DEPARTMENT OF HEALTH CARE SERVICES

Stakeholder Advisory Committee (SAC)

October 21, 2021

1:30 p.m. – 4:30 p.m.

MEETING SUMMARY

Stakeholder Advisory Committee Members (SAC) Attending (by webinar)*:* Maya Altman, Health Plan of San Mateo; 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; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; Virginia Hedrick, California Consortium of Urban Indian Health; Sherreta Lane, District Hospital Leadership Forum; Anna Leach-Proffer, Disability Rights California; Mark LeBeau, California Rural Indian Health Board; Kim Lewis, National Health Law Program; 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; Libby Sanchez, SEIU; 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; Doug Shoemaker, Mercy Housing; Stephanie Sonnenshine, Central California Alliance for Health; Bill Walker, MD, Contra Costa Health Services; Anthony Wright, Health Access California.

SAC Members Not Attending: Bill Barcellona, America's Physician Groups; Anne Donnelly, San Francisco AIDS Foundation; Jonathan Sherin, Los Angeles Department of Mental Health; Ryan Witz, California Hospital Association; Stephanie Welch, California Health and Human Services, ex officio.

DHCS Staff Attending: Michelle Baass, Jacey Cooper, Palav Babaria, Lindy Harrington, Susan Phillip, Bambi Cisneros, Norman Williams, Jeffrey Callison, Morgan Clair.

Public Attending: 180 members of the public attended by phone.

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

Baass welcomed members to her first SAC meeting as DHCS Director and offered a brief summary of her background as an introduction. Director Baass commented that her priorities are the successful implementation of the many efforts underway at DHCS, including CalAIM, the expansion of Medi-Cal to undocumented persons over age 50, the managed care procurement, behavioral health initiatives, and the Home and Community-Based Services (HCBS) Spending Plan. She noted that this is a time to redefine how we

think about healthy communities, how we achieve equity in our communities and how we hold the health care delivery system and ourselves accountable for a healthier California for all. She noted that it is critical to engage and listen to consumers and partners. By incorporating what the community's experiences are, we will create better policies and programs.

Baass recognized and thanked four members who are leaving SAC due to transitions. She expressed her appreciation for the contributions of Dharia McGrew, Susan DeMarois, Nate Oubre, and Maya Altman, and wished them well in their new endeavors. She thanked the California Health Care Foundation for its ongoing support of SAC.

Director's Update
Michelle Baass and Jacey Cooper, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/102121-SAC-presentation.pdf

Baass provided updates on the managed care procurement. DHCS announced in early October that the release date of the managed care procurement Request for Proposal (RFP) was moved to February 2, 2022. The additional time will ensure that DHCS can incorporate feedback and input from stakeholders. This will not change the implementation date of new contracts scheduled for January 1, 2024. DHCS has conditionally approved all 17 counties that have submitted a letter of intent for county plan model changes and will post a final list of counties moving forward in early November.

Cooper provided an update on the 1115 and 1915(b) waiver requests. DHCS has submitted formal responses to the Centers for Medicare & Medicaid Services (CMS) on the 1915(b) waiver, which consolidates the Medi-Cal managed care plans, mental health plans, Drug Medi-Cal Organized Delivery System (DMC-ODS), and dental managed care plans into one waiver. In the 1915(b) waiver, DHCS also requested federal authority for contingency management. Discussions on the 1915(b) waiver are going well with CMS, and DHCS is optimistic about receiving CMS approval by the end of the year. The 1115 waiver includes ambitious requests, such as the justice-involved package and the Providing Access and Transforming Health (PATH) model. CMS has not responded to the request to include faith/natural healers, but DHCS will continue to pursue this in discussions. DHCS submitted the State Plan Amendments (SPA) tied to CalAIM implementation on June 30; CalAIM will begin in January 2022.

