DEPARTMENT OF HEALTH CARE SERVICES
Stakeholder Advisory Committee (SAC)
Behavioral Health Stakeholder Advisory Committee (BH-SAC)

May 17, 2022
9:30 a.m. – 1:30 p.m.

SAC AND BH-SAC JOINT MEETING SUMMARY

SAC Members Attending*:* Bill Barcellona, America's Physician Groups; Doreen Bradshaw, Health Alliance of Northern California; Michelle Cabrera, County Behavioral Health Directors Association; John Cleary, MD, Children's Specialty Coalition; Kristen Golden Testa, The Children's Partnership/100% Campaign; Michelle Gibbons, County Health Executives Association of California; Virginia Hedrick, California Consortium of Urban Indian Health; Anna Leach-Proffer, Disability Rights California; Sherreta Lane, District Hospital Leadership Forum; Mark LeBeau, California Rural Indian Health Board; Kim Lewis, National Health Law Program; Beth Malinowski, SEIU; Farrah McDaid Ting, California State Association of Counties; Sarita Mohanty, MD, SCAN Foundation; Erica Murray, California Association of Public Hospitals and Health Systems; Linda Nguy, Western Center on Law and Poverty; Andie Patterson, California Primary Care Association; Chris Perrone, California HealthCare Foundation; Brianna Pittman-Spencer, California Dental Association; Janice Rocco, California Medical Association; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Cathy Senderling, County Welfare Directors Association; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Stephanie Sonnenshine, Central California Alliance for Health; Kaycee Velarde, Kaiser Permanente; Bill Walker, MD, Contra Costa Health Services; Ryan Witz, California Hospital Association; Anthony Wright, Health Access California.

SAC Members Not Attending: Anne Donnelly, San Francisco AIDS Foundation; LeOndra Clark Harvey, California Council of Community Behavioral Health Agencies; Jarrod McNaughton, Inland Empire Health Plan; Doug Shoemaker, Mercy Housing.

Behavioral Health Stakeholder Advisory Committee (BH-SAC) Members Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Jei Africa, Marin County Health Services Agency; Ken Berrick, Seneca Family of Agencies; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Laura Grossman, Beacon Health Solutions; Andy Imparato, Disability Rights California; Veronica Kelley, San Bernardino County; Kim Lewis, National Health Law Program; Linnea Koopmans, Local Health Plans of California; Karen Larsen, Steinberg Institute; Robert McCarron, California Psychiatric Association; Farrah McDaid Ting, California State Association of Counties; Maggie Merritt, Steinberg Institute; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; Jonathan Porteus, WellSpace Health; Hector Ramirez, Consumer Los Angeles County; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Cathy Senderling, County Welfare Directors Association of California; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Chris Stoner-Mertz, California Alliance of Child and Family Services; Gary Tsai, MD, Los

Angeles County; Mandy Taylor, California LGBTQ Healthand Human Services Network, a Health Access Foundation program; Catherine Teare, California Health Care Foundation; An-Chi Tsou, SEIU; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Stephanie Welch, California Health and Human Services; Jevon Wilkes, California Coalition for Youth.

BH-SAC Members Not Attending: Carmela Coyle, California Hospital Association; Jessica Cruz, NAMI; Alex Dodd, Aegis Treatment Centers; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sarah-Michael Gaston, Youth Forward; Britta Guerrero, Sacramento Native American Health Center; LeOndra Clark Harvey, California Council of Community Behavioral Health Agencies.

DHCS Staff Attending: Michelle Baass, Jacey Cooper, Kelly Pfeifer, MD, Palav Babaria, MD, Susan Philip, Rene Mollow, Lindy Harrington, Tyler Sadwith, Anastasia Dodson, Jacob Lam, Jeffrey Callison, and Morgan Clair.

Public Attending: There were 232 members of the public attending.

