The Children's Partnership

California Children's Trust

CENTER ON POVERTY and INEQUALITY
GEORGETOWN LAW

ECONOMIC SECURITY and OPPORTUNITY INITIATIVE

# REIMAGINING MEDI-CAL:
## *Collaborating with Families and Communities to Advance Child Health Equity*

**EQUITY THROUGH ENGAGEMENT FINAL REPORT**

SEPTEMBER 2022

## EQUITY THROUGH ENGAGEMENT PROJECT

This report is the culmination of the Equity Through Engagement (ETE) project, a partnership of The Children's Partnership, the California Children's Trust, and the Georgetown Center on Poverty and Inequality to advance child health equity in California. As part of the ETE project, the partners conducted policy-relevant quantitative and qualitative research and analysis to examine opportunities for California to integrate community partnerships and interventions into its Medi-Cal health care financing and delivery systems in order to advance child health equity. In addition to this final report, the ETE project produced the following materials to illustrate how these areas of focus can advance child health equity:

- Care Coordination Issue Briefs: Key Components of Children's Care Coordination and Care Coordination for Children in Medi-Cal discuss why care coordination services are a pivotal component in whole-child health care and their relevance to the early and periodic screening, diagnostic, and treatment (EPSDT) entitlement, and share ways to better deliver culturally concordant services to Medi-Cal beneficiaries.
- Family Engagement Report: This report presents the results of qualitative research with parents and families about their experiences with their children's Medi-Cal covered healthcare services, and what they need to productively engage with Medi-Cal managed care plans.
- Child Opportunity Workbook: This workbook uses Child Opportunity Index (COI) scores developed by Brandeis University and the Ohio State University to assess social drivers of health by race and county across California. It provides policymakers and advocates interested in improving child health care equity with a useful snapshot of disparities in opportunity across California.

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# Executive Summary

Half of California's children are covered by Medi-Cal (California's Medicaid program)—nearly three-fourths of whom are children of color—giving the program a significant opportunity to advance children's health equity. All children covered by Medi-Cal are entitled to the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit which provides for a comprehensive array of pediatric-specific preventive and primary care, as well as medically necessary treatments and interventions. Yet California's Medi-Cal program has not lived up to that promise—with low preventive care and screening rates as well as a large gap between mental health care needs and access to mental health care. This persistently poor performance contributes to child health disparities.

California has made a laudable commitment to improve the physical and social-emotional health of children covered by Medi-Cal, centering its reform landscape predominantly on managed care plans (MCPs) through which 92% of Medi-Cal children receive care. This focus creates challenges because MCPs operate under a distributed risk model, whereby financial incentives that drive their decisions may be at odds with children's wellbeing. Childhood development and long term health are profoundly affected by social emotional factors, and MCPs have not traditionally covered interventions to address these social emotional needs. Thus, the children who are at greatest risk for negative health outcomes are covered by a system that is not designed to improve those outcomes, nor financially incentivized to mitigate that risk through proactive interventions.

In the final report of the Equity Through Engagement (ETE) project, we examine Medi-Cal managed care as a tool to advance child health equity. We look at the extent to which MCPs can play a central role in Medi-Cal responding to social drivers of health and health-related social needs, particularly for children's health. Given the population-based nature of social drivers of health, we also explore how communities and families themselves, as experts in their own needs, can be better centered in the equation between health care systems and child health equity.

*"Using the metaphor of a stream, upstream factors bring downstream effects. Social needs interventions create a middle stream. They are further upstream than medical interventions, but not yet far enough. Social needs are the downstream manifestations of the impact of the social determinants of health on the community. Improvements in our nation's health can be achieved only when we have the commitment to move even further upstream to change the community conditions that make people sick."*

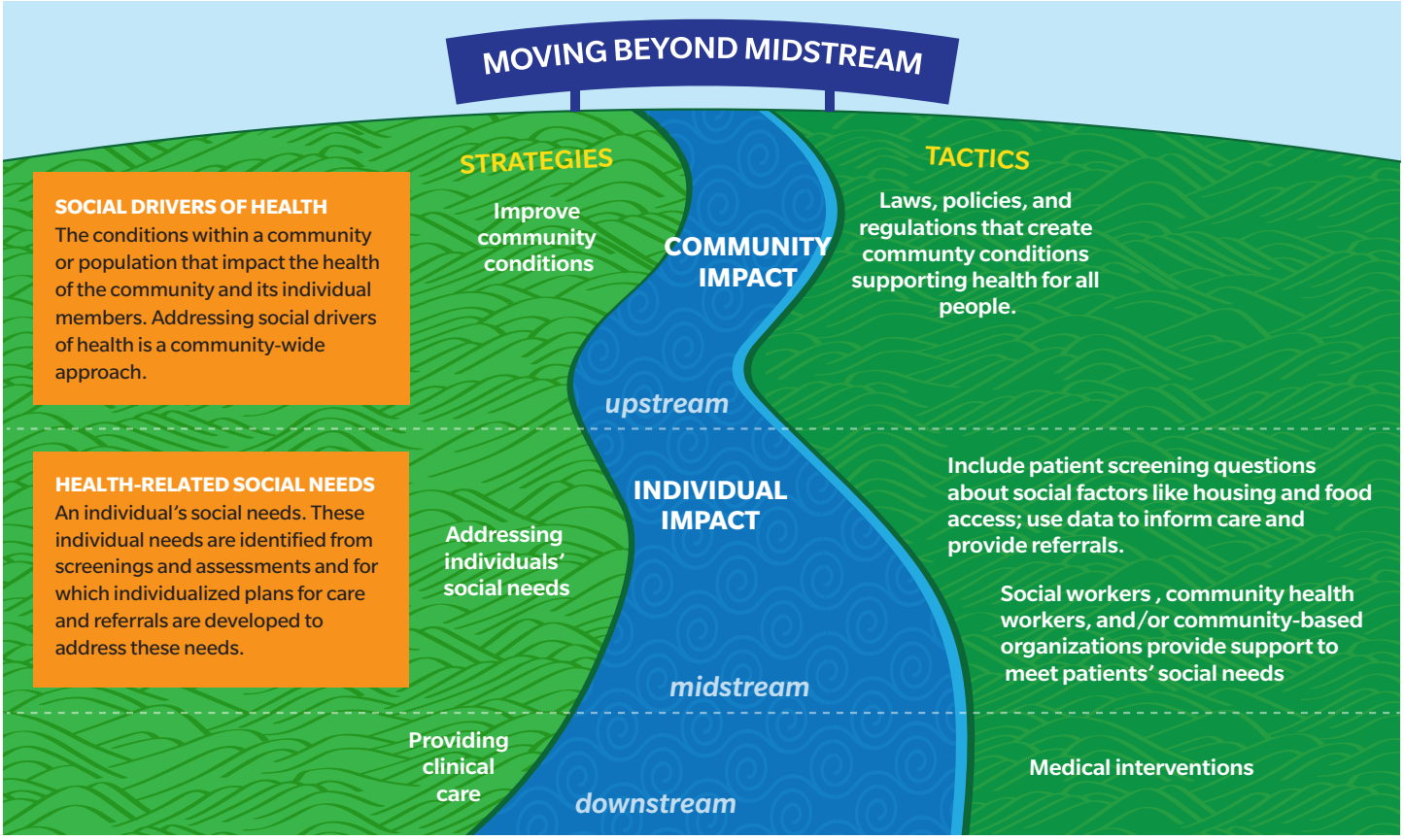
**—BRIAN C. CASTRUCCI AND JOHN AUERBACH**
***Health Affairs*, "Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health," January, 16, 2019**

# *Meeting Children's Health Needs: Upstream, Midstream, and Downstream*

Health inequities arise from disparities in social and economic opportunity—this is the foundation of the Social Drivers of Health (SDOH) model.[1] SDOHs are the structural, social, and economic conditions and environments that shape health outcomes such as child mental and physical well-being. Racism, itself a driver of health, shapes these conditions and ultimately creates and perpetuates racial inequities in health outcomes. The Child Opportunity Workbook we produced illustrates children's opportunities as a compilation of SDOH indicators by county and by race.

SDOHs are often conflated with health-related social needs. The primary difference is the lens through which we examine both the problem and intervention: one focuses on *individuals,* the other focuses on *communities.* At midstream, health-related social needs are individual needs caused by community conditions such as an individual's or family's food insecurity, housing instability, and immigration challenges. Such individual social needs are identified through screenings and assessments and can be addressed for the individual child or family through social support services and interventions. SDOHs, by contrast, occur further upstream and are the community conditions that shape health and well-being such as inequities in access to jobs, affordable and stable housing, high-quality public education, and other opportunities needed to thrive.

Recent Medi-Cal managed care reforms such as the Population Health Management program and Enhanced Care Management (ECM) may offer some opportunities to improve midstream conditions and downstream opportunities for children's health and child health equity through integrated support services, CBO partnerships, and family engagement. While important and necessary, managed care plans are not designed to play a central role in addressing community needs further upstream where children's health is impacted by systemic racism and social drivers of health in their community. Community collaboratives are essential for responding to upstream SDOHs, with participation and investment from managed care plans.




Adapted from source: Brian C. Castrucci, John Auerbach

# A Path Forward to Reimagine Health Equity for Children in a Managed Care Context

The path toward health equity and system transformation requires fundamental shifts of power toward shared decision-making and centering families and communities as essential partners and experts in the design and delivery of care.

The essential partners in a reimagined child-focused mental and physical health system are:

### Families

Across a range of disciplines—including child welfare, juvenile justice, education, early childhood, and health—family engagement is a critical tool for system transformation. For participation to be authentic and thus effective, families must be included in the development of policies and programs that promote children's well being development, learning, and wellness, including shared decision-making in planning, development, and evaluation of family engagement strategies.[2] Read our Family Engagement report to learn more from families.

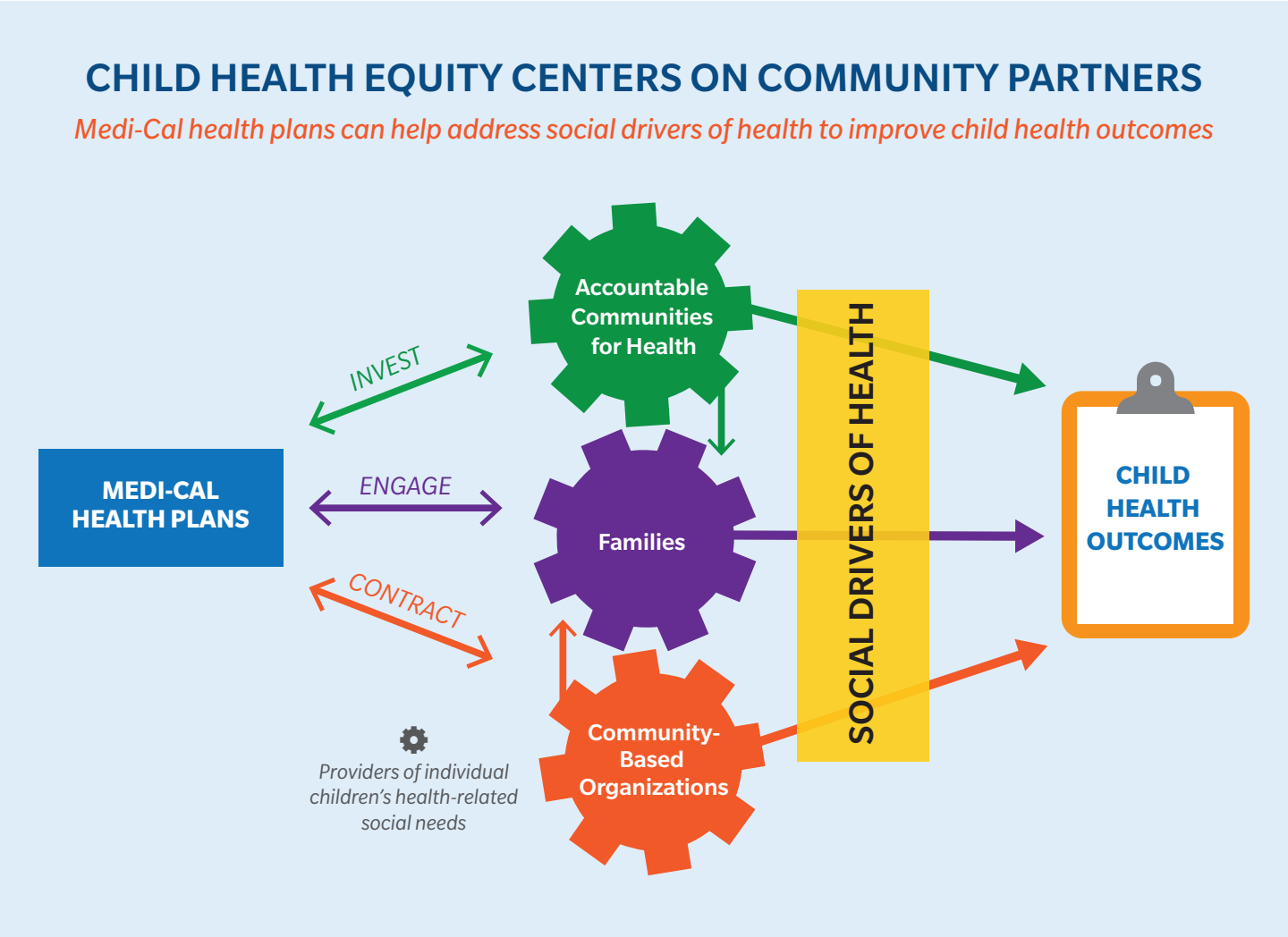
### Community-Based Organizations

CBOs are nonprofit organizations that work at the local level to meet the community's needs in a culturally concordant manner. They are representative of a community, often equipped by staff with shared lived experiences. For example, CBO partnerships with MCPs can offer an array of relational care opportunities that CBOs and Community Health Workers and Promotoras (CHW/Ps) provide to MCP enrollees when MCPs establish contracts for reimbursable transactions with CBOs.

### Accountable Communities for Health (ACH)

ACHs are a structured way to bring together local clinical providers with public health and mental health departments, schools, managed care plans, social service agencies, community organizations, and residents in a collective effort to prevent health conditions and promote health in their community. MCPs can invest in ACHs by contributing to community "wellness" funds where the use of funds is collectively determined among the ACH participants.

Although the managed care plan model is not designed to effectively respond to SDOHs, this ETE final report asserts that Medi-Cal and its MCPs can contribute to addressing SDOHs by shifting the balance of power through investing in community collaborative models such as ACHs, contracting with CBOs, and authentically bringing the voice of beneficiaries, particularly parents and caregivers into decision making. A new framing (See graphic below) where ACHs set the table in which MCPs join and invest in upstream SDOH strategies could provide the opportunity to address both upstream and midstream needs. (The 2022-23 State Budget invested $15 million in existing and new local ACHs across the State.) MCPs could contract with more culturally concordant CBOs and invest in non-clinical supports to help families address children's health-related social needs. This collaboration and partnership framework more directly centers families' voices in decision making in their child's health care, recognizing the shared power and agency critical to dismantling structural racism and authentically advancing health equity.



# *Learnings from MCPs, CBOs, and Parents on Child Health Care*

Below is a snapshot of learnings from group discussions with parents of children covered by Medi-Cal, interviews with managed care plans, and community-based organizations, as well as our ETE research.

## Core Learnings

- When addressing the **health-related social needs of individual children covered by Medi-Cal,** MCPs with the appropriate infrastructure, accountability, and CBO/community partnerships can facilitate identifying and connecting children to the needed social supports.
- With regard to the **social drivers of health in the communities that children live**, MCPs are not designed to sufficiently address population-based conditions but they have an important supportive role to play.

## Learnings from Parents and Families

- Parents/families are the experts in their child's experience.
- Parents/families want more holistic care for their child including access to mental health care.
- Parents/families are not aware of, and do not receive, care coordination.
- Parents/families prefer a person to help them navigate their child's health care rather than informational material.
- Parents/families are eager to participate in MCP community engagement strategies but need support to do so—childcare, interpreters, and compensation for their time and expertise.
- Family engagement is more than data points. It is iterative, relational, and collaborative—and must be culturally concordant.

See Family Engagement report for more details

## Learnings from Community-Based Organizations

- Because CBOs operate in the currency of relational trust, they are effective conduits for MCP engagement with families and in the promotion of preventive care.
- Many CBOs provide care coordination and yet MCPs are not contracting with them to do so.
- CBOs have difficulty navigating MCP organizational structure in order to build ongoing business partnerships.
- CBOs may need technical assistance and intermediary entities to contract with health plans.
- When it comes to funding non-health support services, MCPs tend to support local grants for social support services rather than long-term contracts.
- Health plans may not be motivated to contract with CBOs unless there are underlying policy requirements, financial mechanisms, and/or performance metrics incentivizing them to do so.

## Learnings from Managed Care Plans

- Midstream and upstream investments in children often do not have financial return for MCPs.
- Little is known about the extent to which children with Medi-Cal receive care coordination and providers may not have adequate systems for tracking and reporting on referral follow-ups. (See Care Coordination Issue Brief for more on MCP obligations)
- While MCPs do engage with community partners and their members, the business model of most health plans is not conducive to power sharing.
- MCPs value community engagement but are not the hub for effective community collaboration.
- MCPs recognize their role in responding to social risk factors but it is challenging to navigate multiple social support systems.
- MCPs want the Department of Health Care Services (DHCS) to clarify which social support services, and under what circumstances, can be included under children's EPSDT benefit.

# Recommendations for Advancing Child Health Equity

## Addressing Children's Social Drivers of Health Through Accountable Communities for Health

Community-driven cross-sector collaboratives, such as Accountable Communities for Health, can serve as the bridge between managed care plans, social drivers of health, and community supports, working together to impact child health outcomes. The state can cultivate these local ACH by:

- Promoting the creation of **local ACHs statewide;**
- Supporting the **creation of local wellness funds** from which ACH can invest in local interventions;
- Requiring Medi-Cal managed care plans to contribute a portion of their capitation, as part of their **community reinvestment, to ACH wellness funds.**

## Addressing Children's Health-Related Social Needs and Health Equity Through Medi-Cal Managed Care

The following list is an abridged summary of recommendations. For more detail see the ETE final report.

- Managed care plans need to **fulfill the EPSDT mandate,** and family input should be incorporated in any EPSDT outreach campaign.
- **Managed care plans must engage in robust partnerships** with CBOs to connect families to supports that address their health-related social needs.
- **Care coordination—an explicitly required EPSDT benefit under MCPs—must be measured and monitored to ensure delivery,** and a robust family outreach campaign through CBOs and MCPs is needed to connect families to available care coordination.
- Medi-Cal should **invest in the care coordination infrastructure** (similar to ECM infrastructure investments) and **incentivize and support MCP contracting** with CBOs, particularly for care coordination.
- **MCPs should establish formal ongoing partnerships with ACHs** to co-operate their Population Health Management Programs and community engagement activities.
- MCPs need **DHCS guidance on which child social support services can be covered and claimed** against the medical load of their capitation payments.
- DHCS and MCPs should meaningfully **engage, support, and compensate parents and families** for their input.
- DHCS should **develop and report on equity measures and standards for MCPs,** including culturally concordant care, patient satisfaction, and national quality standards for equity (NCQA Health Equity Plus Accreditation.)[3]
- California Health and Human Services should **develop a cross-sector child health and opportunity dashboard,** including a Kindergarten readiness metric.

# Conclusion

DHCS has set ambitious goals for reforming Medi-Cal, and has finally centered their quality objectives on children's preventive care and mental health integration. Underlying much of Medi-Cal's reforms is the assumption that the managed care plan model can achieve these bold goals. Managed care plans certainly have a critical role to play and are well-equipped with the right incentives to deliver quality children's medical care and respond to children's health related social needs with CBO partnerships. However, when responding to social drivers of health, communities and families—as experts of their own needs—must be at the center of any effort to improve child well-being and address child health equity. This is especially true for communities most impacted by structural racism which creates and perpetuates inequities in health outcomes.

