DEPARTMENT OF HEALTH CARE SERVICES
Stakeholder Advisory Committee (SAC)
April 29, 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; 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; Michelle Gibbons, County Health Executives Association of California; Kristen Golden Testa, The Children's Partnership/100% Campaign; 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; Dharia McGrew, California Dental Association; Farrah McDaid Ting, California State Association of Counties; Erica Murray, California Association of Public Hospitals and Health Systems; Linda Nguy, Western Center on Law and Poverty; Nate Oubre, Kaiser Permanente; Chris Perrone, California HealthCare Foundation; Janice Rocco, California Medical Association; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Cathy Senderling, County Welfare Directors Association; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; 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: Anne Donnelly, San Francisco AIDS Foundation; Jarrod McNaughton, Inland Empire Health Plan; Andie Patterson, California Primary Care Association; Jonathan Sherin, Los Angeles Department of Mental Health; Stephanie Welch, Ex Officio, California Health and Human Services Agency.

DHCS Staff Attending: Will Lightbourne, Jacey Cooper, Palav Babaria, Michelle Retke, Jacob Lam, Lindy Harrington, Norman Williams, Jeffrey Callison, Morgan Clair.

Public Attending: 198 members of the public attended by phone.

Welcome, Introductions, and Today's Agenda
Will Lightbourne, DHCS Director

Director Lightbourne welcomed all members and thanked the new members for joining SAC: Doug Shoemaker, Mercy Housing; Nate Oubre, Kaiser Permanente; Virginia Hedrick, California Consortium of Urban Indian Health; Mark LeBeau, California Rural Indian Health Board; Jarrod McNaughton, Inland Empire Health Plan; Susan DeMarois, Alzheimer's Association; John Cleary, MD, Children's Specialty Coalition; Dharia McGrew, California

Dental Association; and Janice Rocco, California Medical Association. DHCS thanked the California Health Care Foundation for their support of the SAC meetings.

Director's Update

Will Lightbourne and Jacey Cooper, DHCS

Slides: https://www.dhcs.ca.gov/services/Documents/SAC-presentations-042921.pdf

Director Lightbourne informed members that the Governor's May Revision will be out in approximately three weeks. State revenue is better than was projected at this time last year, and the federal American Rescue Plan Act will bring additional resources to state and local governments. President Biden's proposed American Families Plan has implications for both Medi-Cal and Medicare, and DHCS is tracking this because we're launching the Office of Medicare Innovation and Integration.

The Biden Administration has indicated its intent to continue the COVID-19 public health emergency (PHE) in 90-day increments through 2021. In California, COVID-19 infection rates are slowing and vaccination efforts are accelerating, although concerns remain in communities of color and low-income communities. The Governor has indicated that the Blueprint for a Safer Economy, with its tiered guidelines for safely reopening, will expire in mid-June. Over time, DHCS and other government business practices will resume in person. Many DHCS staff will continue to work virtually, and meetings such as SAC will continue virtually through 2021.

DHCS is working with consultants to identify opportunities and develop targets to close disparities and improve equity. The intention is to reference DHCS equity goals in the draft Medi-Cal managed care plan (MCP) procurement Request for Proposal (RFP) in June, and then to improve upon it, based on stakeholder feedback, for inclusion in the final procurement RFP later this year. DHCS has created a position, Chief Quality Officer and Deputy Director of Quality and Population Health Management, and hired Dr. Palav Babaria for this new role. She introduced herself and offered brief highlights of her history and experience working in the safety net, recently with the Alameda Health System.

Michelle Retke from DHCS presented on MCP procurement activities since the last SAC meeting. She reviewed the current Medi-Cal managed care models operating across the state. Counties have the opportunity to transition to a different managed care model for implementation in 2024. A change in the model requires DHCS' review and approval. If a county transitions to a model that includes a local plan, then DHCS may remove that county from the commercial plan procurement (for a single local plan model) or reduce the number of commercial plans procured in the county (for a Two-Plan or Regional Model). Retke then reviewed the process and timeline for counties to propose a change in the local managed care model. DHCS released letter of intent instructions for counties and plans to submit information if changes were being proposed. The original deadline of March 31, 2021, was extended to April 30, 2021 for submission. The proposed changes submitted by the original deadline are listed below and a full listing will be made public through stakeholder announcements and posted online following the final deadline.