Welcome, Director's Opening Comments, Introduction of New Members, Roll Call, and Today's Agenda
Michelle Baass, DHCS Director

Baass welcomed members to the second joint meeting of SAC and BH-SAC and reviewed the meeting format. Baass introduced a new SAC member, Beth Malinowski from SEIU, and new BH-SAC members, An-Chi Tsou, also from SEIU, Laura Grossman from Beacon Health Solutions, and Karen Larsen from the Steinberg Institute. Baass commented that there was no time to add the requested topics of the CARE Court and vaccine incentive programs to today's agenda. They will be discussed at a future meeting. Baass announced that Dr. Kelly Pfeifer will be leaving DHCS and thanked her for her service and commitment. Baass thanked the California Health Care Foundation for its ongoing support of these meetings.

Director's Update
Michelle Baass and Jacey Cooper, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/051222-SAC-BH-SAC-core-presentation.pdf

Baass provided an overview of a member survey gathering feedback on the new meeting format. The input was generally positive, and members indicated that the combined format offers greater efficiency and exchange across stakeholder groups. Some disadvantages mentioned included less time for comment and some topics that are not relevant across the full group. Staff will work to shorten presentations to address these concerns. Most members prefer a hybrid format for future meetings.

Baass offered an update on Medi-Cal Rx, including stabilizing call center operations and prior authorization (PA) timelines. A special population clinical liaison was launched in response to input from California Children's Services, the Genetically Handicapped Persons Program, and county behavioral health partners. The 180-day transition policy will not end in July as

planned. There is no date set for its ending, but a 90-day notice will precede the ending of the transition policy.

Questions and Comments

Witz: Related to Medi-Cal Rx, Centene announced they are selling Magellan later in the year. Once the sale is approved, what are the interactions and plan for transitioning to the new pharmacy benefit manager?

Baass: DHCS is reviewing the transaction, working through the process, and will update the group at a later date.

Imparato: Many leaders with lived experience have serious concerns about the CARE Court as proposed. This is an important moment for the state to engage with peer leaders. I respectfully request that we have a meeting sooner than the next SAC/BH-SAC meeting in July to discuss this proposal.

Cabrera: Thanks to DHCS for launching the specific line in Medi-Cal Rx for county behavioral health plans. We also look forward to a future conversation around CARE Court, given the significant impact on county behavioral health and our clients.

Lewis: Thank you for delaying the 180-day transition policy. Do you have a timeline for when this may be implemented?

Baass: There is no timeline to report, but we are committed to giving a 90-day notice prior to ending the transition policy. There are multiple changes under review, such as the mitigation strategies put in place in February to address the PA backlogs, and we are thinking through how to put them in place, what is necessary from a clinical perspective, and perhaps phase the changes in a way that does not cause disruption and allows for education and training prior to going live.

Wright: On the meeting format, with such a large group, it could be useful to rely more on the chat and other virtual functions to accommodate quick suggestions, comments, or to signal agreement. On Medi-Cal Rx, now that call center times are stabilized, what communication has happened to Medi-Cal beneficiaries about their access to drugs? Are there plans for any surveys? I would appreciate a future conversation on the second stage, the negotiation phase to lower the cost of drugs.

Baass: We don't have a plan for surveys, but there are regular conversations with organizations, and indications are that Medi-Cal Rx is working well now. We are thinking about negotiations and looking at other states' practices and will bring that topic back for a future meeting.

Ramirez: We are seeing a flash point at this moment on civil rights topics around the country. The CARE Court is significantly important as a civil rights issue and a body-autonomy issue. The lack of conversation and stakeholder engagement from people who will be impacted is significantly concerning. Without a platform for dialogue at this level, it is difficult to convey the potential impacts, and it creates a risk to broad support for this approach. We are starting

to hear from young children with schizophrenia and psychotic disorders that are becoming suicidal because they are afraid of how care would be impacted. There is direct impact being caused by not having conversations. We see people pulling away from public health systems, afraid of the consequences that are coming.

Medi-Cal's Strategy to Support Health & Opportunity for Children and Families
Palav Babaria, MD, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/051222-SAC-BH-SAC-core-presentation.pdf

Babaria provided an update presentation on the recently published Medi-Cal's Strategy to Support Health and Opportunity for Children and Families report. Babaria reviewed the guiding principles and offered information on each of the eight action areas. A new staff person, Dr. Pamela Riley, joined DHCS as the new children's health lead and to oversee implementation of the Strategy.

