Medi-Cal Managed Care Advisory Group Meeting

March 9, 2023 – (Webex Only)
Webex Event Number (Access Code): 2598 502 8362
Event Password: MCAG*

Join by Phone: +1-415-655-0001 US Toll
Access Code: 2598 502 8362

DHCS

March 2023

Agenda

- Welcome and Introductions
- Continuity of Care
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- The Managed Care Accountability Sets (MCAS)
- Providing Access and Transforming Health (PATH) Updates
- Incentive Payment Program (IPP)
- Network Adequacy
- Housing and Homeless Incentive Program (HHIP)
- Open Discussion

Welcome and Introductions

Continuous Coverage Unwinding

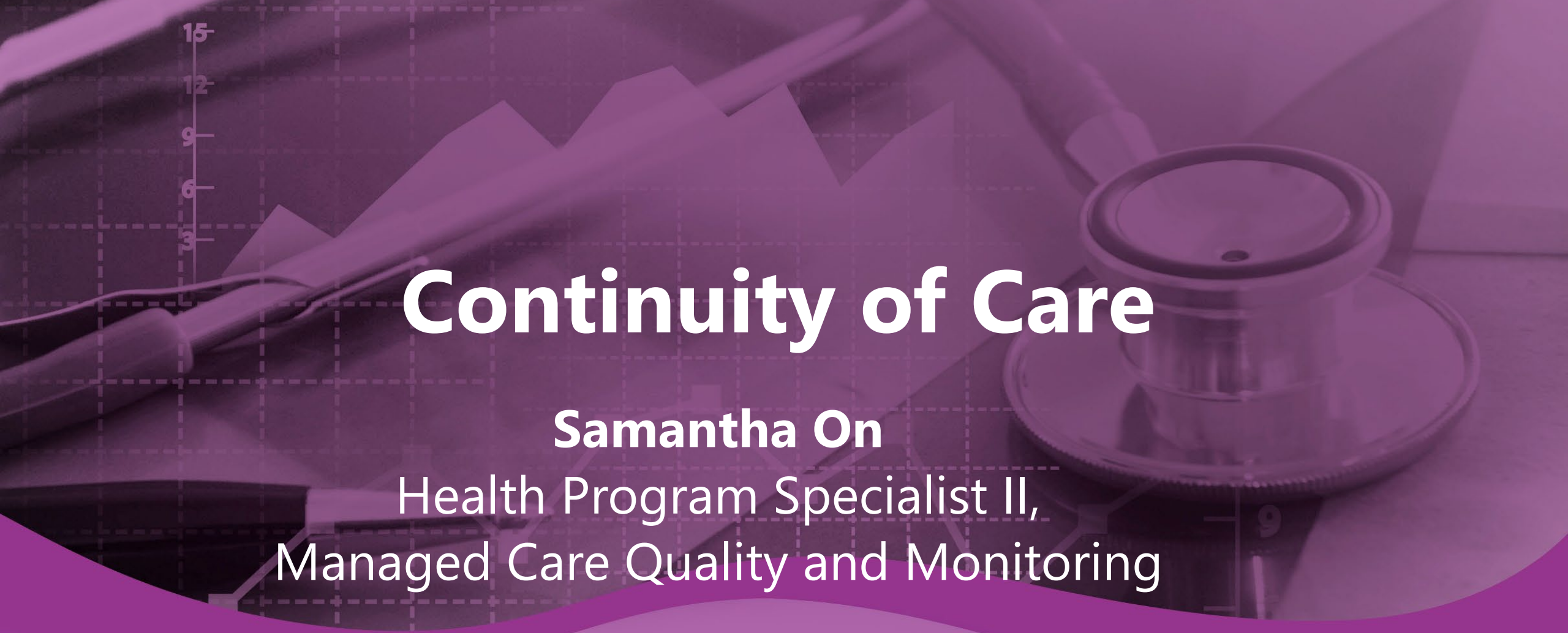
- **The continuous coverage requirement will end on March 31, 2023, and Medi-Cal members may lose their coverage.**
- **Medi-Cal redeterminations will begin on April 1, 2023, for individuals with a June 2023 renewal month.**
- **Top Goal of DHCS:** Minimize member burden and promote continuity of coverage.
- **How you can help:**
  - Become a **DHCS Coverage Ambassador**
  - Join the DHCS Coverage Ambassador mailing list to receive updated toolkits as they become available
  - Check out the Medi-Cal COVID-19 PHE and Continuous Coverage Unwinding Plan (Updated January 13, 2023)

Continuous Coverage Unwinding Communications Strategy

- On February 8, 2023, DHCS launched the Medi-Cal renewal campaign, a broad and targeted public information, education, and outreach campaign to raise awareness among Medi-Cal members about the return of Medi-Cal redeterminations when the continuous coverage requirement ends on March 31, 2023. The campaign will complement the efforts of the DHCS Coverage Ambassadors that was launched in April 2022.

- **Download** the Phase 2 Toolkit that focuses on Medi-Cal renewals and **customize for your use.**

- **Direct Medi-Cal members to the newly launched** KeepMediCalCoverage.org, which includes resources for members to update their information and find their local county offices. It will also allow them to sign up to receive email or text updates from DHCS.



Continuity of Care

Samantha On
Health Program Specialist II,
Managed Care Quality and Monitoring

DHCS

What Problem are We Trying to Solve?

