DEPARTMENT OF HEALTH CARE SERVICES

Stakeholder Advisory Committee (SAC) and Behavioral Health Stakeholder Advisory Committee (BH-SAC)

Hybrid Meeting
October 19, 2023
9:30 a.m. to 1:00 p.m.

SAC AND BH-SAC JOINT MEETING SUMMARY

SAC Members Attending*:* Doreen Bradshaw, Health Alliance of Northern California; Michelle Cabrera, County Behavioral Health Directors Association; Eileen Cubanski, County Welfare Directors Association of California; Robert Ducay, California Hospital Association; Amanda Flaum, Kaiser Permanente; Michelle Gibbons, County Health Executives Association of California; LeOndra Clark Harvey, California Council of Community Behavioral Health Agencies; Virginia Hedrick, California Consortium of Urban Indian Health; Anna Leach-Proffer, Disability Rights California; Carlos Lerner, Children's Specialty Care Coalition; Kim Lewis, National Health Law Program; Beth Malinowski, SEIU; Jarrod McNaughton, Inland Empire Health Plan; Linda Nguy, Western Center on Law and Poverty; Marina Owen, Cen Cal Health; Chris Perrone, California HealthCare Foundation; Brianna Pittman- Spencer, California Dental Association; Katie Rodriguez, California Association of Public Hospitals and Health Systems; Janice Rocco, California Medical Association; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Laura Sheckler, California Primary Care Association; Kristen Golden Testa, The Children's Partnership/100% Campaign; Bill Walker, MD, Contra Costa Health Services; Anthony Wright, Health Access California.

SAC Members Not Attending: Bill Barcellona, America's Physician Groups; Sherreta Lane, District Hospital Leadership Forum; Mark LeBeau, California Rural Indian Health Board; Jolie Onodera, California State Association of Counties; Kiran Savage-Sangwan, California Pan-Ethnic Health Network.

BH-SAC Members Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Kirsten Barlow, California Hospital Association; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; Eileen Cubanski, County Welfare Directors Association of California; Vitka Eisen, HealthRIGHT 360; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Robert Harris, Service Employees Service Union; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; Virginia Hedrick, California Consortium of Urban Indian Health; Samuel Jain, Disability Rights California; Veronica Kelley, Orange County; Linnea Koopmans, Local Health Plans of California; Karen Larsen, Steinberg Institute; Kim Lewis, National Health Law Program; Hector Ramirez, Consumer Los Angeles County; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Chris Stoner- Mertz,

California Alliance of Child and Family Services; Gary Tsai, MD, Los Angeles County; Angela Vasquez, The Children's Partnership; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services.

BH-SAC Members Not Attending: Jei Africa, San Mateo County Behavioral Health and Recovery Services; Ken Berrick, Seneca Family of Agencies; Dannie Cesena, California LGBT Health And Human Services Network; Jessica Cruz, NAMI; Steve Fields, Progress Foundation; Sarah- Michael Gaston, Youth Forward; Meshanette Johnson-Sims, Carelon Behavioral Health; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Jolie Onodera, California State Association of Counties; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; Jonathan Porteus, WellSpace Health; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Catherine Teare, California Health Care Foundation; Jevon Wilkes, California Coalition for Youth

DHCS Staff Attending: Michelle Baass, Jacey Cooper, Palav Babaria, MD, Susan Philip, Linette Scott, MD, Bambi Cisneros, Tyler Sadwith, Rene Mollow, Tyler Sadwith, Yingjia Huang,

Public Attending: There were 189 members of the public attending in-person and virtually.

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

Baass welcomed SAC and BH SAC members to the joint hybrid meeting. She acknowledged this is Jacey Cooper's last meeting before she transitions to a new position with CMS. Baass expressed her gratitude for the vision and brilliance Jacey brought to her tenure in California. Cooper commented that it has been a pleasure to have worked over seven years with DHCS, especially recent work on CalAIM and the expansion of benefits and eligibility.

Director's Update
Michelle Baass and Jacey Cooper, DHCS
Slides available: https://www.dhcs.ca.gov/Pages/101923BHSACMeetingMaterials.aspx

Baass offered an update on the Medi-Cal Member Advisory Committee (MMAC). The 15 current members met three times, providing DHCS the opportunity to hear directly from Medi-Cal members on questions such as, "What does Medi-Cal mean to them? What are their challenges? How do they experience the Medi-Cal program?" MAC members spoke to care coordination, including programs beyond health care, and challenges navigating transitions in mental health care. Baass thanked Chris Perrone and the California Health Care Foundation for their support to establish the MMAC as well as SAC and BH SAC members for assisting in the development of the MMAC.

Baass offered a brief update on bills signed by the Governor, including the proposal to transform the behavioral health system. She noted this is moving to the ballot and will not be discussed in detail due to campaign rules. Other bills include local educational billing, Medicare Part A buy-in, defining gravely disabled, and health care worker minimum wage.

