DEPARTMENT OF HEALTH CARE SERVICES

Stakeholder Advisory Committee (SAC)

Behavioral Health Stakeholder Advisory Committee (BH-SAC)

October 20, 2022

12:30 p.m. – 1:30 p.m.

Hybrid In-Person and Virtual Attendance Meeting

SAC AND BH-SAC JOINT MEETING SUMMARY

SAC Members Attending*:* Bill Barcellona, America's Physician Groups; Doreen Bradshaw, Health Alliance of Northern California; Michelle Cabrera, County Behavioral Health Directors Association; LeOndra Clark Harvey, California Council of Community Behavioral Health Agencies; Anne Donnelly, San Francisco AIDS Foundation; 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; Beth Malinowski, SEIU; Sarita Mohanty, MD, SCAN Foundation; Erica Murray, California Association of Public Hospitals and Health Systems; Jolie Onodera, California State Association of Counties; Chris Perrone, California HealthCare Foundation; Laura Sheckler, California Primary Care Association; Brianna Pittman- Spencer, California Dental Association; Janice Rocco, California Medical Association; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Stephanie Sonnenshine, Central California Alliance for Health; Kaycee Velarde, Kaiser Permanente; Bill Walker, MD, Contra Costa Health Services; Ryan Witz, California Hospital Association; Anthony Wright, Health Access California.

SAC Members Not Attending: John Cleary, MD, Children's Specialty Coalition; Jarrod McNaughton, Inland Empire Health Plan; Linda Nguy, Western Center on Law and Poverty; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Cathy Senderling, County Welfare Directors Association; Doug Shoemaker, Mercy Housing.

Behavioral Health Stakeholder Advisory Committee (BH-SAC) Members Attending: Jei Africa, Marin County Health Services Agency; Barbara Aday-Garcia, California Association of DUI Treatment Programs; Ken Berrick, Seneca Family of Agencies; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; LeOndra Clark Harvey, California Council of Community Behavioral Health Agencies; Jessica Cruz, NAMI; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California

Department of Corrections and Rehabilitation; Andy Imparato, Disability Rights California; Veronica Kelley, San Bernardino County; Karen Larsen, Steinberg Institute; Kim Lewis, National Health Law Program; Linnea Koopmans, Local Health Plans of California; Jolie Onodera, California State Association of Counties; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Chris Stoner-Mertz, California Alliance of Child and Family Services; Mandy Taylor, California LGBTQ Health and Human Services Network, a Health Access Foundation program; Catherine Teare, California Health Care Foundation; Gary Tsai, MD, Los Angeles County; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services.

BH-SAC Members Not Attending: Carmela Coyle, California Hospital Association; Alex Dodd, Aegis Treatment Centers; Sarah-Michael Gaston, Youth Forward; Laura Grossman, Beacon Health Solutions; Robert McCarron, California Psychiatric Association; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; Jonathan Porteus, WellSpace Health; Hector Ramirez, Consumer Los Angeles County; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Cathy Senderling, County Welfare Directors Association of California; An-Chi Tsou, SEIU; Jevon Wilkes, California Coalition for Youth.

DHCS Staff Attending: Michelle Baass, Jacey Cooper, Yingjia Huang, Susan Philip, Michelle Retke, Tyler Sadwith, Jeffrey Callison, Morgan Clair, and Clarissa Sampaga.

Public Attending: Three members of the public attended in person and 192 by phone.

Welcome, Director's Opening Comments, Introduction of New Member, Roll Call, and Today's Agenda

Michelle Baass, DHCS Director

Baass welcomed members to the October hybrid meeting of SAC and BH-SAC. Baass introduced a new SAC and BH SAC member, Jolie Onodera from the California State Association of Counties. Baass thanked the California Health Care Foundation for its ongoing support of these meetings.

Director's Update

Michelle Baass and Jacey Cooper, DHCS

Slides: https://www.dhcs.ca.gov/services/Documents/102022-SAC-BH-SAC-presentation.pdf

Baass provided an update on the Medi-Cal commercial health plan procurement. DHCS announced its intent to award contracts in multiple counties to three commercial plans: Molina Healthcare, Anthem Blue Cross Partnership Plan, and Health Net. Contracting will apply to all Medi-Cal managed care plans (MCPs), including commercial plans, local

initiative plans, and Kaiser. The first-ever statewide procurement is intended to improve quality, increase access, reduce disparities, and improve health outcomes.

