

State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

September 25, 2019

Meeting Minutes

Members Attending: Jan Schumann, Subscriber Representative; Kenneth Hempstead, M.D., Pediatrician Representative; William Arroyo, M.D., Mental Health Provider Representative; Katrina Eagilen, D.D.S., Licensed Practicing Dentist; Ellen Beck, M.D., Family Practice Physician Representative; Diana Vega, Parent Representative; Bertram Lubin, M.D., Licensed Disproportionate Share Hospital Representative; Ron DiLuigi, Business Community Representative; Nancy Netherland, Parent Representative; Pamela Sakamoto, County Public Health Provider Representative; Elizabeth Stanley Salazar, Substance Abuse Provider Representative.

Members Not Attending: Marc Lerner, M.D., Education Representative; Karen Lauterbach, Non-Profit Clinic Representative; Terrie Stanley, Health Plan Representative

Attending by Phone: 37 stakeholders called in

DHCS Staff: Jennifer Kent, Mari Cantwell, Erika Sperbeck, Norman Williams, Morgan Clair, Anna Lee Amarnath, Lisa Albers, Aita Romain, Marilyn Kempster, Carol Sloan, Nellie Limon, Oleg Istratiy, Amanda Font

Guests: Nadine Burke Harris, M.D., Surgeon General of California; Christina Altmayer, First 5 LA, Lindsey Angelats, First 5 LA; Kim Bower, M.D., Blue Shield of California Promise Health Plan; Charna Widby-Martin, First 5 LA

Others: Zachary Corbo, California Dental Association; Verne Brizendine, Aetna; Lisa Murawski, California State Assembly; Baylee Decastro, UCSF; Dennis McIntyre, Anthem Blue Cross; Stephanie Thornton, The Children's Partnership; Kathrina Gregana, California Strategies, LLC; Diann Azevedo, California Dental Hygienists' Association; Ben Johnson, Legislative Analyst's Office; Ryan Beaston, National Union of Healthcare Workers; Toni Panetta, Nurse-Family Partnership; Michael Nguyen, Molina Healthcare; Sarah Crow, First 5 Center for Children's Policy; Katherine Barresi,

Partnership HealthPlan of California; Kelly Hardy, Children Now; Ellesse Flores, California Association of Health Plans

Opening Remarks and Introductions

Ken Hempstead, M.D., MCHAP Chair welcomed those in attendance.

Pam Sakamoto read the legislative charge for the advisory panel aloud. (See [agenda](#) for legislative charge.)

Dr. Hempstead acknowledged Director Kent's resignation, noted her extraordinary accomplishments and advocacy over the years, including her participation at every MCHAP meeting.

Update from California Surgeon General

Jennifer Kent introduced the Surgeon General of California, Dr. Nadine Burke Harris, and acknowledged the sacrifices Dr. Burke Harris has made. In partnership with the Surgeon General's Office, the advent of trauma screenings for both adult and pediatric populations are something that will change generations to come. The Surgeon General will address how we plan to accomplish our goals, and how we can implement this in a meaningful way. These goals will certainly benefit not only the entire Medi-Cal population, but all of California. From where I sit as Director, we have come a long way. There was a time where we were not covering undocumented children, and I'm looking at Dr. Beck who probably counts that as one of her favorite things to talk about. What we have done, both as a state and with this group, has been impressive. I would be remiss if I didn't acknowledge my whole department.

Dr. Hempstead further introduced Dr. Burke Harris. One of the quintessential pediatrician advocates of our generation, bringing to our consciousness the importance of Adverse Childhood Experiences (ACEs) and trauma-informed care, and working to prevent what goes beyond Medi-Cal and affects our entire population.

Update from California Surgeon General

Presentation available here:

https://www.dhcs.ca.gov/services/Documents/OSG_MCHAP_092519.pdf

Dr. Burke Harris thanked Director Kent for her partnership, support, and leadership. Dr. Burke Harris talked about the Executive Order N-02-19, which grounded her role as the state's first surgeon general, and read the first three lines of the order. The Surgeon General will advise the Governor on a comprehensive approach to addressing health challenges as effectively and as early as possible.

