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

May 12, 2022

DHCS

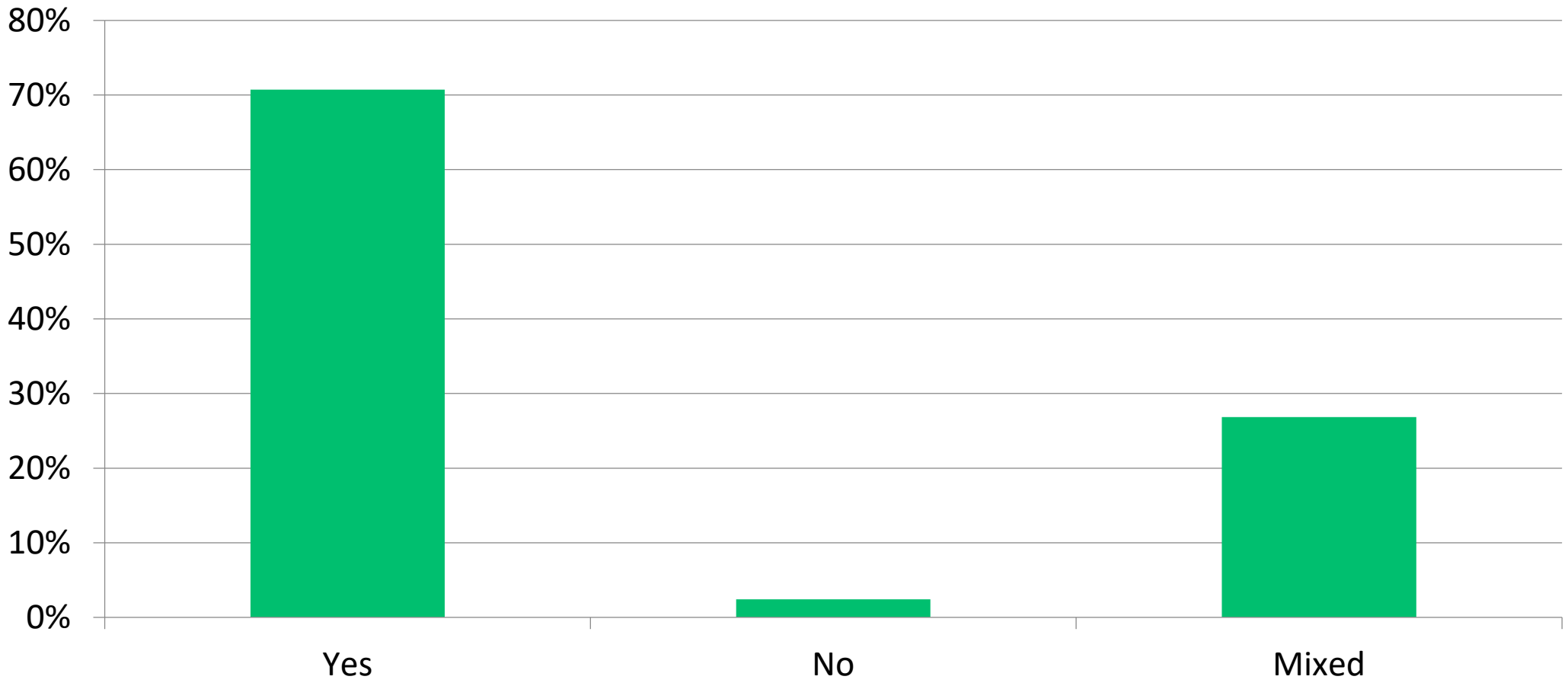
Webinar Tips

- Please use **either** a computer **or** phone for audio connection.
- Please mute your line when not speaking.
- For questions or comments, email: SACInquiries@dhcs.ca.gov or BehavioralHealthSAC@dhcs.ca.gov.

Director’s Update

SAC/BH-SAC 2022 Member Survey
Summary of Findings

Do you think the combined SAC/BH-SAC format is successful?



Advantages of the new meeting format

"I often join both, and I appreciate that the "core" Medi-Cal information isn't repeated twice -- the old system is a time sink for DHCS staff and for the (not small) number of people who attend both meetings."

"So much overlapping work is happening that it's good to be in the know across the two care delivery systems. It is imperative we continue to find ways to better link these two focus areas."

- Less duplication/redundancy of topics and discussion, especially for those who are members of both committees (12 comments)
- Takes less time (9)
- Improved efficiency (8)
- Opportunities to discuss intersecting topics with DHCS at the same time, promoting integration of health and behavioral health (7)
- More opportunities to hear different stakeholder perspectives and combine efforts (7)
- Consistent messaging, updates and information, keeping everyone in the same loops (4)

Disadvantages of the new meeting format

- Less time for in-depth discussion (14)
- No disadvantages (7)
- More issues that are not of direct interest or relevance to the whole group (3)

How to increase participation?

- More time for group discussion and comments (9)
- More actively manage group participation (8)
- More advance preparation materials (7)
- Meet in person (4)
- Use polling questions and voting options (3)

How should future meetings work?

- 56% said they should NOT be virtual only.
- 87% said that even if they prefer virtual meetings, they would attend one in-person meeting annually.
- 81% said they find hybrid meetings effective.
- 65% would regularly attend hybrid meetings in person.

How to make hybrid meetings more effective

- Invest in the right technology, training, and technical support (13)
- Find ways to ensure equal participation by remote participants (9)
- Have not found hybrid meetings to be effective (3)

Medi-Cal Rx Update

- Stabilized call center and prior authorization operations
- Proposed May 1 reinstatement date postponed
- Special population clinical liaisons

Medi-Cal Rx Update (Continued)

- Phased-in reinstatement of claims edits and prior authorizations
- External communication plan to leverage 90-day, 60-day, and 30-day outreach and education activities
- 90-day notification for retirement of the 180-day transition policy

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

DHCS' Commitment to Improving Children's Care

Medi-Cal's Strategy to Support Health and Opportunity for Children and Families was born out of a recognition of the challenges in Medi-Cal identified by state audits and stakeholders, and a state commitment to support health and opportunity for California's children and families.

Stakeholder Concerns / Issues

- Low pediatric preventive care rates and access to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits
- Low immunization rates and provider enrollment in Vaccines for Children
- Wide health disparities for Black and Brown children
- Increase in adolescent behavioral health concerns, with increases in overdoses and suicides statewide
- Low base reimbursement rates for Medi-Cal's pediatric primary care providers *(not including supplemental payments)*
- No clear owner of children's health at DHCS