She also commented that the bill regarding unified healthcare financing will be pursued via a potential waiver.

Questions and Comments

Stoner-Mertz: Related to implementation of SB 525, we are receiving member questions about whether, and how, it applies to community-based behavioral health organizations.

Baass: Please send any questions to me. We can't answer questions just yet, but it would help to understand what issues exist.

Golden-Testa: Thank you for creating an opportunity to have member voices included in how Medi-Cal is operated. Does DHCS have an internal process for incorporating the comments and perspectives heard from the committee into its decision making and process changes?

Baass: DHCS senior leadership attends the MMAC and debriefs after each meeting about what we heard and how to take the feedback to our teams. It's early and we continue to build the rigor of the meeting format and how to circle back on all of the topics raised.

Pittman-Spencer: On the MMAC, how is dental included? Some of the changes in how we talk about the dental program, for example to Medi-Cal Dental instead of Denti-Cal, came from understanding that Medi-Cal beneficiaries didn't know they had a dental benefit.

Baass: We surveyed MMAC members for priority topics. I appreciate the input and will take that back.

Perrone: Some of my reflections on the early experience with the MMAC is that co-design means the agenda should focus on the priorities members identify and DHCS has taken the time to do that. DHCS' intention is to hear input on the big picture of program and policy opportunities and challenges. Members come with immediate issues and problems. The DHCS team acknowledges that they can't expect members to help if they can't problem-solve care experiences. Staff have also checked the use of acronyms and they attend with a learning mindset.

Kelley: What is the timeline for SB43? This change is not straightforward. There are new systems that have to be created both at the state and local levels. Given there are so many current priorities, I want to manage expectations around implementation.

Baass: I can't speak to a timeline for implementation on this or our responsibility in particular.

Lewis: The MMAC is an important entity for input, and we need to utilize it effectively to steer DHCS with a different perspective than advocates offer. The managed care plan implementation in January impacts many people, and I have some concern about how advocates can triage and troubleshoot cases. What is the best way for advocates to identify and communicate problems?

Cooper: We will take that back and offer a process for this.

Baass continued the Director's Report with an update on the September announcement of the go-live decisions for managed care plans (MCPs) scheduled to assume operations January 1st, 2024. She reported that initial beneficiary notices were sent out and will continue to be sent out at 60-days and 30-days and that DHCS estimates 1.2 million members will need to transition to a new MCP. She provided information about FAQs on the website that offer baseline information on the transition, on continuity of care, and how to exercise those rights.

Questions and Comments

Ducay: What is the status of determining network readiness? How is DHCS looking at alternative access? I am hearing from hospitals that some MCPs are waiting until they have rates, yet the January implementation is soon.

Cooper: MCP readiness deliverables have been filed throughout 2023. Prior to announcing the go-live decisions, DHCS did an assessment of the network. MCPs also file interim information meaning they are in negotiation with a hospital. The MCP is required to have a final signed agreement in order to be deemed, however especially in new counties, the conversations may take longer and rates were needed to finalize. This transition requires CMS approval and final network adequacy must be filed by the end of December. We are doing network adequacy review at the subcontractor level as well as prime contractor level and subcontractors also have to meet network adequacy standards if they have a full at-risk contract submitted to CMS. These requirements have increased the number of alternative access standards.

Wright: In Los Angeles, what is the methodology for deciding the members who will transition as opposed to those who will stay with an MCP? If a person doesn't want to transition, can they stay?

Baass: The algorithm to assign lives from HealthNet to Molina includes assessing for acuity mix, family linkage affiliation, and provider overlap to maximize continuity for the member. Member choice is first, then the algorithm. If they don't choose and are assigned, they can still go back if they prefer.

Wright: I appreciate the work on readiness and also know there will be items we did not foresee. For example, should there be a proactive move to increase the field call center capacity, especially since it's happening alongside the undocumented expansion?

Cooper: For readiness, we looked carefully at continuity of care (COC), including provider relations and customer service capacity within the MCPs. We significantly expanded what is included in COC protections in this transition and see it as the new standard for transitions going forward. We are looking at data systems and data flows because we learned in the past that if it's not built in the actual MCP system, then claims can't flow, providers can't get paid,

and beneficiaries get stuck.

Wright: I appreciate the focus on preventing problems. There are things we won't know about, whether it's the call center at the statewide level or county workers or the health plans, and it may be building in reports on whether people are getting the care they would normally get.

Cooper: There is a daily reporting requirement from MCPs to DHCS including denied and approved authorization and utilization that are reported for a period of time. We also do standardized scripts that are sent to MCPs. You raise a good point around eligibility, and we should add that to reports.

Golden-Testa: I see the QR code on the notice. Is there also a link or website to send families for information if they don't have a notice?