Dr. Burke Harris, Surgeon General: There are so many health challenges that are facing our state and nation today. One of the important aspects of the role of Surgeon General

is to identify several of the root cause issues. The three primary priorities that I'll focus on include health equity, early childhood, and toxic stress.

Much of the research stemmed from a landmark study conducted by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente over two decades ago. The study asked 17,500 adults about 10 categories of ACEs. The study showed that ACEs are incredibly common; two-thirds of the study's population experienced at least one ACE, and one in eight experienced four or more ACEs. Based on the California Department of Public Health (CDPH) data from 2017, 63.5% of Californians have experienced at least one ACE, and 17.6% have experienced four or more ACEs. The study also found a dose-response relationship between early adversity and some of the leading causes of death in the U.S. When looking at the 10 leading causes of death, having an ACEs score of four or more is associated with a dramatic increased risk for at least 7 out of 10 leading causes of death.

When an individual is exposed to something stressful or scary, it activates a natural biological stress response, which is normal. However, children are particularly vulnerable to repeated activations of that stress response. If they don't have adequate caregiving to turn that stress response off, it can become overactive and dysregulated, which the American Academy of Pediatrics now calls toxic stress. The result of the overactive stress response changes: brain structure and function, the immune and hormonal systems, and even the way our DNA is read and transcribed. These changes lead to long-term and increased health risks, depending on your individual susceptibility, family history, and buffering factors.

In California, we have the capacity through a coordinated public health effort to cut ACEs and toxic stress in half in one generation, but it will require us to be strategic by:

- Establishing primary prevention through public awareness campaigns.
- Deploying broad scale screening, early detection, and early intervention of ACEs/toxic stress.
- Interrupting vertical transmission of ACEs by advancing screening in children and adults – with special focus on prenatal and early parenting years.
- Coordinating and strengthening the network of referral and treatment systems to make them more effective, accountable, and easy to navigate for children, adults, and providers.

William Arroyo, M.D.: The Lifting Children and Families Out of Poverty Task Force [report](#) that was published in November 2018 might inform your vision and role as Surgeon General. Poverty is probably the most powerful risk factor for adverse health outcomes. There was a study on women who used marijuana during pregnancy and they found a statistically significant rate of premature births. In California, we have recreational marijuana use; how does this affect your thinking on how we move forward in California?

Nadine Burke Harris, M.D., California Surgeon General: The National Academies of Sciences, Engineering, and Medicine released a [report](#) called Vibrant and Healthy Kids.

The report looked at the neurological and sociobiological impact of adversity on health and development on kids. As a committee member for that consensus report, it included a conceptual framework around how early adversity affects our health and wellbeing. The odds that a child would be exposed to ACEs often depends on their zip code, race/ethnicity, household income and other economic stressors. The Governor's Office has been putting forth proposals that address supporting families, such as paid family leave, earned income tax credit, etc., which are part of a comprehensive solution. In terms of your question on marijuana use, we recognize that any type of substance use during pregnancy is risky and puts the pregnancy at greater risk. One of the things we're beginning to see is that mom's own ACEs often sets the odds of her likelihood of using substances during pregnancy. If we're not addressing ACEs and getting to the root causes for how someone came to be using substances to begin with, then it's much harder for us to be successful in our interventions.

Ellen Beck, M.D.: Through our reimbursement structures, we need to fund the healthcare for the parents or the grandparents (family therapy, school-based health centers that serve parents and grandparents) so that the child can be healthy. Is there work being done for following people longitudinally in terms of the development of Alzheimer's to understand that link? In terms of health equity (case management, working with the elderly, restorative dental), are you establishing teams to look at other health equity issues?

Nadine Burke Harris, M.D., California Surgeon General: We recognize that this is a two- to three- generation work, which is fundamental to our approach. Our team in the CA OSG is small but mighty; we recognize that our intention is not to duplicate functions that are happening anywhere else. It's my job to ensure that the teams that are doing the deep dives on this work have all of the information and best practices and tools to build into the work that they are doing.