- **PROBLEM:** The 2024 transition could lead to disruptions in care
  - Knox-Keene continuity of care (CoC) policy applies to all MCP transitions; however, there are additional vulnerable populations that will need enhanced protections for the 2024 transition.
  - Despite DHCS and managed care plan (MCP) outreach, some members will not be aware they will transition to a new MCP on January 1, 2024.
    - Members will miss notifications in the mail.
    - Improving member contact information and outreach cannot guarantee full member awareness.
  - Some members will be in medically vulnerable situations and cannot safely change providers on January 1, 2024, if their provider is out of network with the-members receiving MCP.
  - The scale of the 2024 MCP transition, coupled with the public health emergency (PHE) unwinding, magnifies anticipated challenges during a plan transition.
    - An estimated 1.2 million members will change to a new MCP on January 1, 2024.
- **SOLUTION:**
  - Build on existing policies and release a robust CoC policy that addresses the problem. - **FOCUS OF THIS DECK**
  - Develop and implement a robust plan for communicating with members, advocates, and providers to minimize confusion leading up to and when the transition occurs.
  - Develop and implement a continuous monitoring and oversight plan to track success and mitigate early issues.

CoC Policy Design Principles

In considering the CoC approach for 2024, DHCS aims to **minimize**:

- Service interruptions for all members of MCPs exiting the market, especially for vulnerable groups most at risk for harm from disruptions in care (i.e., special populations)
- Member, provider, and MCP confusion
- Administrative burden while ensuring operational feasibility for DHCS and MCPs

The proposed 2024 CoC policy for members transitioning MCPs due to market exit largely aligns with current CoC policy,* with some additional protections.

*APL 22-032

CoC Policy Levers

DHCS is clarifying its CoC policy for the 2024 MCP transition so that all members of MCPs exiting the market are eligible for CoC protections using the following policy levers.

- CoC for Providers – The member can keep their provider even if the provider is out of network in the receiving MCP
- CoC for Medi-Cal Covered Services – The member can continue an active course of treatment, and the receiving MCP will honor prior authorizations from the member's previous MCP
- CoC Coordination/Management Information – Exiting MCP and receiving MCP work together to transfer additional, non-claims information (e.g., care plans)

These levers are currently deployed in policies through the Knox-Keene Act,* 2023 APLs on CoC and SNFs, and policy guides for Enhanced Care Management (ECM) and Community Supports.

*Knox Keene CoC policy provides protection for some members who will transition to new MCPs in 2024: members with an acute condition, serious chronic condition, pregnancy and postpartum, care of child between birth and 36 months, terminal illness, and authorized surgery or procedures documented as part of treatment plan to occur within 180 days.
For purposes of the 2024 CoC Policy discussion, the reference to Knox Keene is synonymous with Health and Safety Code 1373.96.

Special Populations – *Proposed*

All members of exiting MCPs have CoC protections, but some members – *Special Populations* – need extra support to minimize the risk of harm.

- DHCS will identify "Special Populations" who are:*
  - Least able to access or request CoC protections
  - Most at risk for harm
  - Identifiable using DHCS and MCP data
    - Examples include: Members enrolled in ECM, Community Supports, or Complex Care Management; members in hospice care; members residing in long-term care facilities; members in active treatment for HIV/AIDS, TB, hepatitis A/B/C; and others
- MCPs will be required to take proactive steps to implement CoC for members of Special Populations through MCP outreach to members' providers and data transfer between MCPs
- DHCS will monitor CoC for Special Populations as part of the monitoring that will happen for all members experiencing a transition

CoC for Providers - *Proposed*

All members of exiting MCPs will be eligible to keep their out-of-network (OON) providers for 12 months when transitioning to the receiving MCP. Additional enhanced protections will apply to Special Populations.

- Proposed CoC policy for providers for all members of exiting MCPs, including Special Populations
  - Members of exiting MCPs may continue seeing their OON Medi-Cal providers[1] for 12 months[2] following the member's transition if certain requirements are met:
    - Member and provider have a pre-existing relationship that can be validated
    - Provider is willing to accept the new MCP's contract rates or Medi-Cal fee-for-service (FFS) rates
    - Provider meets professional standards, and there are no quality-of-care issues
    - Provider is California State Plan approved
- Enhanced Protection for Special Populations
  - MCPs contact providers treating Special Populations to initiate the process for entering a CoC agreement.
  - Extended CoC period for certain populations[3]

[1]Eligible provider types include primary care, specialists, select ancillary providers (physical therapy, occupational therapy, speech therapy, behavioral health treatment, and respiratory therapy providers), ***[proposed]*** ECM and Community Supports providers. Excluded provider types include transportation providers and all other ancillary providers, including radiology and laboratory providers.
[2]With some exceptions to this timeframe per Knox-Keene.
[3]In alignment with Knox-Keene.

CoC for Medi-Cal Covered Services - *Proposed*

The proposed policy for continuing active courses of treatment outside of Knox-Keene is new, as is the expectation for MCP outreach to providers treating Special Populations. The proposed policy for continuing authorizations is not new.

- Proposed CoC policy for services for <u>all members</u> of exiting MCPs, including Special Populations
  - Members keep their existing authorizations for Medi-Cal covered services for 90 days following the member's transition to the receiving MCP from an exiting MCP
  - Members can continue their active course of treatment without authorization for 90 days. Any active course of treatment is expected to be documented in member's medical records prior to January 1, 2024
    - Active course of treatment defined as a course of treatment in which a patient is actively seeing a provider and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition*
- Enhanced protection for Special Populations
  - Following the transition, members keep their existing authorizations for 90 days
  - MCPs must contact providers treating Special Populations during the first 90 days post-transition to identify active courses of treatment and authorized services that need authorization in order to continue beyond 90 days

---

* CMS proposed Medicare CoC ruling released for public comment on 12/28/22, with a proposed effective date of 7/1/2023 (https://public-inspection.federalregister.gov/2022-26956.pdf)).

CoC Coordination and Management Information – *Proposed*

Under the proposed policy, care coordination and care management information would travel with members to the receiving MCP. This is not a current expectation under the 2023 CoC policy.