Questions and Comments

Lewis: I commend DHCS for bringing together all of the initiatives into a single report so we have the holistic view of all strategies. I would suggest also bringing in the Children and Youth Behavioral Health Initiative. I appreciate the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) education and outreach initiative, and I am hopeful this effort will educate beneficiaries and families about the benefit and how to access it. On population health management (PHM), it would be great to reference efforts on data-based delivery of care to shore up managed care so kids are screened and get the services they need.

Babaria: Yes, I see PHM as the glue to bring together the various strategies for improvement across all of the delivery systems. DHCS wants to create a specific PHM strategy for for children and families that is dedicated to meeting these needs.

Kelley: The CalAIM Foster Care Model of Care workgroup has not met for a long time, and the Governor's budget also referenced something similar. Is that a new group? What are the next steps on the foster care strategy and this workgroup?

Baass: Yes, it is the same group. The Foster Care Model of Care workgroup is scheduled to meet on August 4.

Golden-Testa: We are thrilled with this strategy and the leadership at DHCS to make this possible. However, we were disappointed that multi-year continuous coverage was not included. Right now, there are about 100,000 children who have gaps in coverage, and this disrupts getting well-child visits. This policy can solidify coverage as a first step of increasing preventive care rates. We hope you will consider that, given it meets several of your goals and is in the Senate budget proposal. The integration is exciting, and we hope that it becomes bi-directional so that WIC families can be enrolled in Medi-Cal.

Veniegas: Thank you for bringing together all of the diverse programs and processes serving multiple youth in California. I want to highlight the continued need for navigation and coordinated enrollment efforts. Food insecurity continues to plague communities, especially

communities of color, and the opportunities to braid WIC, CalFresh, and Medi-Cal enrollments is a very important emphasis. I also want to underscore the need for integrating language across the policies and procedures with regards to substance use. One example is language on when youth may access specialty mental health and substance use disorder treatment. There is a nod to substance use, but full integration must include language and attention to the policies and procedures that address youth substance use.

Babaria: I agree and appreciate all of the input.

Sonnenshine: I echo the excitement about the work DHCS is doing. Our health plan prioritized health equity in its strategic plan. It includes goals to close the gaps for children we serve. We are excited about the state moving upstream and want to suggest a future discussion here at SAC or with managed care plans (MCPs) about the tactics and roles for each of us with accountabilities in this work – the roles of the county, DHCS, health plans - and have that level of detail in the implementation plan.

Babaria: I absolutely agree and will take that back to see what venues are most appropriate.

Malinowski: My colleagues and I will be making sure our locals are familiar with the strategy and want to brainstorm with you about engaging our workforce in it. Also, in the context of this conversation, I want to voice concern about the sunset of the Child Health and Disability Prevention (CHDP) program proposed in this year's budget. As we hopefully revisit that sunset, we want to think about the expertise in the local public health department and opportunities for new collaboration for local public health to support children and families.

Babaria: Thank you. We have been having collaborative, productive conversations with the California Department of Public Health, as well as with local health jurisdictions. If we want to move upstream, that partnership will be critical.

Baass: The expertise at the local level from public health and MCPs and how we can partner together on the Community Health Worker benefit is a priority for DHCS.

Tsai: One thing to lift up is around upstream messaging. For as much progress as we have made through the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver, according to federal and local data, we are only touching 5 percent of people in our treatment systems. There is extraordinary potential to tap the 95 percent of people with substance use disorders who either don't want services or don't think that they need them. While we invest in improving access, there is a need for upstream messaging about how to lower that 95 percent, which would have enormous benefit downstream.

Babaria: Thank you. As you know, one of the three major clinical focus areas for our comprehensive quality strategy is integrated behavioral health, and it is designed to do exactly what you just said.

Pittman-Spencer: CDA also is concerned about the proposed elimination of CHDP. MCPs don’t have networks for dental services, and we have concerns about their ability to do care coordination. We don't want to see the existing CHDP programs go away until we know that MCPs can step up.

1915(b) Managed Care Monitoring and Oversight, including Medical Loss Ratio Stakeholder Process Status Update
Susan Philip, Rene Mollow, Jacob Lam, and Tyler Sadwith, DHCS
https://www.dhcs.ca.gov/services/Documents/051222-SAC-BH-SAC-core-presentation.pdf

Philip spoke about the requirements for managed care oversight included in the 1915(b) waiver standard terms and conditions (STCs).