Cooper presented maps of COVID-19 vaccination data for Medi-Cal beneficiaries that are updated every other week and posted on the DHCS website. Medi-Cal vaccination rates are still trending behind all Californians. Cooper provided an update on the Vaccination Incentive Program with managed care plans (MCPs). All MCPs submitted a vaccine response plan. Most are participating in the direct member incentives.

Cooper provided information about planning for the end of the COVID-19 public health emergency (PHE), most recently extended by the Secretary of the U.S. Department of Health and Human Services (HHS) through January 2022. DHCS has begun planning for what it will take to unwind the comprehensive set of federal flexibilities in place, and what SPAs would be required for items California will continue outside of PHE flexibilities. DHCS is particularly focused on the full redetermination of Medi-Cal beneficiaries over a 12-

month period. By the end of the PHE, it will be close to two years with no redeterminations, and many beneficiaries have moved or changed other circumstances. DHCS is working with health navigators, advocates, MCPs, community-based organizations (CBOs), and others to communicate the need to update beneficiary contact information. DHCS will mail an FAQ to all Medi-Cal beneficiaries, and expects that 9-10 million beneficiaries will go through the redetermination process. Only a portion of individuals will be able to use the *ex parte* process.

Questions and Comments

Rocco: The DHCS vaccination rate information show that some of the biggest national health insurers may be least effective in getting enrollees vaccinated. Are the Vaccination Incentive Program plans submitted to DHCS publicly available so we might help with additional suggestions?

Cooper: I will check with the team to see if we are able to make the plans available, and will follow up as quickly as possible.

Wright: Are there any preliminary insights about what is working to increase vaccination rates? I agree it would be helpful to see the vaccine response plans. Did all plans submit, and did they include recommendations for boosters, children ages 5-11, or other issues for the future? On another topic, we are excited about the expansion of coverage to individuals 50+ regardless of immigration status. Will DHCS release enrollment data to track that the relevant populations are reached?

Cooper: All MCPs and one Coordinated Care Initiative (CCI) plan submitted vaccination plans. The first report will be submitted at the end of October. Once we consolidate the information, it will be posted on the website. The Vaccine Incentive Program does include boosters and ages 5-11. We will post enrollment information as quickly as we can to support advocates and outreach.

Nguy: On health plan procurement, can you share any major changes from the draft that you are making based on stakeholder input? On the model changes for counties, do you expect those that are conditionally approved to become final? Are there any you do not expect to move forward?

Cooper: We are not ready to walk through the procurement changes today. We can highlight the changes in early 2022. We are still reviewing the documents for the conditionally approved counties, but there is a high likelihood most will move forward to the readiness criteria stage which will require counties to file additional information with DHCS. Final notice of approvals will be provided at the end of this month.

Lewis: For the outreach letter and FAQ set to go out in October, I assume it will not include information about the end of the PHE? Given that we expect 60 days' notice from HHS before the PHE is lifted, I encourage DHCS to consider a notice specifically about renewals and when they might hear from counties. It seems we need to send a notice given 9 million people will be asked to submit information when they haven't been asked for over a year or were asked, but weren't cut off from receiving Medi-Cal benefits.

Secondly, it will be helpful once redetermination rolls out to have real time, monthly data about enrollment and terminations. For example, there will be return mail from outreach that could result in action by counties or DHCS. How might we use that as an early indication of who is not getting the notice, wouldn't likely get information from the counties, and what to do to address that before the end of the PHE?

Cooper: The FAQ does include outreach regarding counties resuming case processing. Thank you for the input and ideas. I will take that back.

Gibbons: We should continue to focus on reaching vaccine hesitant people. In addition, we hope MCPs have coordinated with local health departments in the creation of their plan or that we find a way to work in coordination so as not to duplicate efforts or leave gaps. The other thing on vaccinations is that the uptake for those eligible for boosters is much lower than we hoped and anticipated. We need to encourage not just first doses, but second doses and boosters as well.