- This proposed policy applies only to Special Populations.
- Proposed CoC policy:
  - Exiting MCP provides contact information for plan-level contact and care managers to receiving MCP
  - If a member changes care managers, the receiving MCP contacts the member's exiting MCP and/or care manager to obtain non-claims information, including, but not limited to:
    - Results of member assessments, member care plans, and ad hoc communication and coordination between incoming and outgoing care managers
  - Information transfer must be complete within 90 days of the member's transition (March 31, 2024)

Summary: Special Populations Will Have Enhanced CoC Protections

All members of exiting MCPs are eligible for CoC protections, but MCPs will focus resources on proactively initiating CoC protections for Special Populations to minimize the risk of harm.

CoC Policy Levers by Population

CoC Policy Lever*	All Members of Exiting MCPs	Special Populations • Least able to access existing CoC policies • Most at risk of harm when their MCP exits, and they transition to the receiving MCP
CoC for Provider	(Initiated by Request)	(MCP Initiated)
CoC for Services (including authorizations)**	✓ (Initiated by Data Transfer, Claim, or ✓ Request)	✓+ (MCP Initiated) ✓+
CoC Coordination and Management Information		(MCP Initiated) ✓+

*All CoC policies are consistent with the Knox-Keene Act.

** Members maintain their eligibility and keep their authorizations for ECM and Community Supports

CoC Policy for ECM- *Proposed*

Current ECM CoC policies apply to the 2024 MCP transition, which include the requirement that members receiving ECM undergo a direct transfer to the receiving MCP with no reauthorization process.* The proposed 2024 policy also requires MCPs to take additional actions to further minimize disruption in members' ECM services.

- **ECM Network Overlap**
  - MCPs are strongly encouraged to achieve
    - 100% network overlap among ECM providers with exiting MCPs
- **CoC for ECM Authorization**
  - The receiving MCP must automatically authorize ECM for a transitioning member who received ECM during the 90 days prior to transitioning coverage, and who did not meet graduation criteria or chose to discontinue ECM.
- **CoC for ECM Providers**
  - If a member's previous ECM provider is in the receiving MCP's network, the receiving MCP must assign the member to the same ECM provider, unless the member desires to change their ECM provider.
  - If a member's previous ECM provider is out of network with the receiving MCP, the receiving MCP must contact the provider to negotiate a case agreement
  - MCPs must contact the member's exiting MCP and/or care manager to obtain information to mitigate gaps in care.

*See Appendix for current ECM CoC policies.

CoC Policy for Community Supports – *Proposed*

Current Community Supports CoC policies apply to the 2024 transition.* The proposed 2024 policy requires MCPs to take additional actions to further minimize disruption in members' Community Supports.

- **Community Supports Overlap**
  - MCPs are strongly encouraged to achieve
    - 100% overlap of Community Supports with exiting MCPs
    - 100% network overlap among Community Supports providers with exiting MCPs
- **CoC for Community Supports Authorization**
  - The receiving MCP must automatically authorize Community Supports for transitioning members who were receiving a Community Support through the exiting MCP where the receiving MCP offers the same Community Supports. The receiving MCP may adapt the specifications (e.g., amount and duration) of a transitioning member's Community Support to be consistent with the parameters of the Community Support offered by the receiving MCP
- **CoC for Community Supports Providers**
  - CoC applies only when Community Supports overlap between receiving and exiting MCPs
    - If a member's previous Community Supports provider is in the receiving MCP's network, the receiving MCP must assign the member to the same Community Supports provider, unless the member desires to change their Community Supports provider
    - If a member's previous Community Supports provider is out of network with the receiving MCP, the receiving MCP must contact the provider to negotiate a case agreement
- **DHCS will monitor CoC for ECM and Community Supports throughout the transition**

*See Appendix for current Community Supports CoC policies.

Next Steps

DHCS is engaging stakeholders in February and March for feedback on CoC policies.

- Conduct stakeholder engagement on CoC policies
  - Written feedback can be emailed to Samantha.On@dhcs.ca.gov by March 17, 2023
- Release draft policy for stakeholder feedback
- Refine and finalize policy
- Work on data transfer specifications
- Develop outreach and communications plan
- Develop monitoring plan

APPENDIX

Knox-Keene CoC Policy

Knox-Keene protections (HSC § 1373.96) apply to plan-to-plan transitions due to market exit, but ***only*** if the member "raises their hand" and the MCP reaches an agreement with the provider

- **Keep your provider:** An enrollee receiving covered services from a nonparticipating provider when starting coverage with a MCP may complete services from their provider if all the following requirements are met:
  - **If you have one of six conditions:** acute condition* (for the duration), serious chronic condition (up to 12 months), pregnancy and postpartum (up to 21 months),* care of child between birth and 36 months (up to 12 months), terminal illness (for the duration),* and authorized surgery or procedures documented as part of treatment plan to occur within 180 days
  - **If you raise your hand**: The member must request to complete services from their provider by contacting the receiving MCP
  - **If you have a pre-existing relationship:** The member must be receiving covered services for one of the six conditions from the provider at the time of the change in coverage or provider contractual termination
  - **If the MCP and provider agree to terms:** The provider and MCP must agree on a rate, contractual terms, and conditions (similar to currently contracting providers who are not capitated in the same area), and the provider is not terminated for medical disciplinary, fraud, or other criminal activity
  - **If you did not voluntarily choose to change health plans**: This protection does not apply to a newly covered enrollee who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans

*Members with this condition are eligible for extending the CoC period longer than 12 months after transitioning.