Mollow reviewed the Dental Managed Care requirements under the 1915(b) waiver STCs intended to address challenges recognized by DHCS and CMS in Dental Managed Care.

Sadwith presented on oversight for behavioral health services that pertain primarily to county mental health plans and counties participating in the DMC-ODS.

Lam reviewed existing and new requirements for the medical loss ratio (MLR) for MCPs.

Questions and Comments

Witz: Will there be a draft workplan available for stakeholder input? What is the stakeholder process for network adequacy and MLR?

Philip: CMS discussions are moving forward to final stages for DHCS to submit in June. We are holding closely to the existing STCs. Following submission, there will be opportunities for input.

Witz: Are there any proposed changes to the alternate access standards or changes in the process DHCS uses to determine that?

Philip: There are no changes beyond the STCs on alternate access standards.

Witz: It's unclear to us how CMS is expecting DHCS to define risk-bearing. For example, could that mean bundled payments, DRG payments? I'm not clear how far risk is being assessed?

Lam: I will follow up to clarify. We are working with CMS to finalize the extent of risk-bearing.

Savage-Sangwan: On Dental Managed Care, it is encouraging there will be more oversight. Can you remind us if these plans get procured on a specific schedule? The All Plan Letter issued this week spoke to a 3 percent withhold, when we understood it would be 10 percent. Can you say more about why you think 3 percent will actually drive performance improvement?

Mollow: On the procurement schedule, the Governor's budget last year maintained contracts through this year, so we are in the process of developing a Dental Managed Care procurement. On the performance withhold requirement, in accordance with the managed care mega rule, DHCS must make sure that the withhold requirements are attainable and

reasonable. We had not previously accounted for the 10 percent payment withhold in the actuarial soundness of the rates developed. Now, with new rates and new requirements for performance, that methodology will be established in the rates and will be based on actuarial soundness. That is how we came to the different withhold amount. We do think it will be appropriate to accomplish what we need. The withhold is one part of holding Dental Managed Care plans accountable in terms of the delivery of services.

Savage-Sangwan: On DMC-ODS and SMHS plans, to what extent will the access assessments look at racial disparities? We are excited about the dashboard and are one of the organizations that have tried to dig into the open data portal. We request that you continue to put the full data on the portal because it allows us to do analyses in addition to what DHCS posts on the dashboard.

Sadwith: It is a great question on disaggregation or stratification of race and ethnicity data within the independent access assessments for DMC-ODS and SMHS. I will take that back for discussion.

Cabrera: We are excited about the user-friendly snapshots of county behavioral health services through the dashboard. I have not seen anything similar for MCPs that breaks down performance by plan in a digestible format. Does that exist, or is DHCS planning to do that? As we enter CalAIM, this could be useful to understand the non- SMHS benefits managed through health plans. Is DHCS reviewing the degree that non- SMHS are integrated at the provider level and the overlap of specialty and non- SMHS networks across the various MCPs?

Sadwith: Your point about the performance of MCPs on some of the measures that are included in the STCs for mental health services is a great one. We have flagged the issue of MCP data for CMS, especially given that MCPs also provide mental health services. We are discussing with CMS how the delivery system works in California and how mental health services are available across delivery systems. It is important to show performance not only at the county mental health plan level, but at the level appropriate for a given measure. We hope to engage with you and others to provide feedback on that.

Cabrera: Another question is how DHCS is looking at MCP networks for specialty services and in terms of clinical integration with primary care. Administrative plan integration and clinical integration are two different things.

Philip: In the updated MCP contracts for 2024, DHCS has strengthened requirements related to behavioral health integration, referrals, and care management, so that care is coordinated at the MCP. DHCS is working internally to identify how to monitor all the new provisions.

Barcellona: Are there discussions with CMS about the application of the 2012 Center for Consumer Information and Insurance Oversight guidance, which is used in the commercial and Medicare advantage MLR compliance and not used in Medicaid compliance? I represent 80 organizations that are risk-bearing and most are too small to comply with the strict requirements as outlined in the stakeholder meeting two months ago. We continue to be concerned about whether we will have a delegated model in Medi-Cal managed care beyond the end of 2023 because of these requirements.

