Children Now®

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Closing the Loop: Recommendations for Medi-Cal Referral Systems to Support Children and Families

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Introduction

As health systems grow more complex, it is imperative that children and youth can access the array of services they need. Health and social service providers use referrals to connect children and youth to other health or social services when needs are identified through screenings or other interactions. The so-called "web" of referrals can include referrals to primary care, dental, behavioral health, and specialty care providers, or to community programs that can provide nutrition, housing, educational, and/or developmental supports, depending on the child or family's needs. Oftentimes, however, referral practices are inconsistent and must be navigated by parents or caregivers, who may also be facing geographic or language challenges to accessing services or may be ineligible for some programs due to other factors like immigration status or involvement in the carceral system. For children and youth in foster care, these barriers to accessing needed health care are exacerbated by frequent moves and changes in caregivers, providers and insurance plans, as well as the large number of professionals involved who have different but overlapping responsibilities for coordinating their care. Providers making referrals for their patients generally do not have a way to check the status of referrals, placing the burden on parents/caregivers to navigate holding and sharing referral information rather than the system managing and rendering referrals efficiently and making it available to providers who care for children.

> Closed Loop Referrals are defined as coordinating and referring the [Medi-Cal Managed Care Plan] member to available community resources and following up to ensure services were rendered.

This dynamic is changing under the State's multi-year California Advancing and Innovating Medi-Cal (CalAIM) Initiative and the introduction of a transformative requirement in 2025 around a "Closed Loop Referral" policy. The new referral policy, like many other CalAIM reforms, is important for the State realizing its own quality and equity goals to improve care for children under Medi-Cal for Kids & Teens,[1] reduce disparities in children's and maternity care, and improve depression screening and mental health follow-up rates. Furthermore, this new policy shows promise as a critical tool in overcoming health access challenges that children and youth in foster care disproportionately face. However, ensuring that referrals are happening successfully for children and families in Medi-Cal will

require intentional planning, infrastructure resources, and clear policy direction for stakeholders.

In anticipation of the State developing the 2025 "Closed Loop Referral" policy, Children Now conducted research and stakeholder interviews to better understand the current and possible future referral landscape. Based on Children Now's research and stakeholder feedback, this brief describes Closed Loop Referrals and offers five recommendations for successful Closed Loop Referrals for children and families in Medi-Cal (see box for recommendations at-a-glance). In addition, we note special considerations for Closed Loop Referrals for infants and toddlers, school-aged kids and teens, and children and youth in foster care. Finally, we highlight the opportunities the State has already made available for building the infrastructure and partnerships that are foundational to Closed Loop Referrals.

Recommendations At-A-Glance

Successful Closed Loop Referrals for children and families will:

1. Require clear definitions and standards.
2. Leverage data and integrate technology.
3. Rely on trusted partnerships and referral pathways.
4. Require provider training and supports.
5. Resource and monitor referrals.

These five recommendations will promote Closed Loop Referral systems that center children and families without placing the burden on parents/caregivers and providers, establish efficient and streamlined administrative processes locally, and achieve health equity by reducing disparities in outcomes for children and youth enrolled in Medi-Cal managed care.

Background: Population Health Management and "Closed Loop Referrals" Requirements

A major component to population health management is the ability for health care systems to effectively refer patients to other programs or services that will benefit the patient's health or well-being. Referrals involve many players, including Medi-Cal Managed Care Plans (MCPs) who are contractually responsible for managing and coordinating the care of their members. Care coordination is one of the five essential functions to advance patient centered medical homes (PCMH), which are designed to spur collaboration across health care and various other types of providers to achieve better outcomes for patients.[2] The Department of Health Care Services (DHCS) has laid out expectations for MCPs to take steps to establish referral systems for Medi-Cal members in the CalAIM: **Population Health Management (PHM) Policy Guide** (October 2023), which specifically states:

- MCPs are required to partner with primary care and other delivery systems to guarantee that members' needs are addressed. This includes ensuring that each member's assigned primary care provider (PCP) plays a key role in the coordination of care, ensuring each member has sufficient care coordination and continuity of care with out-of-network providers, and communicating with all relevant parties on the care coordination provided.
- MCPs must also assist members in navigation, provider referrals, and coordination of health and services across MCPs, settings, and delivery systems.
- Starting in 2024, as part of MCPs' annual PHM Strategy submission, MCPs are required to review the utilization of children's preventive health visits and developmental screenings and outline their strategies for improving access to those services.

- ***MCPs should begin to establish relationships and processes to meet Closed Loop Referral requirements by January 2025.***
- ***Closed Loop Referrals are defined as coordinating and referring the member to available community resources and following up to ensure services were rendered.***

- Beginning in January 2025, MCPs are also required to coordinate warm handoffs with local health departments and other public benefits programs including, but not limited to, CalWORKs, Early Start, and Supplemental Security Income (SSI). [see box on page 9]
- DHCS envisions evolving and updating the PHM Key Performance Indicators (KPIs) as appropriate as new policy requirements go into effect, such as completing Closed-Loop Referrals in 2025.