Medi-Cal and its managed care plans can play a role in centering community collaboratives in health care systems by sharing power with families and CBOs and investing in local wellness funds and ACHs. In doing so, the state can ensure Medi-Cal is the "essential tool for pursuing DHCS' strong commitment to addressing entrenched health inequities and the resulting disparities that diminish children's health outcomes and life prospects."[4]

# I. Introduction

So much of children's health is determined by conditions shaped by where they live, learn, develop, and play—the social drivers of their health.[5] Particularly in the early stages of life, when 90% of brain development occurs, children and their families need social, emotional, and educational resources and support services in order to be healthy and thrive. **Children of color in particular face greater challenges due to systemic issues like racism and poverty that manifest themselves in inequitable health outcomes such as low birth weight and high rates of hospitalization due to asthma.** Racism itself is a condition creating other social drivers of health.[6] Early childhood development impacts long-term social, emotional, and health outcomes, and early life toxic stress and adverse childhood events significantly impact a child's mental and physical health[7] and development across their lifespan.[8] For these reasons, addressing a child's health-related social needs, as well as the social drivers of health within a child's community, is critical to advancing long-term health equity and well-being.

Social drivers of health (SDOH) are the structural social and economic opportunities and environments, including racism itself, that shape health outcomes, such as child mental and physical well-being. **We use the term "social drivers" of health instead of "social determinants" of health to both denote the influence that social factors, including racism and housing, food, and income insecurity, have on one's health and well-being; as well as acknowledge that social factors do not determine one's health and instead can be overcome through power-sharing, advocacy and systems change.**

**TABLE 1. SOCIAL DRIVERS OF HEALTH**

**RACISM**

| Economic Stability | Neighborhood and Physical Environment | Education | Food | Community and Social Context | Health Care System |
|---|---|---|---|---|---|
| ▸ Employment<br>▸ Income<br>▸ Expenses<br>▸ Debt<br>▸ Medical bills<br>▸ Support | ▸ Housing<br>▸ Transportation<br>▸ Safety<br>▸ Parks<br>▸ Playgrounds<br>▸ Walkability<br>▸ Zip code/geography | ▸ Literacy<br>▸ Language<br>▸ Early childhood education<br>▸ Vocational training<br>▸ Higher education | ▸ Hunger<br>▸ Access to healthy options | ▸ Social integration<br>▸ Support systems<br>▸ Community engagement<br>▸ Discrimination<br>▸ Stress | ▸ Health coverage<br>▸ Provider availability<br>▸ Provider linguistic and cultural competency<br>▸ Quality of care |

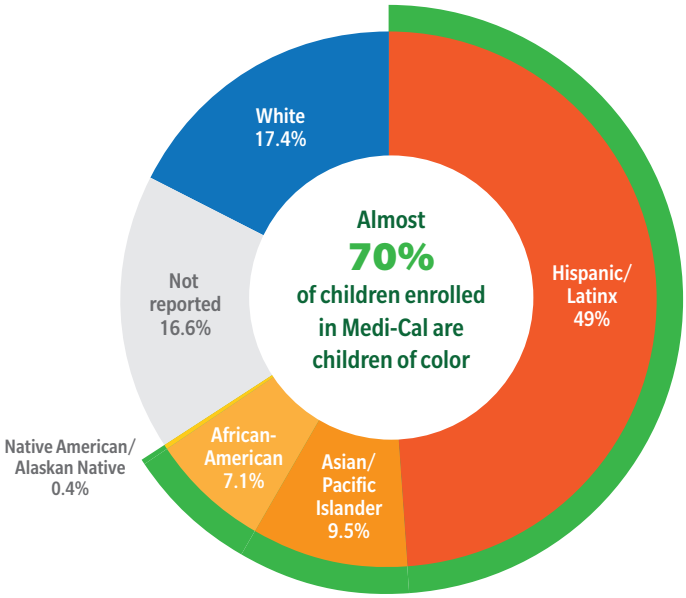
**HEALTH OUTCOMES**

**Mortality • Morbidity • Life expectancy • Health care expenditures • Health status • Functional limitations**

Adapted from Kaiser Family Foundation

Medi-Cal, California's Medicaid coverage program, covers over half—or 5.6 million[9]—of California's children. **Notably, two-thirds of children enrolled in Medi-Cal are children of color from Latinx, Black, Native American, and Asian American communities[10]—and Medi-Cal serves as the primary source of coverage for California's Latinx and Black children, youth, and young adults.[11]** (See Figure 1.) As a result, Medi-Cal has a critical role to play in advancing child health equity by addressing both the individual child's health-related social needs as well as social drivers of health for the community in which the child lives.

**FIGURE 1. Medi-Cal Enrolled Children by Race/Ethnicity, January 2022**




Source: www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-January2022.pdf

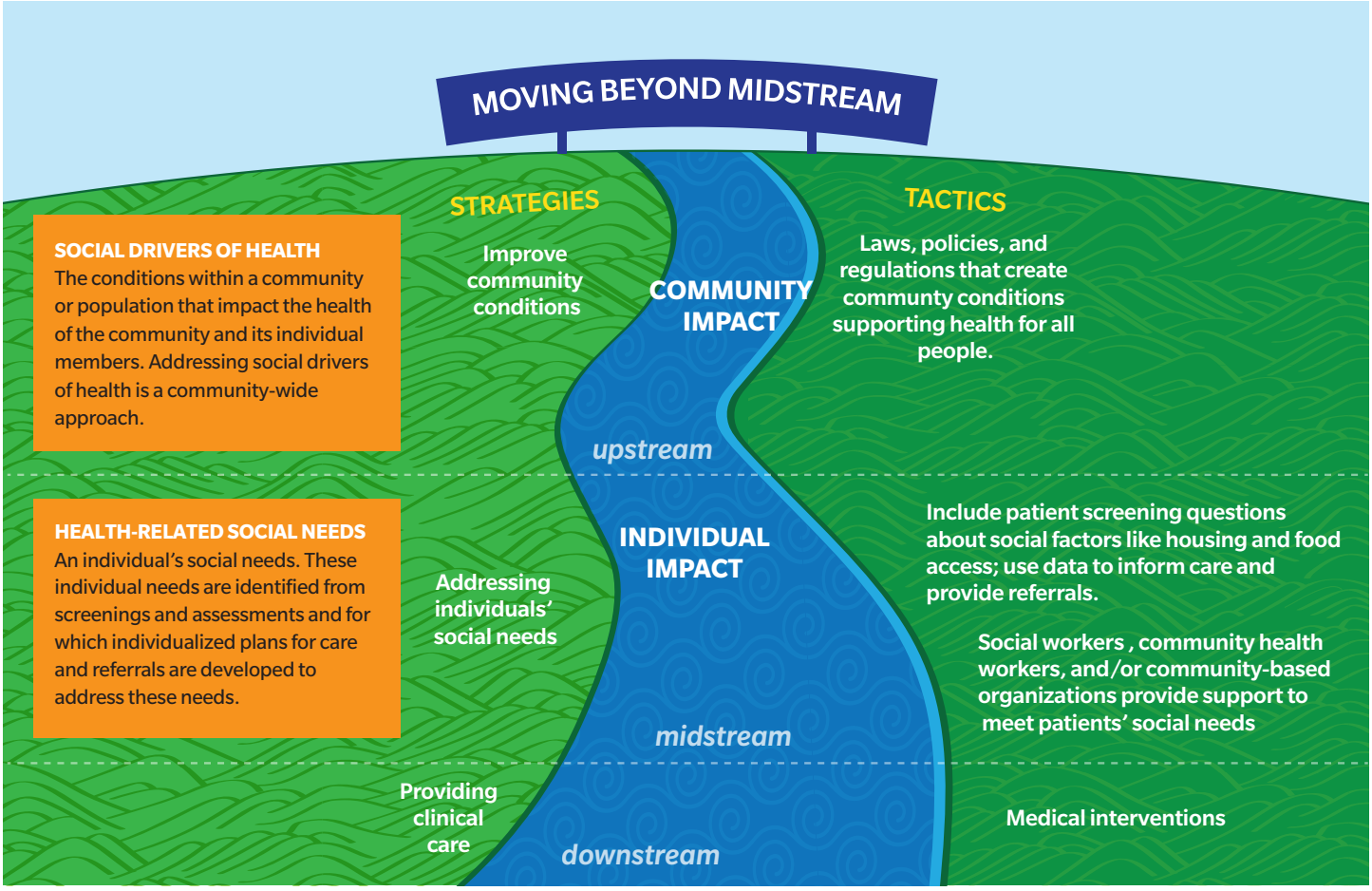
For decades, the federal Medicaid law has acknowledged the importance of early detection and intervention in childhood development by entitling children enrolled in Medicaid across the nation to a comprehensive array of preventive and primary care and coverage of medically necessary treatments and services, called the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. However, California's Medi-Cal program has not been living up to that promise with its low preventive care and screening rates[12] as well as a significant gap between mental health needs and mental health care access.

With the vast majority (92%) of children covered by Medi-Cal receiving their health care benefits through Medi-Cal managed care plans (MCPs), much of Medi-Cal reform efforts—such as the California Advancing and Innovating Medi-Cal (CalAIM) initiative—center around the role that managed care plans, among other goals, can play in improving upon the provision of this comprehensive package of children-centered care while also playing a role in linking children's medical care with social supports to address their health-related social needs. Medi-Cal is also beginning to play a role in responding to community social drivers of health, such as requiring managed care plans to provide community reinvestments.

Because health inequities start from inequities in social and economic opportunity, Medi-Cal-managed health care would appear to be positioned to serve as the bridge between health and the social drivers of health. But is it? Are Medi-Cal managed care plans the appropriate system to address social drivers of health? Our Equity Through Engagement Project set out to examine that question and found the **managed care plan model is not designed to effectively respond to social drivers of health. However, with authentic community partnering—including contracting with community-based organizations—health plans can successfully help link children to social supports.**

*"Using the metaphor of a stream, upstream factors bring downstream effects. Social needs interventions create a middle stream. They are further upstream than medical interventions, but not yet far enough. Social needs are the downstream manifestations of the impact of the social determinants of health on the community. Improvements in our nation's health can be achieved only when we have the commitment to move even further upstream to change the community conditions that make people sick."*

**—BRIAN C. CASTRUCCI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, DE BEAUMONT FOUNDATION, AND JOHN AUERBACH, DIRECTOR OF INTERGOVERNMENTAL AND STRATEGIC AFFAIRS, CENTERS FOR DISEASE CONTROL AND PREVENTION**




Adapted from source: Brian C. Castrucci, John Auerbach

# II. Purpose and Outline of Our Project

Other research projects have examined managed care plans' activities relative to social drivers of health in the community[13] while Medi-Cal reforms have increasingly placed a greater emphasis on managed care plans' responsibilities regarding an individual's health-related social needs.[14] Through this Equity Through Engagement Project, we step back and consider the extent to which managed care plans can play a central role in Medi-Cal responding to social drivers of health, particularly children's health and, given the population-based nature of social drivers of health, how communities, as experts in their own needs, can be better centered in the equation between health care systems and child health equity. **Managed care plans can better understand the full health needs of the children they serve if they collaborate with the families and communities they seek to care for.**[15]

**CHILD HEALTH EQUITY**

*"Child health is equitable and just when every child has a fair and intergenerational opportunity to attain their full health and developmental potential, free from discrimination. Advancing child well-being also requires effort to restore or provide agency and power to children, youth, and families."*

**—CALIFORNIA CHILDREN'S TRUST BELIEF STATEMENT**

Grounded in the definition of equity as redistributing power to community and families, we hypothesize that community collaboratives, community-based services, and authentic family engagement play pivotal roles in establishing an effective throughline from health care to the social drivers of children's health and well-being. In other words, we explore a possible framework for integrating social supports with health care in which managed care plans are not positioned at the center driving the integration, but instead invest in **community collaboratives** to identify and respond to population health needs; contract with **culturally concordant community-based organizations** to deliver relational and culturally appropriate care; and adopt and invest in authentic **family engagement** in the decision making of the healthcare system. In financial terms, while it matters how much managed care plans are investing into children's health care it is equally important what they are purchasing—and it matters from whom they are purchasing. Namely, are plans partnering and contracting with community-based organizations and contracting for community-based culturally concordant services, and is there a shift in culture and power sharing that more intentionally centers community leadership? With the right reframing, the recent Medi-Cal reforms, quality strategies, and managed care reprocurement changes set the stage for promising alignments between the managed care system and community collaboration.

## COMMUNITY PARTNERS

### Families

Because parents know their children and their lived experience best, their expertise is a critical component in integrating health care and social supports. A family's input is important within their own child's multidisciplinary care team as well as in designing and operating delivery systems. Bringing equity to children's health starts and ends with listening and sharing decision making with the experts, namely parents and families, who know their children and their lived experience best.

### Community-Based Organizations (CBOs)

CBOs are nonprofit organizations that work at the local level to meet the community's needs in a culturally concordant manner. They are representative of a community, often with shared lived experiences. CBOs work across various areas and often have established, trusted networks and regularly and authentically engage families by providing care coordination, education and navigation, referrals, and peer support.

### Community Collaboratives

Community Collaboratives, such as Accountable Communities for Health, bring together local agencies, CBOs, and resident leaders in shared governance to identify a shared vision and goals, and to align their strategies to achieve agreed upon outcomes.

**A fundamental question we aim to examine is how the Medi-Cal managed care system can authentically collaborate with communities, including families, in the delivery of a "whole child" approach to care.**

While most of the delivery of care occurs at the practice and service level, this project mainly focused on the state policy level, examining how state policy can impact the delivery of care for children through community collaboration and family engagement. The project recognizes the tremendous opportunity to create change at the policy and systems level, particularly given the current Medi-Cal reforms, new managed care plan reprocurement contracts, and other initiatives being implemented by Medi-Cal.

While there are multiple dimensions from which to focus on children's health-related social needs and social drivers of health, this project focused on the following areas for which Medi-Cal managed care plans have some level of contractual obligation or options for engagement on behalf of the children they serve:[16]

- Fully actualized comprehensive children's benefit (EPSDT);
- Care coordination;
- Linkages to social supports for children and families;
- Partnerships with child-serving CBOs and community health workers/promotores (CHW/Ps);
- Community engagement and collaboratives; and
- Family perspectives and family engagement

## REPORT ROADMAP

| | |
|---|---|
| **Research Approach** | In our methodology section, we outline our quantitative and qualitative research approaches examining children's social drivers of health and health outcomes and the role Medi-Cal and their managed care plans currently play as well as are expected to play in the context of recent Medi-Cal initiatives. Most notably, we examine managed care plans' partnerships with communities. |
| **Background: Child Health Equity Level Setting** | This report starts with a background to level-set some of the basics on the social impacts affecting children's health outcomes and where racial/ethnic disparities occur. This background also outlines Medi-Cal's comprehensive child-specific health benefits and its potential for advancing child health equity. We then outline the historical role and performance of the managed care delivery system[17] relative to children's health. |
| **Potential Opportunities from Recent Medi-Cal Reforms** | We outline several recent Medi-Cal reforms and initiatives that center managed care plans as a means of improving children's health access, quality, and health equity. We highlight reforms and objectives that recognize the important role community partners offer to advance children's health equity. |
| **Proposed Changes That Tap Into the Power of Community** | Community collaboratives for health, community-based organizations providing services and family support, and families themselves, are already players in advancing child health equity. We outline who these partners are and the role they can play in partnership with Medi-Cal managed care plans. Centering community and family engagement, we put forth a new paradigm for the role Medi-Cal managed care can play in integrating social supports with health care for children covered by Medi-Cal. |
| **Observations and Suggestions from Health Plans, CBOs, and Families** | We share observations and perspectives conveyed in interviews and focus groups with Medi-Cal managed care plans, CBOs, and families on the role of managed care plans in addressing children's health-related social needs, managed care plans' partnerships with CBOs, and the extent to which managed care plans seek and incorporate families' input into their delivery of care. We also share some of their challenges and suggestions for improvement. |
| **Policy Recommendations** | Finally, we synthesize these findings into several high-level policy recommendations building on existing Medi-Cal reforms to advance a greater partnership between communities and managed care plans as a throughline to tackling children's social drivers of health and improving child health equity. |

# III. Methodology

We used a combination of quantitative and qualitative analysis to meet our ETE project objectives:

- To examine the racial disparities underlying social drivers of California's children's health;
- To assess Medi-Cal managed care plans' relation to social drivers of health and child health;
- To clarify the relevant role for MCPs in addressing children's health-related social needs and social drivers of health;
- To examine the challenges and opportunities for managed care plans to partner with community providers (such as CBOs and CHW/Ps) as conduits to community social supports;
- To gain input from the true experts—children's parents and families—about their experiences with and suggestions for managed care plans, clarifying what authentic family engagement looks like;
- To suggest how the current Medi-Cal reforms can be harnessed or supplemented to align community collaboration with the Medi-Cal managed care system to serve children.

A combination of quantitative analyses and qualitative observations from relevant stakeholders' methods as well as others' research on the subject provided greater insights into useful models, systemic and operational challenges and gaps, and levers of opportunity with which an equity lens could improve child health outcomes.

## Examining Racial Disparities in Children's Social Drivers of Health and Child Health Outcomes

We examined social drivers of health for California's children by race and by county to better understand the impact of such drivers on children. To do so, we utilized the Children's Opportunity Index (COI),[18] which includes 29 social drivers of health (SDOHs) compiled by researchers from Brandeis University and Ohio State University (see box for details on COI). The researchers developed a county-level database for our project analysis. Similarly, we examined specified child health outcomes broken out by race and county. We used the following indicators of child health from 2017 Let's Get Healthy California and 2011 to 2019 California Health Interview Survey data: infant mortality rates, asthma rates, obesity rates, behavioral concern, and psychological distress. A key factor in selecting these measures was the availability of racial/ethnic breakouts.

### THE CHILD OPPORTUNITY INDEX AS A MEASURE OF CHILDREN'S SOCIAL DRIVERS OF HEALTH

Social drivers of health (SDOHs) for children can be measured using the Child Opportunity Index (COI), a tool created by researchers at Brandeis University and the Ohio State University that "measures and maps the quality of resources and conditions that matter for children to develop in a healthy way in the neighborhoods where they live." The COI includes 29 SDOHs across three opportunity domains: education, social and economic, and health and environment. The COI was created to explicitly measure how child SDOHs cause inequities in health outcomes.[19] It is a comprehensive metric that allows researchers to compare child opportunity across nearly all U.S. neighborhoods (approximately 72,000), and the COI is longitudinal (with datasets from 2010 and 2015), allowing for comparison over time.[20] Comparing COI results by race/ethnicity and location across the state provides a useful snapshot of any disparities in opportunity.

## Examining How Social Drivers of Health Are Related to Children's Health Outcomes and Medi-Cal Managed Care Plan Performance

We assessed the relationship between social drivers of health and child health outcomes by measuring associations between county-wide COI scores and county-wide child health outcome measures. We sought to assess relationships between social drivers and indicators of child physical, behavioral, and socioemotional health to measure how social drivers interact with various domains of child well-being. However, sample size concerns of county-wide child health well-being limited this analysis. To supplement our estimates, we reviewed existing research[21, 22, 23, 24] on the relationship between social drivers of health and child health outcomes.

We also compared Medi-Cal managed care plan performance data on child health indicators by county to child health outcome indicators to determine whether there was a correlation. Similarly, we measured associations between managed care plan performance data and COI county data to determine if there was a correlation. The managed care performance data came from analysis of the 2018–2019 "Medi-Cal Managed Care External Quality Review Technical Report" released by the Managed Care Quality and Monitoring Division of the California Department of Health Care Services and included the following child health performance metrics: child immunization, adolescent immunization, access to primary care practitioners for children ages 12 to 24 months, child access to primary care practitioners ages 25 months to 6 years, child access to primary care practitioners ages 7 to 11 years, child access to primary care practitioners ages 12 to 19 years; and well-child visits in the third, fourth, fifth, and sixth years of life.

### *Clarifying the Role of Managed Care Plans in Children's Health-Related Social Needs*

We conducted 10 interviews with Medi-Cal managed care plan representatives: CEOs, Quality Improvement staff, and community liaisons (see Appendix A for plans). We asked them about their plans' specific interventions related to children's health-related social needs, partnerships with CBOs, and family engagement activities.

### *Understanding Community Partnerships and Family Engagement*

We conducted 11 interviews with various community-based organizations, initiatives with local programs, and navigation platforms (see Appendix A for organizations) to understand their relationship with the health plans in their area, the extent to which they partner with the plans, and the challenges and opportunities.