<u>Single Counties:</u>

- Alameda County: County Organized Health Systems (COHS) with Alameda Alliance
- Contra Costa County: COHS with Contra Costa Health Plan
- Imperial County: COHS with California Health and Wellness
- COHS with Central California Alliance for Health
    - Mariposa County
    - San Benito County

<u>COHS with Partnership HealthPlan:</u>

- Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, and Tehama counties (These counties submitted the full letter of intent)
- Sutter and Yuba counties

<u>Two-Plan with Health Plan of San Joaquin:</u>

- El Dorado County
- Calaveras County
- Alpine County

Retke reviewed the key activities and deadlines, including the draft RFP procurement release in early June to the final procurement release in late November/early December 2021. The draft RFP is being released to solicit public feedback. For example, as referenced previously related to disparities and equity, DHCS wants feedback from stakeholders and advocates on the draft documents that will include both a sample health plan contract and proposal package. Feedback must be submitted within 30 days following the release in an approved format that will ensure it can be incorporated into the final documents. A public webinar will be scheduled shortly after the draft RFP is released. Retke also reviewed the overall roadmap of the procurement process and commented that final proposals are due 60 days following the release of the final RFP. Retke offered details from a memo to counties and MCPs outlining an optional letter of support from counties. It is not required for review of the proposal, but it is part of scoring. The optional letter must be included with the final RFP to be part of the evaluation and scoring process. A letter is only applicable for counties where DHCS is procuring more than one commercial plan. Therefore, a county letter of support is not applicable for COHS or Two-Plan model counties.

Questions and Comments

Walker: Can you offer information about the criteria DHCS will use in deciding whether to approve a county's application for a COHS?

Retke: The letter of intent package outlines the required components, including financial components, provider network and risk requirements, and other elements.

Cooper: We are looking for financial, quality and outcomes, network adequacy requirements, and whether the network can be in place by 2024. That requires lead time to meet expectations. Readiness can take a year to ensure changes are incorporated. There are a few different model changes proposed, and they have different implications related to choice in the market for the beneficiary. There will be standardized criteria for evaluation

that is consistent across the plans.

Wright: We are supportive of the direction of fewer plans with greater accountability. Are there policy considerations other than meeting the minimum standards, especially for counties where there is a reduction in plans?

Cooper: We will be evaluating the MCP experience to date. DHCS has extensive history with the MCPs and has quality dashboards. There are a number of accountability factors to be considered.

Kristen Golden Testa, The Children's Partnership/100% Campaign: Going back to the Director's update, what is the timing of the examination of equity opportunities? Will a report be made public? Who is the consultant DHCS is working with on this?

Lightbourne: The consultants are from Sellers Dorsey through support from the California Health Care Foundation. DHCS will be briefed soon and will share the findings with stakeholder groups.

Murray: Can a conversion to a COHS model be approved through an 1115 waiver, and if so, will this be included in CalAIM, or does it require federal legislation?

Cooper: We have worked with the Centers for Medicare & Medicaid Services (CMS) on this. This is not technically a COHS; it is a single plan. There are two federal pathways to a single plan. Federal legislation is the easiest guarantee, and DHCS has provided technical assistance to counties on this. The other option is through an 1115 waiver. Other states, such as Arizona and Hawaii, use that for their single plan option, so there is precedent. An 1115 waiver would not be within this CalAIM submission. DHCS would work with CMS, subsequent to finalizing any model changes, and add them to the waiver later.