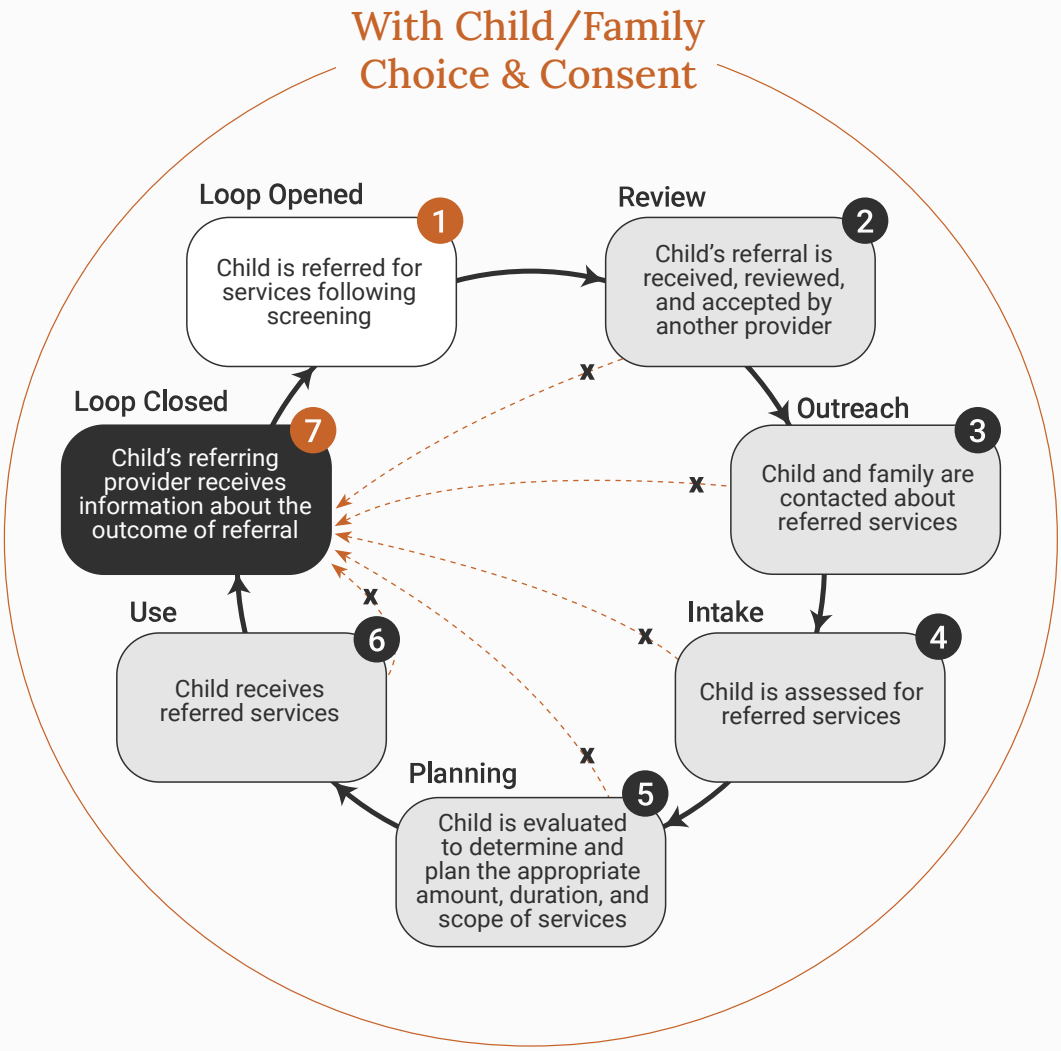
As displayed in Figure 1, MCPs must work with their members' assigned primary care provider to access preventive care well-visits, and, beginning in January 2025, MCPs will also be required to close referral loops for children made to/from: Enhanced Care Management and Community Supports providers;[3] Community Health Workers (CHWs), peer counselors, and local community organizations; dental providers; California Children's Services (CCS); Developmental services; CalFresh; WIC providers; county social service agencies; and specialty mental health and substance use disorder services. A separate Closed Loop Referral requirement already exists for student behavioral health services (see section on page 21), however Medi-Cal Closed Loop Referrals requirements do not extend to childcare assistance, Head Start/Early Head Start, or other early childhood education settings. The role of child welfare agencies and public health nurses that are part of the Health Care Program for Children in Foster Care remains unclear in the context of Closed Loop Referrals.

FIG. 1
Ecosystem of Closed Loop Referrals for Children in Medi-Cal

It is important to keep in mind that a Closed Loop Referral will involve a Referring Provider who opens the referral loop for a child to be assessed for and receive referred services by a Receiving Provider who closes the referral loop once a child receives (or declines) referred services. This is not an immediate process, but rather one that has multiple

stages and plays out over a period and across many touch points; Figure 2 identifies some of the key stages in a closed loop referral process. Research indicates the importance of ensuring receipt of services, since a referral alone might not be enough to impact the health and social outcomes that families experience.[4] Referrals should also work in both directions, such as a primary care provider referring a patient to community services, and a community provider referring a patient to preventive health care services. MCPs have an important responsibility in facilitating bi-directional referrals for their members because that is part of managing patient care, improving outcomes, and meeting the MCP's contractual obligations. In addition, many families relying on Medi-Cal often face various challenges, including financial constraints and language barriers, by considering these challenges MCPs can tailor referrals to best support the specific circumstances of each family. This includes things like proactively involving interpreters or transportation supports along with referrals. One challenge DHCS and MCPs must anticipate during referral systems is that Medi-Cal members may switch plans, move counties or lose eligibility in any given month, but the needs that prompted a referral may still hold. Enrollment churn can have significant consequences for a family accessing services.

FIG. 2
Key Stages in a Closed Loop Referral Process for a Child in Medi-Cal



Critical Questions in Defining How to Successfully Close a Referral Loop

- Does success mean that the referral receiving provider or organization has accepted the referral or does success require the patient to receive a service?
- How long should a referral be left open before closing it and labeling it as unsuccessful?
- Who closes the loop when there is no provider/organization to accept the referral?
- When does an unsuccessful closed referral prompt a need for a follow-up referral (e.g., patient is ineligible for referred program but still has unmet needs, or cannot find a qualified provider locally for referred service) versus an unsuccessful closed referral that respects member choice and agency to decline referred services not prompting follow-up?
- How are new referrals handled if the patient already has a referral pending or is accessing services they have been referred to?