Patterson: On the incentives for vaccinations, there are health centers asking questions because they haven't heard from the MCP. If we could make the incentive plans public on the website, it will encourage more dialogue. I am excited about the energy and intensity we're putting into the contact information for redeterminations. We have heard examples of outreach to 1,000 people, of which the information got to 10, and one showed up. So, it's challenging on the contact information. On the waiver approval, the pharmacy transition wasn't mentioned and would start January 1, 2022. It is a big deal for health centers that the 340B program would stop, and we need to be planning, so I want to confirm my understanding of that.

Cooper: To clarify, the 340B program is not stopping. Medi-Cal Rx is scheduled to go live January 1, 2022, with approval of the 1915(b) waiver that includes approval of what is carved in and out of managed care.

Hedrick: Is there any more you can share on the natural healer benefit discussions?

Cooper: CMS has indicated it is a challenging point for them. We have been advocating for this along with many of you for a long time.

Wright: If there is anything that organizations or advocates can do to be helpful in the final negotiations or conversations with the federal government? Also, given the end of the PHE and redeterminations, I imagine there will be many people with additional income that now qualify for Covered California. Can you speak to how you are working with them and how that transition is happening?

Cooper: On the waiver, we will reach out to you, if needed. The discussions are positive with CMS. We do think there will be shifts from Medi-Cal to Covered California through the redeterminations. We meet with Covered California on a regular basis and will do everything we can to make transitions seamless.

DHCS Major Initiatives Crosswalk
Jacey Cooper, DHCS
https://www.dhcs.ca.gov/services/Documents/102121-SAC-presentation.pdf

Cooper provided an overview and timeline of the initiatives moving forward. New Medi-Cal benefits approved in the 2021-22 budget were highlighted. Cooper reviewed eligibility and enrollment changes to expand Medi-Cal. She delineated payment reforms, incentive payments, and rate changes set for implementation through 2023. Payment reforms include building quality and equity measures into the managed care capitation methodology, as well as behavioral health, nursing facility, and federally qualified health center (FQHC) alternative payment methodology (APM) that will start in 2023. She outlined incentive payments, including CalAIM Enhanced Care Management (ECM) and Community Supports (previously In Lieu Of Services). Beyond CalAIM, there are $1.3 billion in additional housing and homelessness incentives approved in the HCBS Spending Plan. Other incentives include COVID-19 vaccine incentives, behavioral health school incentives, and expansion of Medi-Cal services in schools. She also outlined two rate changes: 1) unfreezing intermediate care facilities for developmentally disabled and freestanding pediatric subacute rates; and 2) regional capitation rates.

Cooper reviewed the overall efforts by DHCS to standardize and simplify. This will include Medi-Cal enrollment of the majority of beneficiaries into MCPs by 2023. The only individuals remaining in fee-for-service (FFS) will be restricted scope and share of cost beneficiaries. Benefits will also be standardized, including long-term care, specialty mental health, and dental initiatives that will move from pilots to a standard benefit. Other standardization initiatives include DHCS requiring accreditation from the National Committee for Quality Assurance (NCQA) for MCPs by 2026 and demographic information for beneficiaries. DHCS will also move forward to standardize county oversight of the California Children's Services (CCS) program and county eligibility.

She outlined three major initiatives under behavioral health (BH) that are scheduled for implementation from 2022 – 2024: Behavioral Health Continuum Infrastructure, the Institutions of Mental Disease (IMD) waiver, and the Children and Youth Behavioral Health Initiative (CYBHI). Overall, the long-term plan is to integrate specialty mental health and substance use disorders by 2027, from an administrative and a clinical point of view. Cooper outlined specific steps for the CYBHI to build the statewide infrastructure, including a stakeholder think tank to develop policy and launch of the virtual platform with a statewide BH network in schools and community organizations. Along with these efforts, DHCS is addressing administrative claiming through Local Education Agency Billing Option Program (LEA BOP) and Senate Bill (SB) 75 to improve access through schools. By 2024, DHCS will also increase access to Medi-Cal services in schools through MCPs.