Baass: Yes, we can send the link in follow up. There is a link on the home page for the MCP transition and then a member page with questions geared to the transition on that landing page.

Veniegas: With regard to the MCP transition, I read that radiology was not going to be included in one of the services. If a beneficiary needs radiology through the transition, does that cost fall to counties?

Cooper: Can you send us the question? Radiology should continue to flow and oftentimes doesn't require a prior authorization unless it's high cost. Even so, prior authorizations should be flowing.

Ducay: Is network adequacy evaluated by time and distance? How are you evaluating adequacy beyond a contract being signed? Is DHCS looking at network adequacy for the county Mental Health Plan, particularly psychiatric inpatient and residential treatment?

Cooper: There are a number of changes on network adequacy over a multi-year period. Two requirements started this year. We increased the number of items and how they are reviewed. Currently, we are working on the data feed from MCPs on assigned lives to have better information to build it into the network adequacy evaluation. For submission, we are doing what is currently in requirements. The transitions will not significantly shift on the county side.

Cooper: We have a shared mailbox to send concerns regarding the transition, including after go-live. This allows for the internal escalation process.

Koopmans: Does the 1.2M members transitioning in Los Angeles include fully delegated Kaiser members that are transitioning to Kaiser under a prime contract?

Cooper: I do not think they are included because that number is 900,000 for Kaiser.

Director Baass continued the Director's Report with information on the DHCS 2023 – 2027 Strategic Plan. She reviewed the core values and spoke to multiple goals included in the plan.

Questions and Comments

Owen: I appreciate the value of innovation because that seems necessary for the scale and scope of transformation DHCS is initiating. How is DHCS working with sister departments such as California Department of Public Health (CDPH) or Department of Social Services (CDSS) and other partners that are required in this transformational journey?

Baass: Our relationships are strong across departments. For example, we have regular meetings with CDPH WIC, vaccine, and staff working with local jurisdictions; the Department Aging on Home and Community Based Services and older adults' behavioral health; with CDSS on child welfare and foster youth, home visiting, Calfresh and CalWORKS; Health Care Access and Information on workforce; Department of Managed Health Care on metrics and delivery systems; the Department of Developmental Services on waivers; as well as Department of State Hospitals on the "incompetent to stand trial" population and community solutions for the populations they serve. There are others also.

Ramirez: Thank you, Jacey for your work in California. My participation in SAC has informed me and I appreciate that my opinions and experiences are heard and acted on. There are a multitude of initiatives happening at the county and state level, and I am starting to see concerning trends. We have a significant shortage of staff. I am seeing interruption of services, not intentionally, but because of confusion and difficulty prioritizing. Staff are overwhelmed and providers are confused and that is resulting in access and quality challenges. As you look at strategies for continuity of services, please focus on those of us that have significant medical needs so there is no interruption in the medication and services that many of us use on a daily basis. I remain excited about the direction we are going in. As an undocumented, disabled, indigenous, queer person, I haven't had access to full medical care until recently. That experience means refamiliarizing myself with benefits and how to access them correctly. There's a number now that I can call and request accommodations for my services. In the past, I had to fight for them. I think many who haven't had access to services find this a brand-new experience. It is bittersweet for you go to the federal level, but I look forward to you having impact.

Cooper: Thank you.

McNaughton: Thank you for the fantastic Quality Summit convened yesterday. I appreciate the lessons learned from sister organizations across the state. On the minimum wage bill that was signed, we are hearing from community organizations and provider offices is that that there will be an impact across the region for organizations not directly impacted.

Status of Medi-Cal Redeterminations and January 2024 Expansions
Rene Mollow and Yingjia Huang, DHCS
Slides available: https://www.dhcs.ca.gov/Pages/101923BHSACMeetingMaterials.aspx

Huang highlighted her appreciation for county partners working hard on redeterminations. She explained that California has obtained 17 federal flexibilities and published 54 policy letters to help counties and members complete redeterminations more easily. Huang reported that in August 2023, the United States Digital Service, an office within the White House, came to California to help increase the rates of ex parte verification that advances a redetermination by using existing sources available to counties without the burden on the member for additional verification. Huang reviewed the interactive dashboard, updated monthly with applications, enrollments, demographic information, and trends. She also provided information on health enrollment navigators working to remind individuals as they come up for redetermination as well as assist anyone terminated for procedural reasons or otherwise needing help. She spoke to a collaboration with CHCF to survey individuals disenrolled for procedural reasons to understand more about whether they no longer need Medi-Cal or other reasons for the lack of response. Huang reviewed the early data on redeterminations and offered that DHCS is on track to eliminate assets from Medi-Cal eligibility as of January 2024. She reported that in January 2024, DHCS will implement Medi-Cal eligibility for individuals with unsatisfactory immigration status age 26 – 49 and reviewed outreach resources available for this expansion.