Baass reported that on September 16, Medi-Cal Rx launched two phases of prior authorization reinstatement for specific drug classes. DHCS is encouraging providers to adopt Cover My Meds. She noted that DHCS is closely monitoring call center lines and prior authorization metrics to ensure they are within timeframes under contractual obligations.

Baass reported on the 2022-23 state budget allocation of more than $1.1 billion for health worker retention payments. The first phase for applications in October 2022 is for hospital and skilled nursing facility workers, followed in November 2022 for clinic workers. The goal is to get all payments out by February 2023.

Cooper provided an update on the California State Auditor’s report on children's preventive services. The report identified concerns related to the underutilization of children’s preventive services, ensuring access to other health care services, health disparities, and promotion of preventive services. The audit identified 18 measures: eight had improved since the previous evaluation, five declined, and five were deemed to be non-comparable because data was not available due to COVID-19 or significant methodology changes. There were substantial disruptions in health care due to COVID-19, and the outcomes for 2020 were likely impacted by the reduction in service utilization. DHCS hired Dr. Pamela Riley, a pediatrician, as an internal child advocate. DHCS released its Comprehensive Quality Strategy, which includes an emphasis on children’s services, including preventative services, behavioral health, and maternity outcomes. The DHCS budget includes $700 million for equity and transformation grants to close gaps identified during COVID-19.

Questions and Comments

Imparato: When tackling disparities, I encourage DHCS to include disparities around communication access for people who are deaf and need therapy in sign language, and people who use augmentative communication devices and other communication barriers. Is there data on vaccines and boosters for children?

Cooper: A vaccination report by age is posted on the website. I will send that link to the group.”

Wright: On Medi-Cal Rx, I am glad to hear the initial challenges are worked out. Since the goal of the Medi-Cal Rx reform was to drive better negotiations with the drug companies, I’m curious about the process, timeline, and expected outcomes from those negotiations?”

Baass: Because DHCS lifted the prior authorizations that are central to how contract drugs are managed, the discussions on receiving additional supplemental rebates were paused. The focus has been to stabilize individuals' access to prescription drugs. In the coming months, conversations with drug manufacturers will be happening.

Cooper: Before going live with Medi-Cal Rx, DHCS signed a number of rebates. I can provide the numbers in a written update. Since January 2022, our focus has been on stabilizing the system. Once that is accomplished and authorizations are back in place, we will continue negotiations. No contracts were canceled, which is a great outcome. We are thinking through the future strategy and will have more on that over the coming year. We are focused on stabilization, rolling out the phases of authorizations, and then continuing rebate negotiations.

Wright: It sounds like the overarching strategy is about rebates rather than what I see in other states, where the focus is on upper payment limit and reducing the outlay of specific costs.

Cooper: It will be both over time. There are different strategies for different issues. We want to use our experience to inform the strategy by looking at the spend and reviewing the changes as prior authorizations are reinstated. The California State Board of Pharmacy is advising our approach to rebates and other topics.

Golden-Testa: I appreciate the update on the Auditor's report. That report mentioned outreach to families that was put on hold during the pandemic. I received a request to review materials for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) outreach. What is the timing of the outreach effort, and what is the distribution plan?

Cooper: DHCS is in process of developing new materials and is seeking informal input, followed by a full public review and comment process. DHCS is also launching a rebranding of EPSDT nomenclature to make it more accessible for families. We will engage externally to get feedback for the rebrand to make sure family members understand their rights. It is a multi-pronged strategy with MCPs, providers and beneficiaries.

Huang: "On the timing question, we are targeting spring 2023 for rollout."

Golden-Testa: "On the audit, it seems the numbers remain very low and not just because of the pandemic. The Department of Managed Health Care released results from 2021 about MCP benchmarks, and the kids' measures were exceptionally low. For example, zero of the 18 MCPs were meeting a 33% standard for children under 15 months getting well-child visits. When the minimum 50% benchmark is implemented,

what is the accountability strategy considering none of the MCPs are meeting that standard?"