Population health is one of the cornerstones of CalAIM, and many of the initiatives will prepare for the 2023 launch of population health policies and services, focusing on data, information gathering, risk stratification, tiering, and care coordination to ensure upstream efforts and to focus on wellness prevention as well as care for complex patients. Cooper reviewed the comprehensive CalAIM Justice Package, which includes a coordinated reentry from incarceration and ensures services are available post-incarceration through Medi-Cal. Cooper reviewed the CalAIM plan for more robust managed long-term care

services and supports (MLTSS) by expanding services, standardizing the process, and data transparency. DHCS is implementing these ambitious initiatives and also looking ahead to plan for the next waiver.

Questions and Comments

Cleary: I want to raise attention to the gene sequence benefit expansion for those who are publicly insured. A pilot was done that showed benefit and saved money. The study was in a small number of hospitals, and this will expand it. We look forward to working with DHCS to support the go-live and future success.

McNaughton: I have several questions. First, what is the timeline for contract amendments based on changes in the waivers?

Cooper: DHCS has floated advance contract language over the last few months and offered other guidance through All Plan Letters (APL) in advance of the go-live in January 2022. Most of the guidance is out to MCPs, even if not all in a consolidated contract.

McNaughton: The student BH initiative will require coordination across all MCPs, counties, and many different schools within a region. If there is anything we can do to facilitate the technical assistance across MCPs and LEAs, let us know. On the quality strategy equity roadmap, how does this connect to the Department of Managed Health Care's (DMHC) efforts on equity measures?

Cooper: We are going to work very closely with DMHC on equity measures and hope to be able to align with our comprehensive quality strategy report, which will be released later this year for comment.

McNaughton: We have talked about CCS having a broader connection through CalAIM. Are there other thoughts on what it could look like for better coordination?

Cooper: I don't have specifics. We are looking at Whole Child Model counties and the evaluation of that program. CalAIM is focused on shoring up CCS oversight for both dependent and independent counties. Next, DHCS will work on the best way to propose children and youth ECM. There is an intersection for some individuals who may be both CCS and ECM eligible. We will work with plans and advocates in 2022 on what that children's ECM bundle looks like to go-live in July 2023.

Sangwan-Savage: On Community Health Workers (CHWs), can you clarify the timelines for when a draft SPA will be submitted? Also, is DHCS planning to do a separate SPA on asthma preventive services? Finally, on the Community Supports needs assessment and gaps plan that MCPs are required to do, is there a required component around engaging beneficiaries in the development of those plans and or engaging CBOs?

Cooper: On CHWs, we heard that more stakeholder work is needed, so the timing of the SPA submission will be dependent on finalizing the input to get language right. That is part of the reason the go-live moved to July 2022. I will need to follow up later on asthma preventive services. Yes, on the gap analysis process: MCPs should be engaging with

CBOs, providers, non-traditional providers, and beneficiaries to inform the plan for the county.

Shoemaker: Can you expand on the homelessness and housing incentive? My concern is whether ECM is sized to consider the commitments made by county health departments and others under the previous waiver for case management and supportive housing. My housing colleagues are trying to understand the integration with MCPs, which are largely new to supportive housing. I want to understand where and how that connection is made.

Cooper: Within the HCBS Spending Plan, there is $1.3 billion focused on increasing access and awareness within MCPs to make sure the homelessness continuum of care is connected to MCPs and to build that infrastructure. There are two parts. First, MCPs will be required to develop a housing and homelessness plan locally in coordination with the homeless continuum of care and housing authority and county. Second, we will tie it to some of the other housing plans that are due next year to connect all of the funding in housing. Then, there is a two-part plan for payment: one focused on outcome measures and one is incentive payments for getting and keeping people housed. In the future, we will try to paint a picture of the three funding buckets and how they're not duplicative, but additive. We have had MCPs working with Whole Person Care (WPC) pilots. They submitted models of care to transition into ECM and Community Supports. There is a robust set of housing recuperative care and supports for homeless individuals or people experiencing homelessness going live January. This is a transition of services, and as you bring the medical and social worlds together, that transformation takes time and money.