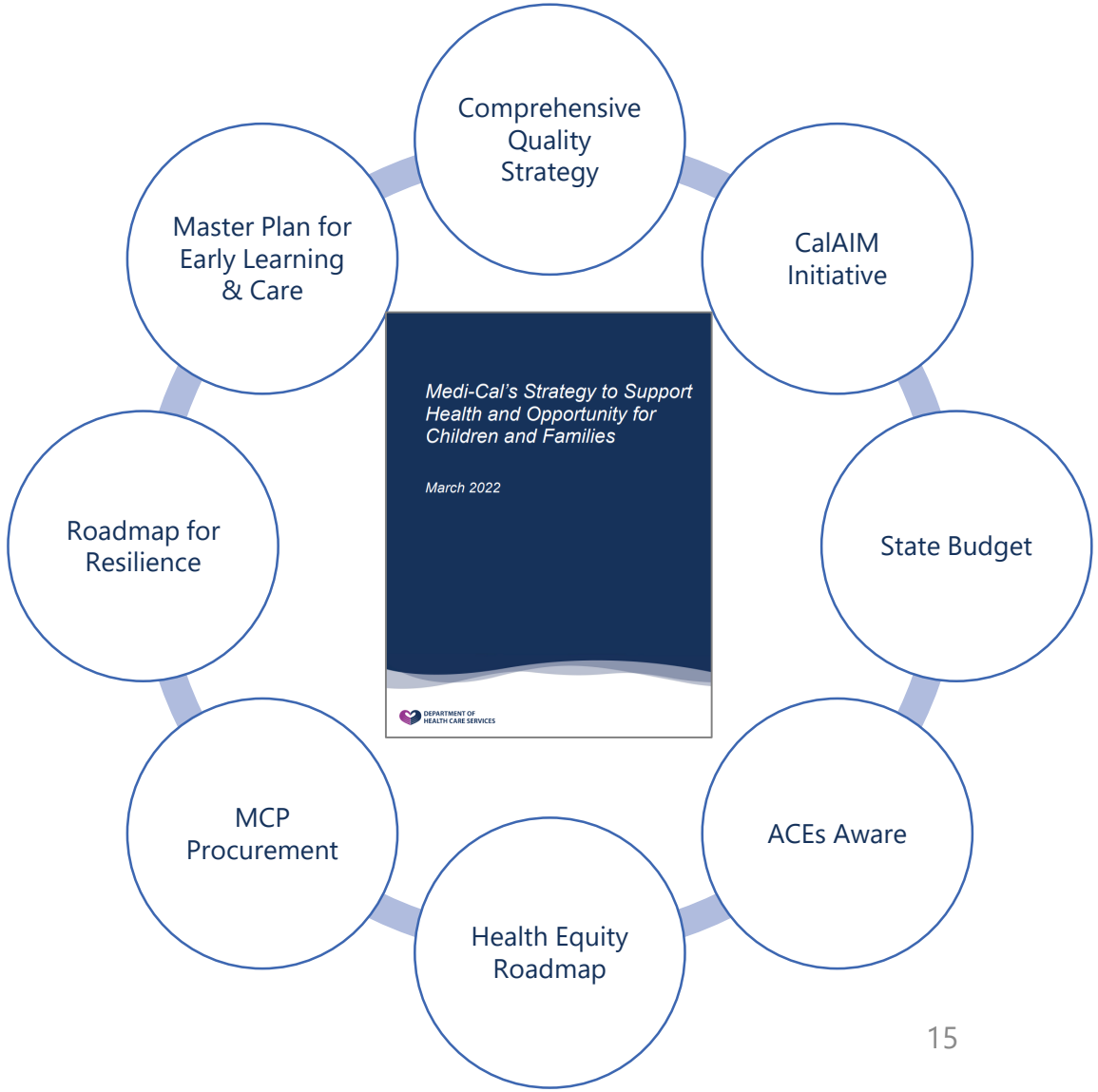
In 2021, The **David & Lucile Packard Foundation supported preliminary research** for DHCS that laid the foundation for Medi-Cal's Strategy to Support Health and Opportunity for Children and Families.

Through this work, DHCS:

- **Interviewed stakeholders** (including children's health advocates, managed care plan (MCP) leaders, and pediatric primary care providers)
- **Reviewed existing and new initiatives**
- **Analyzed data on children's access to Medi-Cal care**

DHCS' Approach

- **DHCS has a strong commitment to addressing entrenched health inequities and the resulting disparities that diminish children's health outcomes and life prospects.**
- **Medi-Cal's Strategy to Support Health and Opportunity for Children and Families** is a **living, breathing document** and DHCS' first step in organizing and communicating a **cohesive, coordinated strategy** to support children enrolled in Medi-Cal.
- Through the strategy, DHCS is **seeking to tie existing and new** children's health initiatives proposed in the initiatives noted in the graphic.



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

- **Forward-looking policy agenda** for children and families enrolled in Medi-Cal that **unifies the common threads of existing and newly proposed** child and family health initiatives.
- **Eight Action Areas** with detailed **key initiatives** that are designed to:
  - Solidify coverage for children
  - Promote whole-child and family-based care
  - Strengthen leadership and accountability structures
  - Implement evidence-based, data-driven initiatives
- Two infographics, including an **easy to read one pager** with Action Areas and a **detailed table with a status update and expected implementation timing** for each key initiative

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

Guiding Principles

- In shaping Medi-Cal's Strategy to Support Health and Opportunity for Children and Families, DHCS was guided by the following principles and considerations:
  - Addressing health disparities and advancing health equity
  - Implementing a whole-child, preventive approach informed by families
  - Providing family and community-based care
  - Promoting integrated care
  - Improving accountability and oversight
  - Looking beyond Medi-Cal

Action Areas

Each action area includes key initiatives – some already underway and others newly proposed – with detailed approaches on how to solidify coverage for children, promote whole-child and family-based care, strengthen accountability structures, and implement data-driven initiatives to support implementation.

- New leadership structure and engagement approach
- Stronger coverage base for California's children
- Stronger pediatric preventive and primary care
- Streamline access to pediatric vaccinations
- New health plan accountability for quality outcomes
- Family-centered approach
- Child and adolescent behavioral health investments
- Next steps on the foster care model of care

1915(b) Managed Care Monitoring and Oversight

Managed Care Oversight

- Improve the **consumer experience** by:
  - Continuing to meet quarterly with advocates and stakeholders
  - Establishing Member Advisory Committee
  - Conducting annual consumer satisfaction survey across all four delivery systems, starting in 2023
- Submit **workplan detailing approach to strengthen monitoring and oversight of plans** to improve member access to care for Medi-Cal Managed Care, Dental Managed Care, SMHS, and DMC-ODS by June 29, 2022
- Support **independent assessments on access to care** for MCMC, Dental Managed Care, SMHS, and DMC-ODS, including an independent assessment comparing MCMC networks with those in Medicare Advantage and private California commercial plans
- **Collect and report on data** to create a comprehensive and transparent view of **access to care, provider network capacity, appeals and grievances, quality, and consumer experience**
- **Ensure full and partially delegated plans and other subcontractors that assume delegated risk meet the standards** outlined for MCMC plans

Dental Managed Care Requirements

- Dental MCP performance measures (STC C.22) will be tracked against the fee-for-service (FFS) delivery system performance:
  - Annual dental visits (adults/children)
  - Use of preventive services (adults/children)
  - Use of sealants (children)
- Performance measure results will determine future contract awards when procuring for new Dental MCPs (STC C.23).

Dental Managed Care Requirements (Continued)

- Performance measures linked to performance withhold methodology to be implemented in CY 2023 (STC C.24).
- DHCS actively tracking Dental MCPs performance to meet parity with the FFS delivery system by December 31, 2022 (STC C.27).
  - DHCS issued Dental All Plan Letter 22-002.
  - DHCS will develop notices to notify Dental MCP members they may be able to disenroll from their current plan if the plan does not meet parity with FFS.
- If a member chooses to disenroll from the Dental MCP after December 31, 2022, DHCS will conduct a review of the plan to determine if the Dental MCP should be suspended or terminated (STC. C.28).