Cooper: It's important to note as people are looking at the numbers that when we talk about reporting year 2021, it would be for measurement year 2020, which is the COVID impact year. By the end of 2022, DHCS will announce the next round of quality scores. We are working with MCPs and others on a tiered quality approach of three tiers. A green tier will indicate one measure below benchmark per domain that will mean the MCP will continue to do various quality work. An orange tier, the middle tier, indicates two or more measures below and would initiate a SWOT(strengths, weaknesses, opportunities and threats) analysis and work with the MCP through a regional collaborative to move the needle. Finally, a red tier indicating three or more measures overall, or two or more in one domain, would mean a comprehensive engagement with the MCP to invest resources for quality improvements, including regular engagement with leadership at the MCPs and reviewing the overall quality structure.

Clark Harvey: Thank you for sharing how DHCS is addressing the auditor's report and the $700 million investment. The slide indicates a robust array across behavioral health and physical health services and includes a bullet on the Child Health Champion and Consumer Advisory Committee. What stakeholder process will happen, and what is the timing for that? How might it intersect with the CYBHI?

Cooper: There are several existing stakeholder engagement groups. We do not intend to add new ones beyond SAC, BH SAC, Maternal Child Adolescent Advisory, and the new Children's Advisory Group launched this year. Those are the four main groups to provide feedback, and there are other strategies for input as well.

Koopmans: A few comments on the Children's Preventive Services audit report. I appreciate the reference to the impact of COVID, both in measurement year 2020 and in measurement year 2021. In addition, from a workforce perspective, the impacts of COVID will be even longer. I think another consideration on performance related to benchmark thresholds is the impact of state policy and COVID closures. Other states that didn't have as many closures and stay-at-home policies show different impacts on providers and services. We absolutely support DHCS' quality strategy and alignment of MCPs' quality strategies to DHCS. On the audit report's recommendation on workforce, how is DHCS working with Health Care Access and Information (HCAI) on new workforce investments? Is there is any nexus with the audit report?

Baass: DHCS is partnering with HCAI on community health workers (CHWs) and participating in stakeholder groups with them. CHWs will be critical for families and children on upstream prevention and will contribute to alleviating pressures on other workforce.

Pittman-Spencer: I want to clarify that the EPSDT and outreach DHCS spoke to will include dental? Annual dental visits in kids are also under 50%. Although there was an increase with Proposition 56 implementation, COVID created new challenges.

Cooper: Yes, dental is definitely included. When materials are out for comment, let us know your input for anything related to dental.

Lewis: The Medi-Cal Child Strategy is important as a larger effort, beyond responding to the audit. It includes various strategies and initiatives across the children's continuum that we want to achieve and shows how they relate to one another. It is a good example of what it means to have an intersectional, goal-driven strategy. I appreciate the work on EPSDT and think it is important to be strategic and specific to behavioral health. DHCS needs to have specific materials that behavioral health plans, Drug Medi-Cal Organized Delivery Systems (DMC-ODS), and specialty mental health services plans can provide to members and to families.

Veniegas: On the California State Auditor's report, given the timing of the 2018 report period and the impacts of COVID during 2020, it seems that the Bright Futures assessments mentioned in the reports include drug use assessments as one of the domains, but that's not part of the Medicaid pediatric core measures. I have not seen drug use assessment listed in some of the past performance evaluations. Is drug use assessment now included, and will there be data that are reported out from the utilization management as listed in recommendations?

Cooper: Between the 2018 report and this 2022 follow up, an SBIRT screening on drug use was added as a requirement on drug use. I need to verify the applicability for kids and follow up.

Gibbons: How is the work by local health departments captured in the metrics that the MCPs are evaluated on? For example, if public health sees kids and does vaccinations for Medi-Cal enrolled kids, how is that factored? Is there a way to identify where kids are getting services?

Cooper: DHCS gets all vaccine and immunization records from the Department of Public Health and the data flow to MCPs. I don't know if this is incorporated into what the MCPs submit for National Committee for Quality Assurance (NCQA) certification. I will check on the technical flow of data to close the loop.