Shoemaker: One of the hard things on the housing and homelessness side is how fragmented it is. As you described who the housing entities were, I'm not sure that the right ones are identified. Perhaps we can talk offline. If I can be of help, let me know.

Cooper: Happy to have a conversation.

Golden-Testa: Three questions. On the quality and equity measures in the capitation payments, is this part of the joint DMHC and Covered California effort? Will there be a stakeholder process? On the PATH payments, when will there be more information on PATH payments to CBOs? When will there be more information on the requirements of health plans for population health management services?

Cooper: The quality and equity capitation methodology is separate from the work we do with DMHC and Covered California, although we hope to align metrics. Yes, in 2022, we will have a stakeholder process. On PATH, we are still negotiating with CMS so it is difficult to know what will end up being allowed. However, we are happy to do a presentation in the future for SAC to make sure people are tracking the opportunities for CBOs and providers. On population health services, we are doing policy work internally and anticipate engaging stakeholders for input in early 2022.

LeBeau: On the CHW initiative, I would like to ask that DHCS reach out to tribal health programs and governments to engage in the development of that work. Tribal clinics have a community health representative (CHR) program that has been in existence for decades. We recently worked with the state to allow for CHR workforce enhancement as a part of

COVID-19 vaccination education efforts. Pairing that with the CHW initiative is timely. I appreciate the discussion on homeless populations and want to remind SAC members that homelessness also exists in rural and frontier regions of California. We see overcrowding in rural and frontier regions, and that compounds the harm of COVID-19, so I encourage stakeholders to advise how CalAIM might support their needs.

Gibbons: The school-based services slide listed CCS. Are there changes related to that?

Cooper: No changes. We just want to make sure people are tracking that it is currently a school-based Medi-Cal service, and we are expanding our footprint in that space.

Update on CalAIM Implementation
Susan Philip and Lindy Harrington, DHCS
https://www.dhcs.ca.gov/services/Documents/102121-SAC-presentation.pdf

Philip offered information on the ECM and Community Supports benefits. ECM and Community Supports are foundational concepts for CalAIM as they build on the lessons learned in WPC pilots and Health Home programs ending in December 2021. ECM is a new benefit as of January 2021 provided by community-based providers, such as counties, health providers, and CBOs are contracted with MCPs. Community Supports are a set of 14 services that are optional, but strongly encouraged for MCPs to implement. Community Supports includes housing transition, housing navigation, short term post-hospitalization housing, and sobering centers. Beginning January 1, ECM will go live in stages, and Community Supports will launch statewide. MCPs may elect to add Community Supports every six months. Currently, 24 MCPs in 47 counties will offer Community Supports as of January 2022.

Harrington reviewed the CalAIM incentive payments and measure requirements. She noted that ECM and Community Supports will require significant investments in care management capabilities, community infrastructure, information technology, and data exchange, as well as workforce capacity at both MCP and provider levels. Program Year (PY) 1 priorities include infrastructure and capacity building for both ECM and Community Supports and quality. The first payment will be tied to MCP submission of a needs assessment and gap-filling plan.

Harrington reviewed the PATH Program. It is comprised of two related initiatives to achieve the CalAIM vision, justice-involved capacity building and support for implementation of ECM and Community Supports.

