Stakeholder Advisory Committee & Behavioral Health Stakeholder Advisory Committee Meeting

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

February 2025

Hybrid Meeting Tips

- Please use either a computer or phone for audio connection.
- Please mute your line when not speaking.
- Members are encouraged to turn on their cameras during the meeting.
- Registered attendees can make oral comments during the public comment period.
- For questions or comments, email SACinquiries@dhcs.ca.gov.

Welcome and Roll Call

Michelle Baass, Director

Director’s Update

Michelle Baass, Director

Governor Newsom's 2025-26 Proposed Budget

DHCS Highlights

Governor’s Proposed Budget

- The Governor's proposed fiscal year 2025-26 budget includes $296.1 billion total funds for all health and human services programs.
- The Governor's proposed budget includes **$193.4 billion total funds for DHCS** and **4,821.5 positions**. Of this amount, $1.3 billion is state operations (DHCS operations), while $192.1 billion is local assistance (funding for program costs, partners, and administration).
- DHCS budget proposals continue to build on the Administration's previous investments and enable DHCS to continue to transform Medi-Cal and behavioral health within a responsible budgetary structure.

DHCS Major Budget Issues and Proposals

- Managed Care Organization (MCO) Tax and Proposition 35
- Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration Approval
- Caseload Impacts Related to Redeterminations
- Senate Bill (SB) 525 Health Care Minimum Wage Impacts
- Behavioral Health Transformation Update
- Home and Community-Based Spending Plan Update
- Trailer Bill Language

Medi-Cal Caseload

- Caseload will be generally steady or only slightly decline through 2024-25 (15 million individuals).
- Assumes the end of discretionary pandemic unwinding flexibilities that result in fewer discontinuances after June 2025.
- Consistent with this assumption, enrollment is expected to fall more steeply in 2025-26 (to 14.5 million individuals).
- Significant variability is possible in the near future due to potential changes in federal immigration policy.

Additional Information and Resources

- DHCS Website Governor's Budget Proposal
- Statewide Budget Website – ebudget.ca.gov
- Department of Finance Website Department of Finance

Enhanced Care Management and Community Supports Data Update

ECM and Community Supports: Quarterly Implementation Report

On December 20, 2024, DHCS published the latest ECM and Community Supports Quarterly Implementation Report with data through Q2 2024.

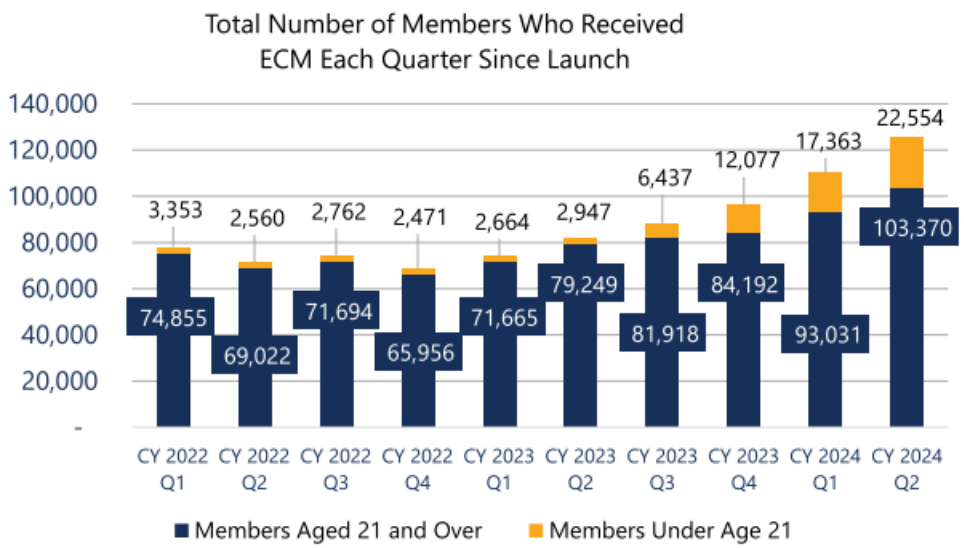
- Provides key updates about implementation of the programs.
- Enables MCPs to understand their performance relative to their peers.
- Supports local collaboration between stakeholders.