Lam: I appreciate your comments and flagging this issue. We continue to meet internally and with CMS on these issues to determine how those requirements will be applied.

Pittman-Spencer: Will DHCS be disenrolling beneficiaries in Sacramento County or giving beneficiaries the opportunity to disenroll? I want to ensure there is clear notice to beneficiaries and providers as well as ensuring the FFS network is sufficient.

Nguy: I request providing robust and comparable mental health data from the MCP and county mental health plans. In addition, I am glad to know that Dental Managed Care will be tracked against FFS, and I want DHCS to consider collecting data on measurements like continuity of care.

Velarde: Kaiser is a subcontractor in 17 counties. We have been following the subcontracted network certification and expect it to come out in 2022. With the work with CMS and the work plan submitted in June, will this deadline be delayed?

Philip: It is on track for 2022. We will circulate a timeline as soon as possible.

Koopmans: Can you be more explicit about the request for engagement in the coming weeks and months on the work plan to clarify the STC requirements, specifically on the timeline and feasibility for any new data? In addition, it would be helpful to have benchmarks for some areas of the workplan.

Philip: I want to clarify that as of now, there are no new data collection requirements in the work plan.

Lewis: Can you speak about how the new consumer advisory group works in unison with the existing stakeholder work groups? How does the state CAC fit with the local CACs and other state workgroups, and what is the information flow between these groups?

Baass: We are working on the design of the statewide CAC with the California Health Care Foundation (CHCF) and Center for Health Care Strategies (CHCS), and look to launch by the end of the year. We want our existing advisory committees to work in alignment and are thinking that through now.

Lewis: Thank you for addressing the dashboard and what is coming. It is critical to build off the performance outcome system data reports that have already existed and may not currently be updated. For example, there were EPSDT reports by county on all services for youth under age 21, and I recommend that those reports continue. I also want to flag there is no granularity on non-SMHS kids are getting from each system and also from both systems.

Sadwith: The behavioral health dashboard will be an iterative and growing asset. We are starting with the core viable product and building on it to incorporate the data that exists to make it accessible, streamlined, centralized, and user-friendly. We appreciate the input on data that will be useful.

Baass: As we refine the behavioral health data in the Current Procedural Terminology (CPT)

transition, we will have more distinct levels of service categories. It won't be immediate, but in the future, there will an opportunity for insight into what services are being provided versus the generic category.

Wright: I appreciate the focus on additional managed care oversight now that 95 percent of the population is in managed care. Will the MLR be public by plan? Also, how will the MLR be evaluated for the subcontractors? On the member advisory committees, it sounded like the state CAC would be comprised of members from the plans. I have a concern if the only people on the CAC are those selected by health plans.

Lam: We are working with CMS to determine data collection from delegated entities and will have this prior to implementation. I will need to follow up on whether the MLR is public.

Baass: On the state CAC, DHCS is working with CHCF and CHCS on best practices to design the group. It will be helpful to have members familiar with the dialogue at the local plan level; however, yes, it will be broader than only members from health plan CACs.

Enrollment in Medi-Cal for Those Ages 50 and Older Regardless of Immigration Status, Effective May 1, 2022
Rene Mollow, DHCS
https://www.dhcs.ca.gov/services/Documents/051222-SAC-BH-SAC-core-presentation.pdf

Mollow reported on the expansion of full-scope Medi-Cal for individuals ages 50 or older, regardless of immigration status, as of May 1, 2022.

Questions and Comments

Gibbons: I want to call attention to how important Medi-Cal Administrative Activities and Targeted Case Management programs are for this expansion. Information sent to counties indicates the expense for these programs will be fully county-funded, while in the past there was a federal share. It is important that the state consider having a financial share to maintain those services.

Nguy: I want to commend DHCS for the transition and highlight the ongoing need for navigation to ensure all are enrolled. Also, it would be useful for DHCS to use the immigrant-friendly language on public charge recommended by advocates.

Mollow: I will check on the language, as we should be using consistent public charge messaging.