We collaborated with **four community-based organizations (CBOs)—**Alpha Resource Center of Santa Barbara, San Ysidro Health, Heluna Health/Eastern LA Family Resource Center, and California Consortium for Urban Indian Health (CCUIH)—to conduct a total of eight focus group discussions with 58 parents of children enrolled in Medi-Cal. We were intentional about partnering with CBOs with a strong history of serving families and children of color in order to actualize the principles of equity, namely power sharing, within the context of doing our research. We wanted to share power with those closest to the community to conduct the research and synthesize the observations from their perspective. The CBO partners led the recruiting and facilitation of eight focus groups with support from TCP (two parent discussion groups per each CBO). The CBOs also led the analysis and write-up of focus group discussion memos that were turned into a larger family engagement report that is a companion to this report. TCP conducted one additional focus group of parents who participated in health plans' Community Advisory Committees. The collaborating CBO organizations and parent participants were financially compensated.

**There were a total of 58 participating parents across the nine discussion groups, including 15 Native American, seven Black, 23 Latinx, six Chinese American, and seven Caucasian. From the 58 participants, 33 were primarily English speakers, 19 were Spanish speakers, and six were Chinese speakers. Most of the parent participants were female (56 parents) and two were male parents.**

Parents were asked questions about their experience with their children's Medi-Cal health plan and where they turn for help in navigating health care for their children. In addition, parents were asked to provide their feedback on how Medi-Cal can improve health coverage and the delivery of care for their children.

# IV. Disparities in Social Drivers of Health Impact Children's Health

There are substantial racial and ethnic inequities in the social drivers of health across California, particularly impacting Black, Latinx, and Native American children, and these racial and ethnic inequities lead to inequities in child health outcomes, further limiting child opportunity.[25] Thus, we examine the inequities in social drivers across racial and ethnic communities in the context of opportunity, using the Child Opportunity Index (COI) to measure and map the quality of resources and conditions that matter for children to develop in a healthy way in the neighborhoods where they live. The table below outlines the measures of the social drivers of health that make up the COI.

**TABLE 2. SOCIAL DRIVERS INCLUDED IN COI SCORES BY DOMAIN**

| Education | Health & Environment | Social & Economic |
|---|---|---|
| » ECE centers | » Access to healthy food | » Employment rate |
| » High-quality Early Childhood Education centers | » Access to green space | » Commute duration |
| » ECE enrollment | » Walkability | » Poverty rate |
| » Third grade reading proficiency | » Housing vacancy rate | » Public assistance rate |
| » Third grade math proficiency | » Hazardous waste dump sites | » Homeownership rate |
| » High school graduation rate | » Industrial pollutants in air, water, or soil | » High-skill employment |
| » Advanced Placement (AP) course enrollment | » Airborne microparticles | » Median household income |
| » College enrollment in nearby institutions | » Ozone concentration | » Single-headed households |
| » School poverty | » Extreme heat exposure | |
| » Teacher experience | » Health insurance coverage | |
| » Adult educational attainment | | |

## Disparities in Opportunity

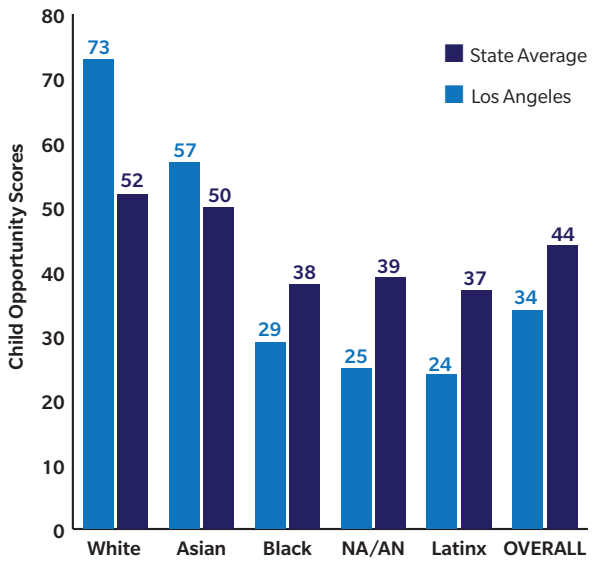
Across all counties, on average, children of color have lower opportunity scores than white children. California's Black and Latinx children's average opportunity scores are 28 and 30, respectively, which are 37 and 35 points lower than white children's average opportunity score of 65, or less than half that of white children. See our county-by-county Children's Opportunity Index workbook. (Appendix B).

Among the bottom 20 counties for child opportunity in California, Latinx children are worse off in 80% of those counties, Black children are worse off in 75% of those counties, and Native American and Alaskan Native (NA/AN) children are worse off in 70% of those counties, relative to white children. Even in the best county for child opportunity in California—San Mateo—Latinx, Black, and NA/AN children have lower opportunity scores than white children. In Los Angeles County, Latinx and NA/AN children have opportunity scores three times lower than white children, with Black children scoring almost four times lower (Figure 2). In the worst counties for child opportunity in California—Madera and Tulare—white children's opportunity scores are still close to two times higher than Latinx children and Black children. (Figure 3).

The next question is whether opportunity or social drivers relate to health outcomes and whether disparities correlate with disparities in health outcomes.

**FIGURE 2. White Children Have Opportunities Three Times Greater Than Black, Latinx, and Native American Children in Los Angeles County**

*Child Opportunity Scores in Los Angeles County by Race and Ethnicity, 2015*

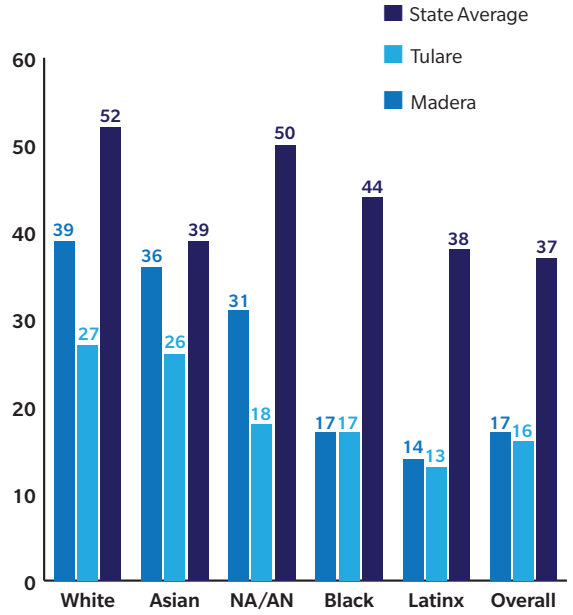



*Source: Georgetown Center on Poverty and Inequality's Analysis of the Child Opportunity Index 2.0.*

Notes: Child Opportunity Scores aggregate and weight data from 29 indicators of social drivers of health to assess child opportunity at the census tract level. Higher scores indicate better child opportunities. The Child Opportunity Index team helped craft county-wide estimates for this project using 2015 Child Opportunity Index 2.0 data and 2013–2017 American Community Survey data. Race and ethnicity have been defined here as mutually exclusive categories. Latinx includes people of any race, whereas all other categories exclude people identifying as Latinx. NA/AN refers to Native American and Alaskan Native. Asian includes people identifying as Native Hawaiian and Other Pacific Islander (NHOPI). Children are defined here as people between the ages of 0 and 17.

**FIGURE 3. Opportunities for White Children Are Close to Twice That for Black and Latinx Children in Madera and Tulare Counties**

*Child Opportunity Scores in Madera and Tulare Counties by Race and Ethnicity, 2015*




*Source: Georgetown Center on Poverty and Inequality's Analysis of the Child Opportunity Index 2.0.*

Notes: Child Opportunity Scores aggregate and weight data from 29 indicators of social drivers of health to assess child opportunity at the census tract level. Higher scores indicate better child opportunity. The Child Opportunity Index team helped craft county-wide estimates for this project using 2015 Child Opportunity Index 2.0 data and 2013–2017 American Community Survey data. Race and ethnicity have been defined here as mutually exclusive categories. Latinx includes people of any race, whereas all other categories exclude people identifying as Latinx. NA/AN refers to Native American and Alaskan Native. Asian includes people identifying as Native Hawaiian and Other Pacific Islander (NHOPI). Children are defined here as people between the ages of 0 and 17.

## Opportunity Impacts Children's Health Outcomes

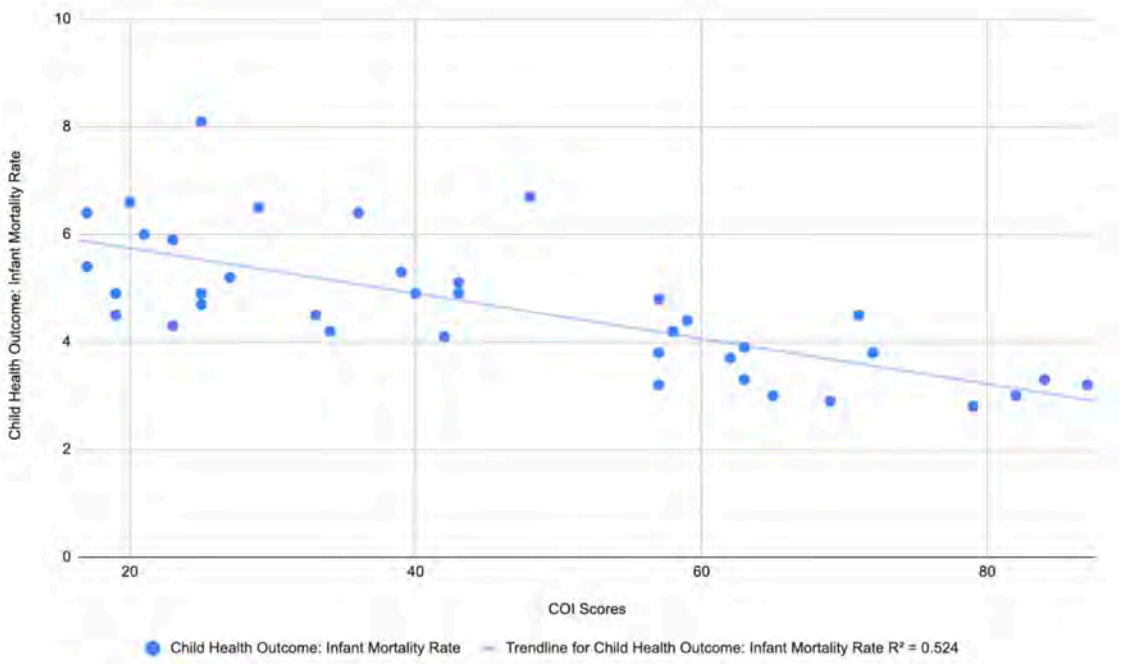
We measured the association of county-wide COI scores and the following indicators of child health: infant mortality rates, asthma rates, obesity rates, behavioral concern, and psychological distress. We did find a strong association between child opportunity and infant mortality. For example, where child opportunity is lower, infant mortality rates are higher, and where child opportunity is higher infant mortality is lower (See Figure 4). There was little association between COI scores and asthma rates, behavioral concern, and psychological distress, and a moderate association between COI scores and obesity.

Similarly, disparities in child health outcomes mirror the disparities in opportunity. For example, Black and Native American children and teens have higher asthma rates than white children and adolescents (Figure 5) while also experiencing disparities in opportunity as compared to white children (Figure 2).

Other research corroborates the association between social drivers of health and child health outcomes,[26] including race/ethnicity as a social driver. One analysis investigated the association of eight social drivers on child obesity, socioemotional health, dental health, and health status and found that low household income and education, low maternal mental health, lack of child health insurance, as well as race (or racism) were all associated with a greater likelihood of a child experiencing poor health outcomes.[27] In addition, the authors of the study suggest that social risk factors have a cumulative effect on child health outcomes.

**FIGURE 4. There Is a Strong Association Between COI Scores and Infant Mortality Rates**

*Correlation Between Child Opportunity Scores and Infant Mortality Rates in CA, 2015-2017*

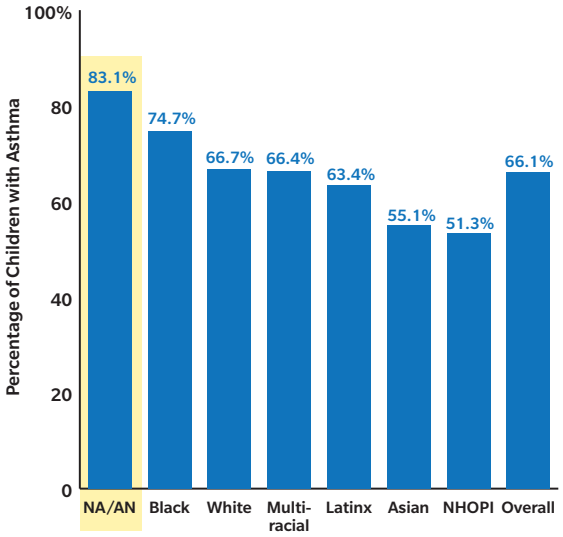



*Source: Georgetown Center on Poverty and Inequality's Analysis of the Child Opportunity Index 2.0 and 2015–2017 California Health and Human Services Let's Get Healthy California data, accessed at https://data.chhs.ca.gov.*

Notes: Child Opportunity Scores aggregate and weight data from 29 indicators of social drivers of health for children to assess child opportunity at the census tract level. The Child Opportunity Index team helped craft county-wide estimates for this project using 2015 Child Opportunity Index 2.0 data and 2013–2017 American Community Survey population data. Counties were excluded from this list if their data was suppressed due to a small sample size. Counties' Infant mortality rate is measured as deaths per 1,000 live births. Infant mortality rate data was calculated using 2015–2017 California Health and Human Services Let's Get Healthy California data.

## FIGURE 5. Native American* and Black Children Have Higher Asthma Rates Than White Children and Teens

*Percentage of Children (0 to 18) Who Have Asthma by Race and Ethnicity in CA, 2011-2019*




*Source: Georgetown Center on Poverty and Inequality's calculations using 2011–2019 California Health Interview Survey data. Accessed at https://ask.chis.ucla.edu.*

Notes: Race and ethnicity have been defined here as mutually exclusive categories. Latinx includes people of any race, whereas all other categories exclude people identifying as Latinx. NA/AN refers to Native American and Alaskan Native. NHOPI refers to Native Hawaiian and Other Pacific Islanders.

*NA/AN is highlighted yellow to indicate that the California Health Interview Survey suggests this estimate might be statistically unstable. While the sample size for NA/AN people in this survey is 6,000, the asthma rate for NA/AN children and teens may be subject to sample size fluctuations, and results should be interpreted with caution. Children and teens are defined here as people between the ages of 0 and 18. Data is averaged from 2011 to 2019.

# V. The Value of Medi-Cal's EPSDT Benefit: A Lever in Child Health Equity

An important SDOH that can be leveraged to improve health outcomes is quality care, which is accessed through health insurance coverage. California's Medicaid and Children's Health Insurance Program (CHIP)-funded program, known as Medi-Cal, is uniquely positioned to support the improvement of children's health outcomes. As the largest Medicaid program in the nation, Medi-Cal covers one-third of all Californians (14.3 million individuals), *more than half of all children in the state* (5.6 million children).[28] The program covers more than half of births to Black (55%), Latinx (63%), and Native American individuals (56%).[29] Medi-Cal (including CHIP-funded Medi-Cal) has contributed to bringing the uninsured rate down to 2%, creating virtually universal coverage for children in California. Serving as the primary source of coverage for Latinx and Black children,[30] Medi-Cal is well situated to also advance child health equity.

With Medi-Cal managed care plans enrolling almost all (92%) of Medi-Cal children, Medi-Cal-managed care plans contractually hold Medi-Cal's obligation to provide the comprehensive array of children's health care services that children are entitled to under Medicaid law. Thus, we examine Medi-Cal managed care plans as a fundamental player in impacting children's health outcomes within the purview of their obligations and the Medi-Cal program's role in effectively holding health plans accountable, starting with comprehensive health care benefits for Medi-Cal children.

## EPSDT: The Medicaid Promise of Comprehensive Health Care for Children

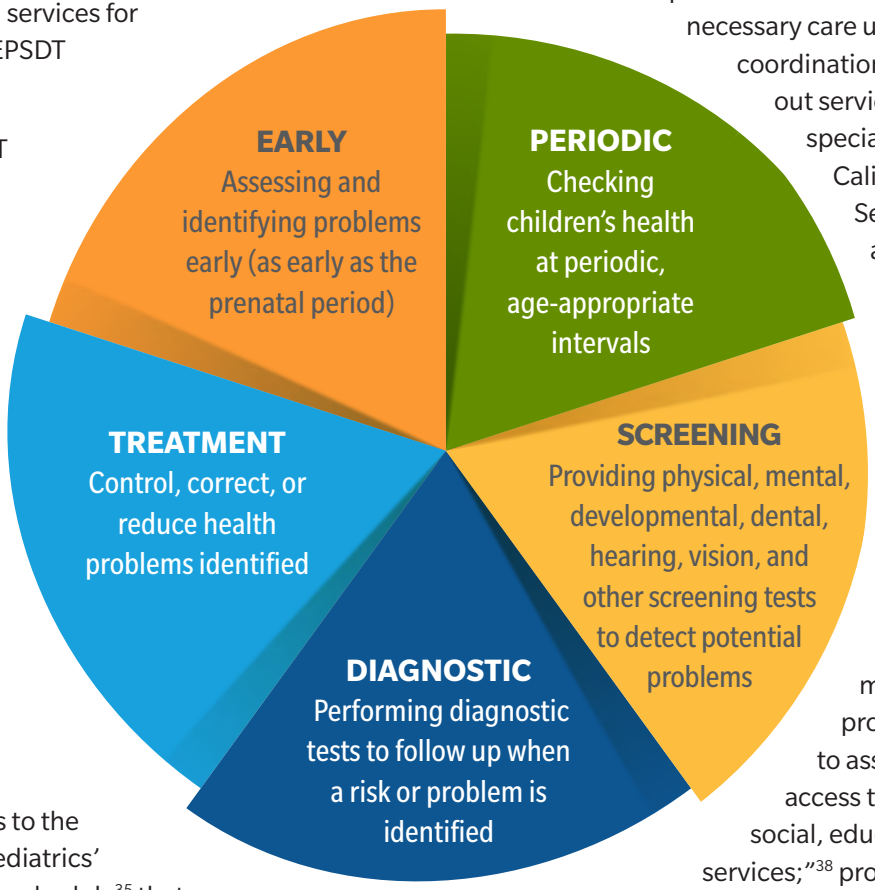
The Medicaid entitlement for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) was created in 1967 as part of a reform package intended to improve pediatric health care. It came on the heels of a government study finding that a third of young men drafted into the military were being rejected, many due to treatable physical, mental, and developmental health conditions that had gone unidentified and untreated. Amendments to EPSDT in 1972 and 1981 added outreach and family support components, and in 1989 EPSDT was broadened to include a comprehensive range of pediatric preventive and treatment services, whether or not such services were otherwise covered under a state's Medicaid plan.[31]

From the outset, EPSDT emphasized the importance of prevention and early intervention in children's health issues. In introducing the legislation to Congress, President Lyndon Johnson explained: *"The problem is to discover, as early as possible, the ills that [impact] our children. There must be continuing follow-up treatment so that [preventable conditions] do not go untreated..."*[32] EPSDT coverage for children is intentionally "more robust" than the benefits

for Medicaid-eligible adults and is "designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible."

More than just the assurance that Medi-Cal will cover the array of services in the EPSDT benefit, EPSDT establishes an obligation for Medi-Cal to proactively ensure that families know about the array of well-child care and recommended parent education,[33] and facilitate their access, including assisting families with making appointments, providing non-medical transportation to the visits and, if needed, interpretation services for all medically necessary EPSDT services.[34]

At the heart of the EPSDT entitlement is the recognition that child well-being involves a whole-child approach to care, with an emphasis on preventive care. By identifying health and developmental issues early in childhood, timely child- and family-specific interventions can mitigate lifelong health conditions. Notably, with regard to health-related social needs, Medi-Cal adheres to the American Academy of Pediatrics' *Bright Futures* periodicity schedule[35] that includes "psychosocial/behavioral" screenings, which are "family-centered assessments that may include a child's social-emotional health, caregiver depression, and social determinants of health."




