State of California—Health and Human Services Agency

Department of Health Care Services

Medi-Cal Children's Health Advisory Panel

December 9, 2021 - Webinar

Meeting Minutes

Members Attending: Ken Hempstead, M.D., Pediatrician Representative; Jan Schumann, Subscriber Representative; Ellen Beck, M.D., Family Practice Physician Representative; Diana Vega, Parent Representative; Nancy Netherland, Parent Representative; Alison Beier, Parent Representative; Kelly Motadel, M.D., County Public Health Provider Representative; Elizabeth Stanley Salazar, Substance Abuse Provider Representative; Karen Lauterbach, Non-Profit Clinic Representative; Stephanie Sonnenshine, Health Plan Representative; Michael Weiss, M.D., Licensed Disproportionate Share Hospital Representative; Katrina Eagilen, D.D.S., Licensed Practicing Dentist; Ron DiLuigi, Business Community Representative, William Arroyo, M.D., Mental Health Provider Representative.

Members Not Attending: Jovan Salama Jacobs, Ed.D., Education Representative

Public Attendees: 70 members of the public attended the webinar.

DHCS Staff: Jacey Cooper, Yingjia Huang, Norman Williams, Jeffrey Callison, Morgan Clair, Audriana Ketchersid.

Guests: Elizabeth Landsberg, Director, Department of Health Care Access and Information

Opening Remarks and Introductions

Ken Hempstead, M.D., MCHAP Chair, welcomed webinar participants. The legislative charge for the advisory panel was read aloud. (See agenda for legislative charge.) The meeting summary from September 9, 2021, was approved, 12-0. Administration of oaths was completed for five MCHAP members: Hempstead, Arroyo, DiLuigi, Eagilen, and Beier.

Opening Remarks from Jacey Cooper, Chief Deputy Director

Cooper provided an updated on Medi-Cal COVID-19 vaccination efforts. Data is published routinely on the DHCS website. There is still a gap between the vaccination rates of all Californians and the Medi-Cal population's vaccination rates. We continue to work with our advocates, stakeholders, and providers on improving that. Since introducing our Vaccination Incentive Program, we have seen increases in vaccinations for Medi-Cal beneficiaries. We are asking for help to educate and get Medi-Cal

beneficiaries in for vaccinations. All managed care plans (MCPs) submitted their vaccine response plans in September 2021. MCPs are taking a multi-pronged approach, including vaccine pop-up clinics at large events, such as concerts and festivals; vulnerable individuals getting homebound vaccinations; and campaigns to counter vaccine hesitancy and misinformation. We partnered with the California Department of Public Health (CDPH) to administer toolkits to MCPs; the toolkits have been tailored for specific race and ethnicity groups. Many MCPs also focused on provider incentives to enroll in the myCAvax program.

DHCS is working with the Centers for Medicare & Medicaid Services (CMS), Covered California, and other partners on the public health emergency (PHE) unwinding, which we anticipate to take place in 2022. This effort is focused on member eligibility and redeterminations. We are preparing for a large redetermination over a 12-month period based on CMS guidance. We're asking our community partners to help us get the word out to beneficiaries. Notices will be sent to all beneficiaries via mail in 2022, so it is important to ask beneficiaries to update their contact information. We are issuing social media posts, including a banner on the DHCS website, and working with key advocates to get this information out in 2022.

For CalAIM, we are finalizing negotiations with CMS. We hope to have approval on the 1915(b) and 1115 waivers by the end of this month in anticipation of a January 1, 2022, go-live for many CalAIM components. Our Whole Person Care (WPC) pilots and Health Home pilots end this year. Enhanced Care Management (ECM) and the 14 Community Supports are included in CalAIM. We have announced a phase-in approach for ECM populations, with the last phase in July 2023 focused on children and youth populations. We are launching a children's advisory committee to help inform the ECM protocols for the children and youth populations.

We are working with CMS on Providing Access and Transforming Health (PATH) negotiations. A portion of the PATH funds are dedicated to justice-involved capacity building. We'll have transition services for WPC services to Community Supports. We'll provide technical assistance to providers, and grants will allow them to bring in consultants to help them meet the needs and, with training initiatives, to build understanding of what we are looking for and how we can grow our provider base.

