DEPARTMENT OF HEALTH CARE SERVICES

Stakeholder Advisory Committee (SAC)

July 29, 2021

9:30 a.m. – 12:30 p.m.

MEETING SUMMARY

SAC Members Attending (by webinar)*:* Maya Altman, Health Plan of San Mateo; Bill Barcellona, America's Physician Groups; Doreen Bradshaw, Health Alliance of Northern California; Michelle Cabrera, County Behavioral Health Directors Association; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; John Cleary, MD, Children's Specialty Coalition; Susan DeMarois, Alzheimer's Association; Mary June Diaz, SEIU; Anne Donnelly, San Francisco AIDS Foundation; Kristen Golden Testa, The Children's Partnership/100% Campaign; Sherreta Lane, District Hospital Leadership Forum; Anna Leach-Proffer, Disability Rights California; Kim Lewis, National Health Law Program; Dharia McGrew, California Dental Association; Farrah McDaid Ting, California State Association of Counties; Jarrod McNaughton, Inland Empire Health Plan; 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; Janice Rocco, California Medical Association; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Doug Shoemaker, Mercy Housing; Stephanie Sonnenshine, Central California Alliance for Health; Bill Walker, MD, Contra Costa Health Services; Ryan Witz, California Hospital Association; Anthony Wright, Health Access California.

SAC Members Not Attending: Michelle Gibbons, County Health Executives Association of California; Virginia Hedrick, California Consortium of Urban Indian Health; Mark LeBeau, California Rural Indian Health Board; Nate Oubre, Kaiser Permanente; Cathy Senderling, County Welfare Directors Association; Jonathan Sherin, Los Angeles Department of Mental Health.

DHCS Staff Attending: Will Lightbourne, Jacey Cooper, Palav Babaria, Michelle Retke, Bambi Cisneros, Norman Williams, Jeffrey Callison, Morgan Clair.

Guest presenter: Sarah Brooks, Sellers Dorsey

Public Attending: 236 members of the public attended by phone.

Welcome, Roll Call and Today's Agenda

Will Lightbourne, DHCS Director

Director Lightbourne welcomed members.

Director's Update

Will Lightbourne and Jacey Cooper, DHCS

Slides: https://www.dhcs.ca.gov/services/Documents/SAC-presentations-072921.pdf

Lightbourne highlighted the major health provisions of the state budget recently signed by Governor Newsom. There are many implications for DHCS, such as funding of full-scope Medi-Cal coverage for undocumented individuals age 50 and older and full funding for the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Other notable items in the budget included:

- A population health management (PHM) platform.
- Providing Access and Transforming Health (PATH) funds to support in-reach to prisons and jails to ensure warm handoff transitions for people leaving incarceration.
- Community Health Workers (CHWs) authorized to become a covered provider in 2022.
- Doula services included as a covered Medi-Cal benefit.
- Authority to lift, then eliminate asset caps, for seniors and persons with disabilities.
- Postpartum Medi-Cal coverage for undocumented women extended from 60 days to one year without the previous requirement of a behavioral health diagnosis.
- Budget resources for health equity mapping and a dashboard.
- Approval of the Office of Medicare Innovation and Integration that will focus on dual eligible and Medicare-only beneficiaries to promote the availability of home and community-based services (HCBS).
- The behavioral health continuum infrastructure program increased from $750 million to $2.4 billion in the final budget, with an immediate investment in local support.
- Behavioral health services for children and the approval of dyadic care as a Medi-Cal benefit.

Federal funding through the American Rescue Plan Act provided resources for the expansion of HCBS of approximately $3 billion of workforce development across DHCS, the Department of Social Services (CDSS), and the Department of Developmental Services (DDS), and program enhancements in support of homeless interventions, expansions of community navigation opportunities, and more. The spending plan has been submitted to the Centers for Medicare & Medicaid Services (CMS), and DHCS expects to receive approval soon. Lightbourne commented that the budget included investments in CDSS and the Office of Statewide Health Planning and Development (OSPHD) for workforce development to build a community workforce and increase underrepresented populations in the workforce. These significant investments in housing and community development programs represent an unprecedented step forward in addressing health equity gaps and goals.