Recommendations to Ensure Successful Closed Loop Referrals for Children and Families

In anticipation of Closed Loop Referral requirements in January 2025, Children Now embarked on an effort to collect information that could help inform the development of Closed Loop Referral policies that are meaningful and family centered. To that end, Children Now conducted a literature review and engaged in conversations with a variety of healthcare and social services stakeholders between May and October 2023 to gather insights, recommendations, and considerations regarding Closed Loop Referrals, including current best practices and challenges with referral systems.[5] Academic literature indicates that there are many factors affecting the performance of a referral system, including: technology (electronic referral, response and feedback), processes (effectiveness, efficiency), organizational (management, policy and planning, rules and regulations), and patient-centered individual characteristics (social capital, transportation, awareness, attitude, satisfaction, and social influence).[6] At the core, a Closed Loop Referral policy represents a significant shift in the way systems, institutions, providers, communities, and families communicate. Based on our research and stakeholder feedback, Children Now offers the following five interrelated recommendations to achieve successful Closed Loop Referrals for children and families in Medi-Cal come 2025.

Require clear definitions and standards

Research shows that the term "Closed Loop Referral" is not consistently understood or used in the same way across providers or sectors, to the extent it is used at all.[7, 8] Definitions and standards will be important for Closed Loop Referral policies so that it is clear to all parties involved the role/responsibility of each entity/person, the information and actions that constitute a referral, and the key steps, sequences, and methodologies, that constitute the closing of a referral loop. In doing so, the State can also identify which types of referrals are the highest priority for tracking and monitoring. These definitional standards need to be consistent statewide and will need to be incorporated into electronic interfaces, workflows, and staffing models across provider types. Health care and social service providers involved in referral loops will need clear directions for how to make referrals and a basic understanding of which MCP members are eligible for services that could be available to them. Further, these definitions should consistently be codified in formal contracts and agreements, like

required Memoranda of Understanding (MOUs), described in a later section.

When developing standards and timelines, including processes for expediting Closed Loop Referrals for urgent needs, DHCS and MCPs must ensure standards are tailored to meet the unique needs of very young children, children in rural communities, children with special health care needs, undocumented children, migrant children, and children and youth in foster care. For example, children who are undocumented, while eligible for Medi-Cal coverage, may not be able to access other resources, such as CalFresh or CalWORKs, due to exclusionary anti-immigrant policies. MCPs and providers must ensure families are directed to local services or other programs they are eligible for. Similarly, an infant with a caregiver who speaks Farsi and is facing eviction or loss of housing should receive support in their language as immediately as possible given the rapidly changing needs of the parent/caregiver and infant, and the need for a safe, stable environment for both. Referrals like these should be flagged as priority for expedited processing and special attention for monitoring. Additionally, DHCS and MCPs must ensure that transportation and interpretation/translation needs do not result in delays in care for children and youth.

What is a "Warm Handoff"?

Distinct from Closed Loop Referrals, MCPs will be required to coordinate warm handoffs with local health departments and public benefits programs like CalWORKs (cash aid) and Early Start (early intervention for very young children) beginning in 2025. However, DHCS has not yet defined what constitutes a warm handoff in the context of the Population Health Management framework.

- Guidance for primary care clinicians defines a warm handoff as "a handoff that is conducted in person, between two members of the health care team, in front of the patient (and family if present)." [9] A transparent handoff of care allows patients and families to hear what is said and engage in communication, giving them the opportunity to clarify or correct information or ask questions about their care. Many practices will need to adjust their workflow when adopting warm handoffs as a standard protocol, and will require resources like staffing, time, and material costs.[10]

- As it relates to the CalAIM Justice-Involved Reentry Initiative, DHCS has drafted minimum requirements for warm handoffs that include: sharing the transitional care plan with the post-release care manager and the individual's assigned MCPs; scheduling and conducting a warm handoff meeting that includes the individual and both the pre- and post-release care managers to begin establishing a trusted relationship between the individual and the post-release care manager, review the transitional care plan with the individual and address questions, and identify any outstanding service needs and other supports required for successful community reentry (e.g., transportation or housing).[11]

- Warm handoffs are a trauma-informed practice,[12] which is why State statute governing the Family Urgent Response System for Caregivers and Children or Youth (FURS) statewide hotline indicates that referrals to a county-based mobile response system for further support and in-person response shall occur with "a warm handoff whereby the hotline worker establishes direct and live connection through a three-way call that includes the caregiver, child or youth, and county contact. The caregiver, child, or youth may decline the three-way contact with the county contact if they feel their situation has been resolved at the time of the call."[13] Because of the sensitive nature of calls to the FURS hotline, staff must be trained on risk assessment which will enable the hotline worker to provide the most appropriate de-escalation and conflict resolution to the family and to provide the relevant information to the County Mobile Response Team during the warm hand-off, including information regarding the recommended level of response, when appropriate.[14]