Malinowski: I want to acknowledge the incredible work being done by DHCS on the worker retention bonuses. We know it's unprecedented for DHCS to be doing an effort like this and appreciate the timeline

Baass: The team stepped up and moved forward very quickly. Thank you for recognizing them

PHE Unwinding and Implementation with Health Plans

Yingjia Huang, DHCS, and Andrea Joubert, Inland Empire Health Plan
Slides: https://www.dhcs.ca.gov/services/Documents/102022-SAC-BH-SAC-presentation.pdf

Huang reported that the federal government renewed the COVID-19 public health emergency (PHE) through January 2023. She also reported that DHCS will continue to cover individuals who enrolled as part of the young adult expansion policy, and who have aged out, or will age out of state-funded full scope Medi-Cal as a result of turning 26 years old from March 2020 through December 2023. Huang also provided information on approaches for MCPs to ensure coverage, county guidance to prepare for the PHE unwinding, and a communications campaign. More recently, DHCS submitted requests to CMS for flexibility to improve the flow of information about a change of address.

Joubert offered detailed information on five innovative strategies (below) and the multiple tactics that the Inland Empire Health Plan has adopted in order to prepare for the PHE unwinding. For example, the health plan hired 50 team members to make calls and send texts to members, completed memorandums of understanding with each county, and partnered with local enrollment assistors to improve continuity of coverage through the PHE unwinding.

Inland Empire Health Plan PHE Strategy:

1. Partner with county Medi-Cal offices.
2. Proactively collect and update member contact information.
3. Provide renewal application assistance.
4. Inform members about the resumption of renewals.
5. Collaborate with DHCS and community partners.

Questions and Comments

Koopmans: Thank you for submitting this waiver to CMS because the change of address is more efficient for updating member information. Do we expect this to be approved

Huang: There are a few states that have been approved. So, there is a precedent, and we are using CMS standardized language. We don't anticipate issues with approval.

Lewis: These efforts are remarkable, especially the texting. Can you confirm that the

waiver will allow the health plan to get the change of address and put it into their system? I thought that was a state or county option, but I wasn't aware that MCPs could rely on that without confirming it with a member as well.

Huang: The MCP can take the updated address from a return label address and transmit it to the county. Under the waiver, the county does not have to go out for verification with the individual, and this shortens the timeline.

Lewis: I am glad to hear you are requiring county readiness assessments. Why is the guidance request for counties to submit the readiness plan only 10 days before the PHE ends, as opposed to earlier when the 60-day notice of the PHE ending is issued? Wouldn't an earlier submission allow more time to ensure readiness and work with counties on problems?

Cooper: We got the guidance out early and have been doing training for many months directly with counties. However, we don't know exactly when the PHE will end. For example, it just got extended to January. Once we get the 60-day notice, we'll give the final filing. Some counties will be ready and submit it immediately. The 10-day timeline was us trying to anticipate some back and forth to finalize readiness.

Huang: We speak with the counties regularly and have biweekly workgroups to walk through the components of the readiness template introduced in August. Although the due date is 10 days prior to the end of the PHE, technical assistance requests happen on an as-needed basis.

Golden-Testa: The work at Inland Empire is impressive and I hope this can become a model. You mentioned doing videos, and we are hearing that videos are very helpful for families; little shorts that get out the message, not with words, but with video. What are the ways across the state for families and MCPs to communicate about address changes? Can other counties get the address change from the MCP or through the benefit website?"

Huang: "Yes, the address updates could be done through all modalities, meaning from the member, the county (BenefitsCal) website, and obviously through phone.

Cabrera: On the intersection of the PHE unwinding and the ratcheting back of other supports to housing affordability and tenancy supports put in place during the pandemic, is DHCS working with stakeholders to anticipate spikes in Medi-Cal members who may be experiencing homelessness and the challenges associated with outreach for benefits continuity?

Cooper: DHCS put forward and received CMS approval for a number of proposals and

flexibilities to allow for a more seamless renewal for people experiencing homelessness, including zero income and an increase on *ex parte* percentages. We hope the changes make it easier for people experiencing homelessness to be renewed during this PHE unwinding period.

Wright: I appreciate DHCS' work around the continuation of coverage for young adults who were aging out. Can you clarify that the group will NOT transition to restricted scope Medi-Cal with this policy?

Cooper: Yes.

Wright: Thank you. On the uninsured COVID-19 aid code, can you offer an update on efforts to connect beneficiaries with coverage in other ways?

Huang: The COVID-19 Uninsured Group Program, implemented strictly for COVID testing and treatment, includes 350,000 individuals. DHCS laid out the tasks as part of the unwinding plan appendices that their coverage ends the last month of the PHE. They will receive a sunset notice, with a copy of the Single Streamlined Application and all of the modalities in which they could continue or seek other coverage that is similar to the welcome packets. It will be translated into all threshold languages.