Jacey Cooper offered additional information on the initial implementation and integration of these initiatives. She noted that the various budget components reflect DHCS' priorities on access, equity, HCBS, social determinants of health, and behavioral health reform, which are connected to CalAIM. Staff are working to ensure the components fit together in a complementary fashion. For example, in the HCBS spending plan, there is a housing and homelessness incentive program, in addition to the CalAIM incentive program, that complements both Enhanced Care Management (ECM) and In Lieu of Service (ILOS)

offerings in CalAIM. This will allow managed care plans (MCPs), counties, and continuum of care providers to draw down additional administrative dollars.

Cooper reported that there are additional PATH funds for homelessness and HCBS provider infrastructure capacity. DHCS is focusing on how to weave the additional budget resources into the infrastructure already rolling out. There is a significant opportunity for community-based residential continuum pilots that are partnerships of providers and MCPs to test and pilot different residential settings similar to long-term care at home. DHCS wants to innovate in residential models for individuals with behavioral health needs within the community and to reduce the institutional footprint, using a combination of federal and state funds. There were several benefits added through the budget, such as CHWs, for which DHCS wants stakeholder engagement to advise on implementation and how to complement PHM and existing benefits.

Lightbourne reported that, related to the Medi-Cal Rx initiative, DHCS has accepted a conflict avoidance plan with Magellan Medicaid Administration (MMA), Inc., a subsidiary of Magellan Health, Inc. (Magellan), and the initiative will be implemented on January 1, 2022. The January 2021 launch date was delayed due to the COVID-19 pandemic response and because, in the interim, the vendor, Magellan notified DHCS it was potentially being acquired by Centene. On July 27, 2021, DHCS announced it accepted a conflict avoidance plan submitted by MMA Inc. to mitigate conflicts associated with the proposed acquisition of Magellan by Centene Corporation. DHCS will post the conflict avoidance plan on its website.

Cooper provided an update on CalAIM and the 1115 and 1915(b) waivers, reporting that the applications were submitted on June 30, 2021. The 30-day federal comment period for the 1115 waiver has opened and will end on August 13, 2021. There is no formal public comment period for the 1915(b) waiver. DHCS met with CMS and will engage with them over the next several months to complete the work.

Cooper reported on COVID-19 vaccination disparities for Medi-Cal beneficiaries. Rates of vaccinations are lower for Medi-Cal beneficiaries than the general population in every county in the state. As of July 18, 45.6 percent of Medi-Cal beneficiaries, 12 years of age and older, were vaccinated, compared to 70.5 percent of all Californians. The disparities are across all ages, as well as lower rates for African Americans and American Indians and Alaska Natives. DHCS is engaging with local organizations, schools, and local health departments to remedy these disparities. This is a priority for DHCS and a stark reminder of the inequities across California.

Questions and Comments

Shoemaker: During the prior waiver period, many public health departments used Medi-Cal funds for supportive housing services. Does the spending plan Request for Proposal (RFP) encourage plans to do something similar? We are concerned that it will be optional, and we will not have longer-term supports beyond that 12-month transition to supportive housing.

Cooper: The majority of that housing work is with county health departments today and will transition under the waiver and CalAIM to MCPs that elect to implement them under ILOS. Services will vary by plan, and they've let us know what they plan to implement. It will be posted in August, and plans can update and finalize later this year. It is the plans' responsibility from a payment point of view, and they will contract with providers. Most will retain the existing footprint, whether it is the public health department, public hospitals, or counties doing the work today.

Shoemaker: It will be a challenge for the field to weave this together; if there is a way to provide a consolidated version of guidance, it would be helpful.

Altman: I am very appreciative of the unprecedented investment in programs, particularly for HCBS, and for the laser focus on vaccinations. I continue to be disappointed and perplexed about the carve-out of Medi-Cal pharmacy from managed care. It is counter to everything we are doing to integrate services under accountable organizations. Pharmacy is an important clinical intervention for health plans.