Leverage data and integrate technology

Data sharing is necessary for Closed Loop Referrals, but currently data sharing is limited and varied. Experience suggests that "the future of resource database design should center on technology and solutions that strengthen pathways for coordination and communication between health care, community resources and community members." [15] Yet, there are many concerns about and challenges around data literacy and how referral and service information will be shared in a timely way across systems and referral management platforms and vendors to close referral loops. The field currently uses many platforms and resource directories for referrals that are not standardized, cohesively linked, up-to-date, or connected, especially with electronic health/medical records systems or health plan data systems.[16] As a result, providers must navigate multiple referral systems depending on the patient's needs, which MCP they are enrolled in, and what Community Support services and community partners are available to the patient. This can also result in duplicate documentation of information into different data referral and management information systems "owned" by MCPs, clinical practices, county agencies, and CBOs. A related issue is that some providers receive referrals that they cannot act on because there is insufficient family information, or they do not know which MCP a patient is enrolled in because referral systems are not statewide and not able to interface. Further, some platforms may not be able to fully capture and/or communicate all stages of a Closed Loop Referral (see key stages in Figure 2), much less share patient care plans or be used for ongoing quality improvement. Patient/family access to their own referral information varies across systems designed towards connecting agencies or institutions, but thoughtful communication modalities and technologies like apps and text-messaging can help close the information gap in some instances. Finally, data sharing can be complicated further for certain system-involved populations, particularly children and youth in foster care, due to a lack of clarity on who can authorize or exchange information due to additional regulations to protect their privacy. For all beneficiaries, a Closed Loop Referral system will have to respect and reflect the choice for a Medi-Cal member or family to request a different provider, or to decline services.

The variation in referral systems creates an unreasonable burden on the providers who are responsible for opening and closing referral loops and may have preferred Electronic Health Records (EHR) systems or other data systems they use for their patient/client/member care. Some informants reported finding referral solutions, such as communicating with external partners through their MicrosoftTeams

communications platform or using the clinic's electronic health record system to fax referrals to community mental health providers. The Office of the National Coordinator for Health Information Technology developed a **Social Determinants of Health Information Exchange Toolkit** that may be helpful for stakeholders.[17] Nevertheless, updating and creating interoperable referral systems is a significant undertaking, with an important direction set with the Data Exchange Framework (DxF)[18] and data-sharing agreements which can potentially address some of the current data-sharing challenges. However, given outstanding questions about the role, functionality, and timeline for the Population Health Management Service,[19] DHCS could provide greater direction and resources to leverage existing referral platforms, Health Information Organizations (HIOs) or health information exchanges,[20] Community Information Exchanges **(CIEs)**,[21] local Homeless Management Information System (HMIS)[22] and Coordinated Entry Systems (CES) for people experiencing homelessness, and EHRs to enable interoperability and become coordinated portals that are able to connect and share the data necessary across health and social service providers who effectuate Closed Loop Referrals.[23] Interoperable data systems and workflows will require training of health providers and staff and providers in community-based organizations on how to use them and ensure appropriate user permissions, and ideally these systems could track all stages of the Closed Loop Referral in as real- time as possible. Additional research is needed on Closed Loop Referral network platforms and potential statewide solutions to the technological challenges, "which might include better integrating closed-loop referral networks into HIOs." [24] The State can also learn from the experience and learnings in other states, such as North Carolina, which created "the first statewide network linking health care and human services providers to one another with a shared technology platform." [25]

Examples of Electronic Health Record (EHR) Systems & Vendors	Examples of Community Referral Platform Systems & Vendors	Examples of Qualified Health Information Organizations (QHIO)
Athena	211	Applied Research Works, Inc.
Cerner	AuntBertha/FindHelp.org	Health Gorilla, Inc.
CommunityWorks	Clarity	Long Health, Inc.
eClinical Works	ClientTrack	Los Angeles Network for Enhanced Services (LANES)
Epic	Client Services Network	Manifest MedEx
GE Centricity	Efforts To Outcomes (EtO)	Orange County Partners in Health-Health Information Exchange (OCPH-HIE)
NextGen	Full Circle Health Network	SacValley MedShare
Practice Fusion	Healthify	San Diego Health Connect
	One Degree Plus	Serving Communities Health Information Organization (SCHIO)
	ServicePoint	
	UniteUs	

There are also significant concerns about sharing personal identifiable and protected health information with other providers or agencies. For WIC agencies in particular, USDA regulations require a consent to share data, when making a referral from WIC to health care or social services, and when responding to a referral from health care and social services to WIC, where the response from WIC staff acknowledges information about the participant.[26] With the transition from paper-based to electronic data sharing, and lack of interoperability across data systems, consent to share data requires several onerous steps that involve participants and WIC staff. Universal Release of Information consent forms would streamline the consent process, but these forms are not currently in place or set to be widely used. The inability for providers to share information perpetuates data silos among providers and makes the referral experience repetitive, cumbersome, and potentially ineffective for families. A recent white paper offers recommendations for consent-to-share data practices, including the development of a standardized consent form and establishment of statewide consent management programs.[27] DHCS can further inform the development of Closed Loop Referral policies by borrowing from user experience design and conduct "process mapping" to better understand how families with children navigate referrals and identify where the information-sharing pain points or breakdowns occur among providers. MCPs and other stakeholders need to work collaboratively to adhere to privacy laws across systems (health, educational, child welfare, etc.) and uphold rights for minors to consent to receive services. The State could also consider if future regulation of Closed Loop Referrals is needed to address stakeholder concerns about how patient or client information will be used, as was the topic of at least one bill during the 2023 legislative session.[28]

DHCS can further inform the development of Closed Loop Referral policies by borrowing from user experience design and conduct "process mapping" to better understand how families with children navigate referrals and identify where the information-sharing pain points or breakdowns occur among providers.