Questions and Comments

McNaughton: I appreciate the thoroughness of the dashboard and want to share thoughts from our partnership with the county teams in Riverside and San Bernardino. We discovered that about 40,000 members with renewal dates over the past four months were disenrolled by the state but are not on the counties' monthly disenrollment files. We hired 60 enrollment partners and are working to identify how we can support reconciliation systems to maintain coverage. How often do you review reconciliation?

Huang: Can you let us know which redetermination list? June would be the best month for using the reconciliation because there were discrepancies in July and August. The counties likely pulled it from the county system and the lists you get from DHCS are pulled from the state system. I am happy to follow up on this.

Lewis: It's important to track the data in real time. We appreciate that DHCS pursued the 17 waivers to increase ex parte rates, but this does result in confusion for workers, especially with an under-resourced workforce, when rules change monthly, and new waivers come online at the same time. We are worried about workers being able to apply those new rules. The ex parte rate is going up, but it is still very low. It's 35%, which is below what we would hope to see and what CMS would expect. California has 87% of its disenrollment for procedural reasons, one of the highest rates in the country and that concerns us. We are hearing from partners that people don't have coverage when they access care and, although they have turned in their packets sometimes multiple times, they are getting terminated. Are you reporting the types of new applications coming in? Some people may reapply with a new application if they are disenrolled. Lastly, do you have information on the percentage of kids being terminated? That rate also seems high to us. New guidance from CMS on continuous enrollment is that kids should stay on when parents' income goes up and even if the parents are terminated.

Huang: Yes, 54 policy letters in 10 months can cause confusion. We are visiting every county and have TA webinars that counties say are helping. The data indicates they are using the flexibilities. There are new automations to increase ex parte numbers for December rederminations and we rolled out a checklist for our counties that outlines each step and has prompts for waivers to strengthen workflows. On disenrollments, I think you are referring to the Kaiser Family Foundation tracker that shows the actual number of individuals being disenrolled for procedural termination. California is at the top because of the high caseload, however, if you compare California by percentage, we are actually in one of the lower brackets, although we acknowledge the large number of procedural disenrollments. Lastly on accelerated enrollment for new applications, we do report out the actual numbers, just not in the visual representation. Once we have a couple months of actuals, we may add more interactive features to our dashboard to demonstrate how this policy is helping the unwinding.

Flaum: On the June disenrollment numbers, do these include the 90-day cure period? Will they be reduced when the data is complete?

Huang: This does not include the cure period. We are anticipating data will come in this month and be published mid-November. It is not clear how the numbers will change based on the additional data.

O*wen*: On the undocumented expansion, is there data that DHCS can provide to MCPs for members transitioning where there isn't the health plan choice. This was raised at our community health worker collaborative. We are aiming for a seamless transition, with primary care selections made and members knowing about initial health assessments. Planning and support for this population is different than the younger population because the language barriers are greater.

Huang: I will take that back to the managed care team.

Golden-Testa: We are hearing that access by phone in multiple counties is very challenging. There are two-hour delays and calls are dropped. I appreciate that workers are doing the best they can with low staffing, but this is a huge concern for beneficiaries. We hope you will look into how to address call center capacity. On the data, even using percentage comparisons, we in the bottom 13% of states. Those states have paused disenrollment, and we request that California do the same. We appreciate your surveying to understand the data because we are hearing there is confusion. For example, even if there is employer coverage, Medi-Cal can wrap around that coverage, and dependent coverage is often expensive and not comprehensive. In our focus groups, we learned that people do not realize that even when their income goes up, they, and their children, may still be eligible. I will share our focus group data in January. Will you update the pending cases along with the 90-day cure period data?

Huang: I appreciate your comments on the call centers. We are working with the counties on that. Thank you for the suggestions and detail around scenarios. I will take this back to enhance our process. The refresh does reflect the final enrollment numbers.

Nguy: I echo appreciation for the waivers and note that some are still pending. We hope DHCS will make many of the flexibilities permanent. California's rate of procedural terminations is worsening, and we also request a halt on redeterminations until each person is evaluated. While the 90-day cure period helps, it is not acceptable to have disruptions in coverage.

Sheckler: I appreciate the unwinding dashboard. It's easy to navigate and very useful. We hope that the expansion of assisters in health centers will help with the high procedural disenrollment rates. One concern to flag from members and partners is that health centers and CBOs are still waiting for the implementation of the integrated release of information (ROI) to track the status of Medi-Cal applications in real time. Without this, navigators are left with time consuming workarounds using the call center. Is there an update on when we can expect to see the ROI functionality go live? Are there county-level estimates on how many eligibles per county there are for the adult expansion?