Wright: I am glad the conflict of interest issues are addressed and would appreciate hearing more about what this means from a patient point of view to ensure this is right for consumers. Also, we have great appreciation for the expansion of coverage to adults regardless of immigration status. Can you say more about the timing for the rollout of new investments like the benefit expansion, asset test changes, and how the initiatives relate to one another? On stakeholder comments related to the federal waivers, do you have thoughts about what is useful to gaining approval?

Lightbourne: The target for launching the coverage expansion is May 2022, based on the capacity of DHCS to get all the elements in place.

Cooper: For the asset test, there are two phases. In July 2022, there will be a significant increase in the asset limits, and full elimination of asset caps is set for January 2024. These timelines are based on extensive planning, and we think they are realistic. There is coordination with CDSS that we need to stay abreast of as well. On the federal comments, we encourage comments in support of the waiver. We want to make sure CMS is clear about the impact of ILOS across the state and the importance of the justice package. These are significant elements of our commitment to address social determinants of health and equity within the Medi-Cal population.

DeMarois: I want to acknowledge the tremendous work on the HCBS Spending Plan. Many of the recommendations from the Master Plan on Aging and the Long-Term Services and Supports Subcommittee are included. The creation of the new Medicare Office of Innovation and Integration is important and, given that the vast majority of Californians with Alzheimer's and dementia are Medicare beneficiaries, this really opens the door to more integration on behalf of that population within the Medi-Cal program.

Lewis: There are so many moving parts in the budget to track, and changes may happen during the rollout. Is there a way to communicate with stakeholders, other than weekly updates, to find out what's happening in real time, like when things are changing and where there is public input allowed via stakeholder processes? Second, we are all really

concerned about the vaccination disparities. Are you looking at creative ways to fund community-based organizations (CBOs) to do specific outreach through navigators or other strategies to reach people that may distrust or feel skeptical?

Cooper: DHCS is working on a comprehensive plan for the next year of external communication on CalAIM and the budget items. We are still committed to the weekly updates for now and will try to maximize that. On vaccinations, we are thinking about how to partner with CBOs and faith-based organizations, and I am happy to convene a group to brainstorm what is working in different parts of the state and to learn about innovations.

Golden Testa: The Children's Partnership welcomes the opportunity to participate in discussions about how to work with CBOs to improve vaccination rates. Is it on the table to fund CBO efforts?

Cooper: Coming up with a focused strategy will help inform those types of investments, and we will reach out for discussion. We're identifying trusted partners in certain communities and look forward to partnering with you.

Murray: I echo congratulations for budget and underscore the disappointment and worry across public health about the increasing rates of COVID-19. Also, we appreciate the effort on the waiver submissions. California has a track record of pushing the envelope, and this is no exception. The evaluation of the Global Payment Program (GPP), to establish ongoing relationships in primary care settings, shows it is working yet needs more time and we hope the five-year renewal will be successful. The waiver proposes to take GPP even farther through proposed equity pools to provide Whole Person Care (WPC)-like social determinants of health services through a separate equity pool model. We also want stakeholders to know how important PATH funds are for shared decision-making between plans and WPC pilots, public health care systems, and counties to ensure services continue and capacity remains strong in the safety net. I also want to echo our disappointment about the Medi-Cal Rx program. There has been important dialogue on concerns about continuity of care and particularly now, with the COVID-19 crisis and so much we are asking health plans to do on CalAIM, that we encourage DHCS to consider a delay of the implementation or at least some markers during 2021 to reflect and see if, in fact, we are ready for a go-live date of January 1, 2022. I would like to be part of the group to discuss improving vaccination rates and can share reports from the Safety Net Institute on best practices in vaccine distribution and administration.

McDaid Ting: We are excited about the investments in HCBS and look forward to the crosswalk you mentioned with CalAIM and other initiatives. I support and appreciate the delay in payment reforms. It is both critical and complex and we appreciate the opportunity to implement it with more time. The vaccine rates for Medi-Cal recipients are shocking, and I'm glad DHCS is focusing on it. Could it reflect data issues related to an individual getting vaccinated at a pharmacy or other site?