1915(b) Behavioral Health (BH) Managed Care Reporting Requirements

- Work Plan for Access Improvement
  - Includes DMC-ODS and SMHS
- DMC-ODS Independent Access Assessment
- SMHS Independent Access Assessment
- Quarterly Grievances and Appeals Report
  - Includes DMC-ODS and SMHS

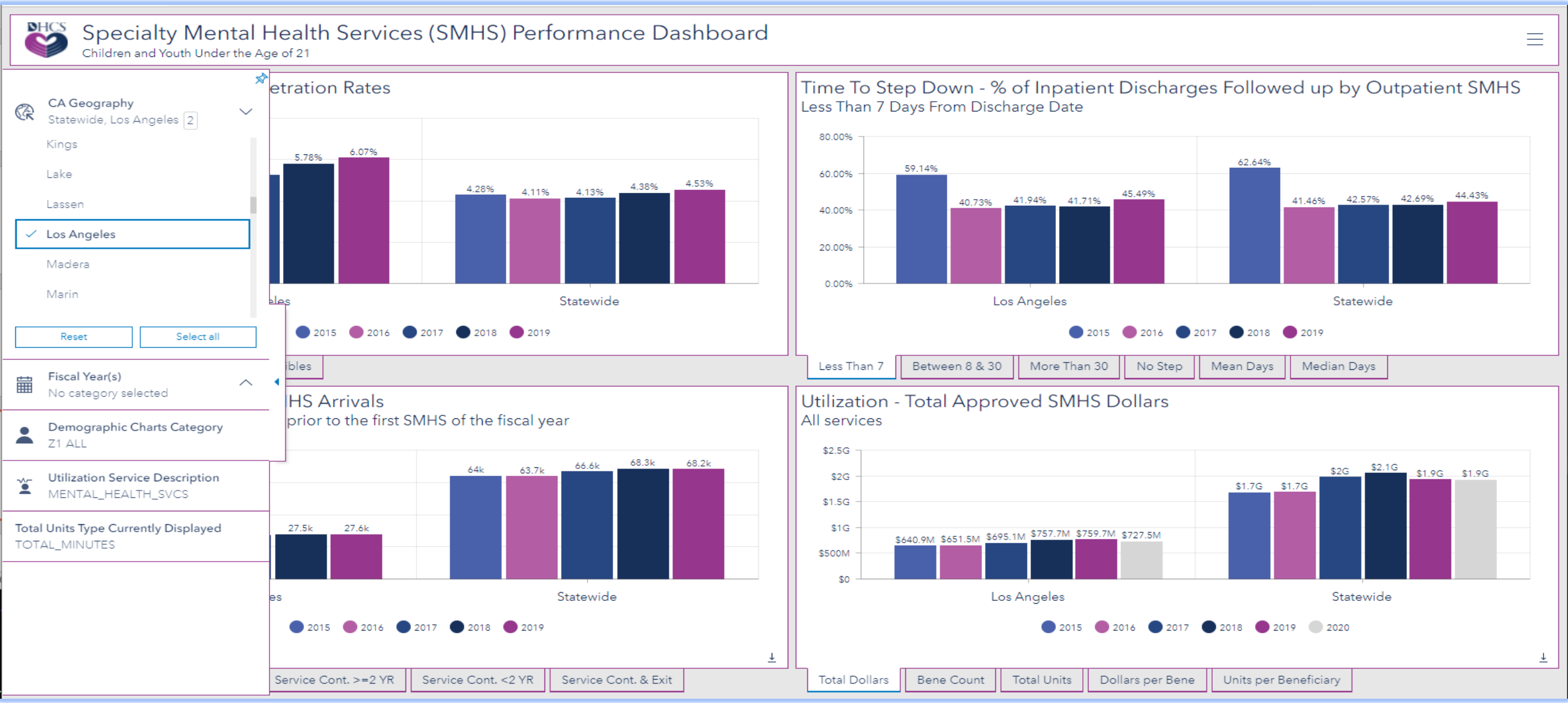
1915(b) Behavioral Health Managed Care Reporting Requirements (Continued)

- CMS requires DHCS to report on additional measures **by county mental health plan (MHP)**:
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Core Set measure SAA-AD).
  - Antidepressant Medication Management (BH Core Set measure AMM-AD).
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (BH Core Set measure APP-CH).
  - Follow-Up After Hospitalization for Mental Illness (BH Core Set measure FUH).
  - Percentage of patients offered timely initial appointments, and timely psychiatry appointments, by child and adult.
  - Percentage of high-cost beneficiaries receiving case management services.

BH Dashboard

- Current reporting is limited to CHHS Open Data Portal and uses an Excel-based report tool with challenging user interface and difficulty comparing counties' performances.
- Moving forward, DHCS is launching a new ArcGIS online dashboard for rich, easy-to-use data visualization geared toward advocates, beneficiaries, family members, and stakeholders, with easier county-to-county comparison.
- Currently developing methodology for reporting county MHP performance.

BH Dashboard Demo



Medical Loss Ratio (MLR)

- **Existing Requirements**
  - MCPs must report MLR to DHCS annually. (42 CFR § 438.8)
  - Starting in 2024, MCPs (except Dental MCPs) that fall below an 85 percent MLR will be required to remit funds to DHCS. (W&I Code § 14197.2(c))
  - For Dental MCPs, this requirement was imposed via the contract as of SFY 2019-20.
- **New Requirements (STC A.11)**
  - DHCS must submit to CMS the MCP-generated MLR reports and documentation of review.
  - DHCS' review must consider MLR requirements related to third-party vendors.
  - MCPs must impose equivalent MLR *reporting* (effective CY 2023) and *remittance* requirements (effective no later than Calendar Year 2025) on their applicable subcontractors.
- **Work plan** to operationalize the new requirements due by July 1, 2022.
  - DHCS engaged MCPs and other stakeholders beginning in March 2022.

Expansion of Medi-Cal for Those 50 Years of Age or Older, Regardless of Immigration Status, Effective May 1

Older Adult Expansion

- As proposed in the Governor's 2021-22 budget and pursuant to Assembly Bill (AB) 133, full-scope Medi-Cal is being extended to individuals who are 50 years of age or older, regardless of citizenship or immigration status, if otherwise eligible.
- Coverage expansion was implemented effective May 1, 2022.
- Policy guidance is posted in ACWDL 21-13 .
- The transition work was modeled after the children's and young adult expansions.

Populations Impacted

- New enrollee population – Includes individuals 50 years of age or older who are eligible for Medi-Cal, do not have satisfactory immigration status for full-scope Medi-Cal, (or are unable to verify citizenship), and are not yet enrolled in Medi-Cal.
- Transition population – Includes individuals 50 years of age or older who are currently enrolled in restricted scope Medi-Cal.

Notices

- DHCS developed three notices with frequently asked questions (FAQ) that were translated into the Medi-Cal threshold languages and are posted on the Older Adult Expansion webpage.
  - First Notice (General Information Notice)
  - Second Notice (Notice of Action (NOA) Snippets)
  - Third Notice (Managed Care Enrollment Notice)

Outreach Resources

- Medi-Cal Eligibility Division Information Letter MEDIL 22-02 provides global outreach messaging for the Older Adult Expansion and is posted on the DHCS website.
- Older Adult Expansion Global Outreach Language Toolkit and Older Adult Expansion Global Outreach Language Toolkit Translations are posted on the Older Adult Expansion webpage.
- For more information on the Older Adult Expansion, contact OlderAdultExpansion@dhcs.ca.gov.
- Spanish translation website for Older Adult Expansion
- Medi-Cal Outreach and Enrollment for Older Californians
  - The Budget Act of 2021 authorized DHCS to implement this outreach program that targets specific enrollment outreach for individuals over 65 years of age, Medi-Cal only, or duals.