ECM Implementation Highlights

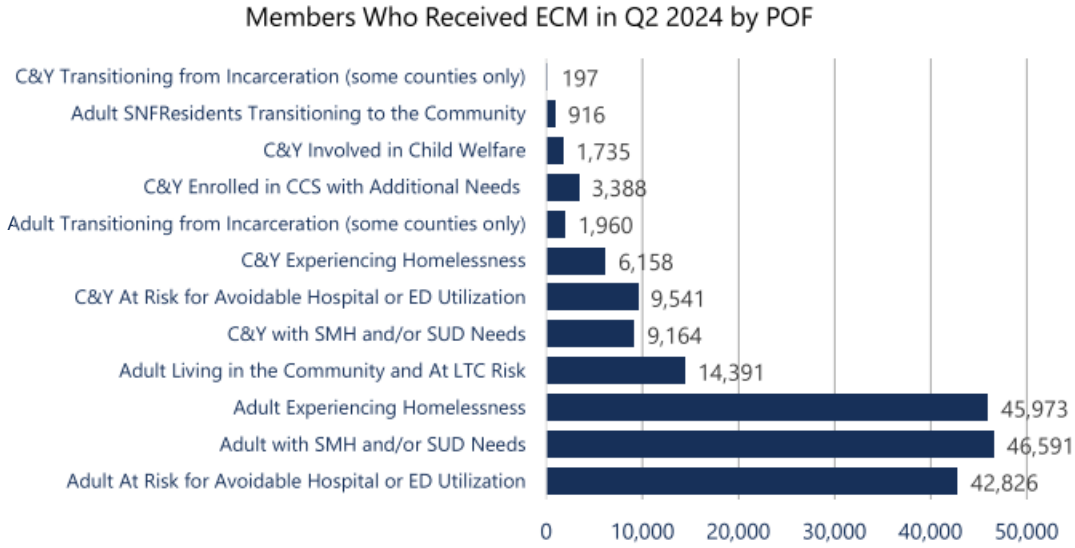
Data from January 2022 to June 2024

Since ECM launched, ~244,800 unique members have received the benefit.

From Q2 2023 to Q2 2024, the number of members who received ECM each quarter increased by 53 percent.



The Children and Youth (C&Y) POF launched on July 1, 2023.



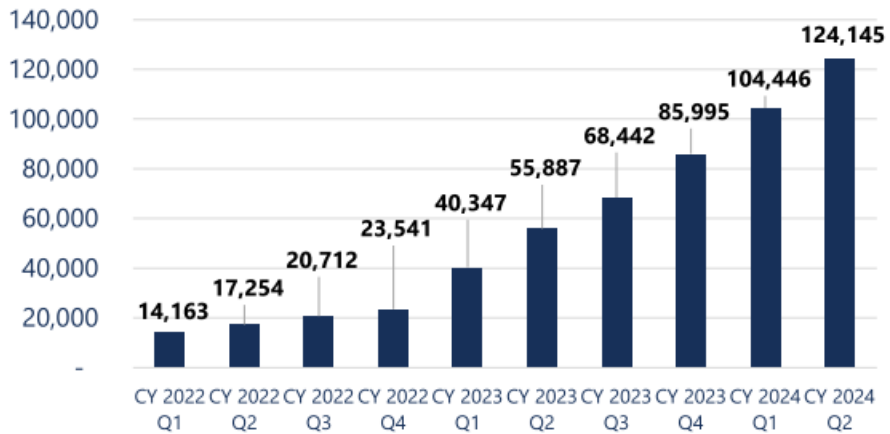
Community Supports Implementation Highlights

Data from January 2022 to June 2024

Since Community Supports launched,
~239,700 unique members have utilized one or more Community Supports services.