Cooper: Unfortunately, the data are pulled directly from the public health database and reflect everyone getting vaccinated, not just Medi-Cal-billed visits.

McNaughton: We are also concerned about vaccination rates for Medi-Cal beneficiaries. Locally, we are experiencing lower disparities between the rates of vaccination for Medi-Cal and the general population, although unfortunately the county has some of the lowest overall rates at just over 50 percent. We have a lot of work to do as a community. I echo previous sentiments about the pharmacy carve out. We have been a strong advocate to keep pharmacy as part of the MCP. We think it makes sense with CalAIM. It would be useful for us to have talking points to share with provider advisory committees as the pharmacy benefit change is a topic of interest for them. Finally, I am wondering if you can speak to coordination between DHCS and the Department of Managed Health Care (DMHC) on CalAIM initiatives and anything we can do to better be a bridge between the entities.

Cooper: DHCS meets with DMHC frequently, and we've shared details on CalAIM. I can follow up with our managed care team to make sure if there is turnover that they are reinforcing the information frequently.

Sonnenshine: The vaccination disparities are such an important issue. As a health plan, even though COVID-19 vaccinations were carved out of our administration and financial responsibility, we partnered with our counties to do outreach and education with our members and providers all along the way. Across the state, there was an early focus on distributing the vaccines through multi-county entities that predominantly serve the commercially insured, as opposed to Medi-Cal. As we go forward, different resources are needed in areas of deeper poverty. I also support the comments on the Medi-Cal pharmacy benefit carve out made by other plans. Regarding implementation, health plans identified a long list of readiness review issues. Can you talk about when DHCS will engage on those readiness activities? Will they be incorporated into the broader initiatives moving forward? The goal of the Medi-Cal Rx policy is savings. Is there a plan to reinvest the savings from Medi-Cal Rx back into the delivery system to improve outcomes for our members? Last question, under conflict avoidance, how does SAC or the public become aware of any challenge to the conflict avoidance plan?

Lightbourne: Yes, the internal team will pick up the work and be re-engaging with readiness steps as part of all the work unfolding over the next months. On reinvestment, yes, the savings stay in the system although I do not think it is possible to track the dollars. On the conflict avoidance, the binding commitments will be part of the contract. The monitor will work to make sure there are very robust procedures in place to prevent breaches. In the event that breaches occur, we would look at seeking damages, and we would make it widely known.

Cooper: In addition, savings are not the only driver of Medi-Cal Rx. Key considerations are standardizing the pharmacy benefit statewide and maximizing pharmacy spending and investment for the entire state.

Nguy: We are very pleased with the budget and especially appreciate the work on the HCBS Spending Plan. On Medi-Cal Rx, can you share the numbers on provider enrollment in the program? Also, is there an estimated budget savings in the current year considering the earlier implementation dates?

Lightbourne: The number of pharmacies enrolled in the program is high, however the number of prescribers enrolled is low. We will work closely with the California Medical Association (CMA) to encourage prescribers to use the learning tools on the Medi-Cal Rx website to make it easier for them; however, they can participate and continue to prescribe without doing this. We expect significantly higher numbers now that efforts have re-started. The budget assumed a January start and health plans have suggested a longer timeline for readiness to transition their pharmacy benefit managers. Therefore, there is not a budget impact there. There is budget impact due to supplemental payments to clinics related to 340B rebate changes, as previously agreed to in the budget.

Clark Harvey: I want to thank DHCS for so much attention to the documentation burden and forming a work group. Can you say more about the screening and transition tool pilots and when information will be shared more broadly on that?

Cooper: I can follow up with you on this.

Martinez Patterson: As much as health centers appreciate the supplemental payment pool, it's important to note that the 340B program kept many health centers financially healthy. Now, at a time when we want to see health centers be the backbone of the health delivery system, many will be operating in the red. We ask to continue finding ways to ensure health centers remain resilient so they can be the best partners they can be.