DiLuigi: For Community Supports, is there a pathway for local health plans, counties, and health operations to suggest additional supports?

Cooper: When we first issued Community Supports, there were only 13. Through stakeholder engagement, we added asthma remediation. Any support added to the list must go through DHCS, and after negotiations with CMS, it must be added to the MCP contract. The new support must demonstrate that it is medically appropriate and cost-effective. We have 14 services now, but DHCS is open to engaging with individuals where there is opportunity to add additional supports in the future. It is not an easy process and takes a lot of time and conversations. Much of the current Community

Supports were locally driven, meaning multiple pilots tested them and they worked, giving evidence they were effective.

Beck: I think this would be a worthy agenda item for a future meeting to make long-term suggestions on Community Supports. I'm pleased about the work being done for justice-involved populations; there is a need for a true transition for someone out of prison. For Assembly Bill (AB)133, what is the implementation process and timeframe, and how are we working with community organizations so people feel safe to apply?

Cooper: The expansion go-live date is May 2022. We have notices ready and are preparing for systems readiness. Anyone currently enrolled in our program will automatically switch over. We are working closely with advocates and navigators to make sure others are aware of their ability to get full-scope Medi-Cal.

Schumann: On slide 6 there is a reference to the targeted gap closure for the vaccination disparities for January 2. Is the Department on track with reaching these targets? Also, a representative from MCHAP should be on the new CalAIM Community Supports workgroup.

Cooper: I believe we do already have crossover from MCHAP for that group. We're happy to engage the panel on what the 14 Community Supports will look like, and we can include that for a future presentation. As an example, respite services for children and adults are included as one of the supports.

Arroyo: I want to underscore what Ellen Beck brought up about the issue of Community Supports. I think waiting until our next meeting is too late. Community Supports can become an essential benefit. Can the Department give us ideas about how we can provide input related to Community Supports now? In regard to Community Supports, can you speak about the financing of these?

Cooper: We have provided information on Community Supports to MCHAP previously. We went through a year and a half of public stakeholder engagements and comment periods to fine tune these 14 supports. We can have it on a future agenda where we talk about it and get feedback. Ideas and comments can come in at any time. In regards to funding for Community Supports, it is a combination of state and federal funds. There was an extensive trailer bill on all of these pieces. It will be built into the capitation rate for MCPs, so they will receive funds for Community Supports as we build that capacity. There are no local funds for Community Supports.

Arroyo: A few days ago, DHCS sent out a notice about a large component of AB 133 that I think this group should be more aware of. At our next meeting, we should discuss the component of this massive data sharing exchange effort. It will drastically change the way agencies communicate with one another.

Cooper: The memo that we released for public comment this week is related to data sharing specifically tied to CalAIM. That memo is focused on ensuring that everyone understands AB 133, which allows for more broad data sharing across delivery

systems. This will feed into the population health management (PHM) service. We can present to MCHAP on the PHM service. We're compiling the planning documents and will be releasing a Request for Proposal in 2022.

Arroyo: I understand this includes information exchange with social agencies, so it would be great if we could hear about it with the opportunity to provide feedback.

Cooper: We will be partnering with our sister agencies to pull in social data. This may take time to integrate.

Netherland: What will happen to the fee-for-service (FFS) beneficiaries with the transition. My understanding is that ECM is focused on managed care only. It seems there is a disproportionate number of medically complex kids who are on FFS. Where can I get more information on this?

Cooper: One of the CalAIM proposals is to transition more populations from FFS to managed care. On our website we have a grid of all our populations transitioning to managed care starting January 1, 2022 (all non-duals and certain zip codes that don't have managed care), and January 1, 2023 (dual individuals). For anyone receiving WPC services on the FFS side, those would end with this transition since ECM and Community Supports are federally authorized on the managed care side. About 85 percent of our population is in managed care today, and in January 2022, it will be closer to 90 percent. In January 2023 it will be even higher.