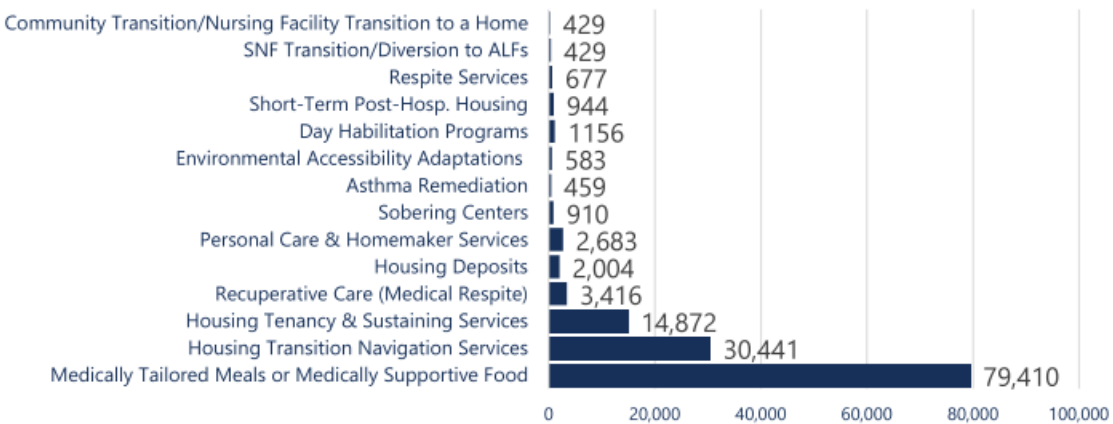
From Q2 2023 to Q2 2024, the number of members who utilized Community Supports services each quarter increased by 122 percent.

Total Number of Members Who Utilized Community Supports Each Quarter Since Launch



Medically Tailored Meals remains the most utilized Community Supports services, followed by the housing services "trio" and recuperative care.

Total Number of Members Who Utilized Community Supports in Q2 2024 by Service



Provider Networks for ECM and Community Supports

Data from January 2022 to June 2024

MCPs had **~2,060 Provider Contracts* to deliver ECM** in Q2 2024, a 70 percent increase from Q2 2023.

Total Number of ECM Provider Contracts by Provider Type in the Most Recent Quarter of the Reporting Period

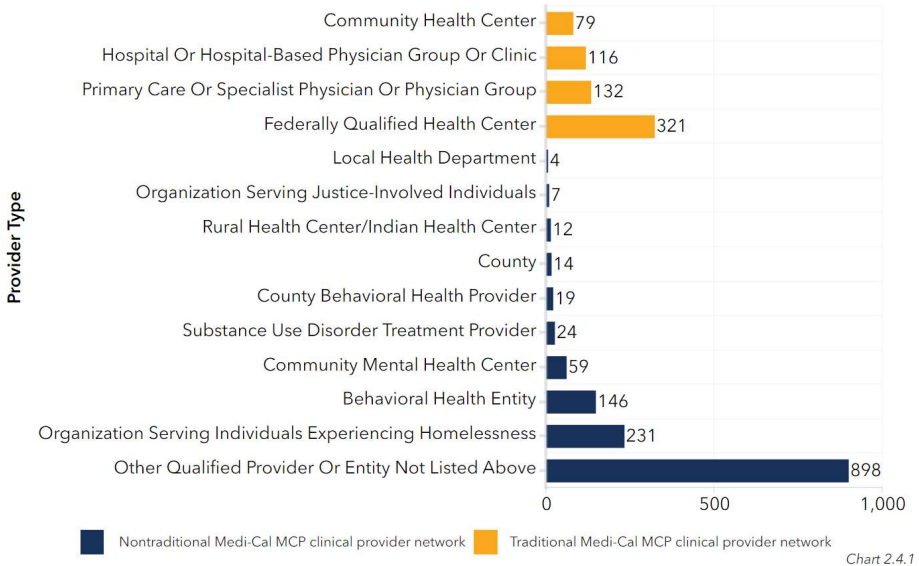


Chart 2.4.1

MCPs had **~2,336 Provider Contracts* to deliver Community Supports** in Q2 2024, a 62 percent increase from Q2 2023.

Total Number of Community Supports Provider Contracts by Provider Type in the Most Recent Quarter of the Reporting Period