Nguy: Considering so many potential COHS proposals, we urge DHCS to consider Knox-Keene licensure to ensure consistency and consumer protection. When is the change in MCP model expected to be approved? Is that before the final RFP release in October? Do you expect this will require change in state statute?

Cooper: Yes, October is when people would know based on the filing of the official ordinances. DHCS does not anticipate any state statute. We have let counties know they should work with their county counsel. If they do want anything solidified in state law, they should be working with the Legislature to move forward.

Bradshaw: There have been a couple of evaluations of managed care and implementation. One was a review of COHS and the regional model commissioned by the California Health Care Foundation. In those reports, network adequacy was still a challenge and was not regularly reviewed. Are you considering additional criteria to evaluate network adequacy as you receive proposals?

Cooper: We have been working on network adequacy, most recently to ensure network adequacy at every level of delegation within the process. We look forward to any

comments that you have on the draft RFP related to the new network adequacy requirements.

Witz: Given the two pathways mentioned earlier to gain federal approval for a single plan, will DHCS lead on this? Will each county go forward individually?

Cooper: DHCS will not be lobbying for federal legislative changes. We provide technical assistance if a county wants the security that federal legislation offers. Ventura County did this many years ago. DHCS has committed to an 1115 waiver and has worked with CMS on other authorities, like Program of All-Inclusive Care for the Elderly (PACE).

Lewis: Will there be advance notice of the exact draft procurement RFP release date to give us time to prepare for the 30-day response timeline? Also, there are many moving parts, changing or reducing health plans, the readiness process, CalAIM benefits, notices to consumers, so it is going to be confusing. The sooner we can get information to people, the better, to reduce confusion about what is happening and what to expect. Enhanced Care Management (ECM) may start with one plan and then potentially switch to a different plan a year later. These are things that could be disruptive for people.

Cooper: We are committed to an early June release for the draft RFP. We agree that the timing of CalAIM and procurement creates many challenges. We are committed to full transparency as quickly as possible to help everyone prepare. On ECM, we welcome input. We expect the ECM provider may have multiple health plan contracts and, therefore, the provider may not change, although the plan may change.

Perrone: For Geographic Managed Care counties, do you anticipate any limitations in the number of plan partners? That has been a strategy used in Los Angeles County. It is a way to expand the size of the network, but often creates siloed networks within an existing plan. Is there a perspective on this in the RFP? Would DHCS welcome stakeholder feedback on that issue?

Cooper: One of our guiding principles, announced in the Request for Information that will be in the draft RFP, is to provide better oversight of delegated entities, including having a better understanding of the prime plan's responsibility for oversight and network adequacy. We have added significant language on this in the draft RFP and look forward to any comments.

LeBeau: I am the CEO of the California Rural Indian Health Board and work closely with 58 federally recognized tribes in rural and frontier regions of California. In addition, we partner with most tribal clinics throughout the state. I worked for several years on the CMS Tribal Technical Advisory Group. Some years ago, we put together a comprehensive list of provisions and federal requirements by CMS on the rules provided to tribal clinics for the delivery of care. Some of that work intersects with managed care. I will forward that to DHCS for review to identify the requirements and recommendations that would benefit tribal clinics in California, as they work in partnership with the state and counties and other entities.

Cooper: Thank you, we welcome that.

Altman: To add to comments from Kim Lewis, the procurement is also happening in the middle of long-term care going to health plans and Dual Eligible Special Needs Plan (D-SNP) alignment. There is potential for great confusion in 2022 to 2024.

Cooper: Yes, we have been mapping out the impacts and look forward to conversations on that.

Update on 1115 and 1915(b) Waivers
Jacey Cooper
https://www.dhcs.ca.gov/services/Documents/SAC-presentations-042921.pdf

Cooper updated SAC members on the 1115 demonstration and the 1915(b) waivers. DHCS is seeking two federal waivers to implement the many CalAIM initiatives. Public comment is open until May 6.