Rely on trusted partnerships and referral pathways

While technology and electronic data-sharing is important for referrals, it does not replace interpersonal work, relationships, and interorganizational networks that are foundational to referrals.[29] Closed Loop Referrals are most effective in promoting equitable health outcomes when caregivers/parents, children, and youth are engaged in a timely manner (e.g., no scheduling delays or geographic barriers to care) and in a meaningful way (e.g., the family's preferred language,

information provided is easy to understand, etc.). Common barriers to closing the referral loop include the lack of collective and consistent use of referral platforms by the entities involved in referrals, as well as challenges finding available and qualified providers and resources (e.g., housing, food, culturally congruent providers, etc.) to refer families to. It is important to remember that MCPs are contractually required to assist members in navigation and coordination of services across MCPs, settings, and delivery systems, and the best way to accomplish that is through trusted local partners. To overcome barriers, Medi-Cal MCPs will need to identify and partner with the various local agencies and providers that are needed and trusted by families and youth, particularly organizations serving kids and families facing the greatest health disparities, such as local First 5s, faith-based organizations, childcare providers, housing and homeless providers, and immigrant rights agencies. Health system partnerships with libraries, places of worship, laundromats, barber shops, fire departments, dollar stores, shopping malls, and other local sites offer the chance to connect with families who most need referral and navigation supports in places within the community they already trust enough to meet their other basic needs.[30] Much like working with families, MCPs will need to authentically engage clinics, local CBOs, county agencies, and other partners to support the establishment of effective workflows, data exchanges, legal agreements, and communication channels. MCPs will need to understand and address the needs and constraints of both the Referring Provider and the Receiving Provider and provide ongoing training, technical assistance, monitoring, and financial resources or incentives to promote Closed Loop Referrals. For example, an MCP seeking to refer an expecting or new parent to voluntary home visiting services will need to work with home visiting programs to navigate the different program eligibility requirements and enrollment timelines to ensure the parent and/or infant is enrolled in the program that best meets their needs. Where possible, DHCS can help share available best practice resources and toolkits[31] for stakeholders to use in establishing Closed Loop Referral systems. Through community health workers and doulas benefits, MCPs and clinics can now leverage more providers that have historically engendered trust with families and communities to help them navigate care. The State could require MCPs in a particular county or service area to consider ways to collaborate

MCPs will need to understand and address the needs and constraints of both the Referring Provider and the Receiving Provider and provide ongoing training, technical assistance, monitoring, and financial resources or incentives to promote Closed Loop Referrals.

around Closed Loop Referrals that will reduce burden on community partners serving Medi-Cal families across MCPs.

Due to the past and ongoing impact of racism in health care, inclusive of systematic segregation, differential medical treatment based on race and ethnicity, and limited resources allocated to people and communities of color, there is wide variability in the availability of and access to local resources in communities. In addition, many parts of the state lack reliable internet and broadband access needed for electronic referrals and data sharing. Gaps in service area resources will need to be identified early to make the best use of available providers and map the places where service expansion will be needed.

Require provider training and supports

Medi-Cal serves a diverse and often underserved population, making it critical to establish an efficient and compassionate referral system that meets the needs of families. DHCS and MCPs should assess the need for initial and ongoing training for providers on how to operationalize a Closed Loop Referral system and coaching to foster a patient-centered approach to making referrals for families.

Operational training equips providers with the necessary skills to effectively navigate and utilize referrals in a digital landscape. Understanding the operational intricacies of a digital system, documentation requirements, referral initiation procedures, and tracking mechanisms is vital for ensuring that the referral process is seamless for families, efficient, and protective of sensitive information. This training ensures providers can use the system proficiently, thereby improving the accuracy, timeliness, and success of referrals they make, ultimately enhancing the quality of care for children and families.

Successful referrals are patient-centered which often requires cultural humility, empathetic communication, and a trauma-informed approach. These skills should be integrated into Closed Loop Referral coaching and supports for all Medi-Cal providers. This coaching would involve guiding providers to actively engage and collaborate with patients and their families when recommending specialized care or additional services, emphasizing the importance of clear and empathetic communication during difficult conversations as well as communicating across health literacy levels with the patient and their family so they understand the process, their options, and their rights and responsibilities when referrals are made.

To ensure referral-making is trauma-informed, providers should be coached on how to prioritize creating a safe and supportive environment and respect the patient's autonomy and choices. They should understand how to consider the potential triggers and sensitivities related to the referral process, aiming to minimize re-traumatization.

A patient-centered approach to referrals also considers the background and circumstances of the patient. Historically, patients of color and varying gender and sexual identities have been discriminated against and disrespected in healthcare spaces. It is critical that providers understand the disparities that affect these communities and are culturally conscious in how they communicate during the referral process. For example, youth who identify as LGBTQIA+ consistently highlight the importance of promoting and reinforcing confidentiality protections to create a safe environment where a child/youth and provider can build a trusting relationship (see citation below). Similarly, MCPs should ensure that Closed Loop Referral providers are trained in serving the needs of LGBTQIA+ youth to prevent and address any discriminatory behavior and/or policies.[32]