Wright: That number is larger than I thought. I will follow up.

Sheckler: I want to highlight the role of community health centers in redeterminations. Health centers serve one in three Medi-Cal members, and there is significant work related to renewals and enrollment that happens within the health center. We are hearing concerns from health centers about the need for additional resources for them to support reenrollment. Some patients are hesitant to engage with the county, and that is where trusted messages from health centers are so important to guide patients through the process. It is good there are plans for media buys and other strategies. Will there also be resources for enrollment workforce?

Huang: The state budget provided another $60 million for outreach and enrollment. Working to ensure coverage through the PHE unwinding is a top priority for these resources

Koopmans: I am glad to hear about the readiness work with counties to prepare them to begin redeterminations as the PHE ends. Is there additional work in 2024, given the expansion of coverage to undocumented adults at the same time as migration of county eligibility systems?

Cooper: I want to highlight that the media campaign will ensure people access the 12-month postpartum coverage as well as the asset limit, and it is a broad-based educational campaign on Medi-Cal eligibility. Yes, we flagged for CMS that we will be undergoing a massive system migration while redetermination is happening. There is nothing we can do about the timing.

Huang: This is a large system migration from CalWIN to CalSAWS that will happen in waves. Placer and Yolo counties will begin next week. We do have a model from previous eligibility expansions, and there will be extensive training for counties. DHCS is currently in application design sessions to coordinate the expansion of eligibility to undocumented individuals 26-49 years of age as a carve-out from the PHE work. We are tracking this very closely and will be able to see from initial waves what issues arise.

Cooper: We will share the schedule with the group. We also learned from the process of turning everything off as the PHE began and will use those lessons as we prepare to turn systems on. It is no doubt that the multiple systems and migrations are a risk for smooth implementation.

Koopmans: I want to follow up on the earlier question related to childhood vaccination data being incorporated into MCPs' HEDIS scores from public health efforts. COVID-19 vaccinations are not part of the childhood immunization status.

Gibbons: Can you clarify if that means health department immunizations count toward the MCPs' HEDIS measure?

Cooper: Yes, we are measuring how many kids are getting immunized from all sources based on the recommended schedule. The data show that immunizations are missed in the younger years, although many catch up eventually. CMS holds us accountable, as does the community, to see that immunizations are happening on the actual schedules.

Gibbons: Let's follow up. It's great the data are captured. Local health departments often don't get credit for the work they do.

Managed Care Readiness and Transition Planning for 2024
Susan Philip and Michelle Retke, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/102022-SAC-BH-SAC-presentation.pdf

Philip opened the presentation with context on DHCS' efforts to ensure MCP readiness for the 2024 contracts. In February 2022, DHCS released the 2024 contract to be used for all MCPs, including commercial, local initiatives, and County Organized Health Systems (COHS). The contract includes new provisions related to transparency

requiring MCPs to publicly report on certain measures, quality improvements, and health equity activities, as well as provisions related to care coordination between health and social services.

Retke provided additional information on operational readiness activities required prior to 2024 to ensure MCPs are able to adhere to all new contract requirements. Major activities include demonstrating network adequacy, having partnerships with local agencies to ensure the MCP is understanding and meeting community needs, and demonstrating the ability to provide services in support of CalAIM initiatives. She reviewed the timeline of readiness activities. Philip continued with information about the changes to the managed care model across counties. DHCS has conditionally approved changes in 17 counties that reflect a move to a single MCP and require federal approval. Philip reviewed the types of MCP models, and also reviewed the specific changes for counties and MCPs.

Questions and Comments

Sonnenshine: I want to clarify that a COHS is not a health fund operated by a county. The county in partnership with local stakeholders determines that a single MCP would best meet the needs of Medi-Cal members in their communities and passes an ordinance enabling that single MCP to operate. The COHS is an independent public entity.

Witz: When will the conditional approvals for the migrations to a single MCP-only county be official? Would a plan be able to back out, for example, upon receipt of rates? On readiness, can you share anything about your expectations for closeout activity post-transition?

Philip: We are in conversation with CMS about the approvals. We don't foresee any red flags.

Retke: As part of the contract, there are readiness operational activities for MCPs that are exiting, such as noticing, data sharing, and other deliverables MCPs would complete during 2023 in preparation for 2024.