Cooper reported that the new 1115 waiver is more limited than past proposals due to budget neutrality. The waiver includes continuation of several programs. There is a proposal for in-reach 30-days prior to release from incarceration for justice-involved populations that will complement other proposals for justice-involved individuals included in CalAIM. DHCS is also re-engaging with CMS on traditional healers and natural helpers within the Drug Medi-Cal Organized Delivery System (DMC-ODS). There's also a proposal to provide access to the Providing Access and Transforming Health (PATH) model.

Cooper reviewed the consolidated 1915(b) waiver. She noted that the 1915(b) waiver process relies on more of a template proposal, and DHCS has created a summary overview. California has had a 1915(b) waiver for specialty mental health services (SMHS) and is now proposing a consolidated waiver with the following elements:

- Medi-Cal Managed Care
- Dental Managed Care
- SMHS
- DMC-ODS

Written comments can be sent to DHCS. In addition, multiple webinar sessions will be held for public comment (April 26, April 30, and May 3). Cooper reviewed the timeline for the initial draft submission (June 2021) to CMS that will incorporate public comment. CMS will first conduct a completeness review, followed by a 30-day federal comment period. DHCS will work directly with CMS to obtain approval by the end of 2021.

Questions and Comments

Murray: I want to voice appreciation for the thoughtful 1115 waiver proposal, including full funding for the Global Payment Program (GPP), five additional years of funding for the Safety Net Care Pool, and an expanded program to address equity issues. There is a new

opportunity on equity as well as PATH payments to stabilize public health systems and transition from Whole Person Care (WPC) to CalAIM.

Nguy: My question is related to the new services for the justice-involved population. Is the 30-day pre-release benefit tied to PATH? How have the conversations with CMS gone to date?

Cooper: There are two separate items. PATH funds for WPC is to ensure they successfully transition to ECM and ILOS to fund community-based organizations and readiness of justice partners, including counties to prepare for the suite of justice services, including the 30-day in-reach. There is a separate line item for the drawing down of federal funds for services provided in that 30-day in reach period. On discussions with CMS, there are some places where California is forging new ground. We meet with CMS on a regular basis and are having preliminary conversations so they will be familiar with our proposal when it is submitted.

Lewis: Thank you for the heavy lift to move ahead both waivers. Some of the substance use disorder related service expansion is moving into the 1915(b) waiver. We have been pushing for a statewide approach that does not require counties to opt in for the enhanced services. The former waiver counties with ODS programs are adding options to provide more services, and I think it will be confusing as to who gets what and where. I will highlight from our comments that many of the counties that have not opted in are rural counties where there is great need. How are we addressing that need by giving counties the option not to participate, especially with the data about increasing deaths from opioid overdoses? Can we push harder to make sure we don't lose people to this condition?

Cooper: There will be only ODS and DMC-ODS. If you are in DMC-ODS, it is comprehensive care, but I understand your comment. We will work with counties to opt in to DMC-ODS. Our goal is to have statewide DMC-ODS so that everyone has access to all of the services available through that option. I look forward to your input.

Update on CalAIM
Jacey Cooper
https://www.dhcs.ca.gov/services/Documents/SAC-presentations-042921.pdf

Cooper reported on CalAIM progress. DHCS completed the public comment period on policy documents related to ECM and ILOS, and reviewed feedback from stakeholders on the overall design. DHCS appreciates the feedback and intends to release final documents at the end of May to ease the challenges with multiple transitions. There are activities underway to support transition from WPC pilots and Health Home Programs (HHP), such as frequent meetings with MCPs and associations as well as webinars and posting FAQ documents on the website.

Cooper reviewed updates on ECM. DHCS is refining the mandatory ECM target population definitions based on public comment, and issuing guidance on how ECM will intersect with other existing programs that offer care coordination. DHCS is also developing guidance for

members transitioning from WPC pilots and the HHP, evaluating policy issues raised by stakeholders, and finalizing the contract requirements and model of care.