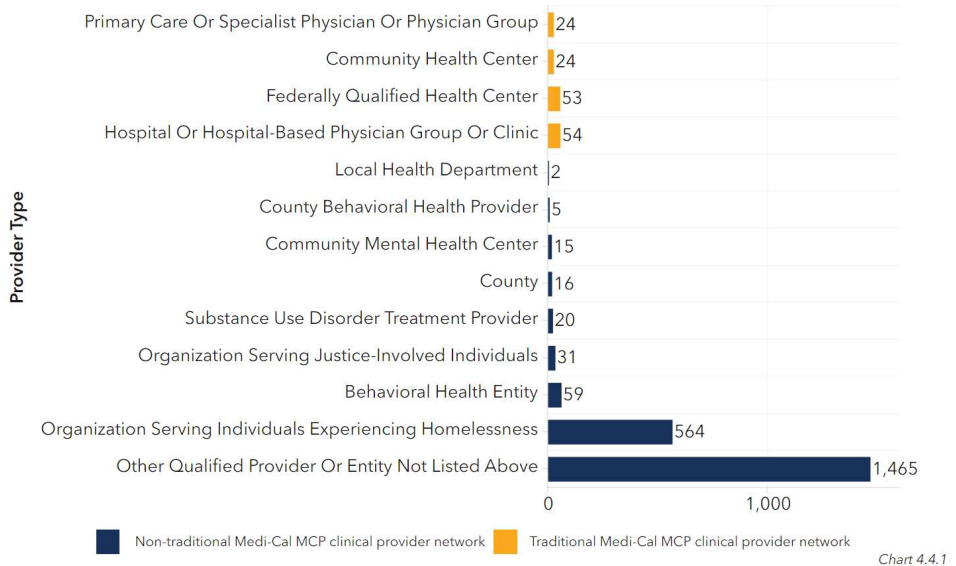


Chart 4.4.1

*A "Provider Contract" is a unique combination of NPI, provider type, MCP, and county.

Prop 1 Update

Behavioral Health Transformation Milestones

Started Spring 2024	Started Summer 2024	Beginning Early 2025	Summer 2026
Stakeholder Engagement Stakeholder engagement, including **public listening sessions**, through all milestones to inform policy creation.	**Bond BHCIP: Round 1 Launch Ready** **294 Requests for Applications (RFA)** received for up to $3.3 billion in funding available through the Behavioral Health Continuum Infrastructure Program (BHCIP).	**Integrated Plan Guidance and Policy** Policy and guidance will be **released in phases,** beginning with policy and guidance for integrated plans.	**Integrated Plan** New integrated plans, fiscal transparency, and data **reporting requirements** go-live in July 2026 (for next three-year cycle).

Bond BHCIP Round 1: Launch Ready

- May 14, 2024: DHCS released the **Bond BHCIP Round 1: Launch Ready**, which will provide up to **$3.3 billion** in funding for behavioral health treatment facilities statewide.
  - $1.5 billion open only to counties, cities, and Tribal entities.
  - $1.8 billion open to counties, cities, and Tribal entities, as well as nonprofit and for-profit organizations.
  - $30 million minimum to be awarded to Tribal entities.
- A Request for Applications posted in July 2024.
- **Application deadline was December 13, 2024.**
- **Funds will be awarded in spring 2025.**

Resources

Behavioral Health Transformation Website and Monthly Newsletter

Explore the Behavioral Health Transformation website for additional information and resources.

Please sign up on the DHCS website to receive monthly Behavioral Health Transformation updates.

Public Listening Sessions

DHCS hosted recurring public Behavioral Health Transformation listening sessions from April – October 2024 to gather feedback from stakeholders. Public Listening Sessions will resume in spring 2025.

Recordings are available on the Behavioral Health Transformation website.

Bond BHCIP Round 1: Launch Ready

Visit the BHCIP website to access the application and learn more.

Please send any other questions to bondbhciround1@ahpnet.com.

Questions and Feedback

Please send any other questions or feedback about Behavioral Health Transformation to BHTInfo@dhcs.ca.gov.

Questions?

Birthing Care Pathway

Karen Mark, MD, PhD, Medical Director of Policy and Evaluation, Quality and Population Health Management

DHCS

Agenda

- Birthing Care Pathway Development and Community Engagement
- Birthing Care Pathway Policy Roadmap
- Looking Ahead
- Transforming Maternal Health (TMaH) Model Update
- Q&A

Birthing Care Pathway Development and Community Engagement

DHCS' Vision for Maternity Care in Medi-Cal

With the launch of the Birthing Care Pathway, DHCS envisions a future in which:

Medi-Cal members have access to a comprehensive menu of maternity care providers and services, regardless of where they live.

Members can access risk-appropriate care and are empowered to choose the provider team and birthing location that align with their needs and preferences.

All members feel respected and heard throughout their pregnancy and postpartum journeys.

Members are educated about the services available to them and receive the navigational support they need for all aspects of their care.