Netherland: For children with medical complexities and former foster youth, where certain managed care entities do not have the services, they often end up in multiple systems. There's a way to be strategic to use FFS to create a patchwork with different providers to create a comprehensive care plan. What is it going to look like for kids who are in multiple systems going into a MCP?

Cooper: Children can be in CCS and managed care. If you are in CCS, you are still eligible for ECM and Community Supports. For true FFS, it is more complicated. It's the MCP's responsibility if they don't have a provider in network to find the patient an out-of-network service to meet the obligation of the benefit.

Netherland: I'm curious about geographic instability of foster youth and the process of continuity of care. If a young person has to travel across county lines, how are we making sure that is facilitated?

Cooper: We appreciated the feedback we received through the Foster Care Model of Care workgroup. Through internal conversations, we are trying to determine how to get the best continuity of care and coordination of services.

Netherland: If patients need to change providers because they are not covered by the MCP, who will help with that transition?

Cooper: There are continuity of care rights in California, and it is a requirement in our MCP contracts. The MCP must continue that continuity with the provider, even if they

are out of network. But the provider must accept the rate from that plan. We have an All Plan Letter (APL) that gives plans guidance on continuity of care expectations.

Beier: In the beginning of the pandemic, we saw general vaccination rates had dropped due to hesitancy. What are we seeing with normal children's vaccination rates?

Cooper: We noticed in May 2020 a decrease of children's vaccination rates across California, mainly because offices had closed down at the time and only allowed for telehealth services. DHCS and CDPH launched a campaign to increase vaccination rates. We are seeing increases, but we have not caught up to pre-pandemic levels of children's vaccinations at all ages. We will continue to push for all vaccinations in 2022.

Beier: Can you speak more to the public health emergency (PHE) unwind?

Cooper: CMS issued guidance allowing for a 12-month transition for the unwinding specific to the redetermination process.

Beier: Inside of that 12-month period, you mentioned that most beneficiaries will be contacted during the scheduled annual renewals. When will families receive this information?

Cooper: Beneficiaries will stay on their normal redetermination month. Since we don't know when the PHE will end, we are broadly telling people to be aware. We anticipate it will end in 2022.

Beier: In regard to expanding financial limits, who does this apply to and what percentage of poverty level?

Cooper: We are not making changes to income eligibility. California will increase the asset limits and eventually eliminate asset evaluations as a factor in determining Medi-Cal eligibility.

Beier: Can you provide clarification on the 14 Community Supports?

Cooper: Community Supports offer services to an individual in lieu of an already approved benefit in Medi-Cal. It has to be medically appropriate, meaning there needs to be some eligibility or clinical driver for why the service would ultimately improve someone's health outcome or prevent future utilization of high-cost services. Additionally, it has to be cost-effective for the replacement of that Medi-Cal benefit. For example, asthma remediation is in lieu of a potential emergency room visit for someone who does not have that remediation at home.

Beier: Is the rollout structured in a way that ensures people who are duals are covered so they will not fall off Medicare after a transplant?

Cooper: This might be too technical for me; we will take it back. Starting January 1, we are requiring all major organ transplants be a requirement of Medi-Cal MCPs. With the crossover of the dual piece, I need to consult with my eligibility and policy team.

Beier: When is that transition?

Cooper: If someone is in the process of the transplant, they would finish that with FFS and then transition to managed care. Future transplants would stay in managed care.

Schumann: Regarding the assets no longer being considered to determine Medi-Cal eligibility, will that have an effect on Medi-Cal Estate Recovery?

Cooper: We'll get back to you on that.

Hempstead: For the Vaccination Incentive Program, how much of that money is being distributed and used? Can you explain how that system is working?

Cooper: Of the $350 million for the incentive program, $100 million was dedicated for direct member incentives. Gift cards are predominantly being used by MCPs ($50 per member). MCPs will invoice us for direct member incentives. We must ensure beneficiaries are receiving the incentive for the vaccination, and there has to be parity. In the first quarter of 2021, we did see increases in vaccinations across various population groups. MCPs are working closely with community-based organizations and providers to reduce the vaccination gap between Medi-Cal beneficiaries and all Californians. On our dashboard, there are multiple slides that break down the numbers further by county, plan, race, ethnicity, age groups, etc.