Elizabeth Stanley Salazar: How do we take your message on prevention and identify key projects across systems where you can have the biggest impact? What does this mean to the perinatal network of services, and what can you do to advance the integration of the use of ACEs and intervention for perinatal services this year?

Nadine Burke Harris, M.D., California Surgeon General: I recently had a meeting, the ACE Reduction Leadership Team Meeting, at CHHS with leaders across state agencies. My charge to them was what can your department/agency do? What is your plan to cut ACEs in half in a generation? Everyone is clamoring to be a part of this. That work is happening, and the outcome of these efforts will be in the Surgeon General's report on ACEs and toxic stress in California.

Nancy Netherland: What kind of quality measures can be set so that different Medi-Cal plans have accountability for creating pathways for responses and interventions? Have we taken a look at the current lag in referrals? What's available plan-by-plan, and can we look at some of the best practices to see if those could be replicated?

Nadine Burke Harris, M.D., California Surgeon General: What you described is part of the reason why it's so important that California is implementing a broad scale screening for early adversity and trauma-informed response. I've convened a small group to advise me on this issue, the Trauma-Informed Primary Care Implementation Advisory Group. This group includes providers, experts, health plans, payers, and other statewide health care leaders. The questions you asked are exactly the types of questions that we're asking. One of the things we hope to establish is fundamental standards that are evidence-based that we can hold providers and plans accountable to. We are also working with DHCS to determine who will hold them accountable and how.

Dennis McIntyre, Anthem Blue Cross: I was struck by your very last bullet in your last slide where you called attention to the need to coordinate and improve navigating the myriad of support systems that we have. We have many methodologies, but it still remains difficult. Do you agree that there's a "starvation in the midst of plenty" that we're just not maximizing?

Nadine Burke Harris, M.D., California Surgeon General: As a community pediatrician working in an extremely under resourced community in San Francisco, when I read this research, my first thought was implementing this in my practice. I started screening for ACEs in 2008. From there, I started a center that was dedicated to changing the way society responded to this problem, and looked at developing best practices, screening tools, clinical protocols, and created the National Pediatric Practice Community. With support from the Governor, as we move to broad scale implementation, we'll have an online training for providers to make sure that they begin screening so that they can get certified to bill for ACEs screening. We're also creating and deploying a physician, education, and quality improvement collaborative toolkit. We will be launching in five regions across the state learning collaboratives, where physicians and clinics can look at best practices for deploying and responding to screenings, impacting outcomes, and operational issues. We're considering all of the challenges there will be with deploying on a broad scale level and making sure that we're investing in tools that will allow for effective scalability to allow for excellent outcomes.

Ron DiLuigi: In terms of the ACEs, is this something you see occurring in one particular disciplinary setting? It seems like a big task; do we have the resources to be able to do it in that timeframe?

Nadine Burke Harris, M.D., California Surgeon General: We're screening for ACEs in the primary care setting. The purpose of screening is for prevention and early detection. It's not that we don't currently identify when individuals have been exposed to ACEs; we identify it after they are already symptomatic.

Ken Hempstead, M.D.: I'm sure I can speak for the panel for not only thanking you for being here, but our door is certainly open. To the extent that there's anything that you need from us in terms of our input on this, we would welcome that.

Nadine Burke Harris, M.D., California Surgeon General: Thank you all for your service and engagement in this process and in supporting the health and wellbeing of the children in California.

Opening Remarks and Introductions

[Meeting minutes](#) from July 11, 2019 were approved 11-0.

Norman Williams, DHCS: Responses to the follow-up list have been posted to the [MCHAP web page](#).