Behavioral health services and social supports are accessible to all members, their newborns, and their families.

Data collection and sharing are improved to strengthen care for pregnant and postpartum members.

Birthing Care Pathway

» Comprehensive **policy and care model roadmap** that will cover the journey of all pregnant and postpartum Medi-Cal members from conception through 12 months postpartum.

» Roadmap includes a series of **policy solutions that address members' physical, behavioral, and health-related social needs.**

» Goals include **reducing maternal morbidity and mortality** and **addressing significant racial and ethnic disparities.**

Report Overview

DHCS published the Birthing Care Pathway Report in February 2025.

The Report:

- Summarizes the current state of maternal health in Medi-Cal.
- Shares findings from Birthing Care Pathway Medi-Cal member engagement.
- Provides an overview of partner engagement conducted to date.
- Discusses the policies DHCS has implemented/is implementing for the Birthing Care Pathway and shares progress to date.
- Identifies strategic opportunities for further exploration.

The Birthing Care Pathway is generously supported by the California Health Care Foundation (CHCF) and the David & Lucile Packard Foundation.

Report Development

To develop the Birthing Care Pathway DHCS:

Conducted a landscape assessment to review California's existing maternal health policies and initiatives, and identify evidence-based programs, policies, and interventions.

Engaged Medi-Cal members through a Member Voice Workgroup, interviews, and member journaling to ensure their lived experiences shaped the design of the Birthing Care Pathway.

Interviewed more than 25 state leaders, providers, community-based organizations (CBO), associations, health plans, and advocates to inform the design of the Birthing Care Pathway.

Launched the **Clinical Care Workgroup, Social Drivers of Health Workgroup,** and **Postpartum Sub-Workgroup** to identify challenges and opportunities in perinatal care and develop and validate policy options for the Birthing Care Pathway.

Engaged Medi-Cal Members

- DHCS engaged 30 members who were either currently pregnant or up to 24 months postpartum to share their lived experience.
- Medi-Cal members were selected to represent a diversity of experiences, especially the lived experiences of groups that experience health disparities.

Activity	Description
Interviews	Conducted **1:1 interviews** with **6** members.
Journaling	Invited **6** members to submit five biweekly **journal entries** about their perinatal experience.
Member Voice Workgroup	Launched a **Member Voice Workgroup** with **18** members and held three workgroup meetings.
All members were compensated for their participation.	

Birthing Care Pathway Medi-Cal Member Engagement Key Findings (1 of 2)

Feeling respected and heard by health care providers is critical to a member's perinatal experience in Medi-Cal. Members often feel that their birth plans and breastfeeding choices are not respected. However, members feel like midwives and doulas listen to their needs and preferences.

Some members **experienced discrimination in their health care encounters** during all three perinatal phases. Members felt connected to their health care providers and better supported when they received racially concordant care.

Key moments for trust building with members are often missed, particularly around mindful discussions on behavioral health screening results and referrals to services, trauma-informed approaches to intimate partner violence (IPV) screenings, smooth hospital discharges after birth, and timely access to high-quality breast pumps.

Birthing Care Pathway Medi-Cal Member Engagement Key Findings (2 of 2)

Medi-Cal members often felt like the **onus was on them to independently navigate and coordinate many aspects of their perinatal care** – ranging from coordinating their care across different health care providers to ensuring Medi-Cal coverage for themselves and their newborns.

Finding mental health providers that accept Medi-Cal, are taking new patients, and have perinatal experience is difficult. Medi-Cal members want more frequent and intensive mental health supports.

Medi-Cal members often **do not understand what Medi-Cal benefits and public benefits/social services are available** to them in pregnancy or during the postpartum period (e.g., doula services; Enhanced Care Management (ECM); Women, Infants, and Children Program (WIC)/CalFresh; and transportation services).

Key Informant Interviews

DHCS interviewed more than 25 state leaders, perinatal care providers, advocates, and representatives from CBOs, associations, and health plans to inform the development of the Birthing Care Pathway.