Wright: We are thrilled with the expansion. Is there a breakdown of the 250,000 individuals regarding how many were shifted from restricted scope to full-scope coverage versus those going through an application process? At some point, it would be great to have data published on enrollment numbers by county and beneficiary demographic information.

Mollow: The 250,000 are individuals who transitioned from restricted scope to full-scope Medi-Cal. We don't have information on the individuals going through an application enrollment. We will be reporting these numbers as we have the data.

Murray: We appreciate the thoughtfulness of using lessons learned to leverage past experience. From the public health care systems' perspective and drawing on the experience of transitioning from the Low Income Health Program to Medi-Cal, we want to emphasize care continuity and simplicity in the process. We appreciate the opportunity to continue talking.

Ramirez: Looking forward, there is a great need for dental care for older adults, including partial or full dental implants, rather than dentures, to improve oral health. This is an equity issue and a mental health issue, especially for communities of color.

Veniegas: As part of the Senate Bill 75 kids expansion, the California Community Foundation supported resources for 11,000 kids and families in Los Angeles to access the first Medi-Cal expansion for all immigrant children, regardless of immigration status. As we look forward to the 2024 expansion implementation, I want to offer our support and resources, especially related to coverage retention. Given the anticipated redetermination, we are all concerned about a drop off in coverage retention, especially for community members experiencing long haul COVID. I think there are data approaches that could be used to focus on subpopulations of concern for retention and coverage over time.

CalAIM Update
Susan Philip, Anastasia Dodson, Tyler Sadwith, and Jacob Lam, DHCS
https://www.dhcs.ca.gov/services/Documents/051222-SAC-BH-SAC-core-presentation.pdf

Dodson reviewed the five goals and initiatives of the Master Plan for Aging. She offered information about how CalAIM initiatives map to the Master Plan goals, including housing supports, long term care services and supports, integrated care for dual eligible beneficiaries, community- based alternatives to short term nursing home stays, and others. DHCS holds monthly stakeholder meetings for in-depth discussions of these topics. Beginning in 2023, dually eligible individuals in Cal MediConnect will automatically transition to a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) managed by the same organization as their Cal MediConnect plan.. Also in 2023 all dually eligible beneficiaries statewide will required to enroll in a Medi-Cal managed care plan. By 2026, all MCPs will be required to establish a D-SNP . In addition, Dodson reviewed how dual eligibles will be served through CalAIM Community Supports (CS) and Enhanced Care Management (ECM) benefits and services.

Philip offered an update on the CS and ECM launch in January 2022, including county level data on what services are available.

Sadwith highlighted the steps taken on behalf of individuals who have been involved in the justice system; described DHCS' request to cover Traditional Healer and Natural Helper services; outlined the timeline for CalAIM behavioral health initiatives; and discussed several key behavioral health initiatives, including payment reform.

Questions and Comments

Cleary: What metrics for success are built in for the programs described? The experience in

the Whole Child Model and improved care management showed us that working from the family backward can bring different perspectives. For example, are there improvements with care management? Do they know who to call? While there has been significant progress, I think there's room for more. The metrics used and who you look to for success can give varying results.

Philip: It's a good point. DHCS is working internally to develop the measures to gauge success and improve health equity. We would love to engage with you on that.

Savage-Sangwan: Thank you for continuing to push for Tribal healers. On the standardized screening tool, I want to understand the testing process and to what extent translation of the tool is incorporated into testing. A strict translation from English doesn't work well in different languages, particularly for behavioral health.

Sadwith: That is important input, and I will take that back for action so that we meet the needs of individuals for whom English is not their primary language.

Savage-Sangwan: The take-up on CS is impressive. There were concerns there would be more variation from plan to plan and county to county. Is there an assessment of what services plans are interested in providing where there are capacity gaps? Will PATH funds be targeted based on where we need to build the capacity of community-based providers, (e.g., for housing support)?

Philip: As we develop the PATH application design, we are thinking through considerations of need and the allocation process. The application process is also an indicator of where there is need, and we may phase allocation to allow organizations to become ready. DHCS also wants to ensure there is outreach, so organizations are aware of the PATH opportunity. We welcome suggestions about how to build awareness of the opportunities.

Witz: On ECM and CS MCP incentive payments, how does DHCS view the interaction of incentive payments during a time when procurement is happening as well? There could be incentive payments to MCPs who are not in the market in 2024 or potentially new partners in the market.