Cooper: MCPs attested that they are moving forward subject to readiness and approval by DHCS, primarily related to their ability to meet network adequacy obligations. We don't negotiate rates with MCPs. We contract with actuarially sound rates.

Murray: For Two-Plan counties, now that certain MCPs are moving from a competitive model to a single plan, what is the relationship between what was supported in the default algorithm and the deliverables in the contract? For example, is the default algorithm used to encourage quality metrics? What deliverables are being asked of the

single plan in the contract?

Cooper: There will be no MCP default with a single plan because all lives go to the COHS or single MCP in a county. All MCPs will have the same contractual obligations. The most important element driving default is quality. MCPs with a higher quality score get a higher proportion of the lives that are defaulted. When a member doesn't choose a plan, the MCP assignment goes through a default algorithm, and there is a very complicated formula that develops that default algorithm. The key factor in that algorithm is the quality scores. Although there is no default with a single plan or a COHS, DHCS holds them to the same quality thresholds, and deliverables are the same.

*Perron*e: There has been work accomplished to tie more money to quality and other performance outcomes of MCPs. Can you say more about what work is underway and what the timing is for defining the pay-for-performance initiative for MCPs?

Cooper: The approach is not pay-for-performance as it was done in the past. For 2023, DHCS embedded quality scores into the rate adjustment for MCPs. Those with higher quality receive various adjustments to the Per-Member Per-Month (PMPM) to incentivize quality improvement. In 2024, an equity lens will be added once there is sufficient data to incorporate it. We can follow up with more information

Perrone: Can you speak to the scale of the incentives? Is it 1% of PMPM or 5% PMPM, or is that not a way to frame it?

Cooper: I will need to follow up with our team.

Lewis: It's important to note that the MCP model changes lead to people losing choice when the change is to a single plan. There will be an overall reduction of plans as well as other changes happening in 2024, including the Kaiser single plan option once CMS approves it. Redeterminations also will happen in this same timeline. There is confusion about how the changes will impact individuals. It will help if we can get user-friendly information out to providers and members as quickly as we can, especially where MCPs are changing."

Baass: Currently, DHCS is developing messaging about the changes for providers and members that is not specific to county or MCP. As the MCP contracts become more settled, there will be county-specific messaging with contact information for questions. I will take your recommendation for direct noticing to members back to the team for discussion.

Cooper: One challenge to the timing is that we are still ensuring network adequacy so I

will take this back for discussion. To clarify, the single-plan counties were previous local initiatives that now will cover the entire county, and there are no commercial plans in single plan counties. There is a waiver posted for comment that will be submitted to CMS for single-plan counties.

Wright: We are supportive of many of the changes related to procurement: higher standards, fewer plans, and greater accountability. Related to continuity of care, do you know the number of people who will need to change plans? Is there an estimate yet of how many people would need to change providers in addition to changing MCPs? What are the provisions and timelines for people to stay with existing providers?

Baass: The general messaging being developed will outline the continuity of care requirements. About two million members will transition to new MCPs. We don't have the number that will need to transition providers, and that will be an ongoing assessment. The MCPs will submit recurring network files to clarify the continuity of care needs. The biggest goal is maintaining continuity with providers wherever possible. Readiness includes proactive outreach to monitor and close the gaps in provider networks, not just waiting for a member to file their continuity of care requests with the MCP. In addition, DHCS is reviewing MCP staffing availability to process the continuity of care requests. One of the biggest disruptors with plan changes is often formulary changes, so a benefit of having the statewide Medi-Cal Rx means this will not change.

Philip: DHCS is working with MCPs on primary care provider linkages, service authorizations, and continuity of care for services authorized that will transition to a different MCP.

Sheckler: The Alternative Payment Mechanism (APM) will go live in 2024 at the same time as the MCP changes due to procurement. Is there anything in the readiness process related to criteria for engagement with health centers joining the APM? The application process for health centers includes MCP readiness and engagement. The APM will impact rate setting because there won't be any historical utilization for the MCPs that are changing. The APM applications will be released in December and health centers in counties with plan changes are concerned about whether they can apply or not without knowing these details.

Philip: I will follow up on the rate-specific questions. Readiness does include broad engagement with FQHCs and clinics; however, it is not specific to the APM.