## Managed Care Plans' Obligation to Deliver the EPSDT Benefit and Care Coordination

As noted, Medi-Cal managed care plans have been obligated to fulfill Medi-Cal's EPSDT requirement since their inception but it has been through the more recent clarifications that the full extent of their obligation has been defined. In 2018, EPSDT medical necessity requirements were reinforced in clarifying state legislation and subsequent guidance to managed care plans in the form of an All Plan Letter (APL) and in the Medi-Cal Provider Manual. Most recently, Medi-Cal 2024 reprocurement contracts reiterated with great specificity the plans' EPSDT responsibilities for children.[36] In addition to providing timely access to preventive and other medical care, managed care plans are responsible for *coordinating* physical and mental health care, including assistance with appointment scheduling, non-medical transportation to appointments, interpretation services for all medically necessary care under their contract, and coordination of care with carved-out services such as dental care, specialized mental health, California Children's Services (CCS) services, and services provided through Regional Centers.[37]

While Medi-Cal's EPSDT benefit does not generally cover social services such as food, housing, or economic development, Medi-Cal does require managed care plans to provide case management to assist children "in gaining access to needed medical, social, educational, and other services;"[38] provide referrals to social services and supports;[39] and encourage connections to social service programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). In other words, Medi-Cal managed care and the Medi-Cal providers serving children are in the position not only to identify and address health and mental health conditions, but also to screen for health-related social needs and provide referrals to those services—an important gateway to identifying and addressing children's other health-related social needs.

# VI. Medi-Cal Managed Care: Its Role and Performance in Children's Health

## The Predominance of Managed Care

For decades, Medi-Cal managed care has been the predominant delivery system for children's physical and mental health. While services for some populations, such as those eligible for the California Children's Services (CCS), have traditionally been covered on a fee-for-services basis, California is transitioning more Medi-Cal populations into managed care as well, starting with CCS "Whole Child" model pilots in several counties. Certain services are carved out of Medi-Cal managed care such as specialty mental health, which is provided through county mental health plans, and dental care.

All counties have some form of Medi-Cal managed care, although the model may differ by county. Historically, the models include a "two-plan" model with one county-sponsored plan (a "local initiative") and one commercial plan; a County Operated Health System (COHS); a Geographic Managed Care model with multiple commercial plans; and a Regional model with two commercial plans serving multiple rural counties.[40] Most recently, in conjunction with the 2024 Medi-Cal managed care reprocurement process, counties could modify their managed care model. Several rural counties changed to a COHS model and a few chose a new single model operated by a county-sponsored plan.[41]

## Managed Care Plan Performance on Children's Health Access and Outcomes

Despite the longstanding predominance of Medi-Cal managed care systems and explicit contractual requirements, Medi-Cal managed care plans are not yet fulfilling their EPSDT obligation. Children covered by Medi-Cal are not receiving basic preventive care: Only 55% of children received the well-child visits recommended in their first 15 months of life.[42] Only a quarter of children received required developmental screenings.[43] California ranks 43rd in the nation for providing early behavioral, social, and developmental screenings to young children and 48th in the nation for the number of children without an age-appropriate physical or dental preventive care visit within the past year. With only 30 percent of children needing mental health care receiving it, California's ranking on that measure has worsened to 48th in the nation.[44] The 2019 National Survey of Children's Health found that of the 1.2 million Californian children with public health insurance who needed care coordination, 40% (517,501) did not receive it.

Indicators of health access for children covered by Medi-Cal do not seem to be improving and in some cases have been getting worse. An analysis of quality metrics across all types of Medi-Cal managed care plans over time found **three of the four current measures that declined over time were related to the care of children.**[45] Six of the nine quality measures related to children declined or stayed the same; there was an improvement in only three of the quality measures.[46] There is great variability in performance by plan and by county, with many plans' performance falling below standards in several children's indicators, as shown in this Health Plan Performance table.[47]

We asked managed care plans and CBOs their perspectives on how managed care plans were approaching children's health care—specifically a whole-child care approach. A consistent comment from managed care plans and CBOs alike was that **there were no current financial incentives for managed care plans to focus on children's care**. Despite the clear contractual requirements for providing children covered by Medi-Cal comprehensive primary care and treatments, children have previously not been "on the radar" of health plans. From the perspective of several

## Learning from Families

Common themes from discussions with parents of children covered by Medi-Cal:

### Medi-Cal Program

- Parents value having coverage for their children.
- Maintaining their children's Medi-Cal coverage is cumbersome and time-consuming.
- Families have difficulty transitioning coverage for their children with special needs to adult coverage.
- Medi-Cal informational materials are difficult to understand.
- Parents want more support in choosing a health plan.

### Medi-Cal Managed Care Plans and Providers

- Health plans are not sufficiently helping families manage their children's care.
- Parents do not feel that their health plans have played a role in providing and connecting them to social support services.
- Parents want a more holistic "whole-child" approach to their children's care, particularly including services to help with mental health concerns.
- Families do not always receive accurate interpretation services.
- Health plans often do not communicate important information to parents regarding their children's eligibility for certain services and supports, including care coordination, and are often not up to date with policy changes.
- The lack of cultural awareness, understanding, and sensitivity among Medi-Cal providers causes fissures and distrust between families and the health care system.
- Parents are often dismissed by their providers and not considered experts in their child's condition and care.

Source: FAMILY VOICES MATTER: Listening to the Real Experts in Medi-Cal Children's Health, The Children's Partnership, June 2022.

CBO's, managed care plans seem to consider children's health as being more in the public health realm and not managed care. Without an explicit financial and comprehensive policy priority from the Medi-Cal program, managed care plans do not have the incentive to focus on children. While children account for over 40% of the Medi-Cal population, they only account for about 14% of Medi-Cal spending.[48] Child capitation rates are roughly half to a third less than adult capitation.[49] Most children's health care is relatively inexpensive because most children do not require intensive health care treatments to manage. In addition, Med-Cal's rate setting methodology is built upon past utilization, and thus the low child capitation rates reflect EPSDT low utilization and arguably do not sustain full EPSDT utilization for children.

In an attempt to explain the variation in managed care plan performance in children's health access as well as to understand any possible relation social drivers of health might have on managed care plan performance, we compared Child Opportunity Index (COI) scores to managed care performance. Our analysis showed little to no relationship. For example, we found little association between managed care performance on child immunization rates and COI. Similarly, there is little association between child opportunity and managed care performance on children's access to primary care. (See Appendix C for both correlation tables.) We were a bit surprised by this finding; we might have expected areas with lower opportunity scores to have lower access to health care services. However, in examining particular counties, Madera and Tulare rank the lowest in child opportunity scores yet outperform state averages in managed care plan performance. The health plan performance in counties with the highest overall child opportunity score—San Mateo and San Jose—was average, with some above average performance indicator ratings. Unfortunately, managed care plan performance is not yet reported by race/ethnicity in order to determine any correlation when racial/ethnic disparities are taken into account. Also, countywide opportunity scores may mask neighborhood differentials which could influence access to care. Regardless, these findings suggest that managed care plan quality metrics are not merely reflecting the social conditions in a given location.

We had expected to see some correlation between managed care plan performance on child health access indicators and child health outcomes (see side box), as the overarching aim of health coverage is to improve health outcomes by providing access to quality and timely health care. However, here again we did not find a relationship.

For example, we found little association between the performance metrics for access to primary care practitioners for children ages 25 months to 6 years and child asthma rates (see Appendix C).[50] Although there is an established link between primary care quality and child asthma severity,[51] managed care plan performance on the HEDIS score related to primary care practitioners is not associated with child asthma rates. This could suggest that there is no relationship between plans' quality in access to primary care practitioners and child asthma rates, or that the power of the performance metric itself prevents the detection of any relationship between plans' quality and child asthma. We found similarly weak associations between each child performance metric and the child health outcomes indicators used in our analysis.

While it is certainly possible that managed care plan performance does indeed have little to no effect on child health outcomes, the current metrics used in this performance assessment may simply be failing to capture the relationship between these variables. An alternate explanation is that the disconnect between plan performance and child health outcomes may not be just a measurement issue. More broadly, if social drivers of health are significant indicators of health outcomes, we may be expecting too much of health care access to influence health outcomes in the absence of addressing social needs and social drivers of health.

Existing analysis of managed care plan performance has relied significantly—or primarily—upon HEDIS scores. With this in mind, it is important to be conscious of the limitations of this particular metric. Evidence suggests that HEDIS scores may not be well-suited to accurately assess child health outcomes and disparities in California. A California Department of Health Care Services (DHCS) Health Quality report published in 2018 suggests that MCPs adequately provide care to the state's Latinx population and, in most cases, better serve Latinx beneficiaries than white beneficiaries.[52] This finding conflicts with our initial analysis of Social Drivers of Health in California,[53] which indicates that Latinx communities throughout the state face significant barriers to high-quality health services and health outcomes.

Perhaps impacting health outcomes necessitates the inclusion of more community-based support indicators as well as measures of patients' relational experience with their health care. In the context of systems of health, the current managed care framework of health care delivery would need to incorporate greater integration with community-level needs and social support as envisioned in CalAIM's Population Health Management Program. The issue at hand is not just making the integration of population health a contractual requirement centered on the managed care plan, but instead reframing the power dynamics to center on community collaboratives, CBOs, and families in partnership with managed care plans.

**The Healthcare Effectiveness Data and Information Set (HEDIS) scores used in this analysis were for the following indicators:**

- Weight assessment and nutritional counseling for children
- Weight assessment and physical activity counseling for children
- Child immunization rates
- Adolescent immunization rate
- Child access to primary care practitioners, ages 12 to 24 months
- Child access to primary care practitioners, ages 25 months to 6 years
- Child access to primary care practitioners, ages 7 to 11 years
- Child access to primary care practitioners, ages 12 to 19 years
- Well-child visits in third, fourth, fifth, and sixth years of life

**The CHIS child health outcomes measured:**

- Child asthma rates
- Child obesity rates
- Infant mortality rates
- Child behavioral concern rates
- Rates of psychological distress for children and teens

*Given the tie between social drivers of health and health outcomes, Medi-Cal should consider measuring MCP performance using community-based indicators (access to community-based social services), as well as patient experience and relational care.*

# VII. Recent Medi-Cal Managed Care Reforms: Potential Opportunities for Children's Health

Medi-Cal is currently overhauling its delivery system to improve quality and health equity, and provide greater integration of care, including linkages to social supports. While many of the reforms focus on those with complex conditions, there is a reinvigorated emphasis on children's health, including placing children's health as a priority goal in Medi-Cal's reprocurement process for managed care plans, making children's preventive care a key clinical focus area for their quality strategy, and most recently, hiring a new high-level official to serve as "children's health champion" within DHCS.

Below is an abbreviated outline of the recent Medi-Cal reforms and initiatives that offer potential opportunities for advancing children's health and child health equity through community collaboration and engagement. The core principles and objectives reflect an equity model that places the patient at the center of their care and takes a whole-person approach through prevention, social support integration, and community engagement.

## DHCS' Comprehensive Quality Strategy

In this Comprehensive Quality Strategy (CQS),[54] DHCS recognizes that health care services are just part of a whole-person patient-centered approach to health, and a population health approach involves partnerships across multiple disciplines addressing the social drivers on the individual and system level. The quality and equity strategy applies to Medi-Cal programs beyond managed care plans' delivery systems, outlining goals, guiding principles, and the clinical focus areas of children's preventive care, maternal care, and integrated mental health.

### DHCS' MEDI-CAL QUALITY AND EQUITY STRATEGY

**GOALS:**

- *Members as owners of their health care*
- *Healthy families and communities through prevention*
- *Early intervention for "rising risk"*
- *Whole person care for high risk individuals addressing drivers of health*

**GUIDING PRINCIPLES:**

- *Eliminating disparities through anti-racism and community-based partnerships*
- *Data-driven improvements that address the whole person*
- *Transparency, accountability and member involvement*

## Medi-Cal's Strategy for Supporting Health and Opportunity for Children and Families

To emphasize Medi-Cal's prioritization of children's health, DHCS compiled Medi-Cal's Strategy for Supporting Health and Opportunity for Children and Families[55] to highlight the recent reforms and initiatives that are intended to advance the health of and health equity for children covered by Medi-Cal. Some of the core guiding principles and considerations are similar to the CQS described above, such as addressing disparities and advancing equity, promoting a whole-child preventive approach informed by parents, and providing family and community-based care. Each of the strategies in the box below includes several new and existing initiatives.

### DHCS'S MEDI-CAL STRATEGY FOR CHILDREN AND FAMILIES

**GOALS:**

- ☑ *Implement a new leadership structure and engagement approach*
- ☑ *Strengthen the coverage base for California's children*
- ☑ *Fortify the pediatric preventive and primary care foundation*
  - *EXAMPLE: Equity and Practice Transformation grants to bring to scale pediatric models of whole-child approach targeted in communities most in need*
  - *EXAMPLE: DHCS outreach campaign to providers, plans and families about EPSDT preventive services*
- ☑ *Strengthen access to pediatric vaccinations*
- ☑ *Enhance accountability for high-quality and equitable care for children*
- ☑ *Apply a family-centered approach*
  - *EXAMPLE: New Medi-Cal community health worker and doula benefits and dyadic care for children and their families*
- ☑ *Address the child and adolescent behavioral health crisis*
  - *EXAMPLE: Direct grants to build infrastructure partnerships and capacity to increase school-based behavioral health services such as peer-to-peer programs*
- ☑ *Develop next steps on the foster care model of care*

**GUIDING PRINCIPLES:**

- ☑ *Addressing disparities and advancing equity*
- ☑ *Promoting a whole-child preventive approach informed by parents*
- ☑ *Providing family and community-based care*

## Community-Based and Family-Centered Models of Care

Recognizing that the health of children enrolled in Medi-Cal is linked to the health of their parents and caregivers, siblings, and communities in which they live, Medi-Cal is supporting several dyadic models of care and engaging community health workers/promotoras, doulas, peers, and others who are positioned to offer culturally concordant care rooted in shared lived experiences and community connections. For example, in order to increase positive birth outcomes, Medi-Cal will begin covering doula services, which include emotional and physical support to pregnant individuals and families throughout pregnancy, labor, birth, and the postpartum period. Starting this past April, Medi-Cal also extended postpartum coverage from 60 days to 12 months, directly supporting postpartum individuals and their health care needs, along with benefiting their children and families by supporting their health and recovery after giving birth.

### ✔ COMMUNITY HEALTH WORKERS: BRINGING RELATIONAL HEALTH CARE TO FAMILIES

In establishing an intentional, anti-racist health care structure, cultural competency and humility can be enhanced by incorporating staff with lived experience such as Community Health Workers and promotoras (CHW/Ps). Programs that employ CHWs as part of the medical home find that families are more engaged and more comfortable responding to and establishing connections with staff contacts who have similar life experiences as their own. Because families can quickly build trust with CHWs, these staff can also help improve the relationship between professional health care providers and families.

CHWs can also play a critical role in children's relational health care: Nurturing relationships and intimate bonding are foundational to a child's healthy childhood development—their "relational health." In turn, relational health care recognizes the importance of social connections, and fosters and supports a child's relational health by ensuring engagement, trust, and partnerships with families.

In addition, Medi-Cal created new non-specialty mental health benefits—specifically the Family Therapy Benefit and soon to be implemented Dyadic Benefit. (See box below.) Reimagining behavioral health as a support for healthy development (not a response to pathology) is consistent with both the spirit and stated intent of the EPSDT benefit and represents important progress in integration support for health-related social needs in pediatric and family practice settings.

As a key part of DHCS' strategy to address health disparities in communities of color served by Medi-Cal, Medi-Cal will soon be covering preventive services from community health workers and promotoras (CHW/Ps), who are often from the community and have shared experiences with those they serve, facilitating trusted relationships with patients and families. CHW/Ps' services include health navigation, patient advocacy, and health education, including child health and development.[56] The Administration also proposed as part of the Governor's 2022/23 budget to increase the community health worker workforce by providing significant funding for training and technical assistance.

Also proposed in the Governor's 2022/23 budget is funding for Equity and Practice Transformation grants with an emphasis on children's health care. The grants are aimed to bring to scale successful models of delivering equitable and quality care for children within local practices targeting grants to those serving communities of color.

## Children and Youth Behavioral Health Initiative (CYBHI)

In recognition of the urgent mental health crisis and unmet need, DHCS created a package of initiatives called the Children and Youth Behavioral Health Initiative (CYBHI).[57] The aim is to reform the children and youth mental health system into an "innovative, upstream-focused ecosystem" where all children and youth are routinely screened, supported, and served for emerging and existing mental health concerns. As part of this package, DHCS will create a child/youth virtual platform for direct services for children and youth as well as referrals. The initiative includes significant funding to increase the pediatric mental health workforce and grants to expand community-defined behavioral health programs and build infrastructure partnerships and capacity for school-based mental health.

### DYADIC BEHAVIORAL HEALTH CARE

The Family Therapy Benefit fundamentally redefines medical necessity and dramatically expands eligibility for children under 21 for an uncapped number of behavioral health visits. The benefit adds new z codes and Current Procedural Terminology (CPT) codes that formally remove diagnosis as a prerequisite for care and allow an expanded definition of Adverse Childhood Experiences (including housing instability and the experience of racial discrimination) as qualifying conditions. This means that the impact of poverty, adversity, and racism is formally and openly used as qualifying criteria for access to care.

Building on the Family Therapy Benefit's reform of medical necessity criteria, the new Dyadic Benefit adds new CPT codes and health and behavior codes that make caregiver mental health services available during the well-child visit. These evidence-based models (Healthy Steps, Child Parent Psychotherapy, Parent Child Interaction Therapy, Trauma Informed Cognitive Behavioral Therapy) have historically faced barriers to scaling through Medi-Cal due to diagnosis driven, identified patient, and medical model coding requirements. The Dyadic Benefit creates a pathway to sustainability for these models, a way to code (and get reimbursed for) support addressing health-related social needs, developing healthy attachment and parenting skills, and managing the social and emotional burden of caregiving.

## California Advancing and Innovating Medi-Cal (CalAIM)[58]

As the next phase of Medi-Cal 2020 reforms, CalAIM is a package of Medi-Cal reforms intended to identify and manage complex conditions through a whole-person approach; improve quality outcomes and reduce health disparities through value-based initiatives and payment reform; and consolidate Medi-Cal into managed care. CalAIM's new enhanced care management (ECM) benefit and accompanying Community Supports (such as in-home asthma remediation) are intended for targeted populations with complex conditions. DHCS provided grant funding to support the CBO and health system infrastructure to deliver ECM services, an initiative called Providing Access and Transforming Health (PATH). Regardless of the defined eligibility groups, under EPSDT, children for whom ECM is determined medically necessary would be (and ostensibly already were) eligible for these care management benefits and new community supports. DHCS' CalAIM Children's advisory group continues to discuss how to define "high utilizer" for children as "high need," which may sufficiently broaden the qualification to include children who have high needs that, if not addressed, could result in serious health conditions.

Most important for children's whole-person care approach is CalAIM's Population Health Management (PHM) Program and the PHM Service. The PHM program is a managed care plan requirement to assess and stratify the level of "risk" for each enrollee and ensure access to the appropriate level of care and care coordination to meet their needs. For example, all enrollees shall be assessed for medical, dental, mental, and social needs, and shall receive a package of preventive care and care coordination under the basic population health management benefit (BPHM) for services identified in the assessment. Based on identified risk, enrollees could qualify for a higher level of care management. Accompanying the PHM program, DHCS is in the process of securing a vendor to provide a PHM platform service in which data can be shared among multidisciplinary providers, managed care plans, DHCS, and Medi-Cal families themselves to better coordinate care. The backbone of this PHM Program and Service is care coordination that managed care plans are required to provide as well as the collaboration with local health agencies and programs and CBOs in addressing social needs (ostensibly individual enrollees' social needs).

## Medi-Cal Managed Care Plan 2024 Reprocurement Contracts

As part of the 2024 Managed Care reprocurement process, the RFP[59] included a model contract that will apply to all Medi-Cal managed care plans. In addition to explicitly reiterating the requirements and obligations for complying with the EPSDT benefit, including the detailed care coordination and care management requirements, the contract expands managed care plans' community and enrollee engagement requirements. For example, the contract outlines detailed requirements for consumer engagement, particularly regarding each plan's more robust Consumer Advisory Committees (CAC) functions, scope, and input. Similarly, the health plans are to engage a broader array of community partners in the development of their Populations Needs Assessment (PNA). Previously a PNA was developed by a managed care plan using its own or DHCS-proscribed data, but the analysis and any interventions included in the PNA were developed by the plan, sometimes with input from their CAC or local partners. The new contract requires robust input from CACs and a wide range of local entities and CBOs.

### NEW MEDI-CAL MANAGED CARE PLAN REQUIREMENTS ON CACs

- CAC members must be representative of the enrollee population and those with health disparities.
- Plan's CAC coordinator onboards and accommodates CAC members' participation.
- Meetings must be regularly scheduled, and meeting agendas and notes must be publicly posted.
- CAC coordinator facilitates communication between plan decision makers and CAC.
- The CAC must have sufficient resources to support its operation.