She also commented on ILOS. DHCS is incorporating feedback from the CalAIM proposal released in January and finalizing the contract requirements. In addition, DHCS is drafting materials on the role of ILOS in promoting whole person care for Medi-Cal beneficiaries and developing non-binding ILOS pricing guidance to support a seamless contracting experience between MCPs and ILOS providers. Through the spring and summer, DHCS will finalize contractual requirements with MCPs and standard terms and conditions for MCPs to use with ECM and ILOS providers, as well as develop an ECM and an ILOS program guide for MCPs. DHCS is standardizing the groups for mandatory managed care enrollment statewide that will occur in two phases. DHCS is working on a variety of readiness activities; notices will go out to the populations and data are going to MCPs so they will be prepared for the transition.

Phase 1 in January 2022:

- Trafficking and Crime Victims Assistance Program (excluding share of cost)
- Accelerated enrollment individuals
- Child Health and Disability Prevention infant deeming
- Pregnancy-related Medi-Cal (pregnant women only, 138-213 percent citizen/lawfully present)
- American Indians/Alaskan Natives
- Beneficiaries with other health care coverage
- Beneficiaries living in rural zip codes

Similarly for benefit standardization, Cooper reported on activities to finalize policy for the carve-in of organ transplants, followed in 2023 with the carve-in of long-term care. Notices for Multipurpose Senior Services Program (MSSP) will be at 90, 60, and 30 days. For specialty mental health, there will be 60- and 30-day notices. Finally, the provider bulletin, Newsflash, and other standard information will be ongoing.

Questions and Comments

Witz: On benefit standardization, can you clarify if the transplants will be carved out for California Children's Services (CCS) populations in counties that are not Whole Child Model?

Cooper: DHCS is carving in all transplants for everyone in a MCP. If a county is not a Whole Child Model, it will operate the way CCS currently operates. There will be guidance in an All Plan Letter (APL) for non-Whole Child Model counties.

Nguy: Regarding mandatory managed care enrollment, we continue to have concerns about DHCS moving forward without sharing an evaluation of access for the proposed population, specific plan readiness criteria, continuity of care protections, and strengthening disenrollment processes for individuals where managed care does not work. We understand DHCS is working on readiness deliverables, but with the transition beginning as early as January and with limited stakeholder engagement, we are concerned

that beneficiaries will experience disruptions in care. Is there anything that stakeholders can expect beyond the final plan readiness deliverables?

Cooper: As always, we post draft APLs for comments and will post notices for comments as well. The APL is where we typically include readiness criteria, as we have done with other population changes. We have accomplished many transitions, and at this point we have a process in place for moving people into managed care or FFS. We are engaging with MCPs early to share files for network adequacy filings that would take place during this year to ensure adequate access. All continuity of care requirements would come into play here and in the contracts with the MCP.

Nguy: I recall there was an assessment of the proposed populations and the impact on access. Is that available, or is that still in the works?

Cooper: I am not aware of any such report. We did conduct extensive data analytics to inform the populations that are recommended for the transitions from managed care to FFS or vice versa. MCPs will need to ensure network adequacy for access to services, and over this year, we will work closely with MCPs to ensure services are available.

Behavioral Health in Schools
Jacob Lam and Lindy Harrington
https://www.dhcs.ca.gov/services/Documents/SAC-presentations-042921.pdf

Lam provided an overview of the Student Behavioral Health Services proposal in the Governor's proposed budget. This is one-time funding, $400 million ($200 million General Fund), over three years to increase the number of K-12 students receiving preventive and early intervention behavioral health services offered by school-affiliated behavioral health providers. The funding will be distributed via incentive payments and paid to MCPs to build infrastructure, partnerships, and capacity for school behavioral health services. The incentives do not include payments for treatment services. Eligible school-affiliated behavioral health providers include schools, providers in schools, school-affiliated community-based organizations or clinics, and school-based health centers.