Philip: Great point. This is a transition period, and there may be changes in the MCPs participating in each market. The intent of the funds is to build capacity at the community level, especially non-traditional providers not previously part of managed care contracting. There is an expectation that funding will be driven by community needs and will go to providers at the community level to improve capacity. There may be shifts in MCPs, and this is a challenge, but the overall vision is that the incentive and PATH funding should drive enhancement among community-based providers.

Cabrera: I appreciate the tremendous work of DHCS and county behavioral health plans. We are interested in ongoing tracking and monitoring, especially the multiple entry points, and the efforts to increase access for beneficiaries and remove access barriers, to put the client first in a No Wrong Door approach. I want to flag that the eligibility expansions under CalAIM do not come with additional funding for county behavioral health, and there are resource pressures at the county level. For example, the new benefit for peers will be funded within

existing resources. We are looking at efficiencies, payment reform, and improving the array of services billed to Medi-Cal, and it is still unknown how that will play out. Relatedly, we look forward to engaging in the Institution for Mental Disease (IMD) waiver proposal, as this may be an opportunity for counties to recoup federal financial participation for services currently not claimed under Medi-Cal. Finally, I want to flag the need to ensure that we don't have duplicative assessments for substance use disorder (SUD)/ serious mental illness (SMI) individuals receiving CalAIM services.

Kelley: I am looking for clarity on a few elements of the timeline. Can you offer more detail on what the full integration by 2027 includes? There is a subtle shift from previous language. Are we talking about getting rid of the pilots, or is that still an option? Are you talking about mental health and addiction being integrated? There are so many impacts to counties right now, some already mentioned and some additional ones like CARE Court that are not covered by Medi-Cal and for which we use realignment funding. All of those processes will change in the next four years to get to full integration, and I am looking for more clarity on what that includes.

Sadwith: We couldn't agree more about the overwhelming amount of change that is occurring in behavioral health, and DHCS wants to work with you to manage this. To clarify, administrative integration refers to consolidating contracts with DHCS for SMHS and DMC-ODS for the 37 counties that have a separate contract for substance use, not about integrating with MCPs. We are still doing the pilots with the goal for full integration of mental health and SUD administrative functions in 2027.

Lewis: It is confusing as to what and how much CS are offered in each MCP so it's important to update that frequently on the website. Can you also provide data on the different populations to understand who is getting what so we can assist them and make sure that beneficiaries know how to seek higher-level care management?

Philip: There has been guidance on coding and data to MCPs. The first reports are due May 15, and there will be a period of working on data quality, but the intent is to track utilization at the plan level and make that available publicly.

Lewis: I am excited about both the No Wrong Door implementation and screening and transition. There are a few things to flag. On screening, there will be a need for clarity and guidance on how the tools intersect with the No Wrong Door policy. For example, with automatic eligibility for certain populations without regard to clinical presentation, like foster youth or homeless individuals, will they just show up in SMHS and be screened and assessed or in the county mental health plan and then sent to SMHS regardless of their presentation? The screening tool should be available for both SMHS and MCP without duplication. On transitions and closed loop referrals, there has not been a good pilot opportunity, and there is little known about how this will work, yet it will be important to have that closed loop referral system really working in both directions.

Stoner Mertz: Along the lines of previous comments, we are concerned there may be inconsistency between the questions on the screening tool and what's outlined in guidance (BHIN 21-073) around access. What will the process be if a child or their parent is finding they are not able to access a service across one of these systems?

Sadwith: Yes, it is critically important to have clear information about the intersection of the access criteria in the No Wrong Door policy and the actual statewide screening and transition tools that will be used for adults and children for mental health. There will be more guidance, training, and TA regarding the intersection to ensure appropriate implementation. The overarching principle is that screenings should not be a barrier to care.

Senella: On CS specific to sobering units, right now there is an optional benefit MCPs can elect, but the model isn't very workable. Therefore, we have very few in the state. Infrastructure dollars may be available to launch a facility, but it can't be sustained on current resources. This also ties to mobile crisis response. Individuals brought to sobering centers may or may not be on Medi-Cal, and the provider may or may not have a contract with a MCP. In my estimation, sustainability is impossible with the current model. I hope that as we explore mobile crisis services, we can also look at options for sobering centers. On PATH for justice-involved 90-day pre-release services, what is the likelihood of approval by CMS?