Opening Remarks from Mari Cantwell, Chief Deputy Director for Health Care Programs and the State Medicaid Director

The 1115 and 1915(b) waivers are expiring next year. Currently soliciting workgroup members for five workgroups related to the discussions on the waiver renewals, via the [California Advancing and Innovating Medi-Cal \(CalAIM\) initiative](#). We're looking to make significant changes and improvements to the program to provide better services to our beneficiaries. A [public proposal](#) will be released at the end of October, which outlines the framework that we continue to build upon. Our Stakeholder Advisory Committee and Behavioral Health Stakeholder Advisory Committee meetings on October 29 will focus on the proposal for the first time. The workgroup meetings will take place from November – February. With the feedback received from our partners and stakeholders, DHCS will develop a proposal that will be submitted to CMS next summer.

Ron DiLuigi: Do you have a timeframe for behavioral health integration?

Mari Cantwell, DHCS: More details are included in the proposal, but we do think it will take a few years. The financing is complex with realignment funds.

Ellen Beck, M.D.: How many members will there be for each workgroup?

Mari Cantwell, DHCS: Between 20-30. All the meetings will be open to the public and will take in-person public comment at the meetings.

Jan Schumann: AIM also refers to Access for Infants and Mothers.

Mari Cantwell, DHCS: That's a separate program that's no longer referred to as AIM. We've cleaned our website so when you search for AIM, you'll only get CalAIM results.

Jan Schumann: I'm hoping that if anyone searches for the AIM program, that there's something on the website that would redirect them to the appropriate page.

Mari Cantwell, DHCS: The Young Adult Expansion will go live in January and we're working on the transition plan. The trauma and developmental screenings payments will go into effect on January 1, 2020; the training for the screenings are being developed.

Proposition 56 funds are continuing to support physician and dental services. The Value Based Payment (VBP) Program measures are now available on the DHCS [website](#). We are finalizing the details for the additional component, the Behavioral Health Integration VBP that was added, which is about \$160 million for a 2-1/2 year period. We're hoping to release the details in November or December, with the start date in April 2020. The Governor's Budget will be released on January 10, 2020. The California Children's Services Advisory Group will meet to discuss the Whole Child Model (WCM). The draft evaluation report on the WCM will be released. We're adding quality measure changes around the preventive services for children: CMS child and adult core set measures, increasing the minimum performance level and adding those measurements for the health plans. For those measures that don't currently exist, we're looking at how to develop them to track performance instead of comparing them to another health plan. We also began releasing our quality data with a breakdown on race and ethnicity, and other metrics, to look at particular populations. Our next report will include a breakdown of all of the measures. It would be a good opportunity to discuss the reports at a future MCHAP meeting. We're also looking at a public outreach plan for children in managed care. We'll release a draft notice to families so that they're aware of the services that are provided and how to access them.

Elizabeth Stanley Salazar: I'm requesting an overview of those reports when released. I'm also requesting to see a baseline of where we are today with children's access and the network, and what DHCS sees as gaps? For the January meeting, we should have an update on where the program is now, what does the access look like, where are the gaps related to equity and health access. We should also look at network adequacy. Are there enough providers out there, or are they triggering a lack of access?

Ellen Beck, M.D.: I support that. You can't do screening without treatment. I'm concerned about the response at the adult level; I'm worried about the adequacy of response, and having the resources and coverage in ensuring that the family needs family therapy. I had also asked if we could have an update on public charge, or the fear of public charge, and what it's doing for enrollment. How are we monitoring or tracking that and being proactive?

Mari Cantwell, DHCS: For the first question, absolutely. That's some of the work that we're doing with the Surgeon General. Part of it is the training piece: making sure that providers who are doing the screenings know where to refer. From a data perspective, the way that the trauma screenings will be billed, we'll be able to know how many ACEs were screened for each patient so that we can track what services they're receiving after. With respect to public charge, CHHS does have [significant information](#) on their website on public charge. In terms of data tracking, it's challenging for us to do that. We have seen overall enrollment decrease, but that's consistent across all populations and is likely due to the economic conditions that have changed over the past couple of years. We will continue to monitor as best as we can.

Ellen Beck, M.D.: You might want to consider advertising on the Spanish-speaking radio stations.