The incentive payments will build partnerships and integrate the care students receive between MCPs, behavioral health departments, and school-affiliated behavioral health providers, to align the services that beneficiaries are receiving in the various delivery systems. The proposal is focused on early and preventative services offered at these schools. The goal is not to invest all of the dollars into the MCP and exclude the mental health plan (MHP) or school districts. The focus of this proposal is to identify partnership opportunities and build collaboration. Although this proposal is primarily focused on behavioral health services and the Medi-Cal population, we believe that these partnerships will have a broad impact on the care and treatment of students.

Currently, non-SMHS are provided by MCPs. SMHS are provided by MHPs. Beneficiaries may also access behavioral health services through separate cost-based school programs for youth who have care plans or Individual Educational Plans (IEPs). Nearly half of California's children are in Medi-Cal, and the vast majority are enrolled in MCPs.

Implementing incentives to increase care coordination will significantly impact the delivery of services to this population and ultimately benefit all delivery systems.

The incentives will be in three areas:

1. Planning and Coordination
    - Plan with MCPs, behavioral health departments, schools, and other key local stakeholders.
    - Technical assistance, training, toolkits, and/or learning networks between entities.
    - Improve performance and outcomes-based accountability for behavioral health access and quality measures.
2. Infrastructure
    - Implement information technology and systems for cross-system management between the school and the MCP and county behavioral health department.
    - Expand the workforce.
    - Access to equipment to provide telehealth services.
3. Prevention and Early Intervention
    - Develop or pilot behavioral health wellness programs to expand greater prevention and early intervention practices in school settings.
    - Implement Adverse Childhood Experience (ACE) and other age and developmentally appropriate behavioral health screenings and referral processes in schools.
    - Implement a school suicide prevention strategy.

In terms of implementation, there are multiple models for successful access to service. Acknowledging the variability is important to the design of the incentives. We are currently working to understand how models work in various parts of the state. DHCS will continue conversations into the summer to design incentives and identify how it may work best in different parts of the state.

Questions and Comments

Cleary: My concern is about whether the right stakeholders are engaged. Pediatric mental health is a specialty, and there are additional partners, such as children's hospitals and local medical groups, that should be engaged. It's important to find the right providers, and there are not enough of them. I am not confident the entities outlined in the proposal are sufficient.

Walker: This is an exciting proposal. I am trying to understand the incentive payments; how will the $400 million flow?

Lam: We do not have a specific allocation model for counties or school districts. It is not mandatory for a health plan to participate.

Walker: Will it be a grant application?

Lam: It will not necessarily be a grant application. If the health plan and schools or county mental health program agree locally and meet the milestones outlined in the incentive design, they would receive incentive payments.

Diaz: We appreciate the work to improve behavioral health services and appreciate these one-time incentive payments to build capacity in terms of the availability of services and to expand the provider and staffing workforce. Can you elaborate on what is meant by partnership with county behavioral health, and can you talk more about workforce expansion? SEIU provided comment letters regarding the budget request. We believe that counties as lead entities makes policy sense for this, and we hope that the majority of funding will go to county behavioral health.

Lam: In terms of the county entity, it would be the county behavioral health department and county MHP. There are some schools contracting with those county entities. We do not want to narrow it to an either-or because we don't want to exclude those schools and counties that are already providing services in partnership. On workforce, we heard in our initial discussions that we need to make sure there are providers, so how can we incentivize bringing those providers into a school setting?

Cooper: In addition, we want the model to remain flexible to allow for different types of models and relationships and to make sure we incentivize the best model for local schools and providers because it really varies across the state.

LeBeau: How can tribal behavioral health organizations engage in this partnership?

Lam: We are still working that out. The dollars will flow through the MCP. We are largely flexible as to how the money flows from the MCP to school providers.

Lightbourne: These dollars are to engineer the relationships and set up the capacity. The MCPs are already paid a capitated rate to provide treatment services. We are trying to ensure a connection is being built. If the logical local provider is a tribal clinic, we would be glad to see reimbursement flow to that provider network.