Current ECM CoC Policy

The current ECM policy guide requires continuity of ECM authorizations and assignment to a member's pre-existing ECM provider if there is network overlap. Receiving MCPs are expected to follow the CoC policy in the ECM policy guide, summarized below.*

- The receiving MCP must automatically authorize ECM for a newly enrolled member who received ECM during the 90 days prior to transitioning coverage, and the member did not meet graduation criteria or choose to discontinue ECM
- The receiving MCP must assign the member to an ECM provider for outreach and continuation of ECM
  - If a member's previous ECM provider is in network with the new MCP, the receiving MCP must assign the member to the same ECM provider, unless the member desires to change their ECM provider
  - However, if networks do not overlap, MCPs are not required to establish continuity of provider agreements with out-of-network ECM providers. Members may therefore experience a change of ECM provider
  - If a member's ECM provider will be changing:
    - The receiving MCP must work with previous MCP and ECM provider and/or member to obtain access to the member's Care Management Plan and transmit to the receiving ECM provider
- MCPs are encouraged to bring in network receiving members' out-of-network ECM providers

*CalAIM Policy Guide

Current Community Supports CoC Policy

If a member's receiving MCP offers the same Community Support as the member's previous MCP, receiving MCP is required to honor the authorized Community Support for that member*

- **Where the receiving MCP offers the same Community Support as the previous MCP, the receiving MCP must:**
  - Automatically authorize newly enrolled MCP members who were receiving a Community Support through their previous MCP. The new MCP may adapt the specifications (e.g., amount and duration) of a new member's Community Support to be consistent with the parameters of the new MCP's offered Community Supports
    - Applies only to Community Supports that do not include "once-in-a-lifetime" restrictions
  - Have a process of engaging the previous MCP, member, and/or Community Supports provider to mitigate gaps in care
  - Have a process of reviewing historical utilization data using a 90-day look-back period to identify members receiving Community Supports
- If a member's previous Community Support provider is in network with the new MCP, the new MCP must assign the member to the same Community Support provider, unless the member desires to change their Community Support provider.
- MCPs are encouraged to bring new members' out-of-network Community Supports providers into their network

*DHCS, "Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide," DHCS-Community-Supports-Policy-Guide.pdf (ca.gov)

Current Member Protections: CoC Durable Medical Equipment (DME)*

- Members may keep their brands, items, and supplies of DME from non-preferred providers for a minimum of 90 days following a-FFS to Medi-Cal managed care transition and until the new MCP reassesses
  - After 90 days, the new MCP may require the member to switch to a preferred DME provider

*All Plan Letter 22-032

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Pamela Riley, MD, MPH
Chief Health Equity Officer, Assistant Deputy Director,
Quality & Population Health Management

DHCS

What is EPSDT?

- Federal law enacted in 1967 established the **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** requirement, which requires that comprehensive age-appropriate health care services be provided to all Medi-Cal enrolled children and youth up to age 21
- Requires preventive screening, diagnostic services, and treatment services
- Screenings, coverage requirements, and definition of medical necessity for children enrolled in Medi-Cal are more robust than they are for adult care

Goal of EPSDT

Ensure that children get the

Right Care

at the

Right Time

in the

Right Place

Medi-Cal's Strategy to Support Health & Opportunity for Children & Families

- **Key Initiative:** Outreach and education toolkit on the intent and scope of the EPSDT requirement to enhance understanding and access to care

- **Initiative Elements Discussed in Strategy:**
  - Core audiences of families, providers, and MCPs
  - Toolkit that describes how EPSDT works and what it covers
  - Coordination of toolkit with a range of child-serving stakeholders (e.g., key state agencies, local governmental entities, community-based advocates) to deliver targeted messaging related to services available under EPSDT

In 2019, DHCS started to develop member-facing materials focused on children's preventive services in response to a 2019 California State Audit on children's preventive services; work was paused due to COVID-19. This toolkit builds on this prior work and the follow-up 2022 California State Audit

See Medi-Cal's Strategy to Support Health & Opportunity for Children & Families.

Toolkit Goals

- **Improve member understanding** of how Medi-Cal for children and youth works, what it covers, its role in preventive care screening, diagnosis, and treatment, and medical necessity requirements

- **Increase coordination with a range of child-serving stakeholders**, including Medi-Cal MCPs, providers, key state agencies, local governmental entities, and community-based advocates to help disseminate toolkit materials

- **Develop a standardized EPSDT provider training** for Medi-Cal MCPs to use with their network providers

Toolkit Components

Member Brochures (child and teen versions)

Your Medi-Cal Rights Letter

Provider Training

Toolkit Consumer Testing Process

From October to November 2022, DHCS conducted consumer testing on the brochures and Medi-Cal for Kids & Teens: Your Medi-Cal Rights letter with parents, caregivers, teens, and young adults enrolled in Medi-Cal who live across the state and speak English and/or Spanish.

Purpose of Consumer Testing

- Gauge participant understanding of EPSDT services available to children and youth up to age 21 enrolled in Medi-Cal
- Understand any comprehension issues with the member-facing materials and the actions participants would take after reviewing materials
- Identify language barriers, image concerns, or other issues throughout materials

Testing Methodology

1:1 Observation & Feedback	Remote Group Discussion	Post-Session Survey
17 English sessions 5 Spanish sessions	8 English sessions 3 Spanish sessions	50 surveys completed

Medi-Cal for Kids & Teens: Brochures

Included in the brochures

- Overview of covered services, how to access care, and additional resources available, including free transportation to and from an appointment
- Information about the services provided at check-ups for children and teens/young adults
- Key contact information, such as the Medi-Cal Member Help Line, 988, and specialty mental health resources
- In the **child-focused brochure:** Condensed Periodicity Schedule for well-child visits
- In the **teen/young adult-focused brochure:** Overview of sexual health care and behavioral health care services

Visit the DHCS Medi-Cal for Kids & Teens Webpage for full copies of the child and teen brochures

Brochures will be translated into DHCS' threshold languages and be available in spring 2023

Medi-Cal for Kids & Teens: Your Medi-Cal Rights Letter

Included in the Letter

- Overview of coverage requirements and "medically necessary" services
- Overview of the appeals, State Fair Hearing, and/or grievance processes for managed care and FFS
- Information on what a family can do if Medi-Cal care is denied, delayed, reduced, or stopped, including who to contact, how to file an appeal, how to ask for a State Fair Hearing, and/or how to contact the ombudsman
- Information on how to file a grievance across Medi-Cal managed care and FFS
- Key contact information for Medi-Cal delivery systems to help members find the right delivery system to contact about a concern