Ron DiLuigi: What advice can you give other entities on public charge? Are you sharing this information with all entities, or just the counties? Are there entities giving advice and counsel to the individuals affected by the public charge?

Mari Cantwell, DHCS: We're publicly sharing it. This information is also on the CHHS website.

Elizabeth Stanley Salazar: There's an opportunity to focus on the perinatal substance use treatment network. The network is comprised of residential and outpatient with specific federal guidelines (in-depth screening, parenting classes, etc.), that are tied to the set-aside in the federal block grant. Most of these women and children are now Medicaid-eligible. The Federal government requires that we report when we hit 85% occupancy. There might be unintended consequences from the referral patterns, or in the flow, volume or utilization, that could ultimately cause loss in these resources. Can DHCS look into this?

Bert Lubin, M.D.: What resources are available for impoverished families? Do we know how many immigrant children are in California, and what their health care is like?

Mari Cantwell, DHCS: We can look at how we can break out data like that; I'll work with my team to analyze and present it.

William Arroyo, M.D.: Is there a new acting Director?

Mari Cantwell, DHCS: Richard "Fig" Figueroa is the Acting Director of DHCS while Secretary Ghaly works with the Governor's Office and DHCS' senior leadership team. We're very excited; he's been with so many administrations and we're excited to have his leadership.

Ken Hempstead, M.D.: For public charge, I'm wondering if we should spend more time discussing this at our next meeting. Perception can be different from reality. Even for the most informed citizen, the situation has changed. Is there a way to reassure the public? I'm an advocate for anonymous sampling and exit polling to see if we can gather more granular data on why beneficiaries are disenrolling. To the extent that if we do see it happening, then that data becomes our political capital for trying to create change around that.

Mari Cantwell, DHCS: Operationally, that may be a challenge. Let us think about if there's a way to do what you're suggesting.

Ellen Beck, M.D.: A number of years ago, there was a report breaking down the lowest socioeconomic quarter of the Medi-Cal population. Some of those data were very concerning versus people with higher socioeconomic income still qualifying for Medi-Cal. We should review an updated report. For ACEs, there should be some expectation on the behavior of the clinicians. One could track less than four or four or more; but

couldn't there be a box that asks for a "plan"? Then you can see the written responses, such as referring to the mental health team, follow-up appointment, etc. It's not a plan related to the diagnosis; it's treating for that score as a risk factor. Same way you would treat smoking as a risk factor. Then we can track written responses, whether that plan occurred, barriers to achieving that plan (resources that didn't exist in that part of the state).

Mari Cantwell, DHCS: We are seeking to add the ICD 10 codes related to social determinants of health. Let us think about how to do that, or if there are other ways, to inform how to improve going forward.

William Arroyo, M.D.: Is there a nexus between the Governor's initiative on homelessness and health care, and if so, what is it?

Mari Cantwell, DHCS: Not speaking on behalf of the Governor, but I will speak about where I think the nexus exists. The Whole Person Care (WPC) program, in conjunction with the homelessness issue, is being transitioned into CalAIM. We are looking at continuing infrastructure and support for helping individuals find housing and stay in housing in a way that's still tied to Medi-Cal. We have some federal limitations on using Medicaid funding for housing assistance (finding housing, paying for security and utility deposits). We call these "in lieu of services." For those populations in Medi-Cal, how do we bring those supportive services around, as well as utilize the fact that we're interacting with this population and connecting them with services that aren't Medi-Cal to continue helping them get housed and stay housed? I would highly encourage you to participate in the CalAIM discussions if this is of interest to you.

Ron DiLuigi: For services like recuperative care, prospectively, how does that get addressed? Is it something that California seeks to address in a subsequent waiver, or is there actually potential to convince CMS to begin to reimburse for it?