Hempstead: What I'm understanding is the program is optional for MCPs. Stephanie, do you happen to have any sense of what plans are doing?

Sonnenshine: I can only speak from my plan's perspective. Certainly local plans are deeply engaged in doing this work in their communities. Many of us have worked collaboratively with our public health departments on protective measures and testing messaging and outreach to the community. Our plan is operating an incentive program that includes outreach to members, data analysis, and partnering with local providers and community health departments. We've found trust is a huge barrier. We're working to make sure that the messaging is consistent.

Schumann: Are incentives available for boosters as well?

Cooper: Yes, for all age groups and boosters.

Beck: Will people with restricted Medi-Cal receive a letter saying they have full-scope Medi-Cal? Will that be tracked to ensure people are embracing that and signing up?

Cooper: Yes, anyone on restricted scope Medi-Cal will receive a notice 60 days before the go-live date telling them they are moving to full-scope managed care. When we have the data, we will post the increased numbers we hope to see.

Election of Chairperson for 2021

Dr. Hempstead was the only member to express interest in the position, and he provided highlights from his vision statement. The panel approved Dr. Hempstead as Chair, 13-0.

Children and Youth Behavioral Health Initiative Discussion

Cooper: We are still in the planning and design, so we are hoping to get feedback, thoughts, comments, and ideas. The goal is to focus on a preventive lens of access to behavioral health, meaning both mental health and substance use disorder (MHSUD) services for children, youth, and their families. This $4 billion initiative for children and youth ages 0-25 is across all payers in California and it is not specific to Medi-Cal. DHCS will: lead the behavioral health service virtual platform and e-consult pieces; train pediatric providers on how to use the platform; lead the school behavioral health capacity grants to increase availability of behavioral health services on or near school sites, including higher education; and form a behavioral health think tank. We are working to build out the Behavioral Health Continuum of Care. HCAI will lead the expansion of the behavioral health workforce capacity, specifically focused on behavioral health counselors and coaches.

Hempstead: How do we delineate what non-school-based counselors are doing compared to school-based counselors? How do we ensure there is one therapeutic plan of care and diagnosis? How do we resolve any of that conflict? How do we resolve issues, such as parent involvement and participation? What are the panel's thoughts?

Arroyo: We should change the name of this initiative to "Child and Family Behavioral Health Initiative". Without a family, a child is not going to progress mentally or physically. I am interested in ensuring a robust continuum of care for youth as it relates to substance use. It's cheaper and better to intervene early.

Dilugi: I like idea of engaging schools and making sure they are a key element. How that is best is still to be determined. We have to make sure that there are resources if we bring education into it.

Stanley Salazar: Family engagement should be a critical component. At Phoenix Houses of California, we were a SUD treatment agency in the 90s. We co-located MH services in our adolescent residential treatment programs because the youth needed it. Today I am deeply involved with Health Management Associates, and I am a principal on the youth opioid response grant and stimulant use disorder grant. We accomplished 18,000 screenings for youth because we had four federally qualified health center (FQHC) partners who built screening right in their centers. We do not have the service capacity on the ground to meet the needs of the complex cases we are seeing for youth in the foster care system and juvenile justice system, let alone move upstream to build capacity. There is a crisis. The Department of Social Services has to join with DHCS to resolve this partnership between licensing formulation and mental health.

Beck: Often we know that it is a parent who may have a serious problem, which leads to a problem in the child. Actual care for parents and family therapy should be seen. SUD treatment for the parent should be a part of this model. I worked with a school district on a comprehensive model; we offered a class to children on being a youth health promoter. The kids would learn and see themselves as being a promoter around school. There are models that exist for that kind of collaboration with schools. The carve-out, at least in San Diego, is a serious problem in which kids fall through the cracks. I also work with university students, and there is a huge stigma about mental health, and sometimes there are structural issues.

Hempstead: Karen, can you comment on that, or anyone else who has experience in their local schools? What have our informal pilots taught us so far?