CAC provides input on the following: PNAs; cultural appropriateness of communications, partnerships, services; quality improvement strategies; health equity strategies; member satisfaction results; PHM activities; care coordination; and priorities for health education.

In addition to addressing identified disparities in their PNA, managed care plans have several new equity requirements. First, managed care plans will be required to have an Equity Officer who will provide leadership in designing and implementing health equity into the plan's overall strategies and programs, and will design and implement health equity programs, partnering with local agencies and CBOs. Plans are also required to establish a Quality Improvement and Health Equity Committee, accountable to the board, and develop an annual report on Quality Improvement (QI) and "health equity activities."[60] In addition, managed care plans will need to meet the National Committee for Quality Assurance's (NCQA) new Health Equity accreditation, which is focused on advancing the delivery of more equitable and culturally and linguistically appropriate services for enrollees.[61] (The next level of accreditation—Health Equity Plus—starts to address community collaboration and cross-sector partnerships in addressing social drivers of health).

### STANDARDS FOR NCQA HEALTH EQUITY ACCREDITATION

- Organization readiness
- Data collection, reporting by race/ethnicity, language, gender, sexual orientation
- Access and availability of language services
- Provider network cultural responsiveness
- Assessing and monitoring health care disparities

Source: NCQA, Standards and Guidelines for Health Equity Accreditation, 2022.

Within the 2024 reprocurement contract, managed care plans are newly required to contract with child-serving systems, most explicitly with local school districts. In other words, plans are required to provide Medi-Cal services, such as child and youth preventive services and mental health services in schools and school clinics.

With regard to accountability, Medi-Cal intends to shift to more Value-Based Purchasing, including using quality and health equity outcome measures to adjust base capitation rates for managed care plans starting in 2023. The intent is to tie financial incentives to quality and equity performance.

As a federal requirement, managed care plans must report their "Medical Loss Ratio" (MLR)—or the portion of their capitation payment spent on medical care and quality improvement activities. If the MLR is less than 85% of the capitation, the plan must return the remittance to DHCS. Similarly, managed care plans will report on how much of their capitation's medical costs are spent on primary care with the expectation that DHCS will likely be moving to setting a target for primary care spending similar to the MLR approach. In addition, health plans are required to direct a portion (up to 7.5%) of their net income to community reinvestment activities. Also, if minimum quality standards are not met, an additional percentage of net income will be directed to community reinvestment activities.

Medi-Cal will be adding several new child and maternal quality metrics to the list of performance standards, and many of the metrics will be required to be disaggregated by race/ethnicity. Each plan will have a publicly released dashboard of their quality outcomes. DHCS is also embarking on cross-agency collaboration to increase enrollment for Medi-Cal beneficiaries into CalFresh, WIC, and home-visiting programs.

Altogether these reforms, strategies, and initiatives offer a promising platform from which to make significant advancements toward improved health equity. The work is still ahead to operationalize these bold objectives and initiatives. Notably, while community partners and families are acknowledged as having a key role, the question is whether managed care plans will still be the central power or whether there is an authentic shifting of power to the community.

# VIII. Promising Community Partners: An Equity Framework

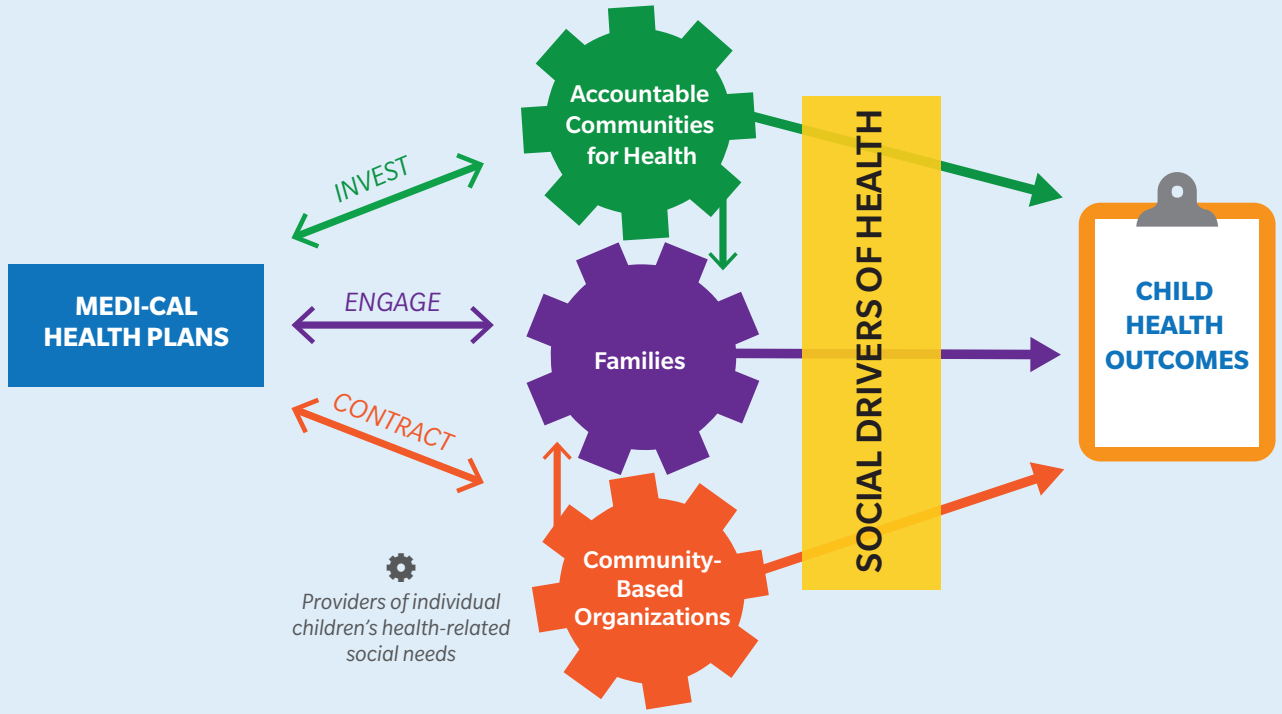
DHCS has recognized that children's health must become a core priority for Medi-Cal and has laid out promising goals for transforming Medi-Cal quality and equity for children. The reforms and strategies to achieve these goals center around managed care plans: integrating mental health care coverage with medical care coverage, developing a population-based management program, focusing on preventive care, tying performance to payment, holding greater accountability to a broader range of child health access performance standards, and providing community-social supports within a whole-person care management benefit.[62]

Can managed care plans deliver on these transformations? And do the strategies depend upon the managed care business model to deliver on reforms or is the reform the transformation of how managed care plans operate?

Perhaps it is worth stepping back and assessing what managed care plan models should deliver and what other players are needed to supplement what managed care plans cannot deliver. Most notably, the community itself—via community health collaboratives, community health workers, community-based organizations, and families—brings to the table an expertise in the lived experience of the population Medi-Cal is serving, as well as cultural competency, understanding of protective factors, and the trust of families. Advancing child health equity and quality may not be just a matter of how much managed care plans invest in children's health care, but also what they pay for and who is delivering it. Though even that assessment presupposes that managed care plans are at the center, deciding who else to invite to provide input. In the context of child health equity, an intentional redistribution of power is necessary. A new framing could be: Community health collaboratives set the table that managed care plans join and invest in. Such a collaboration and partnership framework reflects the recognition of shared power and agency critical to dismantling structural racism and authentically advancing health equity.

**Figure 6. Child Health Equity Centers on Community Partners**

*Medi-Cal health plans can help address social drivers of health to improve child health outcomes*



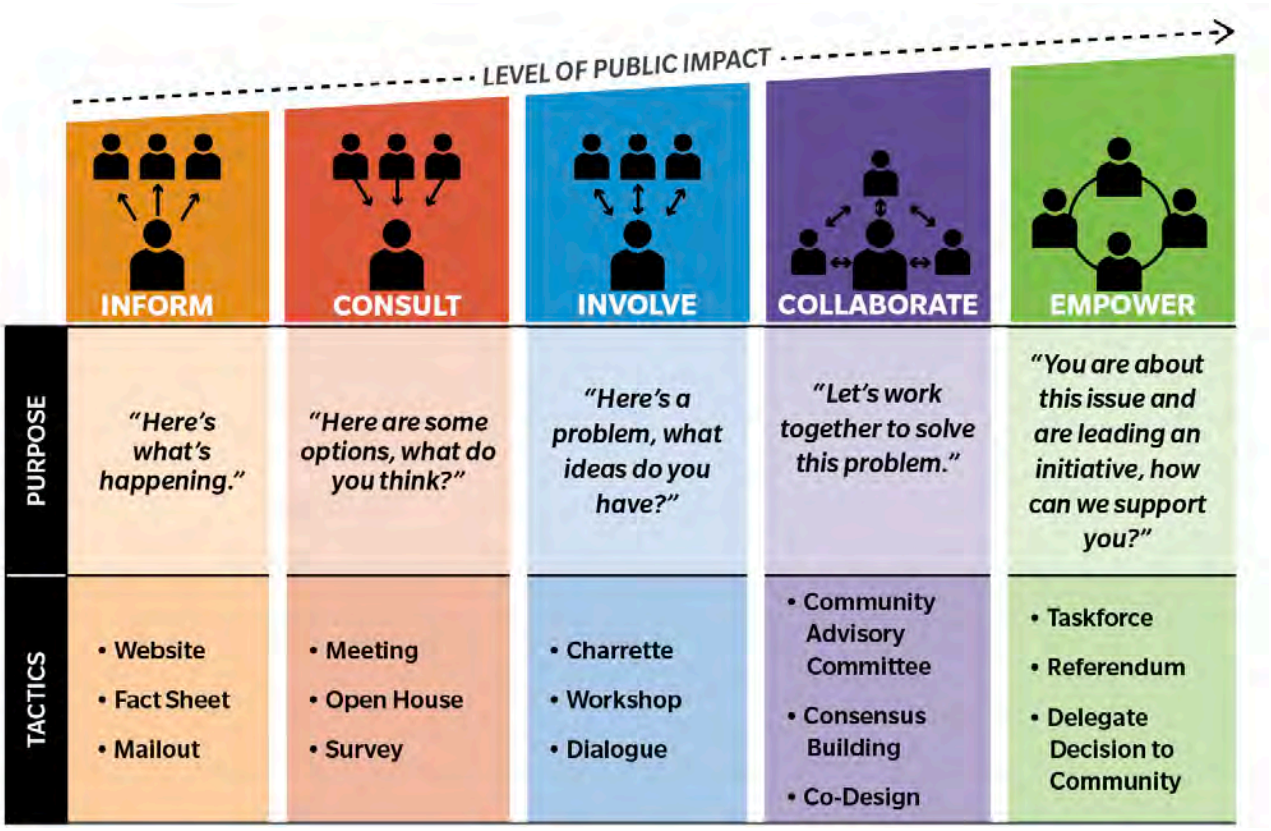
## Why Is Community Partnership Needed to Advance Child Health Equity?

Dismantling systemic racism starts with acknowledging not just racism as a relic from our health system's history but its embodiment in the current systems and their distribution of power and agency. The path toward health equity requires centering community and individual agency and redistributing power—for children, youth, and families in their health care: "Nothing about us, without us."[63] In addition to being the experts on their children and their lived experience, families also know best how the barriers inherent in the health care system are failing them. Similarly, communities know the needs of their populations and the protective factors they offer, and, with respect to CBO services, provide the culturally relevant care needed to best mitigate barriers.

Equitable delivery and management of care for children starts and ends with the input of and collaboration with their parents and families. Family Voices, a family-run non-profit organization, advocates for placing families at the center of children's health care because of their direct expertise and representation of their community experience.[64] System transformation involves fundamental shifts of power toward shared decision-making and centering families and communities as essential partners and experts in the design and delivery of care.

There are varying degrees of engagement, whether family or community engagement, along a spectrum ranging from informing, where community members are provided information but with little opportunity for feedback, up to shared decision-making and empowerment, where community members make decisions that are supported by systems. One description of the degrees of engagement envisions a spectrum of public participation, in which a more equitable system is achieved when decision-making authority is more evenly distributed between the public and the government.[65]

**Figure 7. Spectrum of Public Participation Model**




*Source: Adapted from PlanH*

The higher up the spectrum of engagement, the greater agency given to families and the community. In the context of health systems and health plans, we would argue that collaboration should be the aim.

In addition to the level of engagement, there are different types of community partners and their unique contributions and engagement. As previously mentioned, they include:

- Families, youth, and community members themselves
- Community collaboratives
- Community-based service organizations

## What Is Family Engagement?

Across a variety of disciplines, including child welfare, juvenile justice, education, early childhood, and health, family engagement is a critical tool for systemic transformation. For family engagement to be authentic and thus effective, families must be systematically included in policies and programs that promote children's development, learning, and wellness, including shared decision-making in planning, development, and evaluation.[66] Because families are experts in their own experience, a system devoted to serving them must center the parent perspective and respond to the child's needs as parents/caregivers define them. Family engagement is more than a data point collected through consumer surveys and focus groups to be analyzed and acted upon by health systems' decision makers. Family engagement is an iterative, relational, and collaborative process.

*Authentic family engagement is relational and moves at the speed of trust.*

Family engagement occurs in multiple dimensions of health care delivery. At the individual patient level, the parent and child themselves should be part of the child's health care team and collaborate on treatment plans. At a system level, such as within a managed care plan, families' input should be incorporated into how a health plan makes operational and investment decisions through authentic collaborative decision-making, optimally with family representation on governing boards and robust advisory committees.

## What Is Community Collaboration?

Family engagement is a microcosm of another dimension of engagement in population health, namely community engagement, whereby local leaders, community-based organizations, and local agencies partner with health plans to identify social and environmental issues—both risks and assets—of their population, and to develop and provide appropriate interventions.

Reframing a system of care within a child health equity construct moves the community beyond engagement to collaboration, where power shifts toward a community collective, such as an Accountable Community for Health, to make decisions about which community needs to be prioritized and what interventions should be invested in. Medi-Cal managed care as a local partner would have a place at the table, bringing with them their required and discretionary investments in the community.[67]

## What Are CBO Partnerships?

Community-based organizations (CBOs) are nonprofit organizations that work at the local level to meet the community's needs in a culturally concordant manner within the community. They are representative of a community, often with shared lived experiences. CBOs work across various areas and often have established, trusted networks and regularly and authentically engage families[68] by providing direct services, care coordination, education and navigation, validation of protective factors, "warm hand-off" referrals, and peer support. Notably, community health workers/promotoras serve as a relational workforce for CBOs.[69]

Much of this work may not fall within a claims code for reimbursement, but the relational aspect of CBOs' work is invaluable to delivering on the quality and equity standards that managed care plans will be required to meet. CBO partnership within managed care plan models translates into contractual and/or reimbursable transactions for the array of relational care that CBOs and CHW/Ps provide.

# IX. Observations of Managed Care Plans' Relation to Children's Health

With this framing, we now turn to the observations shared by some of the players: managed care plans, CBOs, and families. In our interviews and focus groups, they discussed their perspectives on how Medi-Cal managed care plans approach children's health care in the context of the select areas of focus listed below. These areas of focus are particularly pertinent functions in addressing health-related social needs of children and in integrating social supports with Medi-Cal's health care delivery system. Our interviewees shared challenges and opportunities from their perspectives and provided suggestions for improvements in:

- **Care Coordination**
- **Health-Related Social Needs and Community Social Supports**
- **Partnering with Community-Based Organizations (CBOs)**
- **Community Collaboration on Behalf of Children's Well-Being**
- **Authentic Family Engagement by Managed Care Plans**

## Care Coordination

Care coordination services ensure that children and adolescents get the right care at the right time and in the right setting. For families, care coordination should identify where children can be best served and make those connections with a "warm hand-off," creating a bridge across multiple systems that serve children, such as medical settings, community-based organizations, and other child-serving agencies, which might include Regional Centers, schools, and early learning centers. And most importantly, care coordination is relational, supporting families in navigating and engaging in the systems serving their child.

The forthcoming Population Health Management (PHM) program envisions three levels of care management available to Medi-Cal beneficiaries: care coordination as part of a basic population health management program (BPHM) that is available to all Medi-Cal beneficiaries and aims to promote and connect them to primary and preventive care; complex care management, which is available to those who are assessed for "rising risk" and may need a temporary case manager to assist them with accessing services across multiple systems; and enhanced care management.[70]

This Medi-Cal PHM requirement, however, is not a new requirement for Medi-Cal children under the EPSDT entitlement. As we outlined in our first Care Coordination brief, Medi-Cal managed care plans are already required to provide a spectrum of coordination of care for "...all medically necessary EPSDT services delivered both within and outside the MCP's provider networks."

Observations of managed care plans and CBOs on care coordination functions in managed care are summarized below.

***We know very little about the extent to which children covered by Medi-Cal are receiving care coordination.***

Because providers, such as pediatric practices, may not have a tracking system for referral follow-ups, "closing the

loop"—an essential component to care coordination—is difficult for health plans to track. Providers may report a risk identified from a screening but might not be able to report what referral was made and its outcome.

### *Care coordination needs a performance measure and to be tied to capitation payments.*

While Medi-Cal requires managed care plans to coordinate care for children—even for care not provided by the plan—as part of the EPSDT entitlement, Medi-Cal does not measure health plans' care coordination performance (e.g. closed loop referrals) nor is care coordination a category of service under their capitation methodology. What is measured matters. Medi-Cal could also provide guidance and technical assistance to plans and providers in developing a means of tracking and reporting referrals and their follow up.

As Medi-Cal is below the national average capitation for children, an underfunded managed care system is not likely going to invest in building a basic care coordination infrastructure if a managed care plan can utilize and benefit from what local programs already provide. From the community perspective, families and CBOs would rather see CHW/Ps embedded in their community, serving people irrespective of their managed care plan as compared to having each managed care plan hire their own CHW/P who would change when the person's coverage changed.

**CARE COORDINATION MODEL HIGHLIGHT: DULCE**

Developmental Understanding and Legal Collaboration for Everyone (DULCE) is an intervention based in health, legal, and early childhood related settings that assists parents in overcoming the challenges of caring for children from birth to six months of age by addressing health-related social needs and providing families with support for any unmet legal needs, age-related information on child development, as well as ongoing friendly support. These services are organized as an Interdisciplinary Team comprised of a Family Specialist, a medical provider, a legal partner, an early childhood systems representative, a mental health representative, a project lead, and a clinic administrator. Through its Interdisciplinary Team and relational engagement with families, DULCE works to address the accumulated burden of social and emotional hardship of each family served. Because DULCE is part of a patient-centered medical home, the program benefits extend beyond the new baby and parents to the entire family.

Source: Legal Partnering for Child and Family Health, September 2019

### *Models for basic care coordination vary.*

Some plans choose in-house care coordinators, including community health workers/promotoras, and some rely on local community organizations. Funding could be salaries, contracts, or reimbursements for referrals, although managed care plans' arrangements with local care coordination may not always be financially contractual partnerships. Employers are increasingly asking their commercial health plans to include health advocates as a benefit to assist their employees to navigate the health system. Medi-Cal managed care plans could similarly provide this benefit as part of their basic care coordination obligation under the BPHM. Similar to CalAIM's new Enhanced Case Management benefit and community support services, children and families need a basic care coordination model for preventive care that centers around community-based care coordinators. (As part of the ETE project, our care coordination report, Key Components of Children's Care Coordination, outlines a few examples of child-centered care coordination programs and some of the fundamentals that make up effective care coordination.)

### *Shared data on child health needs and health outcomes by race is lacking yet essential.*

Managed care plans can use population health data provided by DHCS or must rely on creating their own data platform. When implemented, Medi-Cal's PHM service is intended to integrate population-level data, incorporating multiple data sources for population health functions and allowing for multi-party (agencies, provider networks, and plans) data access and sharing. The PHM service should also include local population data collected by community collaboratives like Accountable Communities for Health. DHCS should disaggregate these shared data sources—as well as HEDIS and EPSDT (CMS 416 form)— by race at the health plan, county, and state level, and make them available to the public for analysis. This may pose some challenges, particularly for infants for whom race/ethnicity data may be missing or unspecified. When evaluating managed care plan performance by race/ethnicity, DHCS could consider controlling for regional differences in quality, differences in providers available in MCP networks, number of doctors serving that population, and languages offered.