Mari Cantwell: There will be discussions on this for CalAIM. In WPC, we currently pay for recuperative and respite care, housing navigation, and tenancy support services. The CalAIM proposal looks at how we continue to build on that infrastructure and have a Medi-Cal benefit that makes sense for the whole state. One of the biggest challenges was building the infrastructure, such as creating recuperative care beds where they don't exist. We have to think about how to maintain what we've already done in WPC, and how to help support WPC where that infrastructure doesn't exist. Those discussions will be held in the Enhanced Care Management/In Lieu of Services CalAIM workgroup. Under federal rules, we're allowed to pay for things like that as long as we're demonstrating that it's no more costly than the services someone would have received.

We see the value and long-term benefit, but the long-term cost of this program is dependent on us finding ways to keep people healthy and in their homes, and not dependent on emergency room visits/lengthy inpatient stays, which is mostly due to the fact that there's no place to discharge them to.

Ron DiLuigi: Will the proposals end up in a new waiver?

Mari Cantwell, DHCS: In some authority. We likely won't do a large 1115 waiver.

Overview of 'Welcome Baby' Program

Christina Altmayer, First 5 LA, and Dr. Kim Bower, Blue Shield of California Promise Health Plan

Slides are available at:

https://www.dhcs.ca.gov/services/Documents/Maternal_Child_SocialDeterminants.pdf

Christina Altmayer provided an overview of the First 5's.

Dr. Bower provided an overview of Blue Shield of California Promise Health Plan. Promise Health Plan is a small subset of Blue Shield of California, and services Los Angeles and San Diego counties.

Ron DiLuigi: Are FQHCs part of the L.A. Care network?

Kim Bower, M.D.: We are contracted with L.A. Care and have our own network of providers. As we implement projects like this, it will be dependent on engaging our network of providers and asking them to make referrals and be partners.

Elizabeth Stanley Salazar: How do you link to specialty substance use treatment for women and possibly their children when found? Have you developed those relationships?

Christina Altmayer: We talk about the model for home visiting. One of the most significant assets of home visiting is the connection to other resources in the communities. While home visitors aren't substance use or domestic abuse counselors, it's the strong relationships that they have with the agencies that allow them to successfully refer women; the trust they build with women.

Elizabeth Stanley Salazar: Where are you in the role of medication assisted treatment in opioid use disorders in terms of your protocols, trained workforce, etc.?

Christina Altmayer: Need to consider boundaries with home visitors: they are not substance abuse counselors. There are a continuum of models in our home-visiting systems and advantages with a diversity of models.

Kim Bower, M.D.: There are limited resources so we must invest wisely. We feel strongly that investing in these home visiting programs will have a strong return on financial investment. We need to be creative in improving our health outcomes.

Ellen Beck, M.D.: For the outcomes, are you looking at food insecurities?

Kim Bower, M.D.: Our quality teams are not looking specifically for this outcome. We have another set of programs that we're working on to try to address food insecurity.

Ellen Beck, M.D.: I would encourage you to consider using food insecurity as a measure.

Christina Altmayer: Home visiting is a service of voluntary, home-based or an alternative site, that is focused on child development, enhancing parenting skills, assessment and referral services where appropriate to strengthen the mother-child bond. In 2016, the Los Angeles Board of County Supervisors endorsed an initiative that said we want to build a universal system for home visiting for all moms in Los Angeles County, which created an incentive to bring multiple partners together, both public and private, to think about how to contribute to this vision under the board's leadership.

Ron DiLuigi: Are home health visits available to all Medi-Cal patients in L.A. County, or are they specifically through the Blue Shield Promise program?

Christina Altmayer: We are not reaching all Medi-Cal members. In theory, they would be eligible, but we don't have established referral pathways for all Medi-Cal moms.

Ron DiLuigi: How are the home visits reimbursed?

Christina Altmayer: A number of different funding sources. We're looking to increase funding and draw down Title XIX funding.

Ron DiLuigi: Is L.A. County drawing down a federal match?

Christina Altmayer: They are through the Nurse-Family Partnership program. There are opportunities to better expand those programs.

Katrina Eagilen, D.D.S.: How many home visits are proposed for each of the patients?