Rocco: The CMA has done mapping of providers and vaccination sites to identify zip codes with lower vaccination rates. It shows clearly that, in places where it is more difficult to access vaccinations, the rates are lower. The emphasis on multi-county and larger entities and not getting vaccines to community providers has made a difference in access, and this is something to learn from. We are working with DHCS and CDPH to onboard additional community providers.

Cooper: Thank you, and we appreciate your partnership.

Donnelly: We are very excited to work with you on all of the budget initiatives. There was a budget request of $7 million to expand the Family PACT program to serve people who do not present with a family planning issue, but with a sexually transmitted infection, primarily in the LGBTQ community. DHCS used a very different calculation of $128 million for the cost of this expansion. We want to work with DHCS to better understand that estimate. We hope to move forward with this and have confidence in the $7 million calculation for the expansion.

Cooper: I think it is important to work with Rene Mollow, who oversees Family PACT, and Sandra Williams with the Medi-Cal Eligibility Division. We are happy to provide technical assistance as you move forward.

Diaz: Will the HCBS Spending Plan process require state legislation or All Plan Letters?

Cooper: We are working with Department of Finance on any trailer bills. There will be guidance coming from sister departments based on who leads initiatives for various aspects.

Diaz: We represent the public health workers who have worked tirelessly throughout the pandemic. Local health departments work very closely with safety net health care systems at public hospitals on outreach and engagement with communities not yet vaccinated. I wanted to flag that and offer to engage in future conversations to get more people vaccinated.

Cooper: Thank you. We appreciate their hard work and look forward to partnering with you.

Managed Care Procurement Update
Michelle Retke and Bambi Cisneros, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/SAC-presentations-072921.pdf

Cisneros provided an update on the MCP procurement process for commercial plans. With more than 86 percent of all Medi-Cal members enrolled in managed care and even more transitioning as part of CalAIM, DHCS views the MCP procurement as a major initiative to improve access and quality of care. Procurement will further CalAIM's goals to:

- Identify and manage member risk and need through whole person care approaches and addressing social determinants of health.
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Cisneros reviewed each category of comments, offered a summary of themes emerging from the comments, and reported on the current plans for follow-up action. She noted that the contract updates highlighted today are not all inclusive of changes that DHCS is considering for the final RFP. She reported on the timeline and next steps for changes and thanked all who submitted comments.

Questions and Comments

Lewis: A key theme you highlighted and that aligns to our input is that more specificity is needed in the contract language. There are provisions we found to be very broad, not specific enough to delineate what is expected from the plans. You noted additional requirements will be included. I want to confirm if those are items where there will be opportunity for public comment or input, or if those are going to be added later. In addition, can you comment on what is planned for the 18-month readiness period? What will happen?

Cisneros: Yes, thanks for noting more specificity is needed, and I hope I conveyed the rationale for the balance we want to achieve. We restructured a number of items on the oversight of health plans and included changes based on the May Revision. We will have contracts, alongside the ability to detail and provide guidance via APLs. We will have further dialogue with stakeholders and advocates. In particular, there will be more discussion on quality and equity.

Retke: The readiness timeline turns out to be more like 15 months currently. The process is that DHCS will issue a Notice of Award and then move into an implementation contract. There are up to 200 deliverables required from the plans. The operational implementation readiness section of the RFP outlines these, from policies and procedures to setting up the provider network and utilization management systems. There is a phased-in process of submission, and various DHCS divisions will work on approvals. There are timeframes to be met for each phase to ensure readiness by January 2024.

Golden Testa: I am disappointed there is no opportunity for comment on some of the large areas, like PHM, which are central for children. Can you offer more information on what will go into an APL versus the contract? Can you also offer clarification on the quality metrics requiring more flexibility? Does that mean there will not be quality metrics?