### *Community health workers provide relational coordination between health care and community support services.*

Contracting with and reimbursing community-run care coordinators can provide relational coordination for health plans that need coordination and navigation assistance with a trusted local contact. Trained community health workers/promotoras have been shown to be effective at providing a bridge for families navigating between their child's health care and social support.[71] Some plans have hired community health workers/promotoras to provide home visitations. The recent Medi-Cal benefit for CHW services will further increase the number of health plans contracting for these services. The CBOs we interviewed also expressed a need for the State to provide a sample care coordination contract for CBOs/CHWs for child-specific care with a prevention focus.

## Health-Related Social Needs and Community Social Supports

Prior to the forthcoming PHM program, Medi-Cal required managed care plans to conduct an annual Population Needs Assessment (PNA), which is intended to identify populations' and members' health needs and health disparities; evaluate current improvement strategies; and implement targeted interventions to respond to identified gaps.[72] The "population" in both the PNAs and the PHM program most often refers to the population of a managed care plan's enrollees. Such assessments and management programs target health-related social needs of individuals, which is distinct from assessing and addressing the social drivers of health within the community in which the managed care plan enrollees live. While both individuals' health-related social needs and the social drivers of health within a community warrant attention, the latter objective cannot be centered on managed care plans but should instead be centered in collaboration with communities, such as ACHs.

### *Midstream and upstream investments in children don't often have a clear return on investment for an individual managed care plan.*

As noted in one health plan interview, plans have to prioritize the dual-eligibles and "high utilizers," and children get lost as a result. To think and plan "midstream," namely a "whole-child" centered approach to care focusing on children's preventive care including community supports, will generate health benefits, and even cost savings, in the long term. However, upstream or midstream investments do not make business sense within an individual managed care plan business model. Often the long-term health benefits and resulting cost savings are not returned to the managed care plans that invested in upstream interventions, particularly in the lifespan of a child to their adulthood. Instead, upstream investments and interventions by managed care plans would require Medi-Cal regulation, guidance, and financial drivers in order to focus on children's "whole-child" care.

A transformation from a utilization management model to a model built upon a prevention framework on behalf of children is fundamental for managed care plans. Medi-Cal's upcoming Population Health Management (PHM) requirement is intended to increase focus on preventive care and community support services for the general Medi-Cal population, but the PHM program *alone* will not evoke a fundamental shift in managed care plan operations and instead could become simply another case management tool. However, some managed care plans are already investing in population health through family resource centers for a full range of services and resources for communities at large. Health plans are not designed to be population-driven. Often when managed care plans do consider population-driven interventions, the scope of "population" may extend to the plan's enrollees and not the population of the community at large.

### *The usefulness of Population Needs Assessments (PNAs) varies in determining and responding to community needs.*

Is the PNA just a "check-the-box" exercise or an operational plan for community needs assessment and improvement plan? Some managed care plans do use them effectively. For example, one MCP's PNA led to hiring a team of CHWs on staff and launched a CalFresh enrollment campaign. However, in a 2018 audit, the State Auditor found that DHCS did little to monitor whether PNAs' recommended targeted improvement strategies were implemented and whether they were effective.[73] In our own analysis of several PNAs, we found issues or disparities identified in the PNA lacking any response or plan for how the managed care plan intended to address them. Similarly, it was unclear from the PNAs whether strategies that were put in place were being tracked to determine their effectiveness and whether the underlying issue persisted or improved.

One plan interviewee found that the newer PNA guidance is too high-level to generate information that is targeted enough to develop Quality Improvement (QI) or mitigation strategies.

### *To what extent are communities involved in the development and implementation of the PNA?*

Medi-Cal guidance requires MCPs to seek and share input from their Community Advisory Committees (CACs). From the perspective of the CAC members from our focus group discussions, it was not clear whether their input impacted any decision-making with regard to the plan's PNA. Some managed care plans shared that they develop their PNA with community agencies and health systems. Some plans' PNAs incorporate intervention strategies based on those local needs identified by community collaboratives, which are organized through local public health departments. The 2024 managed care plan contracts as part of reprocurement require far greater collaboration with community stakeholders in the development of the PNAs.

### *PNAs should be strengthened to include a clear focus on children.*

A number of plans mentioned the weakness of the PNA in supporting child health equity and that although they are data-driven, without childhood screenings they are not helpful in advancing child health equity. Without reliable data on the results of children's screenings, such as blood lead level screenings, the PNA is of little use for children's health assessment. Our own analysis of several PNAs found data was not examined for children under the age of 5, a particularly critical period in childhood development. One interviewee suggested that it would make sense for health plans to develop a PNA dedicated to children's health.

Integrating and coordinating health care and community social services means sharing data. Some managed care plans are trying to add support services to their members' medical records in order to facilitate care coordination and integration. The health home structure with its coordinated encounter data is a useful model to consider in how to collect, report, and monitor care coordination activities. CBOs and managed care plan interviewees both acknowledged the risk of "medicalizing" the community social support system, while recognizing the need for some interoperability and sharing of information between multiple systems. DHCS recently released an RFP for its Population Health Management Service platform that envisions interfacing the population-health level information from and for multiple types of users (DHCS, health plans, providers, and beneficiaries) and offering provider networks and health plans integrated information about the families they serve.

Health providers overwhelmingly use data on health-related social needs from assessments but face barriers in conducting social needs assessments when they do not have the resources or referral network to address any identified needs.[74]

### *Managed care plans recognize their role in responding to social risk factors but it is challenging to navigate multiple social support systems.*

The health care system is increasingly reframing the model of care delivery to identify health-related social risk factors and responding to social/emotional needs; screening is key. However, identified social/emotional needs often require comprehensive and multi-discipline networks of community service providers in order to respond to those needs. Some MCPs use all touch points to conduct a screen for assets, risks, and experience,[75] and then use navigational directories, like "findhelp" (formerly known as Aunt Bertha), or a closed loop navigation system, like Unite Us, to identify available local resources and support services to recommend to members. Each plan in a county may have its own network navigation approach rather than a consolidated approach among plans.

### *Navigation platforms for social and community services are not just about technology, but relationships.*

Navigating local social supports in a systematic way is difficult for statewide plans since there are many local platforms to navigate. In addition, trust and relationships are key to building an effective navigation structure for identifying available social supports in the community. Data platforms are necessary but not sufficient without the culturally competent and trusted coordinator staff to provide the bridge to services for families. Moreover, the navigation systems need to serve the local CBOs and social services, not just the health care system in its referral and follow-up obligations.

### *The level of investment in social support navigation systems varies.*

Some plans are heavily investing in community-driven navigation systems, others fund private contractors to develop one for the health plan, and still others are

leveraging existing CBO networks. For example, local Help Me Grow programs have built local navigation systems, which the managed care plans benefit from but do not often contribute to. As noted by CBO interviewees, managed care plans could help support the sustainability of a CBO's navigation system so they can build out the hotline infrastructure to serve all pediatricians.

Some MCPs have staffed in-house CHWs for home visiting and social workers to follow up on risks identified from initial assessments. One plan is in the process of contracting with high-use CBOs to collect high-level data on social services use and follow up.

### *When it comes to funding non-health support services, managed care plans tend to support local grants rather than long-term reimbursement contracts.*

One plan created an in-house innovation lab—based on a venture capital business model—investing in a broad number of local programs serving the community with demonstrable or promising success. Some health plans turn to existing community investment funds to invest in social support services rather than identify their own social support service investments. Many plans have MOUs with existing support programs, such as the Supplemental Nutrition Program for Women, Infants, and Children (WIC). This partnership facilitates families' enrollment into WIC, while their enrollment will serve to advance the managed care plan's early childhood intervention efforts, such as through WIC's breastfeeding support and supplies.

### *Some social support services are becoming claimable as health-related Medi-Cal services.*

As is occurring across the country,[76] managed care plans in California are directly contracting with food security programs and housing assistance. CalAIM's ECM benefit[77] is accompanied by community support service benefits that Medi-Cal managed care plans can choose to cover within the medical load of their capitation. This program is an outgrowth of Medi-Cal's "whole person care" pilots in which housing assistance was covered. All but two of the new CalAIM community support services are covered under the federal "In Lieu of Services" (ILOS) provision[78] in Medicaid that allows for support services to be covered if they forgo other health care expenses. However, Return on Investment (ROI) calculations for ILOS might not be as relevant for children's support services. Because children at risk of significant health conditions (and high health care costs) may not yet have manifested those conditions and might not for several years, demonstrating the ROI will likely not satisfy the shorter term ILOS criteria. In fact, investments in general prevention interventions face similar longer term ROIs.

Nonetheless, managed care plans have expressed the need for DHCS guidance to further clarify which social support services can be included under children's EPSDT benefit (e.g. guidance on food as medicine), and under what circumstances. Furthermore, DHCS guidance should explicitly incorporate those eligible social support services within the medical load of capitation rate setting and Medical Loss Ratio (MLR).

### *Covering support services as benefits would drive health plans to invest in support services for their members.*

CBOs and MCP interviewees suggested DHCS make food and housing assistance covered benefits if indicated. Some plans have invested in housing assistance but have not been able to count those costs against their capitation's medical load, and they are instead accounted for as community benefit expenditures. One managed care plan noted that they had a $530 ROI for covering meals for individuals with diabetes. Currently, however, covering housing supports with federal Medicaid matching funds requires federal 1115 waiver approval as in California's CalAIM waiver offering optional housing supports under the enhanced care management benefit. To further support and respond to social support services, DHCS' 2024 reprocurement contracts direct health plans to dedicate

7% of net income in community reinvestments to address social drivers of health and additional percentages for community reinvestment activities if a plan fails to meet certain performance standards. Several states have similar Medicaid managed care plan directives relating to community reinvestment activities.[79] (See chart in Appendix D for a summary of several states' Medicaid managed care plan community investment requirements.)

### *Community support service capacity is not meeting the need.*

Both CBOs and MCPs consistently noted that the capacity of available support services is not nearly meeting families' needs in most communities. Managed care plan investments into the community help but will not be able to make up the gap. In determining that systemic statewide policy change is needed to sufficiently resource local social services to meet the need, one managed care plan decided to invest in policy advocacy for greater state funding for local communities—for housing and telehealth/broadband access, for example.

## Partnering with Community-Based Organizations

### *CBOs and managed care organizations have fundamentally different frameworks and different terminologies of operation.*

While both might share a similar overall mission of improving the health and well-being of the populations they serve, their business models and operations differ greatly. CBOs operate in the "currency of trust," putting a premium on relationship building. Health plans are management systems putting out a service of quality and efficiency in the delivery of care. The organizational structure and terminology of MCPs is difficult to navigate for CBOs and managed care plans' structure and terminology may vary among plans. CBOs are often directed to interact with managed care plans' community liaisons, but CBOs have found it far more effective to work with a plan's Quality Improvement departments because they may more readily see the benefit in partnering with a CBO whose services are aligned with the MCP's QI priorities, and QI offices are given budgets with which to address gaps in performance.

### *Two-way training and technical assistance between CBOs and MCPs would be valuable.*

CBOs indicated that they would value learning managed care plan terminology and the organizational structure of MCPs relative to their community support services. Trainings for CBOs would also be useful to acquaint them with MCPs' claims and data collection processes, privacy requirements, and criteria for grant evaluations (each health plan has its own criteria for evaluation protocols for CBO grants).

Similarly, CBOs can train plans on culturally appropriate service delivery and recruit and train families for participation in managed care plans' family engagement activities. More generally, health plans or health plan leadership may not know the child-serving safety net system and could benefit from a "101" training.

### *CBOs providing care coordinators may not have the requisite capacity and functionality to contract with health plans.*

Contracting directly with small CBOs may require different contracting strategies, such as paying smaller providers up front for their services to make it easier for them to provide services to their members. Intermediaries—such as clinics and coordination networks like San Diego's Neighborhood Networks (see side box)—have contracted with managed care plans on behalf of CBOs and provided CBOs and their Community Health Workers with the legal and financial infrastructure and data systems necessary to partner with managed care plans. One initiative Neighborhood Networks is launching is to co-locate CHWs at pediatric offices and CBOs, and Neighborhood Network contracts with the

**CARE COORDINATION MODEL HIGHLIGHT: NEIGHBORHOOD NETWORKS**

Neighborhood Networks was conceived in part by the San Diego Accountable Communities of Health to help healthcare systems and community-based organizations work together to address the health-related social needs of community members. Neighborhood Networks contracts with health plans to provide care coordination to enrollees with risk factors that span health care and social needs. In turn, Neighborhood Networks contracts with CBOS for CHW services while also providing a variety of management services including specialized training for Neighborhood Navigators, a secure centralized online case management system, quality assurance, and reporting.

Source: https://neighborhood-networks.org/our-approach/

CHW workforce for the health plan. Most MCP contracting is with large systems or clinics and could leverage those relationships as intermediaries to connect with CBOs. For example, county hospitals work with promotoras to make well-child visit appointments for families.

***Health plans may not be motivated to partner with CBOs unless there are underlying policy requirements, financial mechanisms, and/or performance metrics incentivizing them to do so.***

Some state Medicaid programs, like Michigan's, have explicit requirements and incentives for community health workers in their network, and several other states, like Oregon and Arizona, have requirements that plans invest a certain percentage of their capitation into community interventions as a means of supporting those community-based social and emotional support services. How those investments are directed, and who gets to define where, may vary based on state policy. In the next section, we describe Accountable Communities for Health.

## Community Collaboration on Behalf of Children's Well-Being

***MCPs value community engagement but are not the hub for executing effective community collaboration.***

Medi-Cal has been increasingly asking their contracted managed care plans to take on greater responsibilities in ensuring beneficiaries' health, including addressing not only the health-related social needs of their enrollees, but also the community social drivers of health and ensuring health equity, such as requirements for community and family engagement. However, when it comes to the largest factors impacting children's health—namely social drivers of health—health plans are ill-equipped to manage this multidisciplinary array of community interventions and services under their model of care, particularly managing the communities' social drivers of health. Similarly, while managed care plans do engage with community partners and plan members, the business model of most health plans is not conducive to power sharing, or meaningfully bringing the community into decision making within the MCP organizational structure.[80] However, it is worth noting that some local initiatives—locally run non-profit health plans—are required to have "health consumer" and "health care consumer advocates" on their governing boards.[81]

Health equity transformation does involve a shift in power, whereby the community is part of the decision making that impacts their care. The community itself—in collaboration with CBOs and local health and social service departments—is better equipped to understand and identify health-related risk factors and social drivers of health affecting their populations, as well as being more knowledgeable about community protective factors, effective interventions, and available community resources. MCPs should be active partners at this table, but the table should be set by the community.

***Accountable Communities for Health are rooted in the relational and power-sharing nature of true community engagement.***

Community engagement is local, which is difficult for statewide health plans. Accountable Communities for Health—community-driven cross-sector collaborations to advance the health of the community using a collective impact model— offer a more appropriate model for engaging the community in identifying social risk and protective factors and in developing and deciding on community-based interventions. As relationship brokers of trust, Accountable Communities for Health can be valuable partners for Medi-Cal and Medi-Cal managed care plans. While these entities have to be careful in balancing the relational nature of community planning and collective impact with the inevitable transactional nature of implementation and MCP partnerships, ACHs are closer to community trust than MCPs because they are run by the community themselves.

For example, the Long Beach ACH provides parents with leadership training and support to facilitate their participation in collectively developing the ACH portfolio of actions (strategies to advance agreed-upon goals). Similarly, ACH partner organizations receive training

**CARE COORDINATION MODEL HIGHLIGHT: IMPERIAL HEALTH ACH**

The Imperial Health ACH in southern California reduced ER visits for children with asthma and improved school attendance by coordinating services to families across schools, primary care settings, emergency medicine departments and in the home through home visiting services.

Source: Imperial County ACH profile, CACHI. https://cachi.org/uploads/media/CACHI_Imperial_profile.pdf

## ACCOUNTABLE COMMUNITIES FOR HEALTH

Accountable Communities for Health (ACH) are formal and structured vehicles for community collaboration across multiple sectors to address critical community health issues. The model recognizes that health is the result of interdependent factors at work across a community and that no single entity controls enough to address them alone.

» **Multi-Sector Collaboration**
ACHs bring together local clinical providers with public health departments, schools, managed care plans, social service agencies, community organizations, residents, and others in a collective effort to prevent health conditions and promote health in their community. Diverse interests, representing key sectors of the community, provide the insights, resources, access, and capacity necessary to achieve meaningful change.

» **Collective Action**
ACHs facilitate data sharing and accountability to help community partners across multiple sectors develop an understanding of mutual problems and collaborate on a "portfolio of actions." These actions or strategies are designed to connect and reinforce each other for greater impact than any single program or intervention could achieve alone, shifting away from a program-specific approach.

» **Family Engagement**
ACHs emphasize family participation and input in all aspects of their work, so families are actively shaping this new business model for health. By centering equity and community voice in all partner operations, ACHs shift power and resources to produce more equitable outcomes and a more cohesive community.

» **Wellness Fund**
A key component of the ACH is the creation of a "Wellness Fund," which is designed to attract and weave funding and resources to support the long-term sustainability of the ACH. The Wellness Fund will also enable the ACH to align and target funding to fill gaps identified in the portfolio of actions.

There are currently 13 ACHs in California.

Source: California Accountable Communities of Health Initiative.

in active listening. Notably, the support provided to parents was not solely in the service of ACH functionality but relational—serving the needs of parents where they are. When the pandemic first hit, ACH members reached out to the participating parents to make sure their basic needs were being met, and the ACH's other activities were suspended to ensure that participating parents and families received the immediate support they needed.

### *Health Plans have a role to play in Accountable Communities for Health.*

While health plans are not singularly setting the table for ACH collaborations, they are certainly active partners. Most notably, health plans can invest in ACHs by contributing to community "wellness" funds. Local wellness funds are operated by the established governance of the ACH and the use of the funds is collectively determined among the ACH participants. In other words, health plans are not dictating the scope and target of the wellness funds based solely on their own objectives. Other funding streams are blended and leveraged in these funds to best achieve shared goals and outcomes.

### WELLNESS FUNDS HIGHLIGHT: IMPERIAL COUNTY

When Imperial County first moved to its Medi-Cal managed care plan model, which included the Health & Wellness Health Plan, the county negotiated for the creation of a Wellness Fund. This selected California Medi-Cal managed care plan contractually agreed to a per-member, per-month contribution as well as a percentage of shareable revenue to support countywide investments in population health through the Wellness Fund. The Wellness Fund is governed and administered by a Local Health Authority Commission, which includes leaders from the county, local providers, businesses, and a Medi-Cal beneficiary representative. The steering council of community representatives also provides input. The local ACH examines strategies for blending and braiding resources from the Wellness Fund, public health departments, and other sources.

Source: CACHI Issue Brief on Establishing a Wellness Fund.

As previously mentioned, DHCS' Medi-Cal managed care 2024 reprocurement contracts require managed care plans to make community reinvestments as a portion of their net income and if performance minimums are not met.[82] These reinvestments could be placed in a local wellness fund or invested in community activities as determined by the community. There are several examples of states that have required Medicaid managed care plans to invest in community activities, with some, like Oregon, requiring a portion of the organization's previous year's income be directed to the state's SDOH and equity spending program, which is sent to communities. Most recently, Oregon is also directing their Coordinated Care Organizations (CCOs) to invest a percentage of their capitation payments directly to community investment collaboratives.

In addition, the ACH can play an active role in the development and operation of health plans' Population Health Management strategy, beginning with the data collected and shared among the multi-sector partners in the ACH. The ACH can also be relevant partners in developing and implementing interventions within the PHM's continuum of care, particularly care coordination and social/emotional support services and the community organizations providing those services.

**FAMILY ENGAGEMENT PROGRAM HIGHLIGHT: CENTER FOR FAMILY VOICE**

In recognizing that managed care plans could benefit from a better understanding of how to authentically engage families in their children's care, MolinoCares Accord supported Groundwork Ohio—a non-profit organization—to launch the Center for Family Voice. This new program started with exploring best practices in Ohio and the nation in how to successfully engage families in child-serving delivery systems to inform policy and program development. A 2021 report, "Amplifying Family Voice in Advancing Equitable Outcomes for Children," outlines the evidence for the benefits of engagement and how to implement authentic family engagement. The Center provides support for families in lifting up their voices, bolstering their protective factors, and integrating family voice in child-serving systems' policy and program development.