Christina Altmayer: It depends on the program. The Welcome Baby program provides up to three prenatal visits and six post-partum visits. Nurse Family Partnership can provide visits up to the first five years of a child's life and declines in frequency over time.

William Arroyo, M.D.: Nurse Family Partnership's visits begin during the second trimester and end at the end of the second year of the child's life. In L.A. County, many of the young mothers needed mental health services. We started supplying a mental health worker with the home visits. We also pursued to get this funding through Medi-Cal and failed several times. It would be great to have a sustained source of funding because these resources are so desperately needed.

Christina Altmayer: We're excited with the progress that has been made in this year's budget; funding was made available to CalWORKS beneficiaries to receive home visiting as part of their services. One of the challenges is building the infrastructure so that families have the access to take advantage of those services.

Katrina Eagilen, D.D.S.: It would be wonderful to expand that to oral health as well as basic pediatric health for the mothers.

Christina Altmayer: Perspective guidance around milestones; that's a core element around the curriculum, which is to guide moms on what to expect.

Kim Bowers, M.D.: At Promise Blue Shield, the home visiting program is just one aspect of the tools we want to use to improve the care of our pregnant moms and babies. Another tool that we have available is a free app that includes information such as when they are due for a flu shot, regular appointments, and resources for substance users. Part of home visiting is getting them familiarized with the app.

Ellen Beck, M.D.: I imagine that you have moms who are receiving one year of care because they are undocumented. With new legislation covering undocumented adults up to age 26, it seems that home visiting might have a perfect segue to continue their coverage. What happens when a serious problem is identified in the home visiting program and the parent is about to lose coverage?

Christina Altmayer: One of the universal components across all of the programs is assisting with enrollment for benefits. When we did data match efforts in Orange County, we saw that women were less likely to churn when part of a home visiting program.

Ron DiLuigi: This is a great program. A lot of the questions are returning to the home visit because of the funding aspect, which is so uncertain.

Christina Altmayer: About two years ago, the L.A. County Department of Mental Health dedicated about \$40 million of MHSA funds to support the expansion of home visiting. First 5 LA dedicates about \$35 million per year in home visiting programs. Now we're trying to ensure that we're taking advantage of the new funding from the state and making sure that we're developing the referral pathways to ensure that moms are connected to the services.

Bert Lubin, M.D.: We started a program in Oakland called Brilliant Baby. At the birth of a baby from a low-income family, we started a savings account for college. The money can't be drawn out of the account; it has to be for college. If they move to another county, the money goes with the child. Just something to consider adding in to the home visiting program.

Kim Bower, M.D.: The Blue Shield Promise health plan is unique in that it owns two primary community clinics in Antelope Valley. We're at about a 50 percent engagement rate. The challenge will be expanding to Long Beach. The final step, if successful, is expanding this model to the entire state. The expansion statewide would require help in terms of payment models, waivers, or even legislation.

Christina Altmayer: Does the referral that comes from a health plan or primary care provider increase a woman's trust? Our acceptance rate, depending on where we are in the county, varies between 50-60 percent. If we can change the community norms so that women feel more comfortable accepting the service, we're more likely to identify those women who are at the highest risk. How do we break down those barriers and

create those cultural norms that all families need support, and some families need more intensive support?

Ron DiLuigi: If we look at the social determinants as crucial, we're looking for in-lieu of services. I don't know if the state has considered this model to line up full funding.

Christina Altmayer: The opportunity for this to be recorded within the electronic health record is exciting; it will advance this program from a statewide perspective and inform policy.

Ellen Beck, M.D.: Are you approaching women at the time of delivery?

Christina Altmayer: Ideally, we'd want to identify women as early as possible. If they haven't been approached by us before delivery, we would make contact at the hospital.

Ellen Beck, M.D.: For those who choose not to enroll, I assume you would ask why. Some of our patients would need an enormous level of trust because of their legal status, so can the meetings take place outside the home?

