CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

# MEETING MINUTES

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

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| **Date:** | Thursday, July 10, 2025 |
| **Time:** | 10 a.m. – 2 p.m. |
| **Type of Meeting:** | Hybrid |
| **Members Present:** | 12 |
| **Public Attendees:** | 76 |
| **DHCS Staff Presenters:** | Michelle Baass, Director; Pamela Riley, MD, MPH, Assistant Deputy Director and Chief Health Equity Officer, Quality and Population Health Management; Sabrina Atoyebi, Branch Chief, Integrated Systems of Care Division; Cheryl Walker, MD, Medical Director, Integrated Systems of Care Division; Donny T. Shiu, O.D., Chief, Medi-Cal Vision Program |
| **Additional Information** | Please refer to the Director's Update and PowerPoint presentation used during the meeting for additional context and details. |

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**Member Attendance:**

- Michael Weiss, M.D.; Present; In Person
- Ellen Beck, M.D.; Not Present
- Elizabeth Stanley Salazar; Not Present
- Diana Vega; Present; Virtual
- Nancy Netherland; Present; In Person
- Jeff Ribordy, MD, MPH, FAAP; Present; Virtual
- Karen Lauterbach; Present; In person
- Kenneth Hempstead, M.D.; Not Present
- William Arroyo, M.D.; Present; In person

- Ron DiLuigi; Present; Virtual
- Lesley Latham, D.D.S., MS; Present; Virtual
- Alison Beier; Present; Virtual
- Jovan Salama Jacobs, Ed.D; Present; In-Person
- Kelly Motadel, M.D.; Present; In-Person
- Jan A. Schumann; Present; In person

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| **10:00 – 10:10** | Welcome, Opening Comments, Roll Call, and Agenda |
| **10:10 – 11:10** | Improving Children's Preventive Care Outcomes |
| **11:10 – 11:45** | Director's Update |
| **11:45 – 12:30** | California Children's Services (CCS) Quality Metric Redesign |
| **12:30 – 1:00** | Break |
| **1:00 – 1:30** | Medi-Cal Vision Services |
| **1:30 – 1:45** | Public Comment |
| **1:45 – 2:00** | Final Comments and Adjourn |

Please note that the agenda order was adjusted for scheduling purposes.

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## Welcome and Introductions

**Type of Action:** Action

**Recommendation:** Review and approve the March 13, 2025, meeting minutes.

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

**Materials/Attachments:** MCHAP Meeting Minutes - March 13, 2025

**Action:** Approve the minutes from November 7, 2024

- **Aye:** 10 (Weiss, DiLuigi, Arroyo, Netherland, Motadel, Vega, Latham, Beier, Schumann, Ribordy)
- **Didn't Vote:** 2 (Jacobs, Lauterbach)

- **Members Absent:** 3 (Beck, Salazar, Hempstead)
- **Abstentions:** 0

**Motion Outcome:** Passed

## Improving Children's Preventive Care Outcomes

**Type of Action:** Information

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

**Discussion Topics:**

- DHCS provided an update on children's preventive care as a key focus area within its Comprehensive Quality Strategy. The update showed both progress and ongoing challenges across multiple measures, with some improvement in overall quality performance compared to the prior year. The variability in results among Medi-Cal managed care plans was noted, underscoring the need for continued efforts to strengthen care delivery and coordination. Strategies outlined to improve outcomes included expanding access through flexible appointment scheduling, increasing engagement in primary care, and enhancing collaboration with community partners, such as Women, Infants, and Children (WIC), First 5, and schools. Efforts to improve the quality and timeliness of data reporting were also emphasized, along with targeted outreach to populations with low utilization of preventive services. DHCS highlighted the importance of sustained partnerships and community-based approaches to address barriers, such as lead screening gaps and vaccine hesitancy.
- A member commented on the need to improve both access to care and data collection. They noted that it would be helpful for members and their families to have access to their claims history. This could allow them to see what services have been used and provide a visual reference for when preventive care was last received.
- A member referenced earlier comments about baseline versus current barriers to care and noted that meeting people where they are is becoming increasingly important. They suggested expanding access to school-based health services, either through formal clinic partnerships or by utilizing existing health care staff. The member noted that schools may be one of the few consistent points of contact for families.