Source: Center for Family Voice, Groundwork Ohio

## Authentic Family Engagement by Managed Care Plans

### *Parents are the true experts in their children's conditions and care.*

And yet, based on our focus group discussions with parents, their input is often dismissed in the health care setting. Several parents from varying racial/ethnic backgrounds expressed frustration trying to convey their concerns and observations about their children to medical professionals who often did not give parents' opinions much medical importance. One parent relayed her experience trying to raise a concern to her child's doctor despite the provider's apparent indifference. Only when she described the condition using medical terminology did the doctor raise an eyebrow and ask if she had a medical background, to which the mother responded no, but she knew her child and her condition very well. (See our Family Engagement Issue Report for more detailed findings from these parent focus group discussions.)

### *Parents' input in health plans matters.*

MCPs have noted that asking families about specific outreach strategies, such as well-child visits scheduling, can help health plans identify potential barriers and provide feedback on what remedies might address those barriers, such as whether incentive payments to families for vaccinations might help. While parent feedback is relevant for addressing MCPs' targeted objectives, MCPs should also be actively listening to and responding to issues parents raise that need addressing. Parents want to raise concerns with their child's health care providers but cannot figure out how to do so in the health plans' system. Parents noted that MCP grievance protocols seem more geared toward denial of services than to reporting substandard care.

### *Consumer Advisory Committees (CACs) are not the hub of MCP family engagement, but the floor.*

Authentic family engagement strategies serve to bring the voice of those being served into their care—not just complaints, but input that is honored and incorporated into MCP decision making. The original requirement for Medi-Cal health plans to establish CACs was minimally focused on cultural linguistics for MCPs' materials, such as testing out well-child education material. ACHs could serve as a neutral trusted convener on behalf of MCPs to facilitate dialogue between families and the local MCP(s) on a broad range of issues.

***New attention and requirements are strengthening the role of plans' Consumer Advisory Committees (CACs).***

Currently, some health plans have broadened the scope of their CAC to seek input on managed care plan interventions such as Quality Improvement strategies. Others have created child-specific advisory groups for children served by California Children's Services (CCS) and, in some cases, disease-specific CACs. One plan we interviewed has an Equity Consumer Committee that identifies social support needs (e.g., food security, housing access, and homelessness). Several plans conduct intermittent focus groups, for example, to understand what motivates well-child visits, revealing teens are motivated by movie vouchers for attending the well-child visit. In most cases, these consumer engagement activities are run under community liaison offices and do not have direct ties to organizational decision makers or leadership in the plan's organization. However, one plan interviewed has a child and maternal health advisory committee that provides direct feedback to the plan's board of directors.

As mentioned, Medi-Cal's managed care plan 2024 reprocurement contract requires managed care plans to establish more robust CAC engagement including incorporating CAC members' feedback into the plans' Population Needs Assessments[83] and other topics. In addition, the 2024 reprocurement contract requires greater transparency and support of the CAC operations as well as explicit representative membership.

***Parents want to participate in plans' community engagement strategies, such as CACs, but they need support to do so.***

In order to participate, parents need support such as childcare and interpreters as well as meeting schedules that do not conflict with their work. In addition, parents believe they should be able to participate in determining the CAC objectives and scope, meeting schedules and agendas, and governance and voting structure. CACs offer an opportunity for parents to get their issues addressed but the parents in our focus groups believe all plan enrollees should have the benefit of a forum to provide input.

***Because family engagement is iterative, relational, and time-intensive, CBOs are best equipped to assist families and should be compensated.***

Family engagement is more than a data point—far more than consumer surveys and focus groups to fill in responses

for health plans' organizational research. Families need to trust that their time and input are valued and will be heard by plans' decision makers. Family engagement is an iterative, relational, and collaborative process. Because CBOs and ACHs operate in the relational "currency of building trust," managed care plans could contract with CBOs or ACHs to help recruit, support, and train parents in providing their input to health plans. Plans themselves have also noted that trusted community workers and health advocates can be effective conduits between families and plans, not as surrogates for parents' voices, but in supporting their empowerment. Building those relationships with community workers and CBOs, and compensating them, requires time and funding. Plans have noted that because effective family engagement is time-intensive, reimbursement for those costs should be incorporated as a category of service as a quality improvement activity—as opposed to administration/overhead spending—of their capitation.

*Because family engagement is iterative, relational, and time-intensive, CBOs are best equipped to assist families and should be compensated.*

# X. Recommended Framework for Child Health Equity

In order to effectively respond to social drivers of health for children covered by Medi-Cal, we must be explicit about where managed care plans can play a role and where they can serve in a supportive capacity.

**When addressing the health-related social needs of individual children enrolled in Medi-Cal, managed care plans—with the appropriate infrastructure, accountability, and CBO and local partnerships—can facilitate identifying and connecting children to needed social supports**. Below, we outline several recommendations for how to strengthen Medi-Cal's reform efforts to maximize managed care plans' potential in meeting children's social needs by cultivating, leveraging, and contracting with CBOs in coordinating care and providing social support.

**With regard to the social drivers of health in the communities where children live, managed care plans are not designed to sufficiently address these population-based conditions but they have an important supportive role to play.** We proposed a framework (Figure 6 on page 33) that redistributes power to local community-led collaboratives, such as Accountable Communities for Health, with appropriate functionality assigned to managed care plans within the community, namely in the management of individuals' medical care. Accountable Communities for Health manage and integrate population health and social supports among local multi-sector partners.[84] Clearly, managed care plans and Accountable Communities for Health will need to collaborate and partner closely together with many areas of overlap, such as in Population Health Management. Several initiatives initiated by the Newsom Administration require cross-sector collaboration, including behavioral health transformation, ACEs Aware, and building the health workforce CA needs, in addition to CalAIM's PHM program and service. Our proposed framework starts with spreading and scaling local Accountable Communities for Health across the state. The recommendations below outline several modifications or enhancements to Medi-Cal reforms to reflect how Medi-Cal managed care plans could operate in relation to ACHs as well as to CBOs and community-driven service providers and families themselves.

## Recommendations for Addressing Social Drivers of Health

### *Accountable Communities for Health: A Bridge to Child Health Equity*

Community-driven cross-sector collaboratives can serve as the bridge between managed care plans' efforts to connect families to social needs and addressing the social drivers of health within the community, working together to impact child health outcomes. ACHs center power, governance, and decision making around authentic community collaboration. The state can cultivate these local ACHs, similar to California Accountable Communities for Health Initiative (CACHI), Oregon, and Washington state models by:

- Providing state funding (non-Medi-Cal funding) to support the establishment of local ACHs;
- Establishing local wellness funds for ACHs' convening and governance functions, family engagement, and local portfolios of actions;
- Directing Medi-Cal managed care plans' required community reinvestments to local ACH wellness funds to support ACHs; and
- Directing any managed care plan remittance (due to not meeting their Medical Loss Ratio (MLR) to local wellness funds.

## Recommendations for Meeting Individual Children's Health-Related Social Needs

### *Medi-Cal and Managed Care Plan Strategies for Child Health Equity*

In seeking to advance child equity within the managed care system environment, structural changes to longstanding policies, strategies, and approaches will be necessary. The recent Medi-Cal reforms, initiatives, and 2024 managed care contracts aim to achieve these changes. The reinvigorated prioritization of children's preventive care intends to leverage managed care plans' care management tools to address the historically low preventive care rates for children covered by Medi-Cal. Similarly, the 2024 contract requirements tying quality to capitation payments, if implemented correctly, will align managed care business models with prioritization of children's preventive care.

Based on findings from our ETE project, we provide the following recommendations to further strengthen and build upon the new Medi-Cal requirements, initiatives, and reforms. We focus our recommendations on our original topics of inquiry, plus data collection:

- EPSDT fulfillment and a Whole-Child Care Approach
- Care Coordination
- Social Support Services
- Partnerships with Trusted Community Providers
- Family Engagement
- Data Collection/Reporting

### 1. A "WHOLE-CHILD" APPROACH: FULFILLING EPSDT AND CHILD-CENTERED HEALTH HOMES

Medi-Cal's reforms, strategies, and new requirements lay out a robust roadmap for prioritizing and making improvements in fulfilling EPSDT, from tying quality standards to payment and establishing an EPSDT outreach campaign, to requiring managed care plans to report their primary care spending. These recommendations build upon this roadmap for fulfilling children's EPSDT benefits:

- **Set a "minimum spend" target for the newly reported primary care spending.** DHCS has indicated that the new contractual requirement for managed care plans to report their primary care spending as a percent of total spending could become a target in future years. We strongly support this target or a "minimum spending" proportion for primary care, which will be implemented in other states such as Oregon.[85] This primary care target should be applied to each capitation category, such as the children's category, rather than all enrollees in the aggregate.
- **Promote child-centered health homes in "Equity and Practice Transformation" grants.** The new grants are intended to focus on children's primary care. The grant RFP could target practices that are bringing child-centered health home models to scale, particularly those aiming to build linkages to community service providers and child-serving systems (e.g., early learning centers) as well as those wanting to cultivate partnerships with community health workers. We strongly urge the technical assistance accompanying these grants to assist grantees with building relationships, workflow, and infrastructure needed in structuring these partnerships.
- **Incorporate family input in DHCS' EPSDT outreach campaign.** The parents we heard from suggested that they prefer information provided by someone verbally rather than only written. Also, outreach materials need to clearly indicate what is most relevant for parents to know for their children (as well as being translated by a native speaker).[86] To ensure the effectiveness of DHCS' forthcoming outreach campaign, we recommend DHCS work with families directly on the strategy and materials, and contract with CBOs and CHW/Ps to be direct ambassadors for this outreach campaign.

## 2. CARE COORDINATION

The new Population Health Management program reiterates the important care coordination responsibilities for managed care plans along the care coordination continuum. However, a mere requirement has not historically been sufficient to ensure its adherence. Here are several recommendations to bolster the success of care coordination, particularly basic care coordination, in Medi-Cal managed care:

- **Develop a performance measure for care coordination (e.g., closed loop referrals).** What is measured matters. It is difficult to hold plans accountable for an activity that is not measured. While measuring quality care coordination—particularly between medical and community service providers for children—is relatively new, quality metrics are being proposed,[87] and California can be on the cutting edge by implementing such a metric building upon "a closed loop referral."[88] Given the cross-sector nature of care coordination, the PHM's service should be designing its platform for easy reporting of key care coordination indicators like timeliness of closing a referral loop and in-patient experience.

- **Require reporting on care coordination spending.** While care coordination measures are implemented, care coordination spending can be monitored. Similar to the new requirement to report on primary care spending, DHCS should require reporting of care coordination spending, particularly care coordination activities with community services providers.

- **Provide ongoing outreach to families about accessing care coordination.** Parents had not heard about managed care plans' care coordination benefit. As part of DHCS' EPSDT outreach campaign, care coordination outreach should be included. Managed care plans should train their providers on providing a warm hand-off for care coordination. The PHM Service and PHM Program should also set up triggers to alert families about the availability of care coordination when a screen or assessment identifies a need.

- **Require or incentivize managed care plans to contract with community serving providers,** such as health workers, doulas, and CBOs in the provision of care coordination services and in outreach to families about their care coordination benefit through their managed care plan. Because CBOs are trusted resources for families, community service providers can play a central role in managed care plans' required care coordination activities (and outreach about the availability of a child's care coordination benefit).

- **Fund PATH-like infrastructure grants for care coordination.** Similar to the PATH infrastructure grants provided to ECM providers, the basic care coordination infrastructure envisioned for all enrollees under the PHM benefit warrants its own PATH-like infrastructure grants for community service providers, including CHW/Ps, who may provide some of the PHM's care coordination functions.

- **Develop specific MCP guidance on a required care coordination continuum** with explicit delineation of basic care coordination activities and functions as well as clarity on the care management benefits (e.g., criteria for eligibility; scope of services; and transition between the levels of care coordination from basic care coordination to enhanced case management).

- **Define "at need" children (whose needs may include non-clinical risk factors such as school attendance) as eligible for ECM and community support services.** DHCS' CalAIM Children's Advisory Group began a discussion of how to define "high utilizers" in the child population in the context of eligibility for ECM and community support services, given that high utilization is a less accurate measure for children in need of enhanced care management. The stakeholders agreed that "at need" is a more accurate standard for children with specific reference to social measures such as mental health concerns noted by schools.

### 3. COMMUNITY SUPPORT SERVICES

In addition to establishing local ACHs across the state, managed care plans should be leveraging their partnerships with community service providers and investing in the community support network.

- **Provide clear plan guidance on the types of child-related community support services** (e.g. Infant and Early Childhood Mental Health consultations) that can be Medi-Cal covered but may be more population-based than individualized. Identifying such services that would be claimed against the plan's medical spending (in addition to the ECM Community Supports) can promote managed care plans offering them.
- **Co-develop the PHM Service's data sharing functions** and interoperability with other community social service organizations and local agencies. In order to effectively connect families with needed social supports, these partners should be part of the development of the PHM service to ensure its interoperability.
- **Require plans to meet the NCQA Health Equity Plus Accreditation.**[89] After all plans have met the first phase of Health Equity Accreditation, DHCS can set a timeline for meeting the next stage of Health Equity accreditation which includes community collaboration and greater engagement in community social supports.

### 4. PARTNERSHIPS WITH TRUSTED COMMUNITY PROVIDERS, INCLUDING CBOS AND CHW/PS

In addition to requiring or incentivizing managed care plans to contract with CBOs and with CHW/Ps, Medi-Cal and its managed care plans should cultivate ongoing partnerships with ACHs and local CBOs to co-develop and co-operate their Population Health Management program and participate in plans' Quality Improvement and Health Equity Committees. Managed care plans can also invest in building capacity, pediatric training, and technical assistance for CHW/Ps and CBOs contracted with managed care plans.

- **Promote intermediary entities** like clinics or San Diego's Neighborhood Networks to provide CBOs infrastructure to bridge CBO and health plan partnerships.
- **Provide CBO contract templates.** CBOs may not have the legal contract capacity to partner with managed care plans and could benefit from a contract template that is developed with CBOs' infrastructure considerations in mind.
- **Promote child-serving community health workers.** The new CHW benefit does include pediatric development as a function of CHW services. As part of the State's CHW workforce funding, pediatric and early childhood training for CHWs could also be included and promoted.
- **Include Health Equity Measures relating to culturally concordant care.** As DHCS sets out to advance health equity within the managed care system, it will need to adopt measures for equity such as those being developed by the Department of Managed Health Care's Health Equity and Quality Committee. One possible measure to consider is a RAND measure (not yet National Quality Forum (NQF) endorsed) for "implementation of cultural competency," which is designed to identify the degree to which plans are providing culturally competent care and addressing the needs of diverse populations.[90]
- **Require inclusion of CBOs on plans' Quality Improvement and Health Equity Committees.** The managed care plan 2024 reprocurement contract requires plans to include network providers "who provide health care services to Members affected by Health Disparity, Limited English Proficient (LEP) Members," as well as those serving Children with

special health care needs. While CBOs may qualify for participation under those criteria, DHCS should clarify that CBOs in particular should also be included.

» **Require CBO participation on managed care plans' governing boards.** As a means of promoting a culture of greater community partnership, managed care plan governing boards should include greater community representation.

### 5. FAMILY ENGAGEMENT

As the cornerstone of health care delivery and the real experts in their child's care, families have a lot to offer managed care plans in the delivery of their children's care as well as in the quality operation of managed care plans. The 2024 managed care plan reprocurement contracts lay out requirements for operating Community Advisory Committees (CACs) but few details are provided relative to family engagement in the context of managed care plans' health equity initiatives. The onus is on the managed care plans to support and compensate families in providing their input and to incorporate that input in their organizational decision making.

» **Compensate and provide support for families in providing their input.** If we value families' time and feedback, managed care plans and DHCS should compensate them and remove barriers to their participation.

» **Contract with CBOs to recruit, support, and provide training to families who are being asked to provide their input.** As in the aforementioned model of Ohio's Center for Family Voice, local organizations have the relationships and trust with families and managed care plans and can leverage those relationships by contracting with CBOs to assist with family engagement activities.

» **Include family voice in the development of health equity activities.** In addition to reducing disparities, health equity objectives include community collaboration and partnership. Families should also be represented on the plans' Quality Improvement and Health Equity Committee, or a subcommittee of plan members should be created to inform the activities of the full committee.

» **Allow spending on managed care plans' family engagement activities to be included under the medical load of their capitation payments.** To encourage plans to authentically engage with families, managed care plans' spending on behalf of family engagement activities could be identified as quality improvement activities. DHCS should develop guidance on what activities constitute authentic family engagement spending.

(See our separate family engagement report for detailed recommendations for managed care plans' family engagement strategies.)

### 6. EQUITY DATA AND MCP PERFORMANCE METRICS

Accountability, particularly around reducing health disparities, necessitates appropriate performance measures and reported data broken out by race/ethnicity. In addition, Medi-Cal must begin thinking of performance beyond just standards of access to also include the availability of culturally concordant and relational care.

» **Provide a cross-agency child health and opportunity dashboard.** DHCS should collaborate with other state and local agencies to collect, analyze, and publish data in a child health and opportunity dashboard with a broad set of child health outcome indicators, including child opportunity indices or social drivers of health, that are reported by race and ethnicity. This could build upon the California Department of Public Health's Healthy Communities Data and Indicator Project and Brandeis' child-specific Child Opportunity Index.

» **Regularly provide a consolidated Medi-Cal child performance report** focusing on a to-be-developed EPSDT index, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data and socio-economic status by race/ethnicity at the health plan, county, and state levels, and make it available to the public for analysis.

» **Examine and analyze limitations of HEDIS data in capturing racial disparities and consider what factors, if any, should be controlled to increase validity.** The racial/ethnic breakout data we examined (particularly from DHCS' Health Disparity Reports) had several unexpected results that did not comport with other disparities data, particularly with regard to Latinx children's access to care. This issue warrants further examination rather than just reporting the data as such.

- **Incorporate health equity metrics relating to consumer experience/satisfaction and access to culturally competent care** as well as performance in reducing disparities.
- Incorporate CAHPS ECHO questions related to relational/respectful provider care into managed care plan reporting.
- **Adopt a cross-agency Kindergarten Readiness Metric.** As part of Oregon's Kindergarten Readiness metric, the State has developed with stakeholders four key health aspects of Kindergarten Readiness, including a social-emotional health metric. In January 2022, the social-emotional health metric became operational with Oregon's Coordinated Care Organizations (CCO) on a system level. In future years the metric will be applied at the individual (child) level.

## Further Research Needed

Building off our research and findings, we identify the following areas that warrant further research, analysis, and policy development to advance our policy recommendations in Medi-Cal. Some of these recommendations embark on new statewide initiatives, such as supporting ACHs across the state, while others are relevant to the child-specific implementation of existing Medi-Cal reform efforts.

**1. Spreading, scaling, and supporting local Accountable Communities for Health across the state.** CACHI has provided many of the onboarding tools for emerging ACHs, but actually creating ACHs will be locality-specific, needing technical assistance. Also, further research into other states' efforts to create ACHs statewide, such as in Oregon, can offer important lessons learned, specifically for implementing ACHs' partnerships with Medi-Cal managed care.

**2. Scaling models for coordinated and integrated navigation networks for social supports** to share among health plans and communities at either the practice- or systems-level like Help Me Grow or the regional level like Neighborhood Network. This research will be relevant for the development of the PHM Service and how its functionality will intersect or be interoperable with existing or emerging local navigation platforms.

**3. Building operational and financial bridges between CBOs and CHW/Ps and managed care plans.** As noted in our findings and recommendations, there are large capacity and operational gaps between most CBOs and CHW/Ps and managed care systems. DHCS and Medi-Cal MCPs should continue to engage with CBOs and CHW/Ps to determine their operational challenges and needs in contracting with managed care plans, particularly contract templates, building infrastructure to interact in the health care system. This should be an ongoing analysis and policy discussion in the context of the PHM program and service.

**4. Reframing "high risk" for children as upstream "high need"** for purposes of stratifying children's health-related social needs and care coordination needs in the context of the Population Health Management program. This entails examining and assessing upstream needs that are specific to children and their communities, which may include multi-sector data such as school mental health measures or school absenteeism. In addition to assessing individual upstream needs, a more population-health approach is warranted that resources and trains child-serving systems rather than just assessing an individual, such as training early learning centers in infant and early childhood mental health consultations.