Cabrera: I want to set context as a starting place. We conducted a survey and found that 85 percent of counties are providing school-based behavioral health services. Of those, about one-third cover 80 to 100 percent of the schools. This has taken years of relationship building across county behavioral health and schools. Schools are responsible for school-based mental health services oriented around educationally supporting students; we provide a broader set of services. A student who might be doing well in school and suffers from depression or anxiety would not be a target for a school-based mental health provider. That is where we can help to support services. In many cases, we are not the contractor providing educationally related services. We have a memorandum of understanding (MOU) with the school so that we can be on campus to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and MHSA funded services to children and youth and across multiple payers, not just Medi-Cal. The transition back to in-person school has meant an uptick in the number of youth in acute crisis. Bringing the MCPs into the mix is adding another variable. We need a statewide strategy on the workforce pressure that this new funding will create. And, it is important for the MCPs to

understand our existing footprint and the relationships and different models developed. We also provide substance use disorder (SUD) services. There is a high rate of co-occurring SUD and mental health needs among children and youth. We are supportive of the administration's proposal and want to make sure that this funding is used in a way that can leverage the capacity we have put into schools.

Lam: Those are good points. We do acknowledge the variability of existing services and relationships in schools. MCPs have a responsibility for services to these youth, and we need to bring them in. We want to build on existing partnerships between the counties and schools and agree that infrastructure incentives are a way to build space for services that can be provided through existing partnerships.

Golden Testa: To summarize, from a school perspective this provides seed money for infrastructure because they may not have the ability to connect, talk with, and partner with MCPs, or have a care coordinator directed to do that. But this funding could provide schools that type of seed money. Is that correct?

Lam: Yes, that is one of the incentives we are considering in the design.

Public Comment

Jane Kearny-Ogle, Aurrera Health: There seem to be four counties not engaged in procurement, including Amador, Tuolumne, and Inyo. Will those remain a regional model?

Retke: Those counties did not submit a letter of intent to change, so there will be no change.

Cooper: Although they did not submit a letter of intent, there were conversations with each county, and DHCS provided technical assistance.

Rose Veniegas, California Community Foundation: I appreciate the overview of the efforts to address youth behavioral health needs through this new opportunity. I will forward to DHCS a report from Abt Associates funded by the Hilton Foundation with a national review of the impact of COVID-19 on school Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs. The California Community Foundation and the Hilton Foundation jointly funded implementation of SBIRT in Los Angeles County. The recommendations converge with ongoing needs related to COVID-19 and behavioral health. They include sustaining the telehealth efforts launched under the PHE, sharing program data around emergent mental health and SUD issues, and looking at how changes in school discipline policy or barriers to access caused by the digital divide continue to exacerbate symptoms experienced by youth. Thank you for this opportunity. I am happy to discuss later if you would like to learn more about the SBIRT effort that included Children's Hospital, five federally qualified health centers (FQHC) and the School-Based Health Alliance in Los Angeles County.

Rosario Arreola Pro, California Rural Indian Health Board: I have two questions. On behavioral health services in schools, will federally funded Head Start in tribal and urban

areas be eligible for these funds or to engage with counties in providing services? The other question is on the 1115 waiver. What is the future of the additional telehealth flexibilities? Many rural communities have made progress in promoting access to care during the pandemic by using telephonic services. Having the opportunity to continue that post-pandemic would be very beneficial to those communities and in rural California. As it stands now, tribal communities in rural and remote parts of California would not be able to continue that post-PHE. We hope to garner greater support to make sure that these communities can continue to use telehealth flexibilities.

Next Steps and Final Comments; Adjourn
Will Lightbourne

Lightbourne thanked participants, including new members for attending and sharing their thoughts. He reminded members of the remaining quarterly meeting dates for 2021.

2021 DHCS Stakeholder Advisory Committee Dates

- July 29, 2021 – 9:30 a.m. – 12:30 p.m.
- October 21, 2021 – 1:30 p.m. – 4:30 p.m.