Category	Interviewees
Provider Associations	Representatives from the American College of Obstetricians and Gynecologists (ACOG), California Nurse-Midwives Association (CNMA), and California Association of Licensed Midwives (CALM).
Individual Providers	OB/GYNs; family and addiction medicine physicians; certified nurse midwives (CNM); licensed midwives (LM); freestanding birth center (FBC) providers; pediatricians; reproductive psychiatrists; lactation consultants, doulas, and community health workers (CHW).
County Leaders	Representatives from Black Infant Health (BIH), WIC, and Maternal, Child, Adolescent Health (MCAH) programs.
CBO Leaders & Advocates	Individuals focused on LGBTQ+ health; IPV services; and birth justice and supports for Black, American Indian/Alaska Native, and Pacific Islander individuals.

Birthing Care Pathway Workgroups

Workgroup	Participant Charges	Composition
Clinical Care	Identifying what needs to happen in the hospital, birthing center, provider office, and other community settings from a Medi-Cal member's perspective.	Physicians; midwives; lactation consultants; doulas; Tribal health providers; FBC, behavioral health, and federally qualified health center (FQHC) providers; managed care plans (MCP); and local public health.
Social Drivers of Health	Identifying best practices and needs from programs and providers that currently work to address perinatal health-related social needs.	CHWs; doulas; violence prevention organization representatives; local public health and social service program representatives; home visitors; and providers with Black birthing expertise.
Postpartum Sub-Workgroup	Designing a clinical pathway for what providers can do during the postpartum period to achieve positive health outcomes.	Cross-representation from the Clinical Care and Social Drivers of Health Workgroups, as well as additional physicians.

All three workgroups met throughout 2023 and 2024 to discuss key challenges with the Medi-Cal birthing experience and provide feedback on proposed policy solutions. Workgroup members who indicated financial barriers to participation were compensated for each meeting they attended.

Birthing Care Pathway Partner Engagement Key Findings (1 of 2)

Access to maternity hospitals in rural communities is **rapidly diminishing.**

Midwives and lactation consultants face **barriers to Medi-Cal provider enrollment and reimbursement**, impeding member access.

Limited qualified providers and long appointment wait times hinder access to **perinatal behavioral health care.**

Improved collaboration, integration, and data sharing among perinatal providers and health systems are needed to deliver **coordinated care** to pregnant and postpartum Medi-Cal members.

The **group care model** provides a team-based, whole-person approach to birthing care and builds community.

Birthing Care Pathway Partner Engagement Key Findings (2 of 2)

The Comprehensive Perinatal Services Program (CPSP) should be modernized to bolster access to comprehensive perinatal services to all pregnant and postpartum members.

Pregnant members are not consistently being connected to **providers and facilities that meet their risk level.** Screenings should be updated and streamlined to better assess a member's risk level, connect members to services, and prevent screening fatigue.

There are **limited housing programs** available to pregnant Medi-Cal members.

Medi-Cal members would benefit from additional educational resources on how to navigate the perinatal period.

Additional Input for the Birthing Care Pathway

DHCS received additional input on the Birthing Care Pathway from maternity care and social services providers, state leaders, MCP representatives, Tribal health providers, local public health, and birth equity advocates.

Birthing Care Pathway Policy Roadmap

Birthing Care Pathway Policy Roadmap

Policies DHCS Has Implemented/Is Implementing

The Report also includes **Strategic Opportunities for Further Exploration** which **require additional assessment and planning to determine if implementation is feasible and would be contingent on external factors** (e.g., additional state budget resources).

Focus Areas of Policies DHCS Has Implemented/Is Implementing (1/2)

Provider Access and MCP Oversight. Expanding access to a range of maternity providers – including doctors, midwives, and doulas; enhancing oversight of maternity services delivered through Medi-Cal MCPs; and improving communication to Medi-Cal members on available benefits and provider types.

Behavioral Health. Enhancing trauma-informed care and increasing access to mental health and substance use services.

Risk Assessment. Identifying pregnant and postpartum Medi-Cal members who are high risk and connecting them to needed services and supports; and strengthening intimate partner violence screening.

Care Management and Social Drivers of Health. Delivering whole-person care; addressing social needs, including housing and nutrition; and strengthening partnerships with community providers that have perinatal expertise.

Focus Areas of Policies DHCS Has Implemented/Is Implementing (2/2)

Justice-Involved Care. Facilitating enrollment in Medi-Cal and ensuring access to services before and after release from prison or jail.

Payment Redesign. Increasing reimbursement rates for a range of maternity care providers and supporting value-based maternity care.