Philip shared information about Medi-Cal benefit standardization. Medi-Cal managed care is statewide, yet operates under six different model types with differing benefits across the models. CalAIM will move Medi-Cal to a more consistent and seamless system by reducing complexity and beneficiary confusion through statewide benefits standardization. This also reduces the number of different rate structures that DHCS must develop and manage. In an effort to enhance coordination of care, increase standardization, and reduce the complexity across the Medi-Cal program, DHCS will standardize the enrollment processes statewide to ensure consistency across counties for members and reduce the

variation of aid codes. She reviewed the timeline for beneficiary outreach, choice packets, and notices to achieve implementation by January 2023.

Questions and Comments

Murray: It is important to acknowledge the breath and scope of the changes to Medi-Cal and how it is happening all at once. We are in discussions about how telehealth services can be sustained beyond the PHE and permanently reimbursed. There is also the HHS data exchange workgroup. Can you address the relationship between that data framework and Medi-Cal? Also, can you clarify if the incentives are for MCPs alone, or can be shared with providers?

Harrington: The funding provided to MCPs is to achieve specific metrics. We don't believe that the MCPs will be able to achieve those metrics without working collaboratively with their partners, and we expect that they would share incentive funds with provider partners.

Altman: Can you explain from the PATH slide what is meant by registration-based technical assistance (TA)?

Harrington: DHCS will hire a vendor to provide TA. Providers can reach out to request training or TA on specific topics in what we call a TA Marketplace.

Philip: Yes, DHCS will hire an administrator to vet TA vendors and offer a pre-approved list of TA providers to meet the requests by counties, providers, and CBOs.

Nguy: I'm unclear on the $1.8 billion for PATH. Does this include the $1.3 billion that Jacey described in the HCBS Spending Plan? On PATH that focuses on justice-involved populations, it didn't look like it had a focus on people experiencing homelessness as described in the HCBS Spending Plan. Is that separate? Is there an expectation that 85 percent of PATH funding will go to providers?

Harrington: Under the 1115 waiver, we are asking for expenditure authority to operate the PATH program. We have included about $50 million from the HCBS Spending Plan to go toward activity. The housing and homelessness incentive program is different than the funding for PATH. That is to support the implementation of ECM and Community Supports. PATH funding does not go to MCPs. It goes directly to CBOs and community partners. There is no specific designation for the amount of other incentive funds to go to partners.

Cooper: PATH is $1.8 billion total through the budget. Last year, $100 million was dedicated to justice from the state General Fund (GF) for the non-federal share of PATH. We have $50 million GF dedicated for the homelessness PATH in the HCBS Spending Plan to total $150 million GF. We also have in the waiver proposal a request to use Designated State Health Programs (DSHP) for the other non-federal share of PATH. Harrington described the overall PATH requests from various focus areas, including justice. One part of ECM and Community Supports is the homelessness element in HCBS.

Wright: On ECM and Community Supports, what happens for the people who were in WPC who are not in managed care now, whether they be uninsured, undocumented, or

otherwise? Will it be left to the counties? How will patients know that they are eligible for Community Supports?

Philip: MCPs will ensure that there is an assessment of individuals to identify their needs and match them with services. That is a clear expectation in the contract. There will be notices to beneficiaries as well.

Cooper: It will also be included in the Beneficiary Handbook, and we require MCPs to post their plans on their website. FFS beneficiaries, such as you mention, are not eligible.

Lewis: A lot is happening in two months for beneficiaries: ECM and Community Supports, transition involving the WPC pilots and Health Home program, Medi-Cal Rx carve-outs, and people moving into managed care. I am worried about how many notices people will get. There are four different notices just for WPC. I understand we need to give people the right information. How will we ensure there is availability to answer questions? Relatedly, many elements of what will happen are unclear. Who will have the answers?

Cooper: Yes, there are a lot of changes, and the hard part is that different changes impact different people. That makes it a challenge to consolidate too much of the information into one notice. The team has consolidated where possible, but there are significant differences in the populations. I take your point that the different transition notices will hit together, especially for people who potentially receive multiple notices. We will think comprehensively about the call lines, the ombudsman, and others to make sure they remain informed of all of the changes and are ready to respond to beneficiary questions.