- A member responded to a question about engaging hard-to-reach populations. They recommended using plain language, noting that technical or data-heavy language can be overwhelming and difficult for many consumers to understand. The member suggested aiming for a sixth-grade reading level or lower and providing materials in multiple languages.
- A member shared observations from a pediatric infusion center, noting that some children with serious health conditions are missing critical treatments. They emphasized that preventive care may be deprioritized in such cases.
- A member shared they were at a pediatric infusion center and noted that some children are not coming in for critical treatments, such as chemotherapy. They stated that if this level of care is missed, preventive care is likely even less prioritized. The member emphasized the importance of maximizing care touchpoints. They explained that for families managing complex medical needs, preventive care often gets delayed or missed. They recommended offering preventive services during inpatient stays and acute visits, especially when siblings are present, since families often bring multiple children to appointments. The member also suggested partnering with hospital systems and public health programs to expand mobile care, increasing access through schools, and addressing transportation barriers that prevent families from reaching services. Lastly, they recommended using the digital Medi-Cal platform to send reminders for preventive care. DHCS acknowledged the comments and noted that the suggestions align with efforts to transform primary care and better utilize touchpoints.
- A member asked for clarification on the status of data collection efforts. They stated that the identified focus areas were appropriate and noted that improved data collection is essential to addressing access. The member asked whether DHCS believes data collection is progressing effectively, given the time invested, and whether support from partners has met expectations. They also emphasized the importance of collaboration with partners who can contribute insights based on their day-to-day experiences. DHCS responded that the issue has not yet been resolved, but progress is being made. They identified provider-level reporting as a challenge, explaining that services may be delivered, but not reported due to burdensome documentation processes. DHCS noted that some health plans are testing new approaches, and DHCS is working to standardize and align data collection to improve usability and reporting. They also mentioned that the Medi-Cal Connect system is expected to support these

efforts. Additionally, DHCS is working across departments to improve sharing and visibility, specifically for public health and social services data.

- A member expressed appreciation for the depth of the discussion and emphasized the importance of trust in improving access to care. They noted that mistrust in public institutions is well documented and referenced the concept of "sanctuary trauma," where entities intended to help have caused harm. The member questioned whether services should be brought to communities rather than expecting individuals to seek them out, citing international examples, such as vaccine campaigns in Mexico. They shared personal experiences as a parent of children with complex medical needs, stating that it is often difficult to access preventive services like vaccines during hospital or ambulatory visits due to billing and coding barriers. They noted that despite frequent contact with the health care system, preventive care is often missed. The member also highlighted confusion among families about the difference between Medi-Cal and managed care plans, which can affect access to services. They recommended using trusted messengers, plain language, and community-based outreach through peer networks, food pantries, hospital waiting rooms, family advisory groups, and family liaison networks. These approaches, they said, help bridge gaps in trust and access. The member also supported the use of data and suggested involving families in identifying metrics that reflect real experiences with access and barriers, noting that standard measures may not always align with what families encounter. DHCS responded by acknowledging the importance of trust-building as a foundation for improving access and noted that this work is ongoing and complex. They agreed that identifying meaningful performance indicators for access is a key part of advancing equity.
- A member stated that the recent data breach has significantly impacted patient trust. They shared that some families, including those with U.S. citizen children, are canceling services due to fears that their service usage may be tracked and used against them. The member noted that some individuals are hesitant to complete redetermination forms, interpreting them as government efforts to collect data rather than routine eligibility processes. They also shared that providers, who previously reassured patients about the safety of these programs, are now uncertain about how to address concerns related to data security. The member emphasized that these trust issues are compounded by broader fears, including immigration enforcement, and suggested that rebuilding trust will require returning to basic, community-centered approaches. They shared a

personal example of being unable to obtain vaccines for their children during hospital visits due to billing and coding restrictions, despite frequent interactions with the health care system. They described this as a missed opportunity for preventive care. The member also discussed challenges with school-based health services. While they receive requests to bring mobile units to schools, they often decline or proceed cautiously to avoid providing episodic care without follow-up. Instead, they prefer to engage families through presentations about Medi-Cal, eligibility, and how to access services, aiming to connect families to ongoing care rather than one-time interventions. DHCS acknowledged the concerns and noted that while some challenges are specific to the current moment, trust issues are longstanding. DHCS suggested that innovative approaches, similar to those used during the pandemic, may be needed to rebuild trust and improve outreach to affected populations.