Sadwith: There is no CMS approval necessary for Medi-Cal eligibility and enrollment processes pre-release. There is approval needed for pre-release Medi-Cal services. CMS must issue a report on this topic to Congress, and following that, issue guidance for implementation. Based on this, we are optimistic about approval.

Tsou: On the youth behavioral health screening tool, what is the overlap between these screening tools and the ones that are being developed in the Children and Youth Behavioral Health Initiative? I believe an external entity is developing recommendations on this screening tool. How is DHCS planning for consistency between those?

Sadwith: The screening and transition tools discussed today will improve the interaction between the Non-Specialty Mental Health Services covered by MCPs and the SMHS covered by county mental health plans. The Children and Youth Behavioral Health Initiative is broader in scope than today's discussion. That initiative is convening a think tank to solicit input and recommendations in support of a number of initiatives and tools. There will not be a duplication of CalAIM tools.

Mobile Crisis Response Update
Tyler Sadwith, DHCS
https://www.dhcs.ca.gov/services/Documents/051222-SAC-BH-SAC-core-presentation.pdf

Sadwith reviewed the opportunity to expand mobile crisis response services in Medi-Cal.

Questions and Comments

Berrick: This is one of the most exciting and most difficult of the many initiatives. Larger counties have separate youth and adult mobile crisis services, but not all areas will be able to do that. There are issues of interacting with schools and the community school movement, and many competencies unique to mobile crisis services. All of that leads me to ask about plans for enhanced TA and support to make this work in a way that addresses the specific needs of children.

Sadwith: DHCS is exploring the needs and opportunities for TA to counties to incorporate this into their delivery system of providers. We agree with the need for extensive training.

Savage-Sangwan: This could have impact on racial disparities that exist, and there is a need to carefully consider the comments we already have communicated to DHCS. From the county survey, do we know the extent that current mobile crisis units are serving Medi-Cal enrollees, and is there consideration to how other payers should contribute to financing this expanding system?

Baass: The California Health & Human Services Agency is convening a group for the overall crisis continuum, and that would be a great venue for this topic given the scope of that effort.

Grealish: This is a key issue for individuals with behavioral health needs who become justice system involved. The survey showed the extent that crisis response relies on law enforcement. We share the goal of keeping people out of the justice system. For us, the key metric is the prevalence rates of individuals in jails and prisons. At a recent meeting, we featured WellSpace as a model of a crisis-receiving behavioral health program. Options for where to divert individuals has been a question for so long. So, as we think about this crisis response, we need to tie this into other efforts that DHCS has underway, like social services and housing, and think broadly about how to divert folks to keep them out of the justice system during that key crisis point.

Sadwith: Yes, we fully agree. The Behavioral Health Continuum Infrastructure Program is a once-in-a-generation opportunity to build the capacity needed for crisis-receiving and stabilizing centers.

Stoner-Mertz: Mobile crisis will be a distinct benefit and, therefore, will have different coding than, for instance, what is currently used for crisis intervention?

Sadwith: It is different for pre- and post-behavioral health payment reform. Prior to payment reform, existing codes are being identified for use. After payment reform, the CPT coding will be more precise.

Stoner-Mertz: Will the benefit be available as of January 2023 with the 85 percent Federal Medical Assistance Percentage (FMAP)?

Sadwith: The goal is for coverage to be effective in January 2023. The FMAP is available for a three-year period during the five years for which these services will be covered. We are assessing internally the best strategic approach to claim that FMAP.

Public Comment

There were no requests to offer public comment.

Plans for 2022 Meetings, Next Steps, and Adjourn
Michelle Baass, DHCS

Kelly Pfeifer offered her appreciation for the work and partnership with stakeholders over

the past years and expressed her confidence in the DHCS team to carry forward the various initiatives.

Baass offered her thanks to Dr. Pfeifer. She also thanked members for their input and discussion.

The 2022 dates stakeholder meetings are listed below:

- July 21, 2022
- October 20, 2022.