Cooper: Historically, we have never put quality metrics into contracts. Typically, there is other guidance that outlines them, and they will be locked in for a period of time. By the end of the year, we will roll out a comprehensive quality strategy and equity roadmap that the DHCS Chief Quality Officer is working on, including extensive stakeholder engagement. There will be accountability for quality in the contract, but not the metrics. PHM will not go live until January 2024; there will be new budgets prior to that and CalAIM will roll out, so there will be more specificity and updates before the contract is signed. The overarching pieces are in the RFP to make sure there is a commitment to them, and then the actual language will be refined. There is going to be extensive stakeholder engagement on PHM, risk stratification, protocols, and more that will happen outside of this RFP process. As those policies are finalized, they will be updated in the MCP contracts, as well as in the APL.

Retke: The final contracts will be the result of everything over the next couple of years from an amendment standpoint.

Cisneros: An example is raising the minimum performance levels from the 25th percentile to the 50th. That was not included in the contract, but rolled out via an APL.

Savage Sangwan: I appreciate the requirement that plans have a Health Equity Officer as an important first step. I understand not wanting equity measures set in the contract and there is similar work at DMHC, so there is a need for a different process for the equity measures. I hope that will allow robust stakeholder engagement around what those measures should be, particularly for equity. On payment, is there continuing discussion about paying plans differently, paying for achievements on equity and disparities metrics, and looking at value-based payments? What is the venue for that?

Cooper: Yes, there is authority in the draft RFP to implement payment changes. We plan on including that in the comprehensive quality strategy and equity roadmap. Other aspects may roll out in 2022 as we fine tune how we will make payment changes,

Children and Youth Behavioral Health Initiative
Jacey Cooper, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/SAC-presentations-072921.pdf

Jacey Cooper reviewed information on the $4 billion investment intended to transform behavioral health (BH) care for all children and youth, zero to 25, regardless of payer. This is not a short-term budget item and will not roll out immediately. This requires planning, policy development, infrastructure investments, and scaling up over time.

Questions and Comments

Altman: Congratulations on an ambitious plan. There's a need to manage expectations. Initial discussions we had with a school-based health center indicated a lack of familiarity of Medi-Cal and an expectation that Medi-Cal is going to cover school counselors and other unlicensed people. This revealed a need to communicate broadly about what Medi-Cal can and cannot cover.

Cooper: Both DHCS and DMHC will be working on a list of services, any criteria needed, and the fee schedule for what all plans, both Medi-Cal managed care and commercial plans, will be required to pay for in schools. We know there is a lot of work to be done and understand there is a lot of guidance and decisions to be made and to disseminate in the future. We have a very long list of stakeholders for this initiative, including the Department of Education (CDE).

Cleary: I applaud this aspirational effort. I think there are parallel investments, like loan forgiveness, that can be leveraged for success in the grander goals here.

Cooper: Agree, there are many interdependencies here, and we connecting many dots. Workforce is critical to ensure we have the right type and number of providers.

McNaughton: This is very exciting. We have been convening to learn about school infrastructure locally and have a few takeaways. Data is a significant challenge to work through. CalAIM will help with that, although there is a lot we will need to work out through partnership and discussion with our school superintendents. I would like to learn more about state level efforts with CDE. As noted, the nomenclature in schools is that a behavioral health provider is a non-licensed school counselor versus our nomenclature of a licensed clinical social worker, psychologist, or psychiatrist. Finally, we have an idea about having MCPs utilize the free and reduced-price meals program to target demographic areas for high-need people.

Cooper: To clarify, I want to mention that prior to the BH initiative in the budget, there was a proposal on Medi-Cal MCPs for a $400 million investment to increase services that would also include commercial plans. This will move quickly through incentives to Medi-Cal MCPs to broker relationships with school districts. With 50 percent of kids enrolled in Medi-Cal, this is a huge focus.

Diaz: We are excited about this proposal, but have concerns about implementation. For example, the definition for behavioral health coaches, and that unlicensed and uncertified individuals can become behavioral health coaches. We would like to work with you on that. We appreciate the investment in the county behavioral health workforce and infrastructure as well as the recommended investment in student mental health. We also want to understand the role of vendors for the digital platform in relation to the state workforce that

would otherwise have done that job. We have questions about how this platform would coordinate with existing state and county eligibility and enrollment platforms to connect behavioral health with health care and potentially with other public programs.