- A member discussed access and practice transformation, framing the issue from the patient and clinician sides. They agreed with previous comments regarding patient access and emphasized the importance of continuing to support telehealth and public health nursing, including home-based services. On the clinician side, the member highlighted the need to reinforce primary care transformation, referencing the advanced primary care model used in Covered California. They noted that this model supports extended access, care coordination, and gap analysis, and aligns with CalAIM initiatives. The member expressed concern that current systems still tend to reward volume of services rather than the development of comprehensive, patient-centered care models. They emphasized the importance of supporting competencies associated with the medical home model and encouraged a review of provider contracts to ensure they incentivize those practices. DHCS responded that it is in discussions with the California Department of Public Health (CDPH) about promoting preventive care and aligning efforts around the medical home model.
- A member emphasized that access and practice transformation are interconnected and highlighted fear as a major barrier to care. They referenced a reported 30% drop in ambulatory visit attendance and stated that without strategies to address fear, access cannot be achieved. They also raised concerns about inadequate language access, noting that without communication in a patient's language, there is no meaningful health care. The member criticized the current process for requesting translation services and urged the use of available technology to improve language access. They also called for stronger

community engagement, questioning the absence of local voices, such as family representatives, religious organizations, parks and recreation, and youth. The member pointed to environmental health concerns in Los Angeles, such as exposure to toxins from fires, and asked whether the state is engaging with local efforts to address these issues. They concluded by urging the state to be more responsive to the real conditions affecting families as it works to improve prevention. DHCS agreed that if people are not coming in, there is no access and acknowledged that this is a longstanding issue. DHCS also affirmed that language access is a core component of access and noted that DHCS is working to improve culturally appropriate standards and explore technology-based solutions to support access.

- A member emphasized the impact of fear on school attendance and service utilization in Los Angeles County. They reported that many families are keeping children home from summer school and extended school year programs due to concerns about immigration enforcement. They shared a specific incident involving ICE presence at the Los Angeles County Office of Education. The member noted that this fear has also affected participation in school lunch programs. They encouraged stronger partnerships with county offices of education, noting that Los Angeles County serves 1.3 million K–12 students across 80 districts and approximately 1,900 schools. They described the county office as a potential information hub that could support broader outreach. The member also referenced a recent conversation with the Los Angeles County Department of Public Health about the "Help Me Grow" program, which supports students with disabilities, and suggested that county education offices could play a larger role in connecting families to public health resources.

## Director's Update

**Type of Action:** Information

**Presenter:** Michelle Baass, Director

**Discussion Topics:**

- DHCS provided an update on the 2025-2026 budget, noting that Medi-Cal will continue to serve about 15 million Californians. The update outlined policy changes, such as reinstating the asset test, introducing premiums for certain adult populations with unsatisfactory immigration status, and adjusting benefits in various program areas. Funding was maintained or added for behavioral health services, family planning, crisis support systems, and provider training

related to Adverse Childhood Experiences (ACEs). DHCS also updated members on federal legislative activity, including House Resolution 1 and its potential implications for the Medi-Cal program. The update included progress on statewide behavioral health platforms BrightLife Kids and Soluna, which have reached more than 319,000 youth and families since launching in January 2024. DHCS shared initial findings from the evaluation of Community Supports, with several services already demonstrating cost savings. The update concluded with an overview of DHCS' preparation for the upcoming CalAIM waiver renewal. A concept paper outlining goals for the next phase of Medi-Cal transformation is in development and will be released for public comment later this year.

- A member asked for clarification on whether the current program freezes and premium increases affect children. DHCS responded that the freeze applies only to individuals aged 19 and older, and the premium increases apply to those aged 19 to 69. Children under 19 are not affected by either the freeze or the premium changes. The member also asked whether dental benefits for children are impacted, and DHCS responded that dental benefit changes also apply only to individuals 19 and older.
- A member asked whether the freeze applies to foster youth ages 19 to 26 and what considerations are being made for that population. DHCS responded that there is currently no exemption for this group. Individuals who turn 19 may maintain eligibility as long as they continue to meet requirements, including submitting redetermination documentation and paying premiums. The member suggested that DHCS or the panel consider studying this population further, noting that foster youth in this age range tend to fall out of care at a higher rate. They expressed interest in identifying a procedural path to ensure this issue receives attention.
- A member asked for clarification on the use of Proposition 36 funds allocated to county behavioral health departments, specifically whether there are rules governing how the $50 million can be used. DHCS responded that budget bill language outlines the allowable uses. Generally, the funds can be used for capacity building to support infrastructure development for county behavioral health systems. A portion of the funds may also be used for services, with a requirement that counties provide matching funds for the services component. DHCS noted that additional Proposition 36 funds exist outside DHCS' purview, and details on those were not available during the meeting.