Huang: On the ability for CBOs to log in to BenefitsCal, we are working on CalSAWS migration, effective October 30th and that means there are multiple changes converging during the unwinding. In tandem is the development of ROI. There are privacy and security pieces to work out that are complex, given the level of security needed for members' privacy. I don't have an estimated date of implementation. I know it's a valuable asset and we are committed to making sure we have the best product as well as to protect the information of members. In spring of 2024, we will have a better timeline. On the county breakdown for the adult expansion, we do have an estimate and will follow up.

Wright: Thank you on asset elimination and the adult expansion. Thank you for the idea to look back to those who were previously denied. It would be great to go back more than six months on the adult transition to full scope Medi-Cal. Is the message about the transition a statewide message or is it adapted county by county? I would encourage the development of county-specific messages. Many of the people transitioning are enrolled in existing indigent care programs that have separate names. They need to understand that they may be losing Healthy LA or Contra Costa Cares or Sacramento Health Partners, but it is replaced with Medi-Cal. In terms of the unwinding, one of the key questions I got when I was in DC was about what's going on with disenrollment? I appreciate the work that's being done with health navigators and the disenrollment survey to get more information. I would add my voice with regard to a pause for December, January, and February to get additional data from the first months of transition and to lower the call center volume as you are doing all of these other transitions. There is reason for a pause to manage workload for DHCS and also county partners.

Huang: Thank you for your comments. We hear you on the request for a pause on disenrollment. Even previous to the pandemic, the highest disenrollment reason was procedural terminations. We are not surprised that it continues to be the highest reason. Our experience during the Affordable Care Act was that pausing termination resulted in other complexities that were difficult to untangle. If you pause, there is still the federal requirement to redetermine every individual in 12 months and that will mean we have to double up on the actual redeterminations.

Cooper: We are tracking percentages prior to COVID to monitor any significant deviation. The

unwinding won't fix all of the eligibility issues, so we need to learn from this experience and implement those learnings in the future. I want to reiterate that we have lessons from the ACA and don't want to repeat mistakes of the past. We think pausing will be worse for members and counties because we still have a 12 month time clock in federal law that we have to meet. If we are out of compliance, there will be federal fund impacts. We are focused on doing everything we can. And I just really want to emphasize that both DHCS and counties have been meeting and constantly tweaking to improve the numbers while not completely disrupting the system. While other states have high procedural numbers now compared to before, we are seeing consistent numbers in California compared to prior to COVID.

Pittman-Spencer: We are hearing from high volume dental providers that there is a drop off in utilization, especially for kids. Are you tracking utilization to compare any changes?

Huang: No, we are not yet reviewing utilization and had not heard this internally. I will take this back.

Rodriquez: I'm glad to hear about the survey in follow up to procedural disenrollments. Will you have a list of members who need extra help as a result of the survey? Our members are interested in follow-up and would appreciate more targeted lists.

Huang: The survey is focused on individuals who did not returning the yellow packet and will gather qualitative data on the reasons. We will use the information to make outreach more effective. There will not be member identifiers although the survey is targeted to individuals who did not respond. Within the survey, we will have a link to enrollment assistance.

Enhanced Case Management (ECM)/Community Supports, Data Sharing and Authorization to Share Confidential Medi-Cal Information (ASCMI) Pilot

Susan Philip, Palav Babaria, MD, and Linette Scott, MD, DHCS

Slides available: https://www.dhcs.ca.gov/Pages/101923BHSACMeetingMaterials.aspx

Babaria provided an update on progress implementing Enhanced Care Management (ECM). ECM launched in January 2022 in 25 counties that previously had Health Homes and Whole Person Care pilot programs. She reported that ECM was implemented in all remaining counties as of July 2022. She noted that ECM for justice-involved populations was also launched in select counties as a part of the Whole Person Care Pilots. Babaria reported that in August 2023, DHCS released the ECM and Community Supports 2022 Implementation Report. She reviewed key data points from the report and noted that the report provides county specific data.

Philip reviewed Community Supports (CS) implementation and data. She reminded the group that CS are optional services, although MCPs are strongly encouraged to offer these services as part of their benefits. She reported that in 2022, the initial year of implementation, CS were offered in every county statewide. As of July 2023, 13 counties were offering all 14 CS.

Babaria outlined areas of focus for DHCS efforts to expand availability of ECM and CS. She offered examples of program design refinements to standardize eligibility, streamline referrals, expand provider networks, increase awareness, and improve data exchange. Babaria also

reviewed resources DHCS has released describing these changes, such as the policy guide for ECM and CS and a cheat sheet for plans and providers about where flexibility exists and where it doesn't. Babaria spoke to practices emerging for improving take-up, such as ensuring there are established relationships where a person making a referral knows the member and their needs. When MCPs use mining to identify eligible members and providers make cold calls, there is a high level of refusal.

Questions and Comments

Lerner: I'm eagerly awaiting the report on ECM for children and youth. Have you looked at variability across counties in terms of the provision of these services?