**5. Operationalizing and monitoring managed care "minimum spend" requirements and community investments.** As managed care plans begin to report their primary care spending as part of the new contractual requirements, DHCS will need to be analyzing primary care utilization and spending to determine what is an appropriate target, particularly for children as part of the early and periodic screening and well-child care.

**6. Developing measurement indicators for equity, care coordination, child mental health utilization patterns, and child health outcomes.** While many of these measures are new or not yet fully developed, California can play a pioneering leadership role in building on existing EQR-endorsed measures to more accurately reflect the impact of equity activities such as implementing culturally competent care, community partnership, community-driven social supports, and care coordination.

# XI. Conclusion

DHCS has set ambitious goals for reforming Medi-Cal, and, at long last, centered their quality objectives on children's preventive care and mental health integration. There is a tremendous opportunity for meaningful change in child health equity but it requires that we examine and dismantle the institutional racism that exists within Medi-Cal's many policies and systems. Underlying much of Medi-Cal's reforms is the assumption that the managed care plan model can achieve these bold goals. Managed care plans certainly have a critical role to play and are well-equipped with the right incentives to deliver quality care for children. However, when considering social drivers of health and child health equity, in order to advance an anti-racist approach in Medi-Cal, communities and families themselves need to be at the center of any effort to improve child well-being, especially those communities who have been hardest hit by structural and historical racism and ongoing discriminaton. Community collaboratives that include community-based organizations and community health workers/promotoras should set the table at which health plans participate in implementing change. The wealth of experience and trusted relationships that CBOs and CHW/Ps have with families are essential ingredients in improving children's health and offer the necessary shift in sharing of power that must occur in order to advance child health equity.

# Appendix A: List of Organizations Interviewed

## Community Partners

Alta Med Health Services

California Accountable Communities for Health Initiative (CACHI)

DULCE/Center for the Study of Social Policy

findhelp (formerly Aunt Bertha)

Groundworks Ohio (Center for Family Voice)

Help Me Grow Ventura, Alameda, Fresno

One Degree

UniteUs

Wellness Together

All Children Thrive, Long Beach

Neighborhood Networks, San Diego

## Medi-Cal Managed Care Plans

Alameda Alliance for Health

Alliance Health

Blue Shield Promise

Blue Shield of California

CalOptima

Contra Costa Health Plan

Gold Coast Health Plan

Health Net

Inland Empire Health Plan

Kaiser Permanente

LA Care

Beacon Health Options (mental health provider)

San Mateo Health Plan

# Appendix B: Disparities in Child Opportunity by County, Workbook

The Child Opportunity Workbook—developed by the Georgetown Center on Poverty and Inequality—assesses social drivers of health by race and county across California using Child Opportunity Index (COI) scores developed by Brandeis University and the Ohio State University. The workbook provides policymakers and advocates interested in improving child health care equity with a snapshot of disparities in opportunity across California.

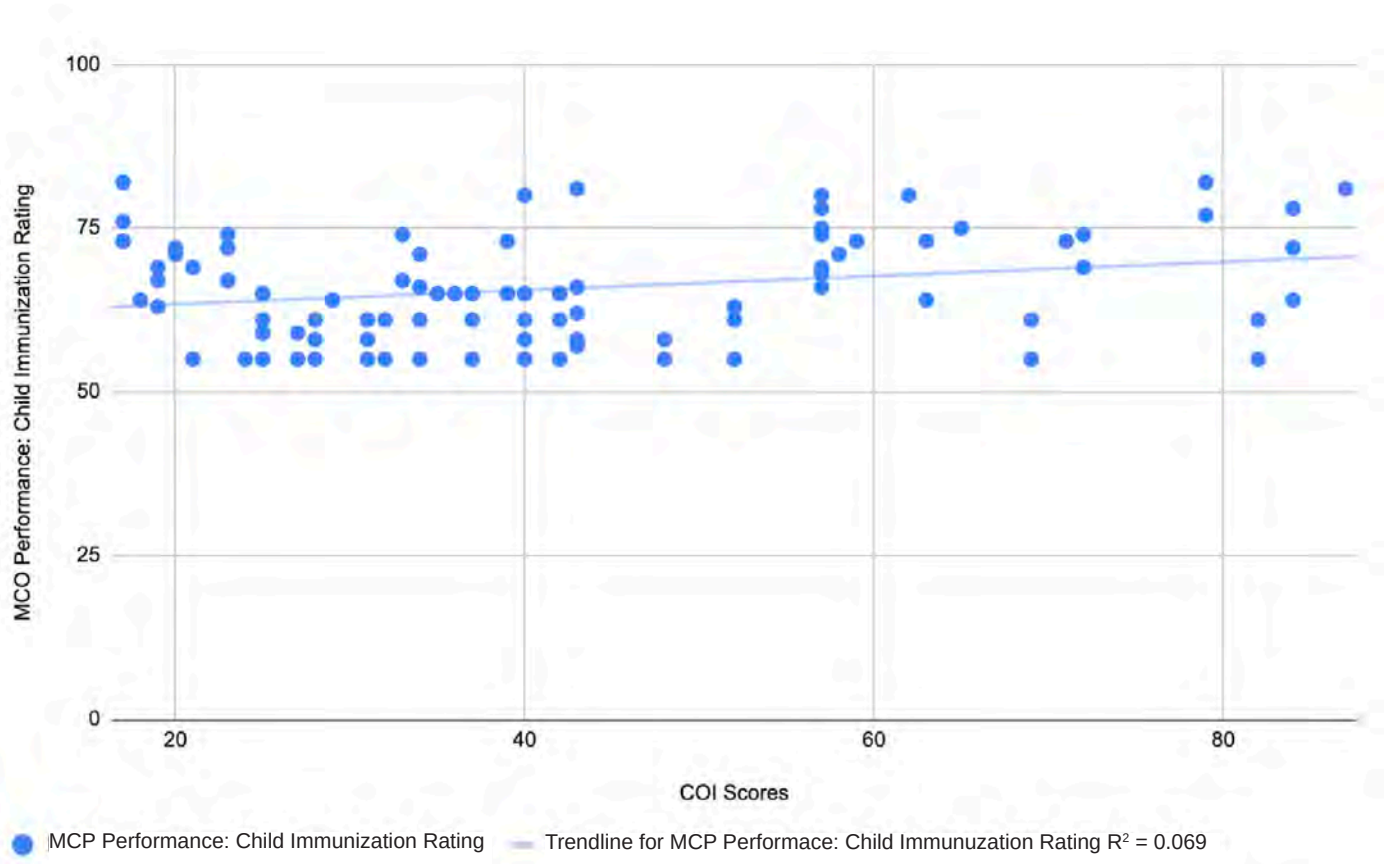
Technical documentation for COI 2.0 data describes the 29 indicators that make up the COI, spanning three domains of opportunity: education; health and environment; and social and economic. This workbook presents those Child Opportunity Scores, aggregated and weighted from 29 different indicators of social determinants of health for children, to assess child opportunity by county in California. Higher scores indicate better child opportunity as measured by those 29 indicators, relative to other counties and racial groups. COI scores range from 1 to 100. Lower scores indicate worse child opportunity relative to other counties and racial groups. Ranges of Child Opportunity Scores vary across counties and racial groups.

The Child Opportunity Workbook is available at https://www.georgetownpoverty.org/issues/equity-through-engagement/

# Appendix C: Managed Care Plan Performance Correlation to Social Drivers of Children's Health and Child Health Outcomes

**Figure 1. Little Association Between Social Drivers of Health and MCP's Child Immunizations Rates**

*Correlation Between COI Scores and MCP Scores for Child Immunizations in CA, 2018*

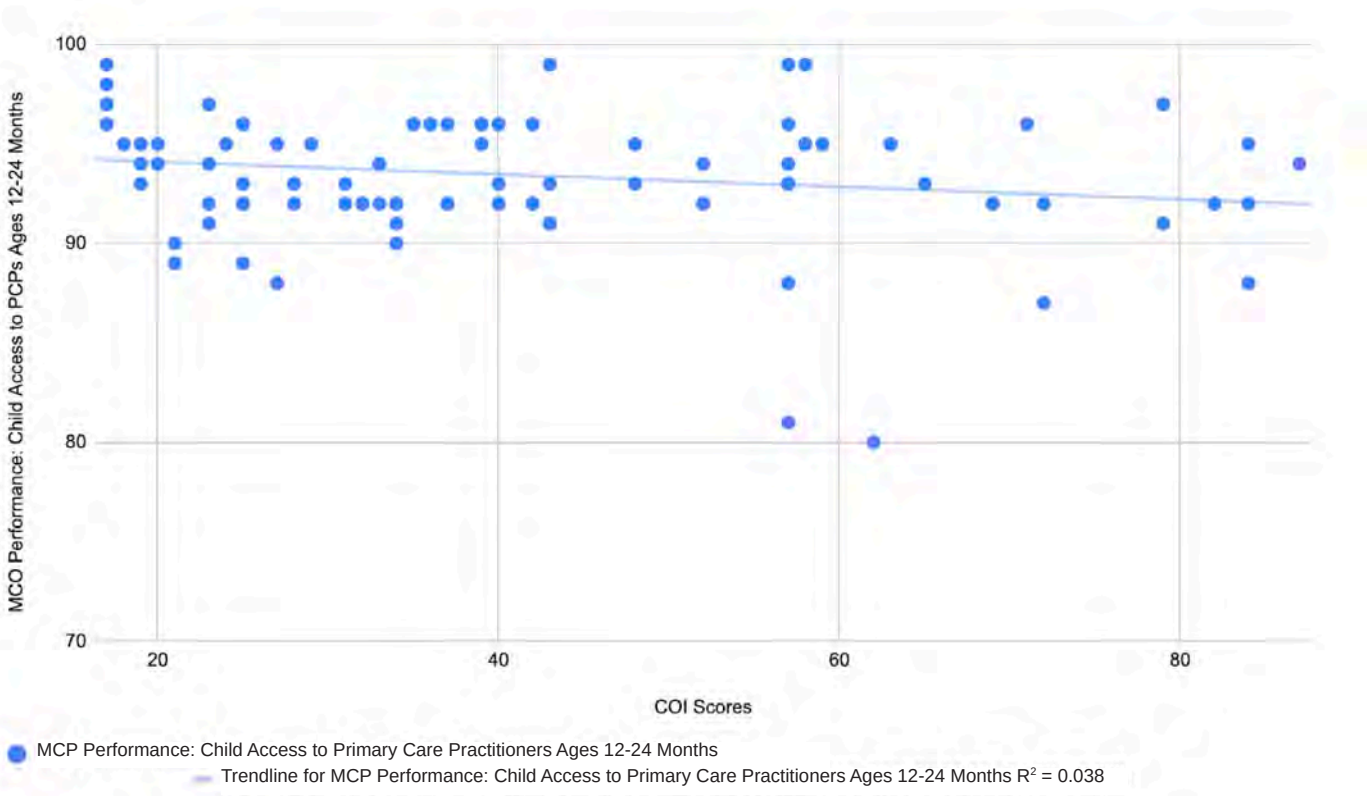



*Source: MCP performance scores are a result of Georgetown Center on Poverty and Inequality's analysis of the 2018-2019 "Medi-Cal Managed Care External Quality Review Technical Report" released by the Managed Care Quality and Monitoring Division of the California Department of Health Care Services. Accessed at https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEQRTR.aspx.*

Notes: Child Opportunity Scores aggregate and weight data from 29 indicators of social drivers of health for children to assess child opportunity at the census tract level. The Child Opportunity Index team helped craft county-wide estimates for this project using 2015 Child Opportunity Index 2.0 data and 2013–2017 American Community Survey population data.

**Figure 2. Little Association Between Child Opportunity and MCPs' Child Access to Primary Care**

*Correlation Between COI Scores and MCP Scores for Access to Primary Care Practitioners Ages 12-24 Months in CA, 2018*

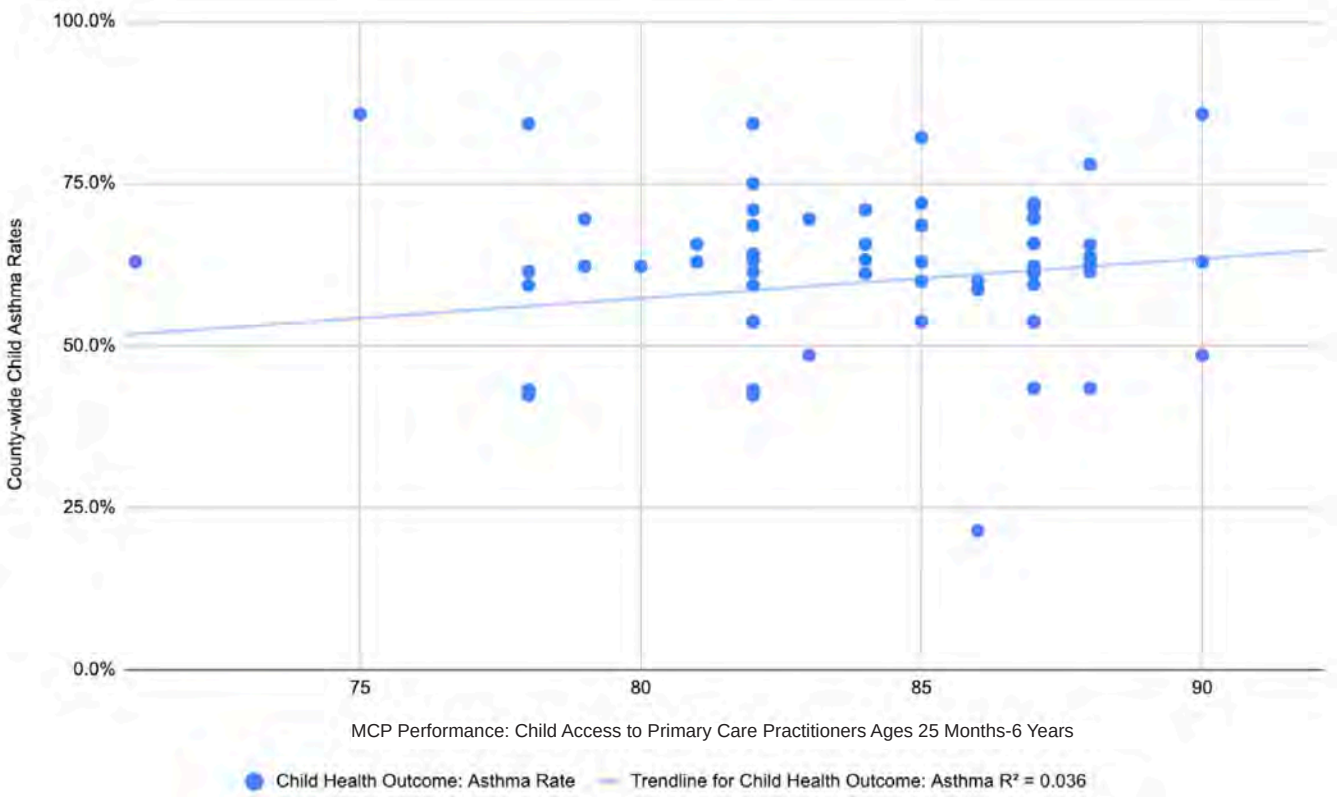



*Source: MCP performance scores are a result of Georgetown Center on Poverty and Inequality's analysis of the 2018-2019 "Medi-Cal Managed Care External Quality Review Technical Report" released by the Managed Care Quality and Monitoring Division of the California Department of Health Care Services. Accessed at https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEQRTR.aspx.*

Notes: Child Opportunity Scores aggregate and weight data from 29 indicators of social drivers of health for children to assess child opportunity at the census tract level. The Child Opportunity Index team helped craft county-wide estimates for this project using 2015 Child Opportunity Index 2.0 data and 2013–2017 American Community Survey population data.

**Figure 3. Little Association Between Child Asthma Rates and MCPs' Access to Children's Primary Care**

*Correlation Between Medi-Cal MCP Performance & Child Asthma Rates for Children Ages 25 Months-6 Years in CA, 2011-2019*




*Source: MCP performance scores are a result of Georgetown Center on Poverty and Inequality's analysis of the 2018-2019 "Medi-Cal Managed Care External Quality Review Technical Report" released by the Managed Care Quality and Monitoring Division of the California Department of Health Care Services. Accessed at https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEQRTR.aspx. Asthma rate data was calculated using 2011–2019 California Health Interview Survey data. Accessed at https://ask.chis.ucla.edu.*

Notes: Asthma rates are defined as the percentage of people ages 0 to 18 who currently have asthma. Child asthma rates were calculated using pooled California Health Interview Survey data from 2011 to 2019. GCPI analyzed MCP performance scores from the 2018-2019 "Medi-Cal Managed Care External Quality Review Technical Report" released by the Managed Care Quality and Monitoring Division of the California Department of Health Care Services. The HEDIS measurement access to primary care practitioners ages 25 months to 6 years evaluates children in that age range who had a visit with a primary care practitioner during the measurement year. There are sample size limitations for 18 of the counties used in this analysis. Results for these counties should be interpreted with caution.

# Appendix D: State Approaches to MCP Community Investments

| STATE | SUMMARY OF APPROACH | PERMISSIBLE USES OF FUNDING |
|---|---|---|
| **Arizona** | Requires MCPs to invest a share of profits in community-based services. Specifically, Arizona requires its MCP plans to spend six percent of annual profits on "community reinvestment activities" and to regularly obtain community input on local and regional needs prior to undertaking these activities. | A recent letter from AZ to CMS states that "while there is no direct requirement today that those community reinvestment dollars be earmarked for SDOH activities, most MCPs previously participating in community reinvestment have directed their dollars in such a manner." |
| **Nevada** | Includes community reinvestment requirements in MCP RFP: State requires MCPs to invest 3% of pretax profits into the community being served. The State requires MCPs to submit a plan to the State detailing the anticipated community reinvestment activities. | Community investments must support "population health strategies" including the State's perinatal quality collaborative and "Project Echo" (Nevada's telehealth solution to connect primary care doctors with specialists). MCPs may propose other activities/projects as part of their plans to be submitted to the state for review and approval. |
| **North Carolina** | Encourages health plan reinvestment into the community being served, by allowing plans that fail to meet the enforceable medical loss ratio (MLR) standard to take some or all of the money they otherwise would need to return to the State as a rebate and, instead, invest it in activities to address social drivers of health. Health plans that proactively reinvest in the community served may be rewarded with a 1% bump in their auto-assignment algorithm. | N/A |
| **Oregon** | Coordinated Care Organizations (CCOs) are required to reinvest a portion of previous net income into Oregon's SDOH and Equity spending program ("Supporting Health for All through Reinvestment (SHARE) Initiative") to invest in local communities (i.e., reducing health disparities, addressing homelessness, providing parenting classes).<br><br>Proposal (House Bill 3353): CCOs are directed to invest 3% of their capitation toward health equity investments, of which 30% goes to community entities, (regional community investment collaboratives (CICs)). Oregon seeking waiver authority to count health-related spending (HB 3353) within medical load when calculating rates does not negatively impact CCOs' future rates. | **SHARE Initiative:** Oregon's guidance document supports MCP investments into the community served. Key requirements include:<br>• Spending must fall within SDOH/Equity domains and include spending toward a statewide housing priority<br>• Spending priorities must align with community priorities from Community Health Improvement Plans (CHPs)<br>• A portion of funds must go to SDOH/Equity Partners.<br>• CCOs must designate a role for the Community Advisory Council(s) related to its SHARE Initiative funds. |

# Endnotes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The Children's Partnership (TCP) is a California advocacy organization advancing child health equity through research, policy and community engagement. We envision a California where all children—regardless of their race, ethnicity or place of birth—have the resources and opportunities they need to grow up healthy and thrive. For more information, visit www.childrenspartnership.org.

The California Children's Trust (The Trust) is a statewide initiative to reimagine our state's approach to children's social, emotional, and developmental health. We work to transform the administration, delivery, and financing of child-serving systems to ensure that they are equity driven and accountable for improved outcomes. The Trust regularly presents its Framework for Solutions and policy recommendations in statewide and national forums. For more information, visit www.cachildrenstrust.org.

The Georgetown Center on Poverty and Inequality (GCPI) works with policymakers, researchers, practitioners, advocates, and people with lived experience to develop effective policies and practices that alleviate poverty and inequality in the United States. The mission of GCPI's Economic Security and Opportunity Initiative (ESOI) is to expand economic inclusion in the United States through rigorous research, analysis, and ambitious ideas to improve programs and policies. Further information about GCPI ESOI is available at www.georgetownpoverty.org.

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