- A member asked whether dental benefits will continue for adults older than age 19 with satisfactory immigration status and requested clarification on the elimination of dental provider payments. DHCS confirmed that dental benefits will remain unchanged for adults with satisfactory immigration status. The elimination applies only to adults aged 19 and older with unsatisfactory immigration status. DHCS also clarified that the dental provider payments in question are Proposition 56 supplemental payments. These payments were originally funded by tobacco tax revenue, which has declined over time. The General Fund has been backfilling the shortfall, but under the Budget Act, these General Fund-supported supplemental payments will be eliminated as of July 2026.
- A member asked whether the decision to limit coverage of GLP-1 medications included consideration of potential downstream cost savings and whether more stringent prior authorization could be implemented. They noted that GLP-1 medications have had a significant positive impact on some children's mental and physical health. DHCS responded that GLP-1 medications may still be approved when medically necessary for conditions beyond weight loss. DHCS is working on establishing the prior authorization process. They explained that the change reflects the rapid cost growth of these drugs, more than 200% in recent years, and the need to manage Medi-Cal spending. When asked whether the coverage change applies to all age groups, including children, DHCS confirmed that it does.
- A member asked when the $30 premiums will begin. DHCS responded that implementation is scheduled for July 2027 and noted that there is currently no infrastructure in place to support it. The member acknowledged the timeline and commented that implementing the premiums will require a significant information campaign.
- A member asked for clarification on the change in federal reimbursement rates from 90/10 to 50/50, specifically questioning whether this change applies to the entire Medi-Cal expansion population. DHCS responded that the change applies to individuals with unsatisfactory immigration status , including those covered under the expansion. Currently, emergency services for these individuals are reimbursed at up to 90 percent FFP, depending on their aid category, such as the Affordable Care Act (ACA) optional expansion or the standard Federal Medical Assistance Percentage (FMAP). Under the new rule, all individuals in this category

will receive a 50/50 federal-state matching rate. This shift results in a reduction in federal funding, which will require the state General Fund to cover the difference.

- Regarding HR 1, DHCS responded that the information being shared is preliminary and not comprehensive. At this stage, the DHCS is tracking approximately $30 billion in federal funding. Initial assessments have been conducted, but further refinement is expected as more information becomes available. DHCS noted that guidance on these matters is still pending, and there are many details yet to be determined.
- A member acknowledged the complexity of the recent changes and asked about the overall communication plan for informing agencies that serve affected populations. The member noted that the changes involve multiple timelines and expressed concern about confusion among staff regarding what has or has not changed. DHCS responded that many of the changes directly impacting members relate to work requirements and semi-annual redeterminations. Other changes primarily involve funding mechanisms. DHCS stated that the state is currently not in a position to backfill the estimated $30 billion in lost federal revenue. These financial and policy considerations will continue to be evaluated in the coming weeks and months. DHCS also clarified that the changes related to work requirements and six-month status reports will not take effect until January 2027, allowing time for planning and communication.
- A member asked if any benefits are changing right now for people on Medi-Cal, other than those related to Planned Parenthood. DHCS confirmed that no other benefit changes are happening at this time.
- During the update on the Behavioral Health Virtual Services, a member congratulated DHCS on excellent user satisfaction for its BrightLife Kids and Soluna platforms and asked whether feedback from families has led to any changes and if there are any plans for expansion. DHCS responded that there are no current plans to expand the platforms. However, it is continuing to improve the service, enhance the platform, and strengthen connections with local partners.
- A member expressed concern that asthma remediation services are not being used as much as expected. They noted that this has also been a challenge locally and suggested a more focused effort to raise awareness about the availability of these services. The member shared that many people are surprised to learn the

services exist, which shows a gap in outreach. DHCS agreed that improving awareness is an important area to focus on.

- During the update on Community Supports and the cost-effectiveness analysis, a member noted there was concern that CMS may not approve similar services, particularly housing-related supports, in future waivers for other states. The member then asked who is conducting the cost-effectiveness study. DHCS responded that the fiscal modeling was completed by contractors, while other components were handled by DHCS. Additionally, a broader evaluation required under CalAIM will be conducted by UCLA, which will contribute to the annual update submitted to CMS.