Visit the DHCS Medi-Cal for Kids & Teens Webpage for full copies of the letter

The letter will be translated into DHCS' threshold languages and be available in spring 2023

Medi-Cal for Kids & Teens Provider Training

Included in the Provider Training

- Starting in January 2024, Medi-Cal MCPs must conduct Medi-Cal for Kids & Teens training for their network providers to ensure they are able to best support families in fully using Medi-Cal for Kids & Teens services
- Overview of the Medi-Cal for Kids & Teens' comprehensive set of services under federal and state law, including screening, diagnostic, and treatment services
- Explanation of the medical necessity definition for children and youth in Medi-Cal
- Information about how providers can support patient access to Medi-Cal for Kids & Teens services.
- Billing codes for required services
- Overview of mental health and substance use disorder services, California Children's Services, and skilled nursing services

The Medi-Cal for Kids & Teens training can be accessed at the **DHCS Medi-Cal for Kids & Teens Webpage** prior to January 2024

Distribution Plan for Toolkit Materials

Child & Teen Brochures and Your Medi-Cal Rights Letter

- The brochures and Your Medi-Cal Rights letter will be mailed in summer 2023 (and annually thereafter) to children and youth up to age 21 enrolled in Medi-Cal
  - Medi-Cal MCPs will be required to mail the member-facing materials annually to households with children and youth up to age 21 and publish on their websites
  - DHCS will mail the member-facing materials annually to FFS households with children and youth up to age 21 and publish on DHCS' website
- DHCS will share the member-facing materials with stakeholders, providers, county offices, local health departments, non-licensed child-serving providers, and Local Educational Agencies (LEAs)/schools for broad distribution

Provider Training

- DHCS will share the provider training with Medi-Cal MCPs and publish on applicable DHCS websites.
- Medi-Cal MCPs will be required to deliver training to network providers at least every two years and publish on their websites

What's Next?

Tasks	2023				
	Feb	Mar	Apr	May	Jun
Publish toolkit in English on the DHCS website					
Share toolkit with stakeholders, state agency partners, MCPs, DHCS listservs, Medi-Cal and Tribal/IHP providers, non-licensed child serving providers, and LEAs/schools					
Present toolkit to stakeholder workgroups and a webinar					
Translate member-facing materials to DHCS' threshold languages, and print and prepare to mail materials					
DHCS and MCPs mail member-facing materials to members					

Medi-Cal Accountability Set (MCAS) for Health Care Delivery Systems

Priya Motz, DO, MPH

Acting Quality & Health Equity Transformation Branch
Chief, Quality and Population Health Management

DHCS

MCAS

- Set of performances measures DHCS selects for annual reporting by Medi-Cal (MCPs)
- Reflects the quality, accessibility, and timeliness of care that MCPs provide to their members

https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx

MCAS High and Minimum Performance Levels

- DHCS establishes high performance levels (HPLs) and minimum performance levels (MPLs) for a select number of MCAS measures
  - HPLs used as performance goals and to recognize MCPs for outstanding performance
  - MCPs are contractually required to perform at or above MPLs.
    - DHCS is authorized to impose sanctions (e.g., financial penalties, auto-assignment withholds) on MCPs that fail to meet the required MPLs on any of the applicable MCAS measures
    - The level and type of sanction depend on the number of deficiencies and the severity of the quality issues identified

Domains	Measures (MY 2023)
Child & Adolescent Preventative Health	• Child and Adolescent Well-Care Visits (WCV)* • Childhood Immunization Status: Combination 10 (CIS-10)* • Developmental Screening in the First Three Years of Life (DEV) • Immunizations for Adolescents: Combination 2 (IMA-2)* • Lead screening in Children (LSC) • Topical Fluoride for Children (TFL-CH) • Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months (W30)* • Well-Child Visits in the First 30 Month of Life - Well-Child Visits for Age 15 Months - 30 Months (W30)*
Reproductive Health	• Chlamydia Screening in Women (CHL) • Prenatal and Postpartum Care: Postpartum Care (PPC-Pst)* • Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)* • Postpartum Depression Screening and Follow Up (PDS-E) • Prenatal Depression Screening and Follow Up (PND-E) • Prenatal Immunization Status (PRS-E)

Domains	Measures (MY 2023)
Behavioral Health	• Follow-Up After Emergency Department (ED) Visit for Mental Illness – 30 days (FUM)* • Follow-Up After ED Visit for Substance Abuse – 30 days (FUA)* • Depression Remission or Response for Adolescents and Adults (DRR-E) • Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)* • Pharmacotherapy for Opioid Use Disorder (POD)*
Chronic Diseases	• Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC-H9)* • Controlling High Blood Pressure (CBP)* • Asthma Medication Ratio (AMR)*
Cancer Prevention	• Breast Cancer Screening (BCS)*—ECDS/Admin • Cervical Cancer Screening (CCS) • Colorectal Cancer Screening (COL)*

Specific Measures

Infant, child, and adolescent well-child visits Childhood and adolescent vaccinations
Prenatal and postpartum visits C-section rates
Prenatal and postpartum depression screening Adolescent depression screening and follow up
Follow up after ED visit for SUD within 30 days Depression screening and follow up for adults Initiation and engagement of alcohol and SUD treatment
Infant, child, and adolescent well-child visits Childhood and adolescent vaccinations Blood lead and developmental screening Chlamydia screening for adolescents

BOLD GOALS: 50x2025

STATE LEVEL

Close racial/ethnic disparities in well-child visits and immunizations by 50%

Close maternity care disparity for Black and Native American persons by 50%

Improve maternal and adolescent depression screening by 50%

Improve follow up for mental health and substance use disorder by 50%

Ensure all health plans exceed the 50th percentile for all children's preventive care measures

Providing Access and Transforming Health (PATH) Updates

Dana Durham

Division Chief, Managed Care Quality and Monitoring

DHCS

What is “Providing Access and Transforming Health” (PATH)?

