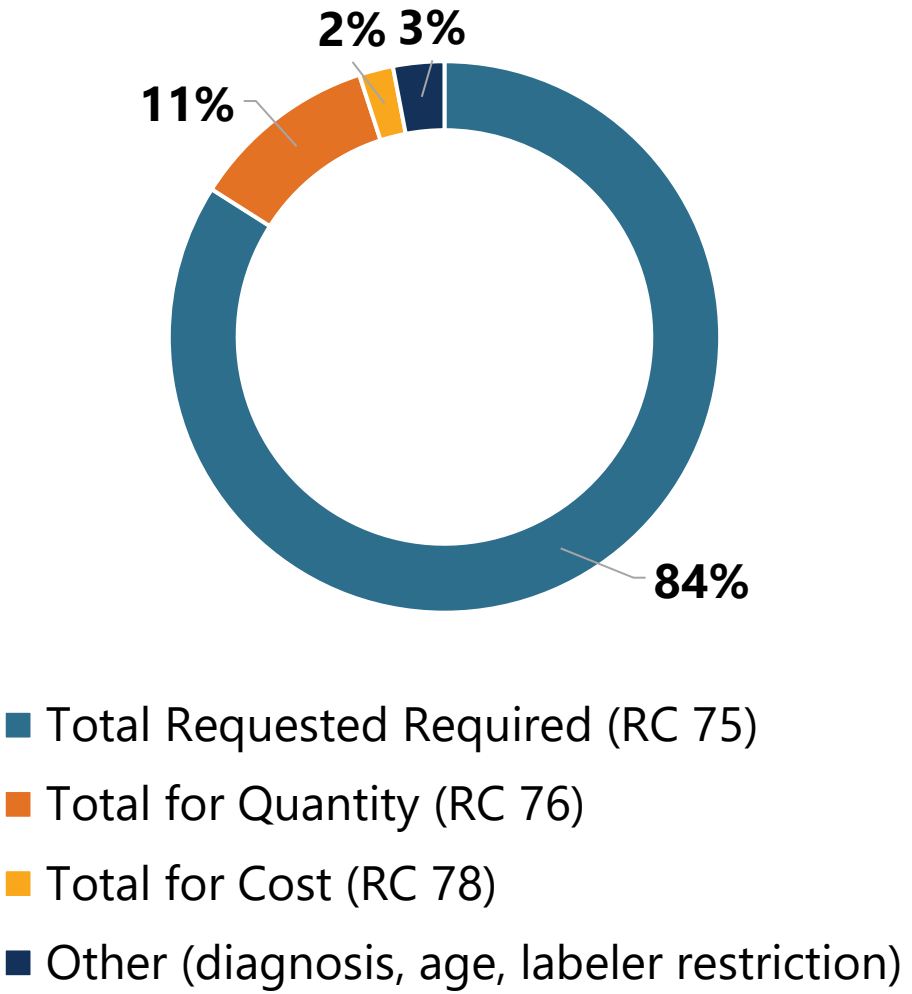
- Medi-Cal Rx pediatric claims paid under California Children's Services (CCS) Panel Authority or with Prior Authorization (PA) as a percentage of total Medi-Cal Rx pediatric paid claims
- Pediatric claims are approximately 14% of total Medi-Cal Rx paid claims. On average, 78% of pediatric claims pay without a PA.



Week 20 Post Implementation: Prior Authorization

6/13-6/19/25

- Medi-Cal Rx pediatric PAs by claim reject code
- Among PA requests submitted, 84% were required due to the drug/product prescribed, unrelated to quantity, cost, diagnosis, age, or labeler restriction. With the increased number of CCS Panel Authorized providers, the volume of PAs associated with RC 75 should decrease.



Budget Changes (1 of 2)

- Step Therapy
  - Component part of the existing utilization management, including PA request review process.
  - Providers may be asked if they adequately considered or tried a medication listed on the Contract Drug List (CDL) that did not meet the patient's medical needs before the requested unlisted medication is approved.
  - Not expected to impact CCS Panel Providers who currently have authority to prescribe most medications without a PA.
  - Providers without CCS Panel Provider status may need to submit more justification for use of a non-CDL product when requesting PA approval. Continuing care will not be sufficient justification.
    - This is another important factor in the decision to seek CCS Panel Provider status.

Budget Changes (2 of 2)

» Continuation of Therapy

- For medications that were on the CDL, but are no longer included, continuation of therapy will not be automatically granted. These medications will now require a PA.
- CCS Panel Providers with Panel Authority will not be impacted, assuming the claim is not denied for other utilization management (UM) edits, such as quantity or cost limits.
- Non-paneled providers must submit PAs for non-CDL medications, even when the member has a history with that medication while it was on the CDL.
- Prescriptions that had been eligible for continuation without a PA under the 5-year maintenance policy will require a PA if the provider does not have CCS Panel Authority.

Medi-Cal Rx Activity Update

- Through effective collaboration and partnership, DHCS and stakeholders worked to improve access to care and reduce administrative workload for prescribers and pharmacy providers which included:
  - Refinement of UM edits.
  - System enhancements to leverage existing data for claim adjudication.
  - Expansion of covered products and contracted medications for pediatric Medi-Cal members.
  - Enhanced educational and outreach resources to better support prescribers and pharmacy providers.

Support for Youth Aging out of CCS

- To support continuity of care and access to critical medications and pharmacy products, DHCS is exploring the feasibility of offering a one-time, 100-day administrative override on existing prescriptions written by providers with CCS Panel Authority.
- This mitigates the risk of therapeutic disruption while members establish relationship with non-pediatric providers.
- DHCS is also exploring policy options specific to CCS members who transition to the Genetically Handicapped Persons Program (GHPP) or adult Medi-Cal coverage.

Emergency Fill Policy Communications

- To improve systemwide understanding of the Emergency Fill policy, DHCS created additional communications:
  - Email to Managed Care Plan partners, CCS County Program Managers, and Medical Directors.
  - Added information in the Medi-Cal Rx Member FAQ.
  - Added information on the Medi-Cal Rx Member Portal.
- The Medi-Cal Rx Customer Service Center (CSC) will track and report instances of access issues.
- Data will be used to assess and address identified issues with pharmacy outreach and education.

Questions?

Public Comment

Public Comment Guidelines

- During the public comment period, we do not answer questions, but simply listen to public comments.
- All public comments are recorded in the meeting minutes.
- Public comments are from members of the public present in the room and those attending virtually.
- Please state your name and organization.
- Please keep your comments concise and limited to 1 minute.

Final Comments and Adjourn

Upcoming Meeting Dates

2025

» November 6, 2025

2026

» March 12, 2026
» June 11, 2026
» September 10, 2026
» November 5, 2026

Thank You.

DHCS