Furthermore, the Closed Loop Referral process should emphasize and acknowledge that providers who are embedded in the community are best situated to make referrals, particularly community health workers, promotoras, and community health representatives (CHW/P/Rs).[33] CHW/P/Rs are valuable care team members and can be liaisons in a referral system to help facilitate and track referrals between different providers and with families. Their deep understanding of community dynamics, cultural contexts, and local resources enables effective communication and coordination between various healthcare providers and families. CHW/P/Rs often possess strong interpersonal skills and lived experience among the populations they serve, fostering trust and rapport with both healthcare professionals and community members, enhancing their ability to facilitate seamless referrals. CHW/P/Rs may already be equipped with the cultural humility and empathetic, trauma-informed communication skills necessary to realize successful referrals, making them key partners in carrying out referrals. Their role as advocates and liaisons within the community positions them to bridge gaps in healthcare delivery, listen to families' concerns regarding the referrals that have been made, and ensure referrals are completed, providing necessary support to families in navigating the complex healthcare system. Moreover, CHW/P/Rs have the capacity to educate families on the importance of referrals, follow-ups, and treatment compliance, empowering them to actively participate in their healthcare journey and contribute to improved health outcomes. By leveraging

their unique position and skill set, CHW/P/Rs could play a pivotal role and provide the expanded capacity needed to enhance efficiency and effectiveness of a Closed Loop Referral system, ultimately promoting better healthcare access and outcomes within the community. Public Health Nurses in the Health Care Program for Children in Foster Care can help serve a similar role for children and youth in foster care. The State can catalyze referrals by developing streamlined processes for CHW/P/Rs and other trained providers to collect data on referrals for vulnerable populations and share it with health and social service providers.

Resource and monitor referrals

The infrastructure to make Closed Loop Referrals possible will need to be fully resourced and sustained. This goes beyond the high start-up costs of technological platforms or data integration, but also applies to the ongoing needs to maintain a workforce (hiring, training, etc.) to manage referrals and ensure there are qualified providers available to receive referrals and deliver referred services. This will require intentional and ongoing efforts and formalized relationships (e.g., contracts, MOUs, etc.) between MCPs and community providers, as well as ongoing, cross-sector community reinvestment at state, local, and MCP levels that is refined over time to fill in gaps and meet the changing needs of children and youth. New opportunities through workforce expansions, such as CHW/P/Rs, doulas, and peer support specialists should be intentionally leveraged and supported in playing an essential part in the Closed Loop Referral infrastructure serving families. Successful Closed Loop Referrals will rely on ongoing and timely communication among the MCP, the child's primary care provider, the parent/caregiver and child(ren), and the appropriate referral entities. Front-line providers and clinics will need to be resourced for the longer engagement appointments that might be required to establish referrals and/or for facilitating same-day referral appointments that can expedite patient access.

DHCS will need to delineate mechanisms to capture consumer experiences with Closed Loop Referrals to inform oversight and accountability efforts.

The most common grievances filed by consumers against MCPs involve issues of provider availability, timely access, provider/staff attitude, plan customer service, and care coordination and case management[34] — all of which impact the outcome of a Closed Loop Referral. DHCS will need to delineate mechanisms to capture consumer experiences with Closed Loop Referrals to inform oversight and accountability

efforts. To promote oversight and accountability of Closed Loop Referrals, DHCS should partner with other state agencies, like the Department of Public Health and Department of Social Services, who have a vested interest in maximizing enrollment, if not the impact on, program utilization by way of Closed Loop Referrals. In addition, as an approach to accountability, DHCS should also convene a workgroup of MCPs and non-MCP stakeholders to set up a framework and timeline for translating Closed Loop Referrals into a Key Performance Indicator (KPI) used for monitoring and oversight in a way that reflects the experience of children, youth, and families. An accountability-focused Closed Loop Referral KPI could potentially be tied to reimbursement for the extra time providers will take to incorporate quality referrals and closed loops into their workflows. DHCS should also engage front line health and social service providers, as well as members of the Medi-Cal Children's Health Advisory Panel (MCHAP), the Medi-Cal Member Advisory Committee (MMAC), the Medi-Cal Managed Care Advisory Group (MCAG), the Stakeholder Advisory Committee (SAC) among others around Closed Loop Referrals to promote transparency and invite partnerships to address disparities, barriers, and gaps.

Furthermore, data captured on both successful and unsuccessful implementation of Closed Loop Referrals should be used to fund and build local infrastructure to meet the needs of Medi-Cal members. The State has already created partnership and infrastructure-building opportunities for Closed Loop Referral systems (see section below); however, these initial opportunities will need to be strengthened and built on over time. For example, as part of each MCPs Community Reinvestment Plan they submit annually, MCPs should be required to detail how targeted investments to strengthen the referral infrastructure will benefit the community, as well as the intended outcomes of those investments. Those investment decisions should be driven by community input,[35] targeted based on Closed Loop Referral monitoring, and informed by gap analyses of available community resources and infrastructure enhancements or maintenance. In addition, DHCS should also work with their colleagues at the Department of Health Care Access and Information (HCAI) to address oversight and accountability of provider networks impacted by Closed Loop Referrals.

Special Considerations in Closed Loop Referrals for Infants and Toddlers

Special considerations should be made with respect to Closed Loop Referrals for infants and toddlers, to ensure optimal healthcare access and outcomes for this vulnerable population. Infancy is a critical time for child development and making connections to early intervention. Early developmental windows are brief, so it is imperative that referrals for babies are expedited, both to and from comprehensive well-child visits where immunizations and other screenings occur. To the greatest extent possible, the state should establish a Closed Loop Referral system that can be leveraged to maximize a family's access to all health and social supports and safety net programs that family qualifies for given eligibility overlap.[36] As described below, some referral pathways are particularly important for infants and unique to early childhood.