Break – 10 minutes

California Advancing and Innovating Medi-Cal (CalAIM) Update

Governor's Master Plan for Aging (MPA)

- The MPA outlines five goals and 23 strategies to build a California for all ages by 2030. The MPA is a blueprint for aging across the lifespan of all Californians. Below are five bold goals for 2030:
  - Goal 1: Housing for All Ages and Stages
  - Goal 2: Health Reimagined
  - Goal 3: Inclusion and Equity, Not Isolation
  - Goal 4: Caregiving that Works
  - Goal 5: Affording Aging
- For more information on the MPA, please visit https://mpa.aging.ca.gov/.

MPA Mapping to CalAIM

- Goal 1: Housing for All Ages and Stages; More Housing, Initiative 9: Explore opportunities to increase availability of housing options with housing for health strategies.

- Goal 2: Health Reimagined; Bridging Health Care with Home:
  - Initiative 35: Plan and develop innovative models to increase access to long-term services and supports and integrated health care for people receiving both Medicare and Medi-Cal ("duals").
  - Initiative 36: Expand access to home and community-based services for people receiving Medi-Cal via CalAIM, by implementing Community Supports and Enhanced Care Management.
  - Initiative 37: Consider home and community alternatives to short-term nursing home stays for participants in Medi-Cal managed care through utilization of a combination of the home health benefit, Community Supports, and a proposed expanded telehealth benefit, including remote patient monitoring.

- Goal 4: Caregiving that Works; Family and Friends Caregiving Support, Initiative 110: Consistent with CalAIM, expand respite care for family caregivers.

Integrated Care for Dually Eligible Beneficiaries

- DHCS continues to prepare for these policies, in collaboration with stakeholders, through monthly public workgroups and frequent meetings with plans, providers, and others.
  - Enroll all dual eligible beneficiaries into Medi-Cal managed care statewide, effective January 2023.
  - Carve-in long-term care to Medi-Cal managed care statewide, effective January 2023.
  - In 12 "matching plan counties" Medicare Advantage plan choice drives Medi-Cal plan choice, to the extent there is a Medi-Cal plan that aligns with the Medicare plan.
  - In seven Coordinated Care Initiative (CCI) counties, transition Cal MediConnect to a Dual Eligible Special Needs Plan (D-SNP) exclusively aligned enrollment (EAE) model, effective January 2023.
  - Implement EAE D-SNPs in additional counties in future years, with statewide for all Medi-Cal plans no later than 2026, subject to feasibility study results.
  - Continue identifying strategies for integration and information sharing across plans and partners in all counties, for all dually eligible beneficiaries.

Community Supports and ECM Implementation Status

- **DHCS has adopted a list of 14 Community Supports.**
  - By January 1, 2022, 25 MCPs in 47 counties began offering more than 520 Community Supports across the state.
  - DHCS anticipates about 40,000 members will be transitioned into Community Supports from Whole Person Care without interruption in services.
- **ECM was also implemented on January 1.**
  - ECM implemented in 25 counties that previously served Whole Person Care or Health Homes Program members.
  - Approximately 95,000 individuals were transitioned into ECM.
  - Initial populations of focus include: Individuals and Families Experiencing Homelessness; High Utilizer Adults; and Adults with SMI/SUD.

Community Supports Elections

DHCS

CalAIM Community Supports - Managed Care Plan Elections

Community Supports are subject to changes in alignment with Model of Care updates

Updated January 2022

County:	Managed Care Plan:	Housing Transition/ Navigation	Housing Deposits	Housing Tenancy & Sustaining Services	Short-Term Post-Hospitalization Housing	Recuperative Care (Medical Respite)	Respite Services	Day Habilitation Programs	Nursing Facility Transition/ Diversion	Community Transition Services/Nursing Facility Transition to a Home	Personal Care and Homemaker Services	Environmental Accessibility Adaptations	Medically-Supportive Food/ Meals/ Medically Tailored Meals	Sobering Centers	Asthma Remediation
Alameda	Alameda Alliance for Health	X	X	X	-	X	-	-	-	-	-	-	X	-	X
Alameda	Anthem Blue Cross Partnership Plan	X	X	X	1/1/2023	X	1/1/2023	X	1/1/2023	1/1/2023	7/1/2022	X	X	1/1/2023	X
Alpine	Anthem Blue Cross Partnership Plan	7/1/2023	X	7/1/2023	7/1/2023	7/1/2023	1/1/2023	7/1/2023	7/1/2023	7/1/2023	7/1/2022	X	X	7/1/2023	X
Alpine	California Health & Wellness	7/1/2022	7/1/2022	7/1/2022	1/1/2024	1/1/2024	7/1/2023	7/1/2023	1/1/2023	1/1/2023	7/1/2023	X	X	1/1/2024	X
Amador	Anthem Blue Cross Partnership Plan	X	X	X		X	1/1/2023	7/1/2023	1/1/2023	1/1/2023	7/1/2022	X	X	X	X
Amador	California Health & Wellness	7/1/2022	7/1/2022	7/1/2022	1/1/2024	1/1/2024	7/1/2023	7/1/2023	1/1/2023	1/1/2023	7/1/2023	X	X	1/1/2024	X
Amador	Kaiser Permanente	X	-	X	-	-	-	-	-	-	-	-	-	-	-
Butte	Anthem Blue Cross Partnership Plan	X	X	X	7/1/2023	7/1/2023	1/1/2023	7/1/2023	7/1/2023	7/1/2023	7/1/2022	X	X	7/1/2023	X
Butte	California Health & Wellness	7/1/2022	7/1/2022	7/1/2022	1/1/2024	1/1/2024	7/1/2023	7/1/2023	1/1/2023	1/1/2023	7/1/2023	X	X	1/1/2024	X
Calaveras	Anthem Blue Cross Partnership Plan	7/1/2022	X	7/1/2022	1/1/2024	1/1/2024	1/1/2023	7/1/2023	1/1/2023	1/1/2023	7/1/2022	X	X	7/1/2023	X
Calaveras	California Health & Wellness	7/1/2022	7/1/2022	7/1/2022	1/1/2024	1/1/2024	7/1/2023	7/1/2023	1/1/2023	1/1/2023	7/1/2023	X	X	1/1/2024	X
Colusa	Anthem Blue Cross Partnership Plan	X	X	X	1/1/2024	1/1/2024	1/1/2023	7/1/2023	1/1/2023	1/1/2023	7/1/2022	X	X	7/1/2023	X
Colusa	California Health & Wellness	7/1/2022	7/1/2022	7/1/2022	1/1/2024	1/1/2024	7/1/2023	7/1/2023	1/1/2023	1/1/2023	7/1/2023	X	X	1/1/2024	X
Contra Costa	Contra Costa Health Plan	X	-	X	X	X	-	-	-	-	-	-	X	-	X
Contra Costa	Anthem Blue Cross Partnership Plan	X	X	X	1/1/2024	1/1/2023	7/1/2023	X	1/1/2023	1/1/2023	7/1/2022	X	X	7/1/2023	X
Del Norte	Partnership Health Plan of California	7/1/2022	7/1/2022	7/1/2022	7/1/2022	7/1/2022	1/1/2023	-	-	-	1/1/2023	-	7/1/2022	-	-
El Dorado	Anthem Blue Cross Partnership Plan	X	X	X	7/1/2023	7/1/2022	1/1/2023	X	7/1/2023	7/1/2023	7/1/2022	X	X	7/1/2022	X
El Dorado	California Health & Wellness	7/1/2022	7/1/2022	7/1/2022	1/1/2024	1/1/2024	7/1/2023	7/1/2023	1/1/2023	1/1/2023	7/1/2023	X	X	1/1/2024	X
El Dorado	Kaiser Permanente	X	-	X	-	-	-	-	-	-	-	-	-	-	-
Fresno	Anthem Blue Cross Partnership Plan	X	X	X	1/1/2023	7/1/2023	1/1/2023	X	1/1/2023	1/1/2023	7/1/2023	X	X	1/1/2023	X
Fresno	CalViva Health	7/1/2022	7/1/2022	7/1/2022	1/1/2024	1/1/2024	7/1/2023	7/1/2023	1/1/2023	1/1/2023	7/1/2023	X	X	1/1/2024	X
Glenn	Anthem Blue Cross Partnership Plan	X	X	X	7/1/2024	7/1/2024	1/1/2023	7/1/2023	7/1/2023	7/1/2023	7/1/2022	X	X	7/1/2023	X
Glenn	California Health & Wellness	7/1/2022	7/1/2022	7/1/2022	1/1/2024	1/1/2024	7/1/2023	7/1/2023	1/1/2023	1/1/2023	7/1/2023	X	X	1/1/2024	X
Humboldt	Partnership Health Plan of California	7/1/2022	7/1/2022	7/1/2022	7/1/2022	7/1/2022	1/1/2023	-	-	-	1/1/2023	-	7/1/2022	-	-
Imperial	California Health & Wellness	X	7/1/2022	X	1/1/2023	1/1/2023	1/1/2023	1/1/2023	1/1/2023	1/1/2023	1/1/2023	7/1/2022	X	1/1/2023	X
Imperial	Molina Healthcare of California Partner Plan*	X	7/1/2022	X	1/1/2024	1/1/2024	7/1/2023	7/1/2022	1/1/2024	1/1/2023	1/1/2023	7/1/2023	X	1/1/2024	X
Inyo	Anthem Blue Cross Partnership Plan	7/1/2023	X	7/1/2023	7/1/2023	1/1/2023	1/1/2023	1/1/2024	7/1/2023	7/1/2023	7/1/2022	X	X	7/1/2023	X
Inyo	California Health & Wellness	7/1/2022	7/1/2022	7/1/2022	1/1/2024	1/1/2024	7/1/2023	7/1/2023	1/1/2023	1/1/2023	7/1/2023	X	X	1/1/2024	X
Kern	Health Net Community Solutions	X	7/1/2022	X	1/1/2023	X	1/1/2023	1/1/2023	1/1/2023	1/1/2023	1/1/2023	7/1/2022	X	1/1/2023	X
Kern	Kern Family Health Care	X	X	X	X	X	1/1/2024	-	-	-	-	-	1/1/2023	1/1/2024	X