Kim Bower, M.D.: Yes, maybe if there was a place to meet. Our members do have access to technology sometimes so telemedicine might feel a little safer. Once the referral is transferred to the provider agency, we can't always meet them by phone.

William Arroyo, M.D.: Given the Governor's interest in early childhood, this may be the best time to secure sustainable funding.

Member Updates and Follow-Up

Members approved an update to the MCHAP manual.

Ken Hempstead, M.D.: We're still working to replace one of our parent members. It sounds like there was interest in a more robust presentation on CalAIM. The other item that had been suggested during today's meeting was an update on access and network adequacy. Are there any thoughts or comments?

Ellen Beck, M.D.: Maybe we could look at some targeted areas that we previously knew were issues, such as children's mental health in rural areas or areas that had previously been targeted for access issues; a specific update on those areas. And maybe the update can be linked to looking at the lowest quartile of beneficiaries within Medi-Cal, and looking at their access in particular.

Elizabeth Stanley Salazar: I mentioned the perinatal network several times. An update on the SUD perinatal network, the impact that DMC-ODS may be having on referrals and utilization to that network, and how ACEs can be incorporated into the use and impact of the network.

Nancy Netherland: Adding to the data bandwagon, I'm interested in looking at data for not only the behavioral health referrals, but also at the variation and authorization by plan type and direct Medicaid, in addition to the wait time for service. Sometimes there's

a hidden wait time when a referral is made, to the time of authorization. Health plans have different authorization times. It might be interesting to look at the lowest and highest performers in terms of short authorizations and see what's happening with some of the different direct pay programs.

William Arroyo, M.D.: I didn't know there were different metrics across the Medi-Cal supportive programs. I thought they were all subject to the same federal timeframes.

Nancy Netherland: I believe the implementation is different. I don't know if there has been an audit to see how compliancy is with those referral times. I'm also interested in how authorization can add to it; it's not technically the wait time.

Mari Cantwell, DHCS: I will need to check with our team that does monitoring and oversight. As we think about the January meeting, we can touch base in the interim on how long we want to talk about CalAIM. Whether we want to do a whole overview or targeted discussions, it will affect the other things we can discuss covering during that meeting.

Elizabeth Stanley Salazar: I would not want to spend the entire meeting on CalAIM. I would like an overview.

Ellen Beck, M.D.: What I found most useful is having Mari facilitate and targeting key questions that you know are achievable. Identify areas in which you feel there's an opportunity for the panel to weigh in and ask us.

William Arroyo, M.D.: In keeping with the statutory authority of this group, it would seem that this group would want to focus on any waiver that affects children and provide input before it's finalized.

Elizabeth Stanley Salazar: That's true once we have that level of depth.

Mari Cantwell, DHCS: There will be a lot to look at when it comes out in October. We'll need to work with the Chair to determine how the January meeting will work.

William Arroyo, M.D.: We'll defer to the Chair's discretion.

Elizabeth Stanley Salazar: A few months ago, I reported to this panel that under the State's Opioid Response grant, we had a grant to provide \$11 million in funding to innovative projects related to access to opioid treatment among youth, ages 12–24. We successfully awarded 32 grants; 10 were planning grants and 22 were innovative direct service grants. When our website is launched, I'll supply the information to Morgan because you may want to look closer at some of the innovative project throughout the state.

Ken Hempstead, M.D.: For the ideas that just came up other than on CalAIM, I encourage the Panel to email Morgan with the ideas that were just stated.

Jan Schumann: On the next agenda of the next regular meeting, we should formally thank Director Kent, and in a separate letter format, welcome the new Acting Director.

Ellen Beck, M.D.: Recommend formally including the thank-you letter from the Panel to Director Kent in the meeting minutes.

Public Comment

Michael Odeh, Children Now: Earlier this month the Managed Care Advisory Group meeting shared that they're working on a preventive services utilization report. I just wanted to make sure that the MCHAP members heard that update and that DHCS will engage the members on developing that report.

Mari Cantwell, DHCS: We haven't yet released the report, but can share with the MCHAP members.