## California Children's Services (CCS) Quality Metric Redesign

**Type of Action:** Information

**Presenter:** Sabrina Atoyebi, Phd, Branch Chief, Integrated Systems of Care Division; Cheryl Walker, MD, Medical Director, Integrated Systems of Care Division

**Discussion Topics:**

- DHCS provided an update on the CCS Program Quality Metric Redesign, which was developed to meet statutory requirements for new quality and utilization measures specific to CCS Program specialty care. The work builds upon recommendations from past and current CCS Program Performance Measures Quality Subcommittees, with the goal of standardizing performance measures and enabling comparisons between Whole Child Model (WCM) and non-WCM counties. A new public dashboard with CCS and WCM enrollment and demographic data was launched in December 2024. The update outlined six measures for implementation, including acute hospital utilization, emergency department utilization, plan all-cause readmissions, specialty care center visits, CCS Program paneled provider utilization, and annual visits for hearing-related conditions. Several measures will be stratified by specific CCS Program eligible conditions to better assess outcomes. DHCS noted that while some stratification will be implemented, resource limitations and small data counts may restrict more detailed breakdowns. These measures will inform quality improvement efforts and ongoing monitoring of care for the CCS population.
- A member asked whether the three Healthcare Effectiveness Data and Information Set (HEDIS) measures discussed are currently limited to individuals aged 18 and older. DHCS responded that the measures referenced are ones that the National Committee for Quality Assurance (NCQA) has made available either

currently or in the recent past. DHCS stated that it has been working with NCQA to make the necessary adjustments so these measures can be applied to the pediatric population.

- A member asked whether the state has the authority to define which conditions are included in the CCS Program, noting that this is not determined at the federal level. DHCS confirmed that the state does have that authority. The member then raised a question about the inclusion of types 1 and 2 diabetes in the quality measures and asked if this might be a way to address obesity, given its connection to multiple health conditions. DHCS responded that while obesity is recognized as a significant public health issue by DHCS, the California Department of Public Health, and others, it is not a qualifying condition under the CCS Program. Therefore, it cannot be used as a basis for CCS Program measures.
- A member expressed appreciation for the work being done and requested that, once available, a plain language version of the CCS Program quality dashboards be created for families. They noted that there is strong interest among CCS Program families in understanding the decisions being made.

## Medi-Cal Vision Services

**Type of Action:** Information

**Presenter:** Donny T. Shiu, O.D., Chief, Medi-Cal Vision Program

**Discussion Topics:**

- DHCS provided an overview of vision services available to all Medi-Cal members, including children. Vision care is delivered through managed care plans or fee-for-service providers, with DHCS setting coverage and reimbursement policy. Services include comprehensive eye exams, diagnostic procedures, low-vision services and devices, medically necessary specialty lenses, and eyeglasses for members of all ages. Providers send frames to the California Prison Industry Authority (CalPIA) for prescription lens fabrication at no cost to providers or members. The presentation also described the provider community, which includes optometrists, ophthalmologists, opticians, and ocularists, and reviewed policies for eyeglass coverage, replacement, and the provision of polycarbonate lenses for children under age 18. CalPIA's role in producing quality lenses, preventing fraud, and supporting job training for justice-involved individuals was

highlighted. DHCS shared resources for members and providers, including program information, coverage policies, and contact options for assistance.

- A member asked three questions about Medi-Cal vision coverage: (1) how often children can get eye exams or glasses, (2) whether children with self-image anxiety can get contact lenses for medical reasons, and (3) whether children who play sports can get a second pair of glasses designed for physical activity. DHCS responded that routine eye exams are covered every two years, but children can be seen more often if there is a medical need, such as changes in vision. For contact lenses, DHCS said they can be approved on a case-by-case basis through a treatment authorization request if there is a medical reason, but self-image concerns alone may not qualify. For sports-related glasses, DHCS explained that recreational or occupational eyewear is generally not covered. However, families can choose to purchase sports bands or similar accessories at a low cost. The first pair of glasses is covered, and lenses are made from polycarbonate material, which is impact-resistant and similar to protective eyewear.
- A member asked about the reported eye exam rate for children aged 6 to 21, noting it appeared to be around 17% in 2021 and 2022. The member compared this to national rates, which range from 54% to 63%, and suggested that California could explore ways to increase vision screening as part of broader efforts to improve preventive care. The member also asked whether the current data include only one indicator and suggested separating vision screening and treatment (such as receiving glasses) to better understand satisfaction and service delivery for each part. The member then asked if it was true that there have been no complaints about the quality of vision products, as indicated by a PIA request. DHCS explained that quality is monitored through the reject rate, which tracks when glasses are returned by providers because they don't meet the patient's needs. This rate is currently under 1% of the approximately one million glasses produced each year. DHCS added that glasses are remade at no cost if they don't meet the provider's standards, regardless of the reason. The member followed and asked how families can provide feedback about the quality of care or products. DHCS responded that the most direct way is through the provider, such as the optician or eye doctor. They also noted that providers have access to patient and prescription information, which helps them track and resolve issues. The member suggested that it would be helpful to have a clearer pathway for families to submit concerns or feedback, as it's not always clear whether issues should be directed to the provider, the managed care plan, or