"X" - Offered by MCP

"-" - Community Support Not Offered

1/25/22

*Some Community Supports may not be available to all Members or in all areas of the county. Contact your Medi-Cal MCP for more information.

Updated Community Supports Elections Grid available at:
https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Elections-by-MCP-and-County.pdf

Enhanced Care Management (ECM)

- **ECM Populations of Focus to go live in January 2023:**
  - Individuals Transitioning from Incarceration
  - Members Eligible for LTC and at Risk of Institutionalization
  - Nursing Home Residents Transitioning to the Community
- **Activities underway in preparation of go live:**
  - Finalizing ECM eligibility policy for Dual-Eligibles
  - Refining Long Term Care (LTC) Populations of Focus definitions
  - MCPs to submit updated Models of Care (MOCs) for specific Populations of Focus on July 1, 2022
- For more information and the full "Populations of Focus", see DHCS' ECM webpage and the ECM Fact Sheet.

ECM and Community Supports – Implementation Support Strategies

- In March 2022, DHCS released the final CalAIM Data Sharing Authorization Guidance that supports data sharing between CalAIM participants.
- Technical Assistance Approaches through end of 2022 with highest priority challenges.
  - Authorization and approvals across ECM and Community Supports
  - Data sharing
  - Community Supports webinar series spotlighting specific Community Supports services
  - Implementation support in rural areas
  - Topic-focused: Housing supports, justice-involved population, behavioral health services

What is Providing Access and Transforming Health (PATH)?

- California has received expenditure authority as part of its section 1115 demonstration renewal for the PATH program to take the state's system transformation to the next phase, refocusing its uses to achieve the CalAIM vision. DHCS received partial authorization for $1.85 billion in total computable funding for PATH to maintain, build, and scale the infrastructure and capacity necessary to ensure successful implementation of key features of CalAIM.*

**DHCS is still actively negotiating approval for $410 million in expenditure authority to support the PATH Justice-Involved Capacity Building Program*

PATH Initiatives: Description and Status

PATH Initiative Name	Description	Status
Whole Person Care (WPC) Services and Transition to Managed Care Mitigation Initiative	Time-limited support to sustain existing WPC pilot services that have converted to Community Supports and that MCPs have committed to cover in the future, until they are picked up by MCPs (no later than January 2024).	• Go-live implemented on January 1, 2022 • All WPC successfully transitioned to CalAIM • 10 counties received transitional funding
Technical Assistance (TA) Initiative	TA resources for providers, CBOs, county agencies, public hospitals, tribes, and others through a virtual marketplace.	• TPA Vendor Proposals under DHCS review • TPA expected to be on-boarded in Q2 2022
Collaborative Planning and Implementation Initiative	Support for regional/county-based collaborative planning and implementation efforts among MCPs, providers, community-based organizations, county agencies, public hospitals, tribes, and others to promote readiness for ECM and Community Supports.	• Application period begins in June
Capacity and Infrastructure Transition, Expansion, and Development (CITED) Initiative	Enabling the transition, expansion, and development of capacity and infrastructure for providers, community-based organizations, county agencies, public hospitals, tribes, and others to provide ECM and Community Supports.	• CITED will include multiple open application windows in each year, with the first application window opening in June 2022
Justice-Involved Planning and Capacity Building Initiative	Funding to support implementation of pre-release Medi-Cal enrollment and suspension processes in jails, youth correctional facilities, and state prisons.	• Applications period for first round beginning in May with funding released on rolling basis • Second round of Justice-Involved Grants released in July

Tentative Launch Timeline for Third-Party Administrator (TPA) Supported PATH Initiatives

Activity/Initiative	May	June	July	Aug	Sept	Oct	Nov	Dec
Collaborative Planning and Implementation Initiative launch		***Registration for Collaborative Planning Open***	***Launch: Funds disbursed***					
CITED Initiative launch		***Application Window Open***	***Application Window Closes***	***TPA Reviews Applications and Develops Grant Agreements***		***Launch: Funds Disbursed***		
TA Marketplace launch				***Select TA domains and/or customized assistance may launch earlier if ready***				***Launch: Marketplace Live***
Justice-Involved Initiative launch	***Round 1***		***Round 2***		***Round 3***		***Round 4***	

= milestone = interim milestone = work ongoing

Key Next Steps

- Procure and onboard a TPA to operationalize the Justice-Involved Planning and Capacity Building, Collaborative Planning and Implementation, CITED, and TA marketplace PATH initiatives (May/June 2022).
- Release guidance to stakeholders on the TPA-led PATH initiatives (May-July 2022).
- Launch application periods for subsequent TPA-led PATH initiatives (Summer 2022).