Donnelly: As DHCS works on continuity of care, I hope this includes specialty care as well. For someone with HIV to transition to a primary care provider without HIV experience will impact health outcomes. Our clients report it is challenging to do their own continuity of care requests. Are there ways to offer support with continuity of care requests and other transition issues?

Cooper: We are looking at it internally and provider continuity requests as well.

CalAIM Update

Jacey Cooper, Susan Philip, Michelle Retke, and Tyler Sadwith, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/102022-SAC-BH-SAC-presentation.pdf

Cooper opened the update by noting the significant progress on CalAIM implementation. Enhanced Care Management (ECM) is now statewide, and the DHCS website has a schedule of ECM populations and Community Supports (CS) to be phased-in over the next two years. Cooper also noted upcoming changes for 2023, including carving in long-term care and enrolling dual eligible Medicare-Medi-Cal beneficiaries into mandatory managed care.

Philip offered more details on the populations of focus for ECM implementation in 2023, populations at risk for long-term care institutions, and nursing facility residents transitioning to the community. She also reported on the CS offered by MCPs currently and noted that more than 250 CS services will be implemented in January 2023. Retke reported specific information on the 325,000 dual-eligible members in 31 counties who will be enrolled in managed care in January 2023. She also reviewed the Cal MediConnect transition and highlighted the benefits of Medicare-Medi-Cal Plans for members.

Philip reviewed information about the carve-in of skilled nursing care to managed care statewide through a standardized benefit. Previously, managed care members would have been disenrolled once they transferred to a skilled nursing facility (SNF), but now they will remain in managed care. In addition, current fee-for-service members in a SNF will be enrolled in managed care. She reviewed the continuity of care requirements for long-term care, including a requirement for 12 months of coverage for services at non-contracting SNF facilities.

Retke reported on the schedule of notices and transition dates between now and December 2022. This period is also the open enrollment period for Medicare.

Questions and Comments

Stoner Mertz: Given that MCPs offer different CS across the counties, is there more detailed information about what CS each plan provides?

Philip: There is a summary by MCP and by county we can provide.

Mohanty: Related to monitoring and evaluation of CS, is there information available on the priority needs and what CS are being utilized in each county? Is there specific information on the dual eligible population and what CS they are accessing?

Philip: Yes, we are currently working on the evaluation and monitoring required by CMS for CS.

Kelley: For both ECM and CS, I want to underscore the importance of coordinating with county behavioral health, especially for pregnant and postpartum populations. Coordinating services is complex. I am working with MCPs and one of the many sobering centers in the county. We want to improve treatment outcomes, and it is important to intervene at a moment when people may be ready to go into treatment. MCPs are hiring medical staff, but not alcohol and drug staff. If we have more information, perhaps the county can provide staff capacity.

Veniegas: If MCP contracts for CS and then there is a change in the MCP, are there plans and scenarios being developed about re-contracting CS with the new MCP?

Philip: The change in MCPs won't happen until 2024 so this involves continuity of care for members receiving CS services. This is part of the scenario planning for DHCS to accomplish."

Sadwith continued with the presentation and reported on CalAIM behavioral health policy initiatives and the schedule for implementing the many changes planned over five years. For example, the adult and youth screening and transition tools for MCPs and county mental health plans, as well as contingency management for stimulant use disorder, will be implemented in January 2023. Payment reform and CPT code transitions will occur in July 2023. Administrative integration of substance use disorder and mental health benefits will be completed by 2027 to result in a single contract with DHCS and a more seamless experience for consumers. Sadwith also reviewed specific information on recovery incentives and the mobile crisis opportunity that are planned for implementation in January 2023, pending CMS approval.

Questions and Comments

Tsai: California is leading the effort on contingency management. We would be happy to partner with DHCS in conversations with federal partners to expand the focus of contingency management beyond stimulants. There is opportunity for us to push forward as we demonstrate positive outcomes.

Cabrera: Thank you so much for the overview on the various initiatives, including mobile crisis and payment reform. This is a massive lift in terms of the scale and scope. While we have had decades of experience with mobile crisis in certain regions of the state,

building this out in rural California is no small feat. Payment reform involves an entire overhaul of coding and payment of contract providers, even as we continue to deal with the wake of the pandemic and a workforce crisis. We appreciate the support and technical assistance.