Cooper: Thank you for the comments. We look forward to engaging with you.

Sonnenshine: We appreciate DHCS' efforts to expand access to behavioral health services and look forward to partnering with you. I encourage an ongoing discussion across the state on behavioral health workforce and pipeline. When you look at the outcomes, it is driven by a lack of providers and shortage of resources in underserved communities in rural areas. We are going to struggle to see the services actually get delivered.

Health Equity Roadmap
Sarah Brooks, Sellers Dorsey, and Palav Babaria, MD, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/SAC-presentations-072921.pdf

Lightbourne offered introductory context and a recap of SAC discussions. The dialogue started with a recognition that the extraordinary disparities in health outcomes based on race, income, and class are driven by racism in society and in the economy, and racism built into the health system. DHCS is embracing social determinants of health as a partial tool to mitigate the effects of the underlying social and economic racism. DHCS wants to explore what other tools may be available to address racism in the health care delivery system. To further this work, the California Health Care Foundation engaged external consultants, Sellers Dorsey, to identify potential short, medium, and longer-term opportunities to establish measurable goals for DHCS consideration in its equity work going forward. Dr. Palav Babaria, Chief Quality Officer and Deputy Director of DHCS' Quality and Population Health Management, is leading a portfolio that includes this health equity conversation.

Sarah Brooks from Sellers Dorsey noted that the research conducted was completed in the beginning of 2021 and pre-dated the May Revision and so does not include the many actions taken with respect to health, disparities, and inequities in the final state budget. Sellers Dorsey was engaged to complete an assessment of DHCS' efforts related to race and ethnicity health disparities and equity, and to propose a roadmap for future activities and initiatives. Research was conducted at the state and national level, such as the National Quality Forum. The research resulted in six domains for the health equity roadmap: health equity structure and culture, community partnerships and collaboration, measurement and analytics, performance monitoring and evaluation, program policy changes and interventions, and payment structures and fiscal strategies.

Dr. Babaria commented that the roadmap has been very useful already, and DHCS is working to incorporate new initiatives from the budget. DHCS developed a simplified framework, thinking through how this plays out at the state, health plan, and provider levels so that approaches to equity are consistent and have impact.

Internally, DHCS will continue to map current and planned initiatives and work with stakeholders to identify gaps and build capacity over the next three to five years to address disparities. We want to avoid unnecessary administrative complexity and align our efforts

with ongoing national efforts to simplify the work for plans and the provider network. We are thinking through how the health equity strategy explicitly ties to the new benefits rolling out and will continue to partner with the California Pan-Ethnic Health Network and public health on cultural competence in county mental health plans.

Questions and Comments

Savage Sangwan: I really appreciate DHCS and Director Lightbourne's leadership to name and address racism in the health system. I have a specific question about community health workers and doulas as new benefits. Is there a process for engagement to figure out how to implement this in a way that will help close disparities? Can you share any more information about potential engagement with stakeholders?

Cooper: Yes, there will be stakeholder engagement and we hope to get information out soon. Lisa Murawski, the Division Chief for Benefits, joined DHCS recently and will work with her team to get engagement in place. We agree that implementing community health workers and doulas is quite different than a benefit like glucose monitors. We look forward to engaging with you on those calls.

Golden Testa: Will DHCS share the report from Sellers Dorsey? I was disappointed not to see enrollment as a pillar of advancing equity. I would also love to see additional local engagement of CBOs and beneficiaries because they are best speaking with their own voice on these issues.

Lightbourne: Thank you. We will share a summary of the report from Sellers Dorsey. Very specifically in the recommendations is a stakeholder process, apart from SAC, that gives voice to beneficiaries and people who have been the victims of racialized care. I definitely see your point on enrollment. One thing I forgot to mention about the 2022 budget is that we have moved to post-enrollment verification. There has been a concern that we were losing people through the previous policy of up-front verification. That isn't the complete answer to what you are raising, and we will take that back to our team and see where it fits.