Justice Package

- 2022:
  - Justice-Involved Advisory Group
  - PATH supports to help justice-involved initiatives' capacity building and prepare for implementation
  - Access to recovery services for individuals, including for justice-involved populations
- 2023:
  - Mandatory Medi-Cal application process upon release from county jails and juvenile facilities
  - Services for eligible justice-involved populations for 90 days pre-release
  - Coordinated re-entry, including:
    - Behavioral health warm handoff to plans and counties
    - ECM population of focus for coordinated re-entry
    - Community Supports (e.g., housing support, medically supportive foods) for justice-involved upon re-entry

Justice Package (Continued)

- Upon System Readiness:
  - Enhancements for facilitating data sharing, including for justice-involved populations
  - Automated suspension process

Traditional Healers and Natural Helpers

- In 2021, DHCS submitted a request to cover Traditional Healer and Natural Helper services.
  - Section 1115 expenditure authority for Traditional Healer and Natural Helper services
  - Provided by Indian health care providers
  - To DMC-ODS beneficiaries
  - From January 1, 2022, through December 31, 2026

Traditional Healers and Natural Helpers (Continued)

- CMS has neither approved nor disapproved the request
- DHCS remains committed to securing CMS approval
- Tribal MAT Project *Tribal and Urban Indian Community Defined Best Practices* funding and technical assistance opportunity to support planning and implementation efforts

CalAIM Behavioral Health Initiatives Timeline

Policy	Go-Live Date
Specialty Mental Health Services - Criteria for Services	January 2022
Behavioral Health No Wrong Door	July 2022
Contingency Management	Fall 2022
Behavioral Health Standard Screening and Transition Tools	January 2023
Behavioral Health Payment Reform	July 2023
Behavioral Health CPT Code Transition	July 2023
California Behavioral Health Community-Based Care Waiver	October 2022 (Earliest to CMS) July 2023 (Starts)
Administrative Integration of SMH and SUD	January 2022 (Starts) January 2027 (Fully Integrated)
DMC-ODS Traditional Healers and Natural Helpers	TBD

Behavioral Health Payment Reform - Key Elements

- Go live: July 1, 2023
  - Transition counties from cost-based reimbursement to FFS.
  - Transition from Certified Public Expenditures to Intergovernmental Transfers (IGT) for the county provided non-federal share.
  - Transition from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, known as CPT coding, when possible.

Payment Reform Guidance

- **Updated Billing Manuals (effective July 1, 2023) and other coding transition guidance.**
  - Available Now
    - SMH Billing Manual
    - 837 Companion Guides
  - Coming Soon
    - DMC Billing Manual
    - DMC-ODS Billing Manual
    - HCPCS to CPT Coding Crosswalk
- **Additional guidance is forthcoming.**
  - County rate schedule
  - CPE to IGT transition Information Notice
- For questions, email: BHPaymentReform@dhcs.ca.gov

What is the aim of the No Wrong Door (NWD) for Mental Health Services Policy?

- To ensure beneficiaries receive timely mental health services without delay, regardless of where they initially seek care.
- To ensure beneficiaries can maintain treatment relationships with trusted providers without interruption.

How did DHCS develop the NWD policy?

Workgroups

2019-2020 CalAIM stakeholder workgroups demonstrated the need to ensure beneficiaries have streamlined access to services and treatment.

CalAIM Proposal

CalAIM proposal released for public comment in January 2021.

CalAIM Section 1115 Amendment submitted in June 2021.

AB 133 chaptered in July 2021.

NWD Public Comment

Draft policy released in January 2022.

DHCS reviewed and integrated stakeholder feedback.

Final Policy

Released in March 2022 via BHIN 22-011 and APL 22-005.

No Wrong Door Policy

- Clinically appropriate and covered Non-Specialty Mental Health Services (NSMHS) and SMHS services are covered and reimbursable Medi-Cal services even when:
  - Services are provided prior to determination of a diagnosis, during the assessment period, or prior to determination of whether NSMHS or SMHS access criteria are met;
  - The beneficiary has a co-occurring mental health condition and SUD;
  - Services are not included in an individual treatment plan* **OR**
  - NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

**Applies to NSMHS per APL; SMHS guidance forthcoming via BH Documentation Reform*

Peer Support Services and Certification

- The Peer Support Services benefit will be covered as a county option with July 1, 2022, as the earliest effective date.
- DHCS issued Peer Support Specialist Certification requirements through Information Notice 21-041.
- Many counties designated the California Mental Health Services Authority (CalMHSA) as the entity that will implement their Medi-Cal Peer Support Specialist Certification Program in FY 2022-2023.

Standardized Screening and Transition Tools for Adults and Youth

- Adult and youth screening and transition of care tools go live on January 1, 2023.
- Adult tools were beta tested in fall 2021 and are currently undergoing pilot testing.
  - Adult tools will be released for stakeholder comment following pilot testing.
- Youth tools were beta tested in March 2022 and are currently out for stakeholder comment. Youth tools will be pilot tested in summer 2022.
  - Youth tools will be released for stakeholder comment following pilot testing.
- Informational and technical assistance webinars will begin later this year.

1115 BH Community-Based Continuum Demonstration

- DHCS will apply for a new Medicaid Section 1115 demonstration to expand access to and strengthen the continuum of community-based mental health services for Medi-Cal beneficiaries living with serious emotional disturbance or mental illness.
- California's 1115 demonstration will amplify California's ongoing behavioral health initiatives, and be informed by findings from DHCS' 2022 *Assessing the Continuum of Care for Behavioral Health Services in California*.
- **DHCS plans to release a concept paper to solicit stakeholder feedback on the proposed demonstration approach.**

Mobile Crisis Response Update

Crisis Care Mobile Units (CCMU) Project: Support and expand behavioral health mobile crisis and non-crisis services.