LeBeau: I want to highlight and thank DHCS for continuing to engage in dialogue with CMS to cover traditional healers. This is important for Tribal clinics, urban Indian clinics, and Tribal governments. Motivational incentives are effective when developed by Tribal communities and should be categorized as evidenced-based, although oftentimes they are not.

Philip provided detailed information on Providing Access and Transforming Health (PATH). PATH is initial funding to community organizations, providers, counties and local governments, and Tribal partners to complement other funding that builds and scales infrastructure and capacity for ECM and CS. This includes:

- Collaborative planning initiative to convene MCPs, agencies, hospitals, Tribes, and others to work on readiness. DHCS recently finalized facilitators for regional collaborations and is matching the facilitators to participants who applied to join collaborations.
- Capacity and Infrastructure Transition, Expansion, and Development (CITED) initiative will have five rounds of funding from 2022 to 2025. DHCS is reviewing applications for round one to award $100 million among 205 applicants with requests that totaled approximately $520 million.
- Technical assistance marketplace initiative will match pre-approved vendors beginning in January 2023 to a range of technical assistance needs related to ECM and CS.

Questions and Comments

Gibbons: As local health departments engage in PATH, we are learning there may be additional support required for them to meaningfully engage. For example, the requirement in CITED to show progress toward a contractual relationship is deterring participation. Local health departments are not at the point of knowing whether this is an opportunity or not. Discussion is needed with MCPs about intersections with the child population focus and how data might be shared across systems. Aspects of CalAIM coincide with existing responsibilities for health departments, such as CCS intersections with ECM. In addition, ECM cannot overlap with targeted case management. There is learning that needs to happen and a gap in the existing supports to provide dedicated staff to CalAIM. We would like to engage to solve this.

Baass: The relationship between MCPs and local health jurisdictions is something we want to foster. We should discuss offline to think through how we can support this.

Grealish: It would be very useful for DHCS to post grantees for all PATH initiatives.

Philip: Thank you, I will take that back for discussion.

Teare: It would also be interesting to understand whether applications represent a comprehensive ecosystem and see the balance of big, small, new, or established partners.

Phillip: That is exactly the analysis we are conducting now.

Sadwith continued with a presentation on the PATH Justice-Involved Capacity Initiative to support individuals with services pre-release, such as Medi-Cal enrollment and connections to behavioral health and social services to support reentry from prisons, jails, and youth correctional facilities. PATH funding of $151 million over multiple rounds of funding will support the planning and implementation for protocols and IT system modifications. Negotiations are ongoing with CMS so plans for PATH Justice Involved Initiatives may change.

Questions and Comments

Lewis: There are several states that have had pending requests for waiver approval for a long time. I'm wondering if you are optimistic that something will move forward shortly?

Sadwith: We have mentioned to stakeholders over time that we are cautiously optimistic. We are upgrading to being optimistic this could be approved.

Veniegas: LA County Hospitals and Healthcare Delivery Commission established a standing committee on correctional health services and has been tracking the availability of medication-assisted treatment (MAT). The Correctional Health Services Standing Committee is a ready partner to operationalize the anticipated waiver. Related to MAT, what does network adequacy and access look like when someone is released at 2 a.m. and there isn't a provider open to provide an overdose prevention kit?

Sadwith: It would be great to follow up with you and learn more about the Correctional Health Services Standing Committee. We are working on the real world challenge related to releases.

Public Comment

Leslie Napper, pronouns she, hers: I am part of the Mental Health Services Act Steering Committee in Sacramento County, and I am a peer advocate with Disability Rights California. One of the challenges I see in trying to support filling the gaps around behavioral health services, particularly for justice involved and communities of color, is access to disaggregated data. How do we know race and ethnicity links under the

minutia to really understand where the gaps are and how to fill them? How can we engage with our systems partners to have that disaggregated data? Thank you.

Plans for 2023 Meetings, Next Steps, and Adjourn

Michelle Baass, DHCS

Please hold the calendar dates listed below for 2023. We will continue to hold hybrid meetings.

- February 16, 2023 – 9:30 a.m. – 1:30 p.m.
- May 24, 2023 – 9:30 a.m. – 1:30 p.m.
- July 20, 2023 – 9:30 a.m. – 1:30 p.m.
- October 19, 2023 – 9:30 a.m. – 1:30 p.m.