Data and Quality. Building integrated systems for data sharing; supporting cross-enrollment of Medi-Cal members into crucial safety net supports; and creating new performance metrics to improve the quality of Medi-Cal maternity care.

State Agency Partnerships. Coordinating across different California programs for maternal health – such as home visiting and Paid Family Leave – to boost member awareness and access.

Focus Areas of Strategic Opportunities for Further Exploration

The opportunities for future discussion for the Birthing Care Pathway are in the following six focus areas:

- Provider Access and MCP Oversight and Monitoring
- Behavioral Health
- Maternal Care Models and Access
- Provider Resources
- Data and Quality
- State Agency Partnerships

Looking Ahead

Continued Community Engagement on Birthing Care Pathway

- The Birthing Care Pathway is a **multi-year initiative.**
- **DHCS aims to continue to engage a diverse set of partners** to implement and further develop the Birthing Care Pathway.

Transforming Maternal Health (TMaH) Model Update

TMaH Model Overview

In January 2025, the federal Centers for Medicare & Medicaid Services (CMS) announced California as one of 15 states selected to implement the **TMaH Model**.

- TMaH is a **10-year delivery and payment model** designed to test whether evidence-informed interventions, sustained by a **value-based payment (VBP) model**, can improve maternal outcomes and reduce Medicaid and Children's Health Insurance Program (CHIP) program expenditures.
- DHCS will implement TMaH in five Central Valley counties: **Fresno, Kern, Kings, Madera, and Tulare.**
- DHCS will receive **$17 million in federal funding** and targeted technical assistance.

TMaH Model Partners

DHCS will partner with providers, care delivery locations, and other partner organizations, including MCPs and CDPH, to implement various TMaH elements in the model test region. DHCS has already been engaging with many of these partners through the Birthing Care Pathway.

Partner Providers

- OB/GYNs, midwives, physicians, maternal-fetal medicine specialists, nurses, and other clinical and support staff, such as doulas, lactation consultants, and perinatal CHWs.

Partner Care Delivery Locations

- Hospitals, OB/GYN and family medicine practices, safety set providers (FQHCs and RHCs), Tribal sites, birth centers, and other sites of care.

Partner Organizations

- MCPs, CDPH, CMQCC, California Perinatal Quality Care Collaborative (CPQCC), Pregnancy-Associated Review Committee (PARC), universities, CBOs, and other non-clinical partners.

TMaH Model Timeline

Pre-Implementation Period: Model Years 1-3

January 2025-December 2027

- **Model Years 1-3:** DHCS receives technical assistance to develop the TMaH Model and achieve pre-implementation milestones.
- **Model Year 3:** Infrastructure payments are made to providers.

Implementation Period: Model Years 4-10

January 2028-December 2034

- **Model Years 4-10:** DHCS implements the TMaH Model
- **Model Year 4:** Quality & Performance Incentive Payments are made to eligible providers.
- **Model Year 5:** DHCS will transition to a VBP model

Questions?

Contact us at BirthingCarePathway@dhcs.ca.gov with any questions.