Lauterbach: We have a comprehensive behavioral health program at one of our school-based health centers. As a result of the pandemic and everyone going virtual, we had kids accessing services who had never accessed them before. The feedback the therapists were getting was that it can be stigmatizing when kids walk in the door. The virtual side helped them feel free to access the services. Stigma is huge especially for teenagers. Integrating that is key for kids accessing services. It's important to assess if the family is safe as well, because some kids come from places where it is not safe to have the family involved. Is this only for kids with Medi-Cal? We see at our health centers a population of kids looking to bypass health insurance; they don't want a record or their parents finding out what they're accessing.

Cooper: This initiative is for ages 0-25 and all payers. The only Medi-Cal-only part is the dyadic services benefit that is being added in the future.

Hempstead: Now that kids are back in class, is there still a virtual option?

Lauterbach: Yes. Kids are savvy with phones and do not seem to have technology issues. Connecting or setting up services where kids don't have to physically walk into a place is important. We didn't realize how much of a barrier that was.

Hempstead: How does it work virtually? If they have an 11 a.m. appointment, they still need to go somewhere to take the call.

Lauterbach: My understanding is they provide services after school as well. They have multiple times they can do it. I'm happy to get more details on how that works.

Hempstead: I think the details do matter. How is having a 4 p.m. appointment any better than not accessing it through the school? I think there is a downside of having more than one therapeutic relationship and diagnosis.

Arroyo: I used to be an employee of the Los Angeles Unified School District and was a direct service provider onsite. We worked to identify hotspots throughout the district where kids had higher levels of mental health challenges. The low hanging fruit was where school sites already had some sort of extensive health service infrastructure.

Trying to coordinate the service array for kids on campus was a challenge. There are confidentiality laws that restrict the exchange of information. These different laws challenge communication among professionals and school staff. Maybe AB 133 will resolve a lot of this, but stigma remains problematic for some kids. In the hotspots we identified, there were opportunities for families to get care after school hours and sometimes on weekends. There are current models in California. The pandemic has compromised some operations in various places. With the additional funding, there is an opportunity to better meet the needs of students. There is a preponderance of problems from students in alternative school settings, and it is challenging for districts. The level of need for services for MHSUD was very high when I worked with these schools.

Cooper: We are still developing which services are part of the all-payer mandate available for all children.

Schumann: Will there be telehealth reimbursements? It would be difficult for parents who are reserved in allowing exchange of information between two therapists.

Cooper: We aren't changing the schools' requirements for individual education plans or any school-based educational requirements that exist today; that continues to be their responsibility. We envision a virtual platform, but we are also supporting telehealth within the use of school services as well.

Vega: How is that going to be different than the requirement for the school district to provide educationally-related mental health assessments? Would parents be notified that their child is getting services?

Cooper: We are happy to collect your input and comments right now, but since policy discussions are still ongoing, unfortunately I am unable to answer questions at this time. As we think through policy decisions, we can have your comments inform that work.

Vega: I'm concerned about starting services in school without parental consent.

Beier: I suggest including community peers to help model behaviors for the kids. For continuity, between providers at school and other providers, it's important to consider family, teachers, regional centers, etc. if the school is going to take this on. A concern regarding grant money is whether auditing programs are in place, ensuring all schools and districts are meeting best practices benchmarks. As a plan for schools to follow, there should be baseline recommendations and new contractors being vetted. School therapies are vastly different compared to outside ones. At age 12, you lose access to your parents to view medical records. Because of this consent, there should be separate programs for children under age 12 and over age 12.

Hempstead: Please email any thoughts we didn't get to today to the MCHAP mailbox. Dr. Lee mentioned the Student Mental Health Work Group; the November meeting ended up being canceled.