California has received targeted expenditure authority as part of its section 1115 demonstration renewal for the “Providing Access and Transforming Health” (PATH) program to take the State’s system transformation to the next phase, refocusing its uses to achieve the CalAIM vision. DHCS has currently received authorization for $1.44 billion total computable funding for PATH to maintain, build, and scale the infrastructure and capacity necessary to ensure successful implementation of Enhanced Care Management (ECM) and Community Supports under CalAIM.

PATH is intended to complement and enhance other CalAIM funding efforts and should not serve as a primary source of funding. PATH funding for all initiatives is time-limited and should not be viewed as a sustainable, ongoing source of funding.

Key PATH Program Initiatives

PATH Initiative Name	High-Level Description
Collaborative Planning and Implementation Initiative	Support for collaborative planning and implementation groups to promote readiness for ECM and Community Supports. Application process is ongoing, and funding anticipated to begin in December 2022.
Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative	Grant funding to enable the transition, expansion, and development of capacity and infrastructure to provide ECM and Community Supports. Application process is ongoing, and funding anticipated to be distributed in first quarter 2023.
Technical Assistance Marketplace Initiative	Technical assistance to providers, community-based organizations, county agencies, public hospitals, tribal partners, and others. TA Vendor application process is ongoing and TA recipient application process and funding anticipated to begin in January 2023.
Justice Involved Capacity Building	Funding to support collaborative planning as well as infrastructure and capacity needed to maintain and build pre-release enrollment and suspension processes and implement pre-release services to support implementation of the full suite of statewide CalAIM justice-involved (JI) initiatives in 2023. Application process and funding is ongoing.

Collaborative Planning and Implementation Initiative

Background

- Local collaborative planning groups will work together to identify, discuss, and resolve topical implementation issues and identify how PATH and other CalAIM funding initiatives – including IPP – may be used to address gaps identified in MCP Needs Assessments and Gap Filling Plans while avoiding duplication.
- PATH TPA will work with stakeholders in the region to convene and facilitate county or regional collaborative planning efforts
  - There will generally be a single PATH-funded collaborative planning group in each county/region

Collaborative Planning and Implementation Initiative Funding

- Initiative funding will be used to support a designated PATH collaborative planning facilitator in each county or region
- Individual collaborative planning participants will not receive funding via this initiative
- Entities will not be required to participate in collaborative planning efforts in order to apply for PATH CITED funding.

Collaborative Planning and Implementation Initiative

Critical Activities

- **Collaborative Participant Registration** is currently open, and registrations are being reviewed on a rolling basis. Click here to register!
  - Currently there are 876 participant organizations registered.
- **Collaborative Facilitator Awards** were announced on December 14, 2022. Click here for a **comprehensive list of Collaborative Facilitators and collaborative county/regional assignments**.
- **Collaborative Group Kick-off Timeline**:
  - Collaborative Group Welcome Letters to Participants: Late December/early January 2023.
  - Additional participant recruitment: December 2022-January 2023.
  - Collaborative Participant Kickoff and Pre-Work Webinars: January 2023.
- For **more information** visit https://ca-path.com/collaborative or submit questions directly to collaborative@ca-path.com.
- **Participant Collaborative Website** Launched in January 2023. Participant organizations assigned to each collaborative is public facing.

CITED Initiative

Background

- CITED funding will support the transition, expansion and development of ECM and Community Supports capacity and infrastructure.
- Applicants who wish to receive CITED funding must submit an application with their funding request, describing how they intend to use CITED funding.
- Funding will be made available in multiple application rounds from 2022-2025.

CITED Initiative Funding

- DHCS will review and score applicants based on specified criteria.
- Funding disbursed to applicants based on achievement of milestones.
- Each application window has a target allocation limit. Entities may apply for multiple rounds of funding.

CITED Initiative

Critical Activities

- **Round 1** Grant Application was open from August 1 to September 30, 2022.
  - DHCS received over 200 applications for a total of about $526 million requested funds.
- Due to the large number of funding requests, Round 1 is split into Round 1A, notifications were sent to those applicants on January 31, 2023 and Round 1B, notifications will be sent to those applicants in March 2023.
- **Round 1 will disburse** between $250-$290 million dollars.
- **Round 2 Grant Application** launched on February 28, 2023. To stay informed about upcoming dates, refer to the CITED website.
- Submit questions directly to cited@ca-path.com.

Technical Assistance (TA) Marketplace Initiative

Background

» The TA Marketplace allows funding for the provision of technical assistance (TA) for entities that intend to provide ECM and/or Community Supports. Entities may register for hands-on technical assistance support from vendors and access off-the-shelf TA resources in pre-defined TA domains

» TA resources will be provided through a virtual TA "Marketplace," which will be designed, launched and managed by the PATH TPA

- The TPA will contract with other vendors to provide TA services to eligible entities as part of the marketplace

Examples of TA Marketplace Initiative Resources:

- Hands-on trainings for ECM / Community Supports providers on billing and reporting requirements or contracting with health plans
- Guidance for data sharing processes between ECM/Community Supports providers and health plans
- Accelerated learning sessions or computer-based learning modules for CBOs
- Strategic planning consultations for entities implementing ECM/Community Supports
- Customized project-specific support provided by vendors registered with the TA Marketplace

Technical Assistance (TA) Marketplace Initiative

Background

- **TA Assistance will be initially available in the following Domains in early 2023**
  - Domain 1: Building Data Capacity: Data Collection, Management, Sharing, and Use
  - Domain 2: Community Supports: Strengthening Services that Address the Social Drivers of Health
  - Domain 3: Engaging in CalAIM Through Medi-Cal Managed Care
  - Domain 4: Enhanced Care Management (ECM): Strengthening Care for ECM "Population of Focus"
  - Domain 5: Promoting Health Equity
  - Domain 6: Supporting Cross-Sector Partnerships
  - Domain 7: Workforce
- More information on the PATH TA Marketplace initiative can be found here: https://ca-path.com/ta-marketplace or submit questions directly to ta-marketplace@ca-path.com.