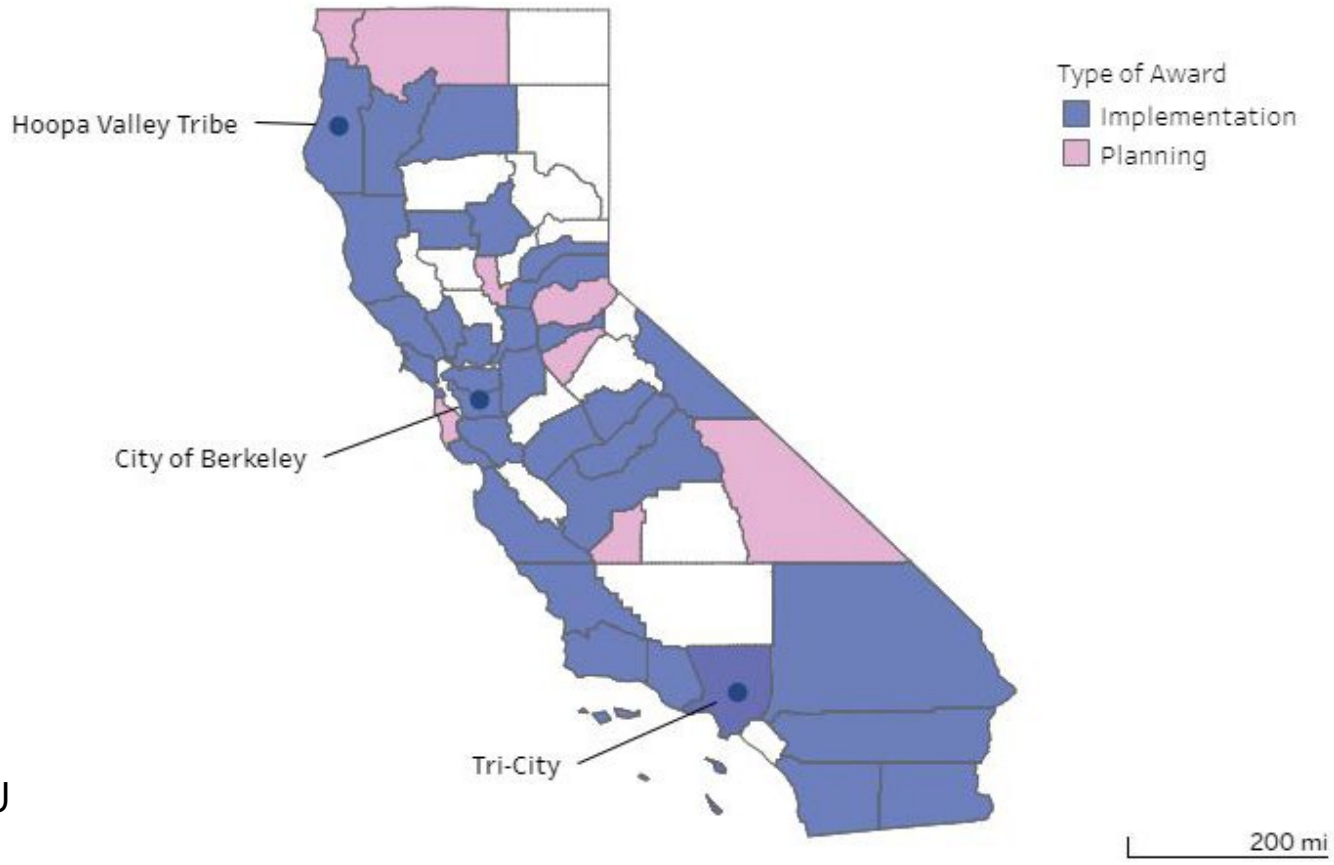
- Grants to implement or expand CCMU programs.
- Provides funding for infrastructure and some direct services to create or enhance mobile behavioral health crisis services.
- Prioritizes services for individuals 25 years old and younger.
- Funded through Behavioral Health Response and Rescue Project (BHRRP) and the Behavioral Health Continuum Infrastructure Program (BHCIP)
  - BHRRP: $55 million
  - BHCIP: $150 million

CCMU Project Impact

- **$160 million** awarded through two funding rounds*
- **51** county, city, or tribal entity behavioral health authorities received funding.
  - **10** planning grants
  - **41** implementation grants
- **130** new CCMU teams.
- **107** enhanced CCMU teams.

*Remaining funding currently allocated to future CCMU activities.

CCMU Awardees



Overview: Medi-Cal Mobile Crisis Services Opportunity

Mobile crisis teams offer community-based intervention to individuals in need wherever they are, including at home, work, or anywhere else in the community where the person is experiencing a behavioral health crisis.

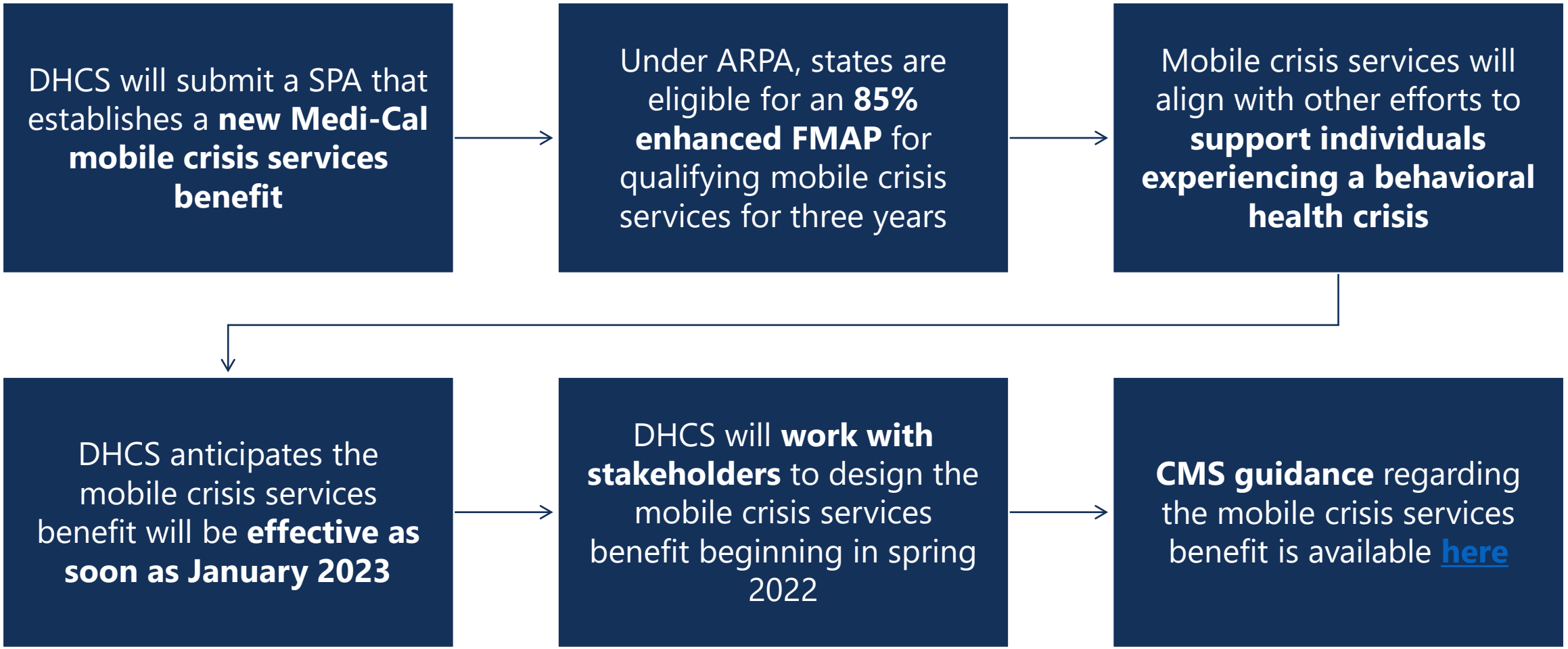
Under the American Rescue Plan Act (ARPA), **states are eligible for an 85% enhanced Federal Medical Assistance Percentage (FMAP)** for qualifying mobile crisis services for 12 quarters between April 2022 and April 2027.

DHCS intends to **submit a State Plan Amendment (SPA)** that establishes a new Medi-Cal mobile crisis benefit, effective as soon as January 2023.

DHCS envisions that its mobile crisis service will align with the state's other efforts to **support individuals experiencing a behavioral health crisis.**

DHCS is **designing a mobile crisis services benefit** to ensure all Medi-Cal members have access to coordinated crisis care 24 hours a day, 7 days a week, 365 days per year.