Behavioral Health Workforce Programs

Elizabeth Landsberg, Director of HCAI, provided an update on Behavioral Health Workforce Programs. Slides are available here: https://www.dhcs.ca.gov/services/Documents/120921-MCHAP-presentation.pdf

Stanley-Salazar: We know how to build a workforce from the ground up with peer counselors. There is a structural problem, especially as we move toward integration of the workforce. We've had two silo workforces through MHSUD. At Phoenix Houses of California, we combined these and know how to do so. A big issue is that when we decided to certify SUD counselors, we decided not to do it through a state agency, but rather through a nonprofit agency. We need a career path in behavioral health services that recognizes specialty areas, particularly among youth. An obstacle as we try to recruit staff is that there is no clear pathway to success.

Landsberg: We are thinking in terms of career ladders as we develop these different classifications. We must show the opportunities that are ahead of them.

Arroyo: Are there any plans to use Spanish-language media to help expand on diversity? I think this public meeting should also provide other language capability.

Landsberg: Some focus groups are in Spanish; we'll look at other language media.

Beck: Our best behavioral counselors came from the community, called promotoras. They did not have official degrees. It's important we are careful on what to expect. We shouldn't have barriers beforehand. There is a lot of inherent trust in these people in the community. A population I think we should look at is university staff. The idea of the primary care psychiatry fellowship should be expanded to all levels of providers throughout their career to have an opportunity to devote themselves to psychiatric work.

Landsberg: Thank you for your input.

Motadel: My prior role at a FQHC had physicians who went through the primary care psychiatry fellowship. They could earn scholarships. Adding incentives for employers would be helpful, especially if you want to achieve diversity. Volunteer opportunities are inherently a barrier to diversity because oftentimes that is not an option.

Lauterbach: For focus groups with homeless youth, I recommend going through homeless access centers they are already a part of. There's a lot more trust with that staff. We've had providers go through the fellowship, and it makes a huge difference. We have a patient advisory council through our clinic, and a consistent issue brought up is wanting to advance in work and understand work opportunities. We haven't been able to do much because it is a bit out of our lane. If we had support and had someone come in and give them information, I think we'd have a welcoming audience. Some of the best staff are the ones who used to be our patients. I also want to echo paid internships and opportunities for increasing diversity. Many opt out because they do not have the privilege of taking something for free. The more we can close that gap, the better.

Schumann: It would be great to offer free classes and first aid for kids as young as middle school who help take care of their grandparents. Getting them interested before high school can build an appetite for the medical field. Promote dual enrollment so that kids can take college classes in high school to learn more about the medical industry.

Eagilen: I'd just like to thank Elizabeth for everything she is doing at HCAI. HCAI funded a program for us, and 60 percent of the students went on to dental school.

Hempstead: There is an untapped resource at the other end of the age spectrum. We have a lot of folks who are retired with a lot of wisdom. There are different community service organizations to look to. Churches are a great resource to think about.

Netherland: I'm thinking about how teens get support and information. When thinking about health coaches and different types of providers who might enter this continuum of care, I encourage thinking about the intersection and how that care is delivered. As a parent of teens, I see the power of them being able to access resources via text and video. We have to think about it on the front-end so that the services is reimbursable.

Landsberg: We are collaborating with DHCS on the online portal. I agree we need to be aware that teens can use information in different formats.

Arroyo: There are a number of different funding streams that support workforce development. We have a strong focus today on behavioral health. I believe there was funding through Proposition 64 for workforce development. Does that come to you?

Landsberg: I'm not familiar with Proposition 64 funding. There are Proposition 56 dollars that support workforce that go primarily to the California Medical Association. We are working closely with the labor agency on a wide range of workforce components.

Medi-Cal and CHIP Total Enrollment Children Ages 0-3

Huang provided an update on children's enrollment trends for ages 0-3. Slides available here: https://www.dhcs.ca.gov/services/Documents/120921-MCHAP-presentation.pdf

Schumann: Is there data available for us to review for children and youth ages 4-25? Can that be put on a per capita basis?

Huang: We have a dataset updated through age 21 we can share. We also have a breakdown of demographics with data by month from the early 2000s for each age bracket.

Beier: Looking at the data, the decrease in births seems it should be above 6 percent. Has DHCS seen any other factors causing this?

Huang: There is an ebb and flow of the different age groups moving in and out of coverage. There probably is some kind of pattern if we were to go back even further than 2019.