Comprehensive Quality Strategy and Equity Roadmap
Palav Babaria, MD, DHCS
https://www.dhcs.ca.gov/services/Documents/102121-SAC-presentation.pdf

Babaria provided a high-level preview of the forthcoming Comprehensive Quality Strategy that will be posted for stakeholder input in November for a 30-day period, then revised for CMS submission in January. Babaria reviewed the goals and guiding principles of the strategy. The principles are to eliminate health disparities through an anti-racism and community-based partnership framework using data to drive improvements that address the whole person and all segments of their care, and then doubling down on transparency, accountability, and member involvement.

There are three clinical areas of specific priority because these require attention and innovation: maternity outcomes and birth equity, children's preventive care, and behavioral health integration. She outlined a Quality/Equity Framework and provided specifics for the three elements of the health equity vision. She noted that there is a need to continue to innovate in these areas across all DHCS programs.

Babaria listed the draft proposed equity metrics for 2022 to be stratified by race and ethnicity on the DHCS managed care accountability set.

She said this is the basic roadmap that will lead to a formal co-design working group with

broad representation of stakeholders to create the full roadmap for the future. Going forward, DHCS expects to tie payments to quality and equity outcomes. There are incentive programs and directed payment programs that are ongoing or launching in CalAIM. Going forward, quality and health equity outcomes will be used to adjust managed care rates and auto-assignment methodology. DHCS' re-organization efforts of the quality program will also support quality assurance and accountability. In addition to posting the strategy for stakeholder comment, Babaria said she plans to lead focus groups to directly solicit feedback through existing meetings or other member groups.

Questions and Comments

Patterson: FQHCs are challenged by the aggressive nature of this proposal, but we are fully supportive.

Cabrera: This is exciting, especially the focus on disparities reduction and equity through the purchasing power of Medi-Cal. I will flag that follow-up after emergency department visits is complicated because the source data is unreliable, and it challenges our ability to understand it. We have heard that some hospitals don't bill MCPs for emergency department visits that are BH-related, and we're not sure why. I understood that this measure would cut across both MCPs and BH plans and in that vein, there is a need to understand that not everyone who visits the emergency department and has a BH need is seriously mentally ill and would meet our eligibility criteria. So, there is a lot to unpack with a deeper dive conversation. I have a comment on the school-based work mentioned much earlier. We surveyed our members and found that 85 percent of counties are doing school-based BH services today. We are using Mental Health Services Act funds to supplement and offset supporting children who otherwise could be covered through commercial insurance or through MCPs. We are happy to see DHCS is focused on MCPs providing services on school campuses and would ask that this is explicit about partnerships with county BH so that we can use our county funding in smarter ways for school wellness or to go deeper on specialty services.

Sanchez: I want to echo the comments on school-based county BH services. When we look at equitable health care delivery, we should make sure that those delivering care are more reflective of the communities they serve. Also, it is important to make sure the jobs are high-road jobs, so we are not increasing the disparity we see in wages. Nationally, Latinas make 57 cents on the dollar of what men make. In California, we make 42 cents on the dollar. It is imperative to think about workforce development as we think about equity.

Lewis: I appreciate the bold goals and 2025 seems far away. Accurate data is so critical to knowing what is going on, and sometimes accurate data isn't available. How do we get to that? How does the effort to collect data on social determinants of health through recent guidance to MCPs around Z-codes and data collection fit into this?

Babaria: Yes, the social drivers of health have to fit into our equity framework, and both the data collection and stratification need to tie into strategies for how to address disparities. It may be we need different tactics to measure at the population level and use aggregate data versus what information is needed at the individual level.

Philip: On Z-codes, there is an APL (APL 21-009) out to MCPs with direction to collect and report this data.

Sangwan-Savage: This is transformative, especially the focus on member engagement in developing strategies, and member engagement and experience in terms of accountability. I appreciate you flagging culturally and linguistically responsive care that we can measure and hold plans and providers accountable. We are happy to work on the focus group.