DHCS. They emphasized the importance of making feedback channels more accessible and understandable for families. DHCS responded that vision-related issues and concerns can be sent directly via e-mail to Vision@dhcs.ca.gov.

- A member thanked DHCS for the presentation and noted the importance of vision screening, especially in identifying whether a child's challenges are due to a disability or a vision or hearing issue. The member asked if there is updated data on how many school-aged children in California are receiving vision services, referencing a previous estimate of around 20%. DHCS responded that while eye exam rates and treatment needs vary, not all children who receive an eye exam require glasses. They shared that, based on available data, about 35% of vision services are provided to individuals aged 0 to 20, and 65% to those older than age 20. This distribution generally reflects the makeup of the Medi-Cal population.
- A member asked if DHCS has a public dashboard for vision services metrics. DHCS said data are monitored internally and available upon request, but not currently published. The member noted this differs from other DHCS programs and asked about turnaround time for glasses. DHCS said glasses are typically ready within five business days, not including shipping. The member also asked if there is a patient advisory panel. DHCS explained that most members receive vision care through managed care plans, such as L.A. Care, which partners with Vision Service Plan (VSP). Concerns can be escalated through providers or care teams. The member expressed concern that vision services lack direct public engagement and clear feedback pathways. They emphasized the need for more accessible, consumer-focused systems, especially for preventive care, and suggested that vision services feel less connected to broader Medi-Cal efforts.
- A member asked if the new state budget includes any changes to vision benefits. DHCS confirmed that there are no changes.
- A member suggested that DHCS consider incorporating a visual dashboard to track the number of children receiving vision services, such as eyeglasses, to monitor any concerning fluctuations in utilization. In response, DHCS acknowledged the suggestion and shared that according to recent data, year-to-year utilization has been trending upward over the past two years.

## Public Comment

**Type of Action:** Public Comment

**Discussion Topics:**

- **Kristine Shultz**, Executive Director at California Optometric Association, thanks DHCS for the opportunity to comment and for including children's vision on today's agenda. She states that her organization is committed to supporting children and their eye health needs. While they appreciate DHCS' efforts to improve Medi-Cal, she notes that too many children are still falling through the cracks. She emphasizes that the best way to prevent this is to ensure all children receive a comprehensive eye examination, at least before entering school. Shultz explains that while vision services and screenings are helpful, they do not catch everything. Citing the American Optometric Association, she notes that one in four school-aged children has a vision disorder, and some school screenings miss up to 75% of children with vision problems. She adds that a vision screening provides less than 4% of the information obtained during a comprehensive eye exam. Even when screenings detect a problem, many children do not receive the necessary follow-up exam and glasses. According to Prevent Blindness, only 5% to 50% of children receive an eye exam after a vision screening referral. She warns that this can lead to misdiagnosis, learning difficulties, and long-term consequences. Shultz offers several solutions. She suggests that DHCS develop a system to track vision screenings, referrals, exams, and follow-up outcomes. She also recommends requiring managed care plans to report data on vision services and conducting outreach to parents about the importance of follow-up care, similar to existing efforts for dental services. She also highlights three additional issues. The PIA system for glasses remains a major source of frustration for providers and must be fixed. Inaccurate provider directories make it difficult for families to find optometrists, especially in rural and underserved areas where wait times of two to three months are common. Lastly, provider reimbursement rates for optometric services have not increased in more than 25 years, which she identifies as a key barrier to access.
- **Michai Freeman, Systems Change Advocate from the Center for Independent Living**, shares that she is a mother of a child with a disability, and also has a disability herself. She expresses support for reducing or eliminating barriers to comprehensive vision care and advocates for the adoption of assessments for binocular vision issues. She explains that her son was identified late for a binocular vision assessment, which she had to pay for privately. The assessment revealed that his eyes were not focusing properly and that he had significant visual irregularities, which contributed to reading difficulties. Freeman

