

## EXECUTIVE SUMMARY

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

SEPTEMBER 2022

**Equity Through Engagement Project**

This executive summary is for the [final report](#) 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 the 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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# Introduction

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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 mode, 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*

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# 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.<sup>1</sup> 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.<sup>2</sup> 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)

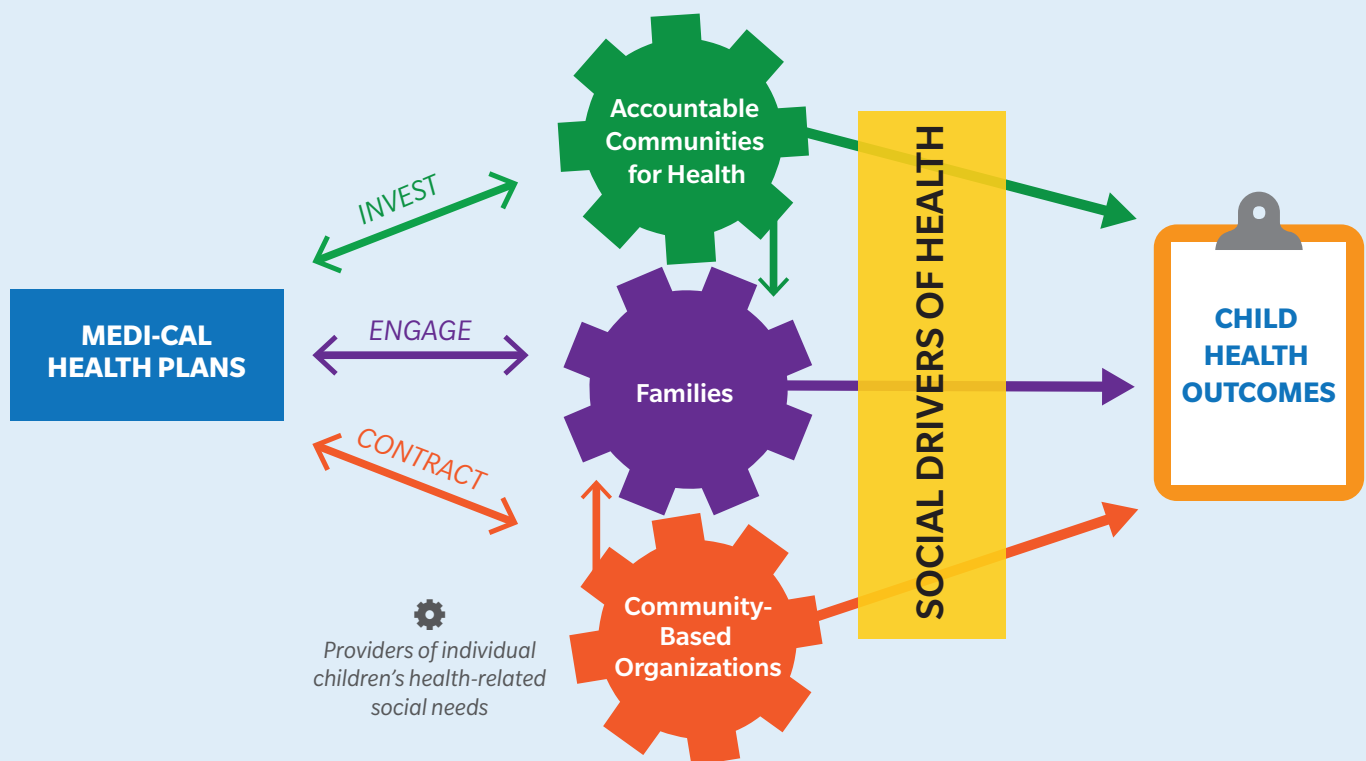
ACHs are a structured way to bring together local clinical providers with public health and mental health departments, schools, managed care plans, social service agencies, community organizations, and residents in a collective effort to prevent health conditions and promote health in their community. 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.

## CHILD HEALTH EQUITY CENTERS ON COMMUNITY PARTNERS

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



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

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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.)<sup>3</sup>
- » 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.”<sup>4</sup>

## Endnotes

**1** We prefer the phrase “Social Drivers of Health,” as used by California’s Medi-Cal program as compared to the conventional “Social Determinants of Health” as social factors strongly influence but do not predetermine health outcomes.

**2** U.S. Department of Health and Human Services, Family Engagement Inventory, <https://www.childwelfare.gov/fei/definition/#:~:text=Family%20engagement%20refers%20to%20the,planning%2C%20development%2C%20and%20evaluation.>

**3** “Health Equity Accreditation—NCQA,” NCQA, June 21, 2022, <https://www.ncqa.org/programs/health-equity-accreditation/>.

**4** Department of Health Care Services, Medi-Cal’s Strategy to Support Health and Opportunity for Children and Families, <https://www.dhcs.ca.gov/Documents/DHCS-Medi-Cal%27s-Strategy-to-Support-Health-and-Opportunity-for-Children-and-Families.pdf>



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](http://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](http://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](http://www.georgetownpoverty.org).