Hempstead: Another driver is eligibility. We potentially have lower unemployment and people earning more money. Can you comment at all in a similar sense to that aspect?

Huang: If we were to zoom out and look at the total enrollment for children ages 0-21, we would see an increase in month-to-month data because of continuing coverage requirements. The total impact from different age groups entering our program is that we do see increases in different age brackets. Total child enrollment is increasing.

Hempstead: Good to keep that in mind along with the PHE and looking at 2022 data.

Member Updates and Follow-up

Hempstead: A potential topic would be the 14 Community Supports so we can all become familiar with them. Dr. Weiss brought up the implementation of Medi-Cal Rx, which will come into play soon. Dr. Arroyo mentioned the AB 133 data exchange effort.

Beier: We had a discussion about the PHE ending, and for people to be aware of mailings coming to their house for updated addresses. I think it would be a worthy discussion to see how information is being disseminated, how do we ensure people are opening the mail, looking for it, etc.

Hempstead: Director Baass can include that in her director updates.

Arroyo: We would want to look at Governor's Proposed Budget for 2022-23.

Schumann: There are a number of pressing items, and we have one MCHAP meeting scheduled within the first six months of 2022.

Beck: Something we've looked at before is the literacy level of documents that are sent out, and I would like us to look at this again. We should look at when budgets come out and have our meetings in a reasonable time in relationship to budgets. Not necessarily adding meetings.

Netherland: I would suggest a consumer review of materials. There should be an opportunity to review what it's like to get assistance, as it is not always easy. With critical communications going out that affect benefits, I would like to see DHCS walk us through what is available for families. What are the adaptations for people who need hearing assistance, etc.? What is the process on making sure addresses are correct? What kind of social media campaigns are going to be used, if any, to get this information out? As we move forward with behavioral health rollouts, I would like to revisit same-day exclusion billing policy. Because of the current prospective payment system structure, FQHCs are not able to bill for two visits (behavioral health and primary care).

Hempstead: ACEs screening is another area ripe for discussion and feedback. I encourage everyone to email the MCHAP inbox for ideas on future agendas.

Public Comment

Tawna Roberts, Pediatric Optometrist and Assistant Professor at the San Bernardino School of Medicine: I want to bring to attention that several studies have shown that children of ethnic minorities often times have vision problems that can be corrected with glasses. However, since the DHCS policy change in January 2020, I have directly witnessed that these children have virtually no access to covered glasses. This is similarly reported by nonprofits across the state. Research has shown the benefits of early intervention on academic achievement. Glasses alone have a major impact on children with development problems, and providing adequate vision correction is a powerful tool. It's time to update the policy and make vision care a priority.

Ida Chung, President of California Optometric Association and Professor of Optometry at Western University Health Sciences: According to the CDC, 1 in 4 children have some sort of vision problem, yet only 15 percent of preschoolers receive an eye exam. The problem is worse for low-income children. With more screen time during the pandemic, we see more children with vision problems, many of which are preventable with timely diagnosis and treatment. I'm asking DHCS and this advisory panel to include data on children's vision care on the Open Data Portal and Medi-Cal Children's Health Dashboard, and convene experts to create an action plan to improve the rate of vision screenings, eye examinations, and timely provision of eye glasses to those in need.

Kelly Hardy, Children Now: I want to echo the request around children's vision services. Eighty percent of kids with a learning disability also have undiagnosed vision conditions. We recently held a forum in Southern California, and a few parents approached my colleagues about troubles getting their kids eyeglasses through Medi-Cal. The request is around data so we can better understand what the problems are, and convening an expert panel that includes families to put together an action plan on screenings, eye exams, and eyeglasses.

Additional Member Updates and Follow-Up

Arroyo: There is a congressional hearing on December 14 at 9:30 a.m. Morgan can hopefully send out information on this.

Beier: Can we add vision to the list of agenda items?

Hempstead: I don't think the evidence supports the contention, which is why it has not been an agenda item. In addition to the congressional hearing, Morgan can send information on the Student Mental Health Workgroup that Dr. Lee invited us to.