emphasizes that a lack of appropriate vision screening contributes to learning deficits. She also raises a question about whether the panel has evaluated how prevalent access issues are for children who are unable to communicate or transfer easily during eye exams. She shares her own experience as a person with a disability who uses a ventilator, noting that for children with high medical needs or medical devices, the inability to use standard eye screening equipment, and the reliance on handheld tools, makes comprehensive exams inadequate. She stresses that access and accessibility must be considered when evaluating providers funded by Medi-Cal. If a child cannot comfortably complete an exam, or if a caregiver must navigate excessive financial or logistical barriers, those exams may be delayed or missed entirely. Freeman concludes by urging the panel to consider how accessible and inclusive provider facilities are for all individuals with disabilities and for young children.

- **Mary Giammona, MD**, Pediatric and CCS Medical Director at Molina Healthcare, states that she is speaking in her capacity as a pediatrician. She makes two comments. First, she encourages DHCS to remind Medi-Cal managed care plans—many of which delegate vision services—that the points raised earlier by Dr. Shiu are important. She notes that many plans follow a two-year periodicity schedule for vision exams and often do not recognize medical necessity, such as a change in vision, as a valid reason for an interim exam, even for children. She explains that advocacy was required to ensure that EPSDT guidelines were followed and that any change in a child's vision would be covered. She suggests that DHCS consider issuing a reminder or an All Plan Letter (APL) to clarify that the two-year schedule applies only to routine screenings and does not override medical necessity, including for adults. Second, she raises a concern related to CCS eligibility and documentation. She notes that families are missing preventive visits due to fear and that CCS is not accepting full scope Medi-Cal enrollment as sufficient proof of residency. She describes a current case involving a mother whose baby, born at 25 weeks and currently hospitalized, is clearly eligible for CCS due to medical complexity. However, CCS has denied services due to lack of proof of residency. The mother is unwilling to provide documentation due to fear of immigration enforcement. Dr. Giammona asks DHCS to consider acknowledging the current climate of fear and to allow Medi-Cal enrollment to serve as sufficient proof for CCS eligibility, particularly when the child qualifies for Medi-Cal and would benefit from CCS case management services.

- **Premilla Banwait, OD, MPH**, pediatric optometrist and faculty member at the UC Berkeley School of Optometry, states that she runs a pediatric clinic serving children on Medi-Cal or without insurance. She notes that recently adopted federal Medicaid cuts are expected to have a significant impact on the state Medi-Cal program and on the low-income children and families who rely on it. At the same time, she emphasizes the importance of not losing sight of the existing disparities in children's vision care. Dr. Banwait highlights several growing concerns, including the rising rates of myopia (nearsightedness), which she describes as a new and increasing challenge to children's vision health. She cites research showing a 25% increase in myopia over the past 40 years, driven largely by reduced outdoor time and increased screen use. She notes that experts now refer to myopia as an epidemic, with more than 40% of Americans currently affected and the number expected to grow. Children are developing myopia at younger ages, along with other vision issues, making early detection critical. She shares that she regularly sees children who have missed screenings or do not receive follow-up exams. At a recent health fair for Head Start Oakland, which served children aged 0–5, she conducted vision screenings and exams and found that 20 out of 100 children showed signs of needing glasses or had binocular vision issues. She states that many of these children are unlikely to receive the follow-up care they need. To address this, she recommends establishing a mandatory eye exam requirement for children entering kindergarten or school age to ensure early detection and access to necessary vision correction. Dr. Banwait also urges DHCS to track key data, including how many children fail school vision screenings and how many receive follow-up exams. She recommends educating families and schools about the importance of outdoor time and limiting screen time, citing studies that show 40 to 80 additional minutes of outdoor time can significantly reduce myopia rates. Finally, she calls for Medi-Cal to recognize myopia as a disease and to cover evidence-based treatments, such as low-dose atropine drops, to slow its progression and reduce the risk of future eye disease. She concludes by stating that the tools to protect children's vision exist and that policies are needed to ensure they are used effectively.
- **Doug Major, OD**, thanks MCHAP for including vision as a topic on the agenda, noting that this is the first time in five years it has been addressed. He states that he is a member of the SLO Alliance Eyes organization, which has provided more than a billion local encounters since 1960. He shares his perspective as a member of the Quality Improvement Committee for a local managed care group.