Wright: Can you say more about keeping plans on track to achieve the goals in 2025? What are the tools or signposts before 2025? Can you expand on a previous question about how this complements DMHC and Covered California and how we can engage?

Babaria: I'm a huge believer that collaborative quality improvement is the process for achieving these goals. It has to start with the data – timelier, actionable data – and being transparent and accountable with that data. We need to be on the same page about what is happening and how are we getting better month after month to track to the 2025 goals. The other piece is that there are problems, barriers, and initiatives that need to be addressed at every level with DHCS, MCPs, providers, and beneficiaries, and community engagement needs to happen. We will look at other states and performance improvement projects that bring all those stakeholders together. On alignment of the DMHC piece, DHCS is working closely with CalPERS and Covered California to align around metrics as much as possible given different requirements at the federal level. For example, Covered California has to use a different measure set than Medicaid. We anticipate building upon the work with DMHC and meeting with DMHC regularly.

Golden Testa: I can't overstate how excited we are by the level of commitment DHCS is putting into the Quality Strategy. There were many mentions of patient and stakeholder involvement. Do you mean that at the MCP level, not just family voices at the table, but also community partnership and community engagement? On the minimum standard of the 50 percent for all children's services, this goal is meeting basic compliance. Are there some consequences of not meeting that, versus other goals, which are more aspirational? My last question is whether the scope of the Quality Strategy is only on the delivery of care, or whether it might also include Medi-Cal enrollment and renewal?

Babaria: There are elements of benefits and eligibility woven into the Quality Strategy. The general answer is anything tied to quality and equity is within the scope for us to consider. On the 50 percent goal, we are pushing innovation and continuous improvement and don't want to leave anyone behind. For that goal, we want a standard that is being enforced consistently across the state and across all plans to ensure a basic level of service and clinical quality outcome. Finally, to your point on member involvement, we definitely see this at all levels to include community members.

Gibbons: I appreciate the alignment with public health and would like that to be even stronger so that public health is brought to the table to influence the strategies and metrics. For example, as we work to close the gap by 50 percent, it really matters what the comparison is and whether it is only within Medi-Cal. Looking only at Medi-Cal hides some inequities across Californians as a whole. I also want to put in a plug for a table that brings other government agencies together in addition to health and public health.

Baass: We are recognizing that as we make efforts to reduce inequities. We are addressing long standing, deep rooted, and systemic inequity. We can all make headway in our own spaces, and if we could have a broader governmental table, that would help move things along even more.

Public Comment
Shelley Chilton, Access TLC: I have a question about how the ECM program will work with the Home and Community-Based Alternatives (HCBA) waiver program. These programs do many of the ECM services already. Are you asking the MCPs to work with the waiver agencies that are in the communities already?

Cooper: DHCS has paid for care coordination in an enhanced way through the HCBA waiver. Someone who's enrolled in the HCBA waiver is not eligible for ECM.

Mike Odeh, Children Now: We are on board with the direction of the Quality Strategy and really appreciate Dr. Babaria's presentation. We look forward to continuing conversations with DHCS about revisiting the premium requirements that more than 700,000 kids and pregnant women are subject to. We think it may undermine some of these quality goals, so we look forward to discussing.

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

Thank you for the discussion today. We appreciate everyone's partnership, dialogue, and feedback as we work to improve the many initiatives we discussed. The February meeting will be virtual, and we will decide later about how the following meetings will be held, whether virtual, hybrid, or in person. I want to thank you all for being here today and for the warm welcome to my tenure.

- February 17, 2022 – 9:30 a.m. – 12:30 p.m.
- May 12, 2022 – 1:30 p.m. – 4:30 p.m.
- July 21, 2022 – 9:30 a.m. – 12:30 p.m.
- October 27, 2022 – 1:30 p.m. – 4:30 p.m.