Developmental Services. Identifying and addressing developmental delays or disabilities as early as possible is critical to the trajectory of a child's health. A well-designed Closed Loop Referral system should prioritize prompt referrals to early intervention services following a developmental screening, ensuring that any concerns are addressed early to optimize developmental outcomes.[37] An MCP's referral network must include California Children's Services (CCS) providers and Regional Centers which are vital for families to receive assessments, case management, and health services, as well as Family Resource Centers (FRCs) which are community-based hubs that provide education about the array of available services and navigation supports for families with children who have developmental disabilities. A robust Closed Loop Referral system should also expedite and closely monitor referrals (or "warm hand-offs") to Early Start, the State's early intervention program under Part C of the Individuals with Disabilities Education Act (IDEA). Because of the critical developmental period during the first three years of life, MCPs should understand the family experience to train staff [38] and closely track referrals to Early Start, which has its own program eligibility criteria and 45-day assessment window, but a referral loop should not close until the child is connected to the services they need, which may be through Early Start or may be within the responsibility of the MCP. Given some of the known access challenges for certain types of providers, like Applied Behavioral Analysis (ABA) or speech therapists, the State and MCPs could establish clear escalation protocols to minimize a child's delay in timely connection to services. Special attention should also be given during the transition from Early Start services to special education/school district services (when a child turns three years of age), where communication and planning across providers is important to help identify continuing developmental delays and coordinate the services a child is receiving.

Help Me Grow: A Referral Resource for Families With Young Children

Local Help Me Grow programs should be part of MCP referral networks because Help Me Grow is a comprehensive and integrated early childhood system model focused on promoting the developmental health and well-being of young children. Help Me Grow connects families with young children to developmental services, nutrition supports, dental care, and parent/caregiver mental health, as well as other services that support their overall development. Especially for some children with mild developmental delays, Help Me Grows connect families with developmental playgroups or other informal supports available in the community.[39]

Nutrition Supports. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and CalFresh are vital links in successful Closed Loop Referrals to help infants, young children, and their families access nutritious foods, nutrition education, lactation and infant feeding education and support, and greater food security. However, only half of people (moms, babies, and young children) who are eligible for WIC receive those benefits.[40] To expedite WIC enrollment, an MCP could establish agreements to adjunctively enroll eligible newborns and pregnant individuals immediately into WIC (with consent) by sharing information before a provider needs to activate a referral. MCPs should also consider integrating referrals to and reimbursement for services of Registered Dietician Nutritionists (RDN) and board-certified lactation consultants (IBCLC) to ensure infants, young children, and their families, especially those in underserved communities, receive guidance on proper nutrition and feeding practices, promoting healthy growth and development.

Dental Care. Oral health plays a significant role in a child's growth, nutrition, speech development, and overall quality of life. Dental referrals for preventive screenings and treatments by a child's first birthday or after the eruption of the first tooth will also contribute to a successful Closed Loop Referral system for very young children to ensure that potential oral health issues are identified early, allowing for prompt intervention and prevention of escalating dental problems and ideally, to a dental home for regular care. MCPs can use gap-in-care data to identify toddlers who could benefit from a Closed Loop Referral to a Medi-Cal dental provider.

Parent and Caregiver Health. Much of a baby's well-being is influenced by the health of their caregivers and the family-oriented services they have access to. Pediatric workflows should incorporate Closed Loop

Referrals protocols following caregiver depression screenings, which could reveal the need for family supports, home visitation services, and parental educational programs to foster a healthy and strong environment for infants. Dyadic care programs like Healthy Steps, where a parent and newborn are seen in tandem, can be leveraged as they integrate child development support and guidance into pediatric healthcare visits, enhancing early childhood development outcomes to foster a strong parent-child relationship and promote healthy growth and development in children from birth to age three. Since Healthy Steps specialists have the added benefit of being present during the pediatric visit with parents, they can be a familiar and trusted partner for parents to help ensure referrals have been rendered. Where locally available, programs like Black Infant Health, Nurse-Family Partnership, Welcome Baby, and Parents as Teachers can be key referral partners and connection points to community supports that equip parents with the tools and information they need to ensure their children are healthy, safe, and ready to learn. A statewide or regional clearinghouse of programs approved and vetted by state or county agencies and community-defined interventions, could be useful to the field in connecting parents and caregivers to the most appropriate program for their families.

Early Childhood Care and Education. Continuity of care for infants as they transition to early childhood will be key. Twenty percent of parents report hardship in finding reliable, quality, affordable, child care;[41] and not being able to find child care for siblings is a leading reason that some children, especially those with disabilities, missed preventive health visits.[42] Even though not explicitly required, a Closed Loop Referral system should facilitate referrals to agencies that provide information about the availability of affordable and high-quality child care in their area and appropriate early childhood education programs like Early Head Start, ensuring a smooth transition from infancy to early childhood and promoting school readiness. A family-friendly Closed Loop Referral system will offer families care coordinator or navigator support in gathering referral documentation and paperwork (e.g., insurance information, medical history, etc.) needed for educational settings, which can sometimes be prohibitive or overwhelming for parents and caregivers. A true Closed Loop Referral system that incorporates the child care needs of families will need to re-think how referral loops get closed when families can spend years on wait lists to access high-quality child care.

Special Considerations in Closed Loop Referrals for School-Aged Kids & Teens

In 2021, roughly 60% of students ages 5-17 in California were eligible to receive free or reduced-price school meals, with eligibility across counties ranging from 28% to 81%.[43] Income eligibility for free or reduced-price school meals overlaps with Medi-Cal income eligibility requirements providing a view into the critical role schools can and should play in meeting the health needs of children and youth.[44] To support children enrolled in Medi-Cal in accessing and receiving wellness and prevention programs, starting in 2025, Medi-Cal managed care plans will be required to enter into MOUs with every Local Education Agency (LEA) in each county within their service area for school-based services to strengthen provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) within schools. Schools have a unique role to play in identifying student health needs and promoting Closed Loop Referrals to and from local managed health care plans and other local/community based providers, while promoting student privacy and choice.