Major explains that local managed care groups want to do the right thing, but are limited by a lack of data. He describes a situation involving Cal Health, where local groups were required to use the prison system for vision services. In response, his group traveled to Sacramento to advocate for maintaining their provider panel. He emphasizes that the issue centers on access and responsibility for the provider panel, which, according to Sacramento leadership, lies with local entities. He states that the core problem is the lack of accessible data—vision care is grouped with other specialties, making it difficult to track. His request is for local managed care groups to be provided with clear data, including the number of people served and the number of active providers. He concludes by stating that with the right data, local groups will be able to take appropriate action.

- **Kelly Hardy**, representing Children Now, thanks DHCS for adding a vision metric to the preventive services report, noting that it provides some visibility into how vision care is being delivered. She points out that the most recent report shows a low rate of service delivery and expresses hope that the upcoming report, expected in mid-August, will reflect improved numbers. Hardy states that Children Now would like to see DHCS develop a plan to hold managed care plans accountable for delivering the vision care services that are being paid for through those plans.

## Member Updates

**Type of Action:** Information

**Discussion Topics:**

- A member reiterates concerns raised earlier in the meeting regarding the impact of federal immigration enforcement activities on local communities. They note that these activities are creating significant challenges for service delivery and other local operations. The member acknowledges that the panel and staff are aware of these issues and are working to address them. They emphasize that as efforts continue to expand access and improve service delivery, these federal-level challenges will continue to pose barriers. The member expresses appreciation for the panel's recognition of the issue and encourages continued efforts to mitigate its effects at the local and state levels. The member also thanks the panel for a productive meeting and notes it was valuable to see agenda items discussed that had not previously been formally addressed.

- A member requests additional data related to vision services. They acknowledge DHCS' efforts and describe the work as intentional and impactful. The member states that further feedback from stakeholders will be beneficial and encourages more collaboration, particularly involving patients, in vision care.
- A member thanks DHCS for organizing the meeting, noting that it provided a substantial amount of information and valuable opportunities for discussion. The member emphasizes the importance of these conversations, particularly considering the barriers currently facing children, and expresses appreciation for the Department's efforts.
- A member emphasizes the need for the panel to remain responsive during a time of rapid change. The member suggests that, with respect to the director, staff, and chair, the group should be prepared to reconvene in a timely manner when necessary, particularly to communicate with the state Legislature and the Governor's Office. The member expresses concern that meetings scheduled far in advance may not reflect the urgency of current developments. The member stresses the importance of being poised to act as conditions evolve.
- A member notes the number of MCHAP meetings has been reduced from six per year to four. The member recommends increasing the frequency of meetings to ensure the panel can remain responsive and engaged with the state budget process and other evolving priorities in the coming years.
- A member echoes support for meeting more frequently and thanks DHCS for the presentations, noting that it is valuable to engage in collaborative discussions. The member expresses interest in having similar reviews and discussions on programs like Cal-MAP (California Child and Adolescent Mental Health Access Portal) and how such initiatives contribute to DHCS' goals for children. The member also expresses a desire to better understand the Medi-Cal Rx transition for CCS, particularly how it is functioning for children and how the panel can support implementation efforts.
- A member suggests adding a standing agenda item to cover ongoing state and federal policy changes. The member notes that the policy landscape is constantly evolving and emphasizes the value of regularly reviewing and discussing these developments during meetings.
- A member thanks DHCS for an informative meeting and for creating space for open dialogue. The member notes the importance of having these discussions during what they describe as a stressful time.

- A member responds to earlier comments about meeting frequency by noting that the next meeting is scheduled for September 11, which is eight weeks away, followed by another meeting on November 6. The member also thanks staff for their work in organizing the meeting and acknowledges the challenges currently being faced. The member emphasize that the constructive feedback provided by the panel is intended to be supportive, and that the panel views itself as an ally to DHCS. The member highlights the panel's role in sharing real-time, frontline information to help inform DHCS's decision-making and stresses the importance of continued partnership and collaboration.

## Upcoming MCHAP Meeting and Next Steps

**Type of Action:** Information

**Presenter:** Mike Weiss, M.D., Chair

**Discussion Topics:**

- The next meeting is on September 11, 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.