Technical Assistance Marketplace Initiative

Recent Activity

- The **TA Marketplace** browsing experience and recipient registration launched 1/31/2023!
  - 47 vendors have been approved across the 7 domains to deliver "Hands on" TA
  - 70 "Off the Shelf" projects are available on the marketplace
- Approved recipients will be able to submit **Project Eligibility Applications** in late February 2023
- The **second round** of TA Vendor applications is anticipated to go live in March 2023

TA Domain	Approved "Hands On" vendors	Approved "Off the Shelf" Projects
Domain 1: Building Data Capacity: Data Collection, Management, Sharing, and Use	16	29
Domain 2: Community Supports Strengthening Services that Address the Social Drivers of Health	17	14
Domain 3: Engaging in CalAIM through Medi-Cal Managed Care	20	4
Domain 4: Enhanced Care Management (ECM) Strengthening Care for ECM "Populations of Focus"	15	7
Domain 5: Promoting Health Equity	15	1
Domain 6: Supporting Cross-Sector Partnerships	22	1
Domain 7: Workforce	13	14

Justice-Involved Capacity Building Initiative

Critical Activities

- **Round 2 Grant Application** was launched on August 9, 2022. The application relaunched on January 30, 2023, to include modified operational criteria that aligns with recent policy changes as outlined in ACWDL 22-27. Please visit the PATH Justice-Involved website for the link to the application and guidance documents, website located below.
- The **supporting materials** are currently being updated to reflect the modifications to the operational criteria.
- **Rounds 3 and 4** to support implementation of pre-release services is TBD.
- For **more information** visit https://www.ca-path.com/justice-involved or submit questions directly to justice-involved@ca-path.com.

CalAIM Incentive Payment Program (IPP)

Shel Wong

Acting Chief, Community Supports and Optional Programs

DHCS

IPP Overview

IPP Vision, Principles, and Goals

IPP is designed to support continued *expansion* of ECM, Community Supports, and other CalAIM goals by incentivizing the use of sustainable infrastructure and capacity, member engagement, service quality, and equity.

Updated **design principles** and **goals** for IPP guided the development of program measures for Submissions 3-5

IPP Vision

Support the implementation and expansion of ECM, Community Supports, and other CalAIM goals through incentives focused on capacity building, infrastructure, equity, and quality.

Design Principles

Strive for **simplicity** by identifying key priorities and finalizing program design

Identify opportunities for alignment with other DHCS programs and measure sets

Apply an equity lens to program measures and milestones

IPP Vision, Principles, and Goals Continued…

Goals Moving Forward

Engagement and Service Delivery/Utilization

- Meet member engagement targets
- Identify and obtain useable information for DHCS to assess member engagement and service delivery

Sustainable Infrastructure and Capacity

- Advance health information technology capabilities, workforce capacity, and MCP provider networks

Quality

- Promote utilization of services to further the goals and requirements of the Population Health Management Program
- Measure the impact of programs

Equity, Access and Support for PoFs

- Continue to advance equitable access for existing Populations of Focus (PoF)
- Establish new IPP components to support access for new PoFs, including children and youth, justice-involved, and long-term care

Upcoming IPP Submissions

Submissions 3-5: Measure Set Preview

DHCS simplified and streamlined the IPP measure set based on stakeholder feedback and experiences with ECM, Community Supports, and other CalAIM initiatives. Submissions 3, 4, and 5 have **fewer total measures, fewer narrative** measures, revised language to **promote clarity**, and a shift from reporting to **performance**. Select **new measures** correspond to emerging CalAIM priorities, including ECM PoF going live in 2023 and 2024.

- ***Similar to prior reporting periods, measures are organized into four priority areas:***
  1. Delivery System Infrastructure
  2. ECM Provider Capacity Building
  3. Community Supports Provider Capacity Building and MCP Take-Up
  4. Quality and Emerging CalAIM Priorities
- ***Most measures require only a quantitative response rather than a narrative. Scoring for most quantitative measures is based on a gap-filling calculation relative to baseline***
- ***Submissions 3-5 have an updated approach to quality measurement with fewer, more targeted measures***
- ***For Submissions 3-5, all measures are mandatory for the relevant class of MCPs***

Submissions 3-5: New Measures

- MCPs will report on a range of new IPP measures in 2023-2024, including:
  - Provider education, training, and technical assistance on ECM and Community Supports
  - ECM network development to prepare to serve the justice-involved Population of Focus
  - Community Health Worker benefit utilization among MCP members
  - Skilled Nursing Facility care transitions
  - Transition and CoC planning for counties undergoing a MCP contracting transition in January 2024


Q
A

Network Adequacy

Sean Barber

Chief, Network Adequacy and Access

DHCS

Annual Network Certification (ANC)

- ANC is an assessment of the MCP-networks. MCPs are required to submit documentation to DHCS to demonstrate network adequacy and compliance with:
  - *Title 42 of the Code of Federal Regulations (CFR) sections 438.68, 438.206, and 438.207, and Welfare and Institutions Code (WIC) section 14197*

- ANC APL 23-001 and Attachments A, B & C
  - https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

Network Adequacy Standards

- Provider to Member Ratios
  - **Primary Care Physicians (PCP)**: 1 Full Time Equivalent (FTE) PCP per 2,000 Enrollees
  - **Total Physicians**: 1 FTE:1,200 Enrollees