One initiative underway to promote health in schools is the state's Student Behavioral Health Incentive Program (SBHIP).[45] The SBHIP aims to eliminate silos and improve coordination of student behavioral health services through increased communication between schools, school affiliated programs, managed care providers, counties, and mental health providers to improve access to and delivery of mental health services for Medi-Cal enrolled children in transitional kindergarten through grade 12. While SBHIP incentivizes plans and schools to collaborate toward the shared goal of improved student behavioral health outcomes, it is not a required program and does not extend to all other health services. It will be critical for DHCS and managed care plans to document the most effective strategies that result in increased access to and quality of care for children and youth to continue scaling school-based and/or school-liked services available to school-aged children.

1. Behavioral Health Wellness Programs
2. Telehealth Infrastructure to Enable Services and/or Access to Technological Equipment
3. Behavioral Health Screenings and Referrals
4. Suicide Prevention Strategies
5. Substance Use Disorder
6. Building Stronger Partnerships to Increase Access to Medi-Cal Services
7. Culturally Appropriate and Targeted Populations
8. Behavioral Health Public Dashboards and Reporting
9. Technical Assistance Support for Contracts
10. Expand Behavioral Health Workforce
11. Care Teams
12. Information Technology (IT) Enhancements for Behavioral Health Services
13. Pregnant Students and Teen Parents
14. Parenting and Family Services

As MCPs and LEAs work collectively to implement SBHIP, they should leverage existing/trusted school staff/administrators and any new staff in Closed Loop Referrals. Whenever possible, MCPs and LEAs should strive to develop policies and data exchange that ensure continuity of services and supports as students change and/or transition between school systems and settings. This will require MCPs and LEAs to collaborate on cross-training and coordination within a school, district, or region. For example, McKinney-Vento[46] and AB 490 educational liaisons[47] can be important sources of referrals for children and youth experiencing homelessness and/or in foster care, two populations that should, by definition, be referred to Enhanced Care Management services. Similarly, school nurses and community school coordinators could help screen and refer children to needed services based on student needs. As noted in a recent analysis of SBHIP, "an area of opportunity for [Managed Care Organization and Local Education Agency] partnership is joint participation in community information exchanges that establish closed-loop referral systems with community-based providers…laying the groundwork for deeper collaboration and data sharing." [48]

Partnership and Infrastructure-Building Opportunities for Closed Loop Referrals

It is worth acknowledging that there are already several opportunities underway to build out the infrastructure that will be needed to support Closed Loop Referrals. For example, specifically for the rollout of the CalAIM Enhanced Care Management (ECM) and Community Supports benefits, MCPs can use Incentive Payment Program (IPP)[49] payments to build out networks of providers, including Community Health Workers, who can support in opening and closing referral loops.

For Primary Care Providers, the recently announced Equity and Practice Transformation (EPT) Payments[50] present opportunities "to advance health equity and reduce COVID-19-driven care disparities by investing in up-stream care models and partnerships to address health and wellness and funding practice transformation." PCPs can use the EPT payments to build the infrastructure and staffing in their practice for Closed Loop Referrals. For example, EPT payments can be used to support activities that:

- Establish, maintain, and use bilateral data feeds with a Data Exchange Framework (DxF) Qualifying Health Information Organization, as defined by the current DxF framework and to be further defined in future DxF policies.

- Define and implement a care team that addresses population health management functions (e.g., gaps in care closure, care coordination) and team-based care for the population of focus (e.g., children and youth).
- Use data to stratify services and/or outcomes measures by a socioeconomic variable that can identify health disparities (e.g. race/ethnicity, sexual orientation/gender identity, etc.), and implement a strategy to decreases any disparities identified.
- Create and implement a formal strategy to better engage and outreach to patients, including patients assigned but not seen.
- Create and implement a formal strategy to address care coordination needs for patients with more complex health and social needs.
- Choose and implement an evidenced-based model for focus population (e.g. Dyadic Care, Doulas, CenteringPregnancy, group visits for conditions like diabetes, Project Dulce, collaborative care model for behavioral health, remove monitoring for patients with hypertension, Medication Assisted Treatment, etc.).
- Integrate behavioral health into primary care practice to provide more comprehensive care for patients.
- Create and implement a formal process for screening for and intervening on patients' social needs/risks.

Finally, MCPs and other stakeholders can operationalize Closed Loop Referral policies through Memorandums of Understanding **(MOU)** requirements.[51] Specifically:

- Starting in January 2024, MCPs are required to enter into MOUs with Third Parties (i.e., various programs and agencies) to facilitate care coordination and information exchange, including county MHPs, WIC agencies, CCS providers, county child welfare departments, and Regional Centers.
- Starting in 2025, MCPs will be required to enter into MOUs with First 5 programs and providers and every Local Education Agency (LEA) in each county within their service area for school-based services to strengthen the provision of EPSDT within schools.

Conclusion

Implementation of the CalAIM Closed Loop Referral requirement offers a transformative opportunity to fundamentally reshape the way children and families experience and interact with healthcare and social systems.

Guided by the five recommendations and special considerations presented in this brief, the State should actualize streamlined Closed Loop Referral systems that place children and families at the heart of the process, alleviating the burdens often placed on parents and caregivers and paving the way for efficient, community-based, and culturally concordant care that eliminates disparities in outcomes for children in Medi-Cal managed care. The creation of robust Closed Loop Referrals can create enduring shifts in the relationships and communications across providers and the communities they serve, but those will need to be sustained and enhanced as the state holds MCPs accountable for the outcomes of children in their care and the improved performance of population health management. A successfully functioning child and family-centered Medi-Cal Closed Loop Referral system has the potential to profoundly transform the well-being of children and families throughout the state for the better.

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