Babaria: Yes, ECM uptake is variable across counties. The 2022 report has county level breakdowns and the penetration rates are highly variable across counties for multiple reasons. There are areas with provider shortages where we are working to build up the network and other areas where the network exists and it's a referral and an awareness problem. Phase one of CalAIM is about building the network and the service infrastructure. We know that members won't necessarily be getting ECM and CS until the infrastructure exists. That said, we are moving to monitoring for some populations of focus that went live over a year ago to follow up where there are gaps and poor performance in uptake and enrollment.

Philip: CS also varies by county and by type of CS service. Some variation is based on availability of providers and we are targeting CITED support to providers and places where there are gaps. There is also utilization variation that is due to the referral mechanisms. One of the barriers is making sure that referrals are coming from providers that know members and understand the individual's needs.

Nguy: I appreciate DHCS' work to standardize eligibility and look forward to guidance being implemented. Is there still opportunity for stakeholder feedback on the guidance?

Philip: We provided an update of the CS policy guide in July. And as we move forward on additional service definitions or refinements, we will have a stakeholder process to work with providers and other stakeholders. There are also work groups focused on implementation guidance and TA that are also a venue for input. I can share that information with you.

Rodriquez: Can you offer details on how the provider types were identified in the data? For example, public healthcare systems could be under FQHC, public hospitals, or behavioral health providers. Also, I noticed organizations serving justice-involved individuals was zero, however, whole person care pilots were mentioned as continuing to see justice-involved individuals.

Babaria: The data is compiled from a quarterly report from MCPs. There is guidance on the ECM and CS webpage on all of the reporting requirements and definitions. However, we know there is overlap of some provider categories—for example, I imagine some FQHCs are part of public hospitals--and so it depends on how that data was reported to the MCP by the ECM provider and subsequently reported to DHCS.

Cooper: I can clarify that Whole Person Care individuals continue to be served. We can work with MCPs to fine tune the quality of that reporting, but we do know that Justice ECM is live in the state.

Owen: I appreciate the transformative work. Our county didn't have Whole Person Care and are moving at the speed of trust to build new relationships and collaborations. The big question is sustainability. Can DHCS comment on the sustainability of CS?

Cooper: We fully intend to move all CS from in lieu services to permanent benefits. We need provider capacity. The cadence of that may vary and once we move to 2024 contracting, it may go faster. We can't create permanent benefits until we have provider capacity because we can't guarantee someone a benefit if we don't have the providers to provide it. That is why we're focused on capacity building in these first few years. There is much more PATH funding coming out to build capacity.

Stoner-Mertz: As we look at the needs of homeless individuals, what limitation or access exists for MCPs to connect with social service departments for existing information, particularly for children and youth, for families that might be homeless and are not getting communications. Is there an agreement at the local level between MCPs and social service departments?

Baass: That varies by plan and county. Would any plans here like to comment?

McNaughton: I can share from a perspective from the Inland Empire. We have robust data sharing agreements with the two counties, and that includes the sheriff's departments as well. There is more to be done, but I think things are moving in the way that we need them to move.

Koopmans: The Housing and Homeless Incentive Program (HHIP) included a metric for obtaining HMIS data. Most local plans have been successful in getting those agreements in place. I don't know the data flow and frequency, however for housing data, HHIP was helpful in getting connections made and data starting to flow.

Flaum: Yes, I agree that HHIP helping us get access to the HMIS data and data sharing has been really helpful in opening up dialogue.

Barlow: Can DHCS comment about the similarities between MHSA funded services, like Full Service Partnerships or ACT models and ECM? And some of the flexible aspects of MHSA today also covered in CS? I understand that MHSA is the payer of last resort, but in many cases, counties implemented those before they were a focus for Medi-Cal. What are the conversations about how to maximize what an MCP provides with what County Mental Health Plans may provide outside of Medi-Cal.

Cooper: Since this is a pending ballot issue, I will offer basic information. The statute reads that for services counties are doing or will do in the future that are eligible for federal match, they are required to obtain that match. That would require, for example, if a CS option is operating in a particular county, they work with the county or with the MCP to have a contract to provide that or be working with the provider network that the MCP has in place to provide those services. They wouldn't be able to use BHSA funds. If it's someone who is not a Medi-

Cal member; someone who is uninsured or a veteran not on Medi-Cal, they would be able to use BHSA for those individuals. There will be comprehensive guidance developed if this is approved through the ballot. Essentially if it's a Medi-Cal benefit, they have to use Medi-Cal to draw down federal funds.

Barlow: Hospitals, as they do care coordination or discharge planning, try to look at what the local resources are. If that changes, hospitals will need guidance to understand how to refer correctly, whether to ECM through the MCP or FSP through the county. Is that a local conversation for each hospital to have with its local MCPs and counties? Psych hospitals in particular take patients from all over the state. There may not be an answer now, but I wanted to raise this as a consideration.