- Mandatory Provider Types:
  - **Federally Qualified Health Centers, Rural Health Clinics, Freestanding Birth Centers, Certified Nurse Midwives, and Licensed Midwives** - MCPs must contract with at least one in each county they operate in where available
  - **Indian Health Care Providers (IHCPs)** - MCPs must offer to contract with all IHCPs in each county they operate in, where available

Network Adequacy Standards (Continued)

- Time or Distance Standards:
  - MCPs are required to meet time or distance standards outlined in Attachment A of APL 23-001
  - **Alternative Access Standards (AAS)**: When a MCP is unable to meet the time or distance standards with the geographic distribution of primary care providers/specialty providers, the plan must submit a request for AAS to DHCS as needed
  - For an AAS request to be considered, a plan must provide a detailed description of all methods the plan has utilized to attempt to contract with additional providers in their service area, including a list of the providers the plan has attempted to contract with and why they were unsuccessful

Assessing Compliance Year Round

Network adequacy reviews are conducted throughout the year. These reviews are conducted to ensure MCPs maintain adequate networks and provide timely access to services.

- Network reviews are triggered by:
  - Provider terminations
  - Medi-Cal expansions
    - MCP expansions of service area(s)
    - Membership expansions

  - Network adequacy reviews consists of:
    - Member impact
    - Impact to available services
    - Time or distance/AAS
    - Capacity/provider to member ratios

ANC - Looking Forward

DHCS is making system improvements to improve the ANC process

- ArcGIS Framework
  - DHCS is working toward operationalizing the use of an ArcGIS framework to measure compliance with time or distance standards

- Population data layer
  - DHCS is collaborating with the Department of Managed Health Care (DMHC) to develop an aligned approach to the ArcGIS population data layer

Subcontractor Network Certification (SNC)

SNC is a component of CMS annual reporting and the CalAIM 1915(b) Waiver Special Terms and Conditions (STCs)

- DHCS is targeting to release APL 23-XXX Delegation and Subcontractor Network Certification in mid-March 2023
  - DHCS will hold a technical assistance call with MCPs in advance of the APL release

- The SNC submission will consists of three parts:
  1. Subcontractor Network Exemptions Request template (Attachment B)
  2. Network Adequacy and Access Assurances Report (Attachment C)
  3. Verification documents

Questions?

Housing and Homelessness Incentive Program (HHIP)

Frances Harville
Chief, Policy and Housing Programs Section

Ashliegh Kemp
Health Program Specialist I, Policy and Housing Programs Section

DHCS

Overview

- Authority: Section 9817 American Rescue Plan Act of 2021
- Budget: $1.288 Billion
- Implementation: January 1, 2022
- Oversight: Managed Care Quality and Monitoring Division/Capitated Rates Development Division
- Duration:
  - Program Year 1 (January 1, 2022 to December 31, 2022)
  - Program Year 2 (January 1, 2023 to December 31, 2023)
- Purpose: Support delivery and coordination of health and housing services for Medi-Cal *Members* by:
  - Rewarding Managed Care Plans (MCP) for developing the necessary capacity and partnerships to connect members to needed housing services; and
  - Incentivizing MCPs to take an active role in reducing and preventing homelessness.

Program Vision, Goals & Strategic Approach

VISION: Improve health outcomes and access to whole person care services by addressing housing insecurity and instability as a social determinant of health for the Medi-Cal population.

GOALS

1. Ensure MCPs have the necessary capacity and partnerships to connect their members to needed housing services
2. Reduce and prevent homelessness

STRATEGIC APPROACH

- **Develop** partnerships between MCPs and social service agencies, counties, public health agencies, and public and community-based housing agencies to address homelessness
- **Provide** rapid rehousing for Medi-Cal families and youth, and interim housing for aging and disabled populations
- **Expand** access to housing services and street medicine programs
- **Improve** access to coordinated housing, health and other social services
- **Reduce** avoidable use of costly health care services
- **Improve** whole person health for Medi-Cal enrollees, including behavioral health treatment and resources
- **Implement** solutions that manage information to better identify populations of focus and Member needs

Incentive Payments

Program Year 1: Local Homelessness Plan (LHP) & Revised LHP	**Program Year 1: Investment Plan**	**Program Year 2: Submission 1**	**Program Year 2: Submission 2**

Year 1 Results

Measurement period: January 1, 2022 – through April 30, 2022

Initial LHP

- LHP Submission Due Date: June 30, 2022
- Focus: Priority Areas
  - Partnerships and capacity to support referrals for services
  - Infrastructure to coordinate and meet Member housing needs
  - Delivery of services and Member engagement

Revised LHP

- Submitted to DHCS on August 12, 2022
- Revised Measures:
  - 1.1 Engagement with CoC
  - 2.1 Street medicine (Optional)
  - 3.3 MCP members successfully engaged in ECM
  - 3.4 MCP members experiencing homelessness receiving housing related community supports
  - 3.5 MCP members who were successfully housed

Investment Plan

- Submitted to DHCS on September 30, 2022
- Common Activity Goals:
  - Housing infrastructure, support, outreach, and placement (reported 116 times)
  - CoC support (reported 102 times)
  - Street medicine infrastructure, capacity, and outreach (reported 101 times)

Program Year 2: Next Steps

Submissions 1 Due: March 10, 2023

Submission 1 Evaluations

Stakeholder Education and Engagement Efforts:

- Technical Assistance Office Hours
- MCP 101 Sessions
- CoC 101 Sessions
- Peer to Peer Learning Sessions

Submission 2 Due: December 2023

Questions

Thank you

Please visit the HHIP Website for more information and access to the HHIP documents and supporting resources: Housing and Homelessness Incentive Program (ca.gov)

Please send questions to DHCSHHIP@dhcs.ca.gov.

Open Discussion

If you have questions or comments, or would like to request future agenda items, please email:

advisorygroup@dhcs.ca.gov.