Mobile Crisis Services Benefit



Overview: Qualifying Mobile Crisis Services

In December 2021, CMS released a State Health Official letter providing guidance on the scope of and enhanced payments for qualifying community-based mobile crisis intervention services.

Minimum ARPA Requirements

- Services are available 24/7 and timely by a multi-disciplinary mobile crisis team.
- Teams include at least one behavioral health professional and other professionals/paraprofessionals with expertise in behavioral health.
- Teams are trained in trauma-informed care, de-escalation strategies, and harm reduction.
- Teams provide screening, assessment, stabilization, de-escalation, and coordination with health care services and other supports.
- Maintain relationships with community partners (e.g., medical, behavioral, and crisis providers).

CMS Recommendations

- Incorporate peers in the mobile crisis team.
- Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion.
- Implement GPS technology in partnership with the region's crisis call center hub to support efficient connection to resources and tracking.
- Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff.

Overview: Landscape of Mobile Crisis Services in California

While many counties in California operate mobile crisis teams, these teams do not cover all beneficiaries, all regions, or all behavioral health services across the state. DHCS is conducting information-gathering interviews with county representatives to identify challenges and opportunities in offering mobile crisis services.

- In the county survey conducted as part of the 2022 *Assessing the Continuum of Care for Behavioral Health Services in California,* mobile crisis was cited as the most urgent need in the crisis continuum. Fifty-one counties (86% of survey respondents) reported seeking to expand or improve mobile crisis services.
- Key takeaways from county interviews include:
  - Mobile crisis services expand and contract based on available funding sources. **Additional funding is needed** to cover transportation and downtime for mobile crisis teams and to ensure timely response.
  - **Workforce is a significant challenge** in staffing teams that are available 24/7, 365 days per year.
  - Most counties interviewed **rely on law enforcement** to mitigate safety concerns and transport individuals to higher levels of care when needed.
  - Counties report a **variety of mechanisms to dispatch teams**, including coordination with 911 and using standalone mobile crisis lines.

County Interviews: Key Takeaways

All counties interviewed reported interest in expanding mobile crisis services; however, they report shared challenges and concerns around standing up mobile crisis teams that are available 24/7.

- **Funding.** Counties report using a combination of Medi-Cal, Mental Health Services Act, and grant funding to pay for mobile crisis services. Programs expand and retract based on available funding sources. Funding is one of the top challenges reported by counties in standing up mobile crisis teams.
- **Workforce.** Counties report challenges with hiring mobile crisis teams and retaining staff. Staffing challenges result in slower response times and the inability to offer services 24/7. No counties interviewed currently offer 24/7 mobile crisis services. Workforce is one of the top challenges reported by counties in standing up mobile crisis teams.
- **Timeliness.** The majority of counties report a 60-minute goal response time after receiving a call for a mobile crisis teams. However, counties are not consistently tracking or enforcing timeliness standards, and many expect that teams are not meeting the 60-minute goal. County representatives expressed concern that introducing an enhanced rate for faster response times could result in negative unintended consequences, including prioritizing geographically close calls or avoiding more complex situations.

County Interviews: Key Takeaways (Continued)

All counties interviewed reported interest in expanding mobile crisis services; however, they report shared challenges and concerns around standing up mobile crisis teams that are available 24/7.

- **Law enforcement.** All counties interviewed reported relationships between mobile crisis teams and law enforcement. Some counties distinguish between mobile crisis teams that consist exclusively of behavioral health professionals/paraprofessionals and co-response teams. Counties report that safety of mobile crisis team members is a priority that can result in law enforcement involvement. Some counties report law enforcement are the primary responders for crises that occur in the middle of the night.
- **Children and youth.** Almost all counties report having at least one youth-specific team that responds to crises in schools or other settings. In some cases, youth teams are exclusively grant funded. Other counties do not staff youth-specific teams, but cross-train mobile crisis team members on youth-specific issues.
- **Peers.** Counties report increased use of peer support specialists onto mobile crisis teams. However, there are concerns around the re-traumatization of peers in crisis settings. One county reports using peers during follow-up after a mobile crisis visit, with a clinician or pair of physicians acting as the first response.

County Interviews: Key Takeaways (Continued)

All counties interviewed reported interest in expanding mobile crisis services; however, they report shared challenges and concerns around standing up mobile crisis teams that are available 24/7.

- **Dispatch.** Counties have different approaches to dispatching mobile crisis teams. Some counties operate standalone mobile crisis lines, while others coordinate with 911 to identify behavioral health crisis calls. Counties asked how 988 will integrate with and supplement existing mobile crisis services.
- **SUD services.** Counties are not consistently delivering SUD services as part of mobile crisis response. One county reported training teams in naloxone administration, but experiencing hesitancy among team members to carry naloxone. Counties shared that emergency medical services (EMS) teams more frequently respond to SUD-related emergencies.
- **Transportation.** Three counties interviewed have some teams that transport beneficiaries to higher levels of care in member vans. For most counties and teams, law enforcement or EMS transport individuals when needed.
- **Technology.** Some counties reported interest in increased use of technology to support mobile crisis service delivery and follow-up, including access to shared electronic health records to inform primary care providers when a beneficiary has received crisis care.

Tribal Interviews: Key Takeaways

All tribal representatives interviewed reported a disjointedness between Tribal and county-led behavioral health services.

- **Minimal Crisis Services.** Tribal behavioral health needs exceed IHP BH capacity. Some county mobile providers serve Tribal members off Tribal lands closer to urban centers. In some areas, county engagement is limited to 5150 holds.
- **Remoteness.** Service barriers for reaching AI/AN individuals on or near Tribal lands include long distances, bad roads, poor cell service, and poor internet connection both on Tribal lands and unincorporated county areas.
- **Reliance on County Sheriff.** Some county Sheriffs co-respond and provide long distance transportation to county ED. Ambulances fearful of responding on Tribal land without Sheriff. Concern about Tribal patients' fear of Sheriff.
- **Disconnected Services.** Sheriff drops patient off for long wait in ED. No alternative destination. No warm hand off from county facility to IHP for follow up. No interface between county and Tribal data systems.
- **Cultural Humility.** Concern about racism and stigma, and county providers not understanding the cultural context of a crisis scene with Tribal community and family dynamics. Reluctance to county assessment via telehealth.
- **Historical Distrust**. Some AI/AN individuals in need of services distrust county providers. Some Tribes reluctant to engage in MOU process with counties due to administrative challenges and a perceived lack of knowledge and respect among some counties for Tribal political status, history, culture, federal/legal rights, and internal processes.

High-Level Timeline: Stakeholder Engagement Approach

Stakeholder engagement will occur throughout the SPA drafting and submission process, leveraging existing forums and standing meetings.

Month	Activity
April	Landscape research
	Information-gathering interviews
	Meeting with behavioral health stakeholders
May	CalAIM BH Workgroup
	BH-SAC Meeting
	Tribal and Indian Health Program Large Group Webinar
June	CalAIM Children and Youth Advisory Group Meeting
	Meetings with associations and consumer advocacy groups
July	All-Stakeholder Webinar
	BH-SAC Meeting
August	Public Comment
	Tribal Notice
	Tribal and Indian Health Program Small Group Webinar

Public Comment

Upcoming Meeting and Next Steps