Baass: We do need to unpack that a bit because there's probably some of it for local conversations and some at the state level.

Sadwith: The ECM policy guide does acknowledge this issue and highlights that individuals who happen to be enrolled in a given county's FSP are not excluded from receiving ECM. It is a local conversation because FSP looks different in every county and counties can cap enrollment. The MOU templates that are out include clauses for the County Mental Health Plan and the MCP to describe processes for coordination and non-duplication between FSP and ECM.

Barlow: Are the MOUs public information posted online?

Sadwith: MCPs, County Mental Health Plans and county DMC-ODS do post executed MOUs on their website, based on 2018 guidance requirements for MOUs.

Scott continued the presentation with information on Data Sharing Authorization Guidance (DSAG) issued by DHCS in March 2022 per AB133 and CalAIM implementation. Scott explained that federal laws haven't changed, however there were flexibilities in the state statute to support data sharing. She reported that DHCS is working on additional DSAG, with input through an advisory group, and has released V2 for public comment. There were 96 comments submitted, many requesting data sharing use cases around particular populations, TA on data sharing challenges, and additional information and linkages to other initiatives. The next version of DSAG will be published this month with webinars and other information sharing. Scott explained that DHCS is also working on specific use cases and population examples to release as V3 with toolkits.

Scott reported that DHCS developed a universal release of information (ROI) form to facilitate sharing of physical, behavioral health and social health data. She described three local pilots of the ROI that each included a community information exchange, MCP, providers, and patients working together for six months. Surveys and other information were collected and will be shared publicly. Scott indicated that feedback shows that most people did grant consent to have information shared. She offered that next steps include identifying considerations for the statewide data exchange framework, work on how consent is collected for data sharing across different areas, such as social services data or justice data, and efforts to continue to be

explicit about when is consent needed or not.

Questions and Comments

Lewis: Participating in the data sharing work group was daunting because it is such a big challenge to know how to collect and share data across health care delivery systems that each have their own rules and then add systems such as child welfare and juvenile justice that also have distinct rules. I want to give credit to DHCS for the guidance. We offered feedback on how to make a very complicated area of law more understandable. The challenge that lies ahead is to move to the next level on a statewide policy. The statute, AB133, isn't legal guidance and a remaining issue is how to avoid varying applications of the rules and accomplish a single system where data sharing is allowed as well as protected, and that people all agree they can do it and they should do it, as opposed to seeing the guidance but continuing on and saying no to all data sharing because of their concerns around liability.

Scott: We appreciate your input. We do hear there are variations based on the fact this is guidance.

Koopmans: On the implementation challenges, is it part of the evaluation to determine if the form needs to change?

Scott: For this effort, we went with a form that was all inclusive in order to learn. Substance use disorder did require an additional action because of existing statute. Under AB133, DHCS has the authority to put it together but beyond that authority, we know there are very technical implications about how to implement a consent form.

Cooper: CalAIM data sharing is across the entire program, not just CS and ECM services. The statute encompasses all MCPs, county behavioral health, SUD and includes CCS and interactions with social services – it is essentially the entire Medi-Cal program.

CalAIM Mental Health: Screening and Transition of Care Tools
Tyler Sadwith and Bambi Cisneros, DHCS
Slides available: https://www.dhcs.ca.gov/Pages/101923BHSACMeetingMaterials.aspx

Sadwith reviewed slides on the screening and transition of care tools for Medi-Cal mental health services. He explained that previously, there were inconsistencies for screening assessments and referral processes. Sadwith described the extensive process conducted by DHCS as they worked with researchers, County Mental Health Plans, MCPs, stakeholders and the public to research, develop, test, and publish screening and transition of care tools for adults and youth that went live January 2023. Sadwith described guidance and FAQs that were disseminated.

Cisneros clarified that the screening tools help determine the appropriate Medi-Cal mental health delivery system for referral and are not clinical assessments to determine medically necessary services. She explained that the transition of care tool is for members receiving

mental health services from either delivery system and need to transition from one delivery system to another or need services added to their treatment from the other delivery system. For both tools, the assessment and determinations should be made by the clinician. The purpose of these tools is to coordinate services across the Medi-Cal mental health delivery systems. She commented that coordination includes sharing the tool, following up with the other delivery system to ensure a timely assessment, ensuing the member has been connected with a provider and the new system, that the new provider has accepted the member, and that all the medically necessary services have been made available. She noted that the screening tools are translated into 12 threshold languages.

Sadwith reported that DHCS will assess the performance of CalAIM behavioral health policy initiatives implemented over the past two years. He offered that DHCS is developing a monitoring approach of surveys, key informant interviews, analyses of claims data and other data sources in order to understand the impact, what's working well, what's not working well, and what the opportunities are for further guidance, clarification, TA or changes to policies. DHCS will finalize a report to be made public in January 2024.