Public Comment

Yvette Willock, Los Angeles County: I appreciate all of this information – it is so very necessary for us to be updated. Thanks to DHCS for taking the time to walk us through the school initiatives and the incredible funding for children and youth. I am happy to hear that DHCS will be engaging with schools. I want to present for your consideration in that engagement dialogue with schools around their hesitancy in allowing students to leave the classroom to receive mental health services. Apparently, that is somehow associated with payments schools get for the students being in class, and that has been a barrier to young people receiving mental health services. Also, there is school hesitancy with having mental health providers, such as our county behavioral health providers, being on their campuses to provide mental health services..

Hellan Roth Dowden, Teachers for Healthy Kids: Only 31 percent of the kids in the U.S. have had COVID-19 vaccinations. A school district in Southern California reached out to

their county to become an immunization provider and were told no because other districts weren't doing it. So, I really think there is a great need to take a look at the barriers to immunization for the school. Currently, through the Local Educational Agency Medi-Cal Administrative Activities program, school districts can provide immunizations on their campuses and get reimbursed, but we have been trying to get a template in place so this can actually happen. A lot of schools are worried because there is no template for audits and investigations. If there is any way that DHCS could work on this immunization issue, we know that school districts would love to do this. We need to remove the barriers around the regular immunizations that are down by 20 percent in some areas. These are just the older kids. We haven't even gotten to what will happen when we get to younger ages.

Next Steps and Final Comments; Adjourn
Will Lightbourne, DHCS

Bobbie Wunsch let SAC members know that several members were in the cue with remaining questions or comments, but there wasn't enough time for all to provide public comment/input during the meeting. SAC members can send questions in writing to Bobbie, and she will circulate responses to all members.

Lightbourne thanked participants and reminded members of the last quarterly meeting date for 2021.

- October 21, 2021 – 1:30 p.m. – 4:30 p.m.

<u>Addendum: Additional Questions from SAC Members and DHCS Responses</u>

Question: How will the Health Equity Plan address the need for additional non-clinical data that affects racial and ethnic disparities in the Medi-Cal program?

> **DHCS Response:** DHCS recognizes that addressing social determinants of health (SDOH) is critical to eliminating racial and ethnic disparities in the Medi-Cal program. CalAIM includes a number of initiatives to better collect and address SDOH data, including the development of a member risk assessment designed to capture drivers of health, improved coding around SDOH by providers and community partners, and the launch of in lieu of services and enhanced care management for select populations to explicitly address social drivers of health. The Health Equity Plan will include these current efforts, but also engage stakeholders to identify future improvements, both in terms of data collection as well as policy and program needs.

Question: How will this effort align with the requirements and data collection and analysis required under Assembly Bill (AB) 470 (Chapter 550, Statutes of 2017) concerning Specialty Mental Health Services (SMHS) Performance Outcomes?

> **DHCS Response:** Under AB 470, DHCS was mandated to lead a stakeholder process to identify existing data to be used for reporting on mental health disparities. During the year-long process, DHCS worked with stakeholders to create new data reports to specifically address the following areas of the provision of

SMHS: access; language capacity and access; quality; and utilization and penetration. The bill also required that these data be stratified by age, sex, gender, race, ethnicity, primary language, sexual orientation, and any other data element that has peer-reviewed evidence to assess performance outcomes related to mental health disparities. By the end of the year, data reports were produced and presented to the Legislature. The reports included data on access, language capacity, utilization, and penetration stratified by age, race, gender, language, and diagnosis. Managed care data on these variables have now been added as mandated . Data on mental health disparities are being reviewed in preparation for a written report that will identify potential areas for technical assistance to reduce mental health disparities. After the report is produced, DHCS plans to reconvene the stakeholder group to review the analyses and proposed technical assistance.

AB 470 data reports are available at: https://data.chhs.ca.gov/dataset/child-youth-ab470-datasets