Questions and Comments

Stoner-Mertz: Can you offer more information about the next steps, once you receive input on the screening tool, and whether you will bring stakeholders together?

Sadwith: The goal for next steps is broad. We are taking in feedback and making changes in a continuous improvement approach. As we develop more systemic findings through the monitoring, we will determine what the needs are, such as strengthening compliance and enforcement mechanisms or making policy adjustments.

Lewis: There is a lot of conversation on the youth screening tool. There are access issues that may be related to the tool and implementation of the rules. For example, there are requests by physicians to go past the MCP to specialty mental health, issues of access, and failure to provide timely services. These are big issues that can't be fixed with revision to a question. We are also conducting monitoring and have put out a three-part report with data analysis, qualitative interviews, and a qualitative secret shopper process. We found similar problems on access and think this is an issue for investigation.

Bobbie Wunsch invited those remaining in the que for questions to send them in writing to her to be included in the meeting summary in order to move to the next agenda item.

Ramirez (follow up communication): There is a lack of patient rights for people with disabilities in LA County. As reported in LA Times, *Strapped down: A Times investigation into the high use of restraints at L.A. General Medical Center* https://www.latimes.com/california/story/2023-10-18/strapped-down. Why haven't the high rates of restraint at L.A. General raised alarms? https://www.latimes.com/california/story/2023-10-19/restraint-psychiatric-patients-oversight-los-angeles-general-hospital

Public Comment

Renee Wachtel, MD: I am a developmental behavioral pediatrician and a clinical professor of pediatrics at UCSF School of Medicine. I'm speaking on behalf of the California Academy of Pediatrics, and we have been working closely with the California Academy of Family Practice Physicians and the California Academy of Child and Adolescent Psychiatrists. We are very concerned about the children and youth screening tool. We appreciate that we have been able to meet with Tyler Sadwith and staff to discuss the importance of being able to have physician-direct referrals to specialty mental health when appropriate and not have to use the screening tool. And we appreciate the fact that the FAQs have been changed as of July of 2023 to allow that, but it is not disseminated to the county specialty mental health programs and needs to be communicated more clearly. In addition, we feel that the screening tool is limited in its ability to identify children ages 0-12 who should be treated through specialty mental health. Having repeated clinical assessments is not the best way to accomplish this. We strongly recommend that an advisory group or work group of clinicians in family practice, pediatrics, and child psychiatry be convened to review the screening tool and offer DHCS guidance about how it can be amended to be more effective. Thank you for the information provided today.

Catherine Nelson, MD, MPH, FAAP, Site Lead, Pediatrics, Valley Health Center (VHC) Sunnyvale
Medical Liaison, Pediatrics, Silicon Valley Medical Legal Partnership: The implementation and use of the CalAIM screening tool by the Santa Clara County Behavioral Health Call Center has been a disaster; it has delayed and blocked children from receiving necessary mental health care. Prior to the implementation of the tool, parents and/or youth would call our Call Center, be assessed, and then be assigned to one of the many mental health agencies who provide mental health care to children/youth with Medi-Cal in our county.

Here is just one example of what families are now experiencing. My patient, an 8-year-old child who recently moved from Colombia with their mom, leaving all other family and support system in Colombia, has suspected panic disorder. I referred them in March 2023 for mental health services through the Call Center; the parent completed the screening with the Call center, the child was deemed “mild-to-moderate” and directed to their Medi-Cal health plan to receive mental health services through its network. The parent made first contact with a case manager from the health plan within one week from the referral. The parent has subsequently had 18 phone calls with the case manager (all documented in the medical record) and has not been able to find a mental health therapist who speaks Spanish and can provide mental health therapy to the child. In each contact, the parent has been given other therapists to call. The parent told me that she feels like a failure because she has not been able to get help for her daughter.

For comparison, in the same amount of time, the patient’s persistent asthma has been diagnosed, she has been seen and treated by a Pediatric Pulmonologist three times, and her asthma is now well controlled and no longer affecting her daily functioning. However, my patient continues with panic attacks and anxiety. On October 13, seven months after the initial referral for mental health services, I gave the parent information for a specialty mental health

agency to call directly, as I have recently received outreach from this agency that they do not have enough patients to treat because of the changes made under CalAIM.

This system is not working. Children and youth are not receiving the help they need, and parents feel like failures in not being able to get their children the mental health care they need.

Next Meeting, Next Steps and Adjourn
Michelle Baass, DHCS

Baass noted that hybrid meetings will continue through 2024. Calendar holds were sent for February 15, May 29, July 24, and October 16, 2024 for 9:30 AM – 1:30 PM for joint SAC-BH SAC meetings and 2:00 PM – 3:30 PM for BH SAC.