Medi-Cal MCP and County Behavioral Health Plan Quality Ratings for 2023

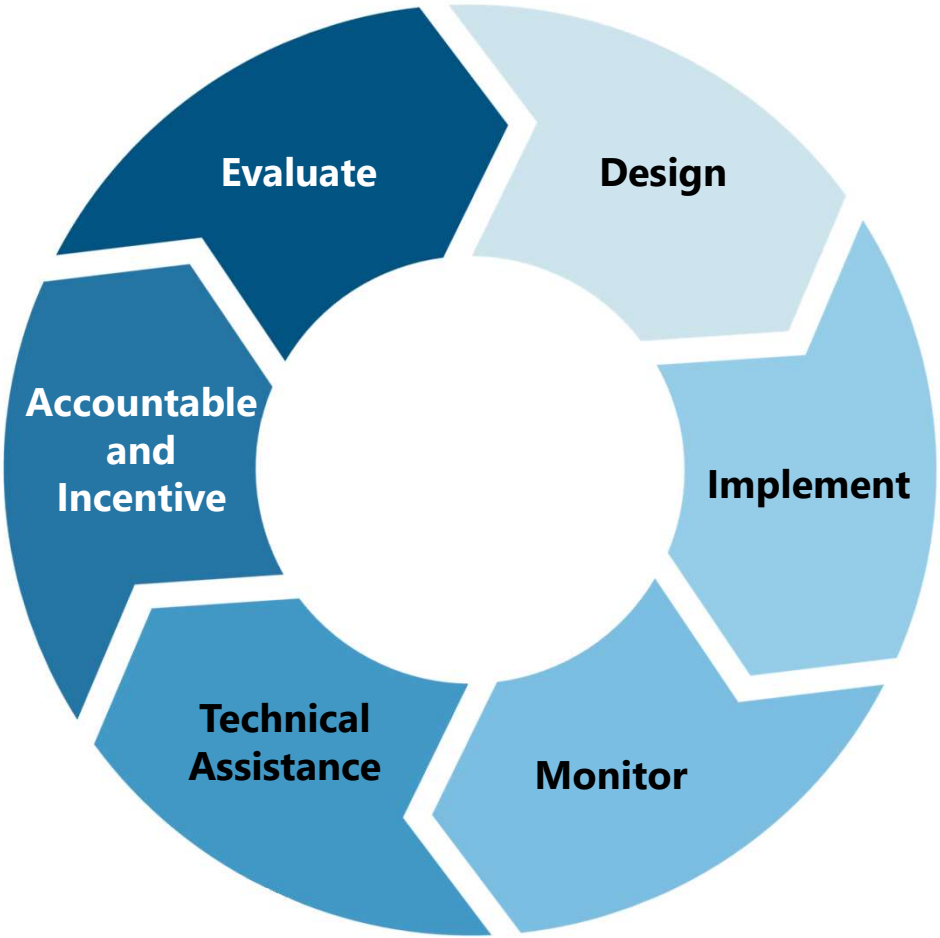
Sarah Lahidji-Sales, Division Chief, Quality and Health Equity

DHCS

Member Story

"I owe a lot of my recovery and sobriety to Medi-Cal and my medication assisted treatment program. Both my treatments and medications were covered! I am so grateful neither me nor my family had to come up with thousands of dollars."

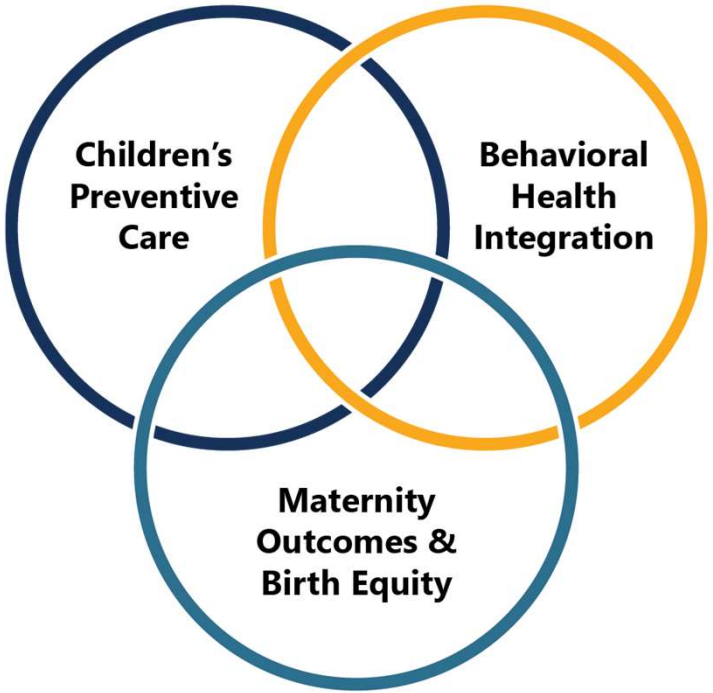
Success through the Policy Lifecycle



- Advancing the quality and health equity of the care received by Californians utilizing Medi-Cal services, requires the application of the policy lifecycle.
- The Quality and Health Equity division delivers services to advance each stage of the policy lifecycle.

Key Priorities for Improvement

Figure 20: DHCS Clinical Focus Areas



Reference: DHCS Comprehensive Quality Strategy, 2022

- DHCS has used a data-driven approach to determine the key clinical areas of focus to address significant quality and health equity gaps in care.
- DHCS established focus in these clinical focus areas in the release of the Comprehensive Quality Strategy in 2022 and will maintain these areas as focus in the next edition of the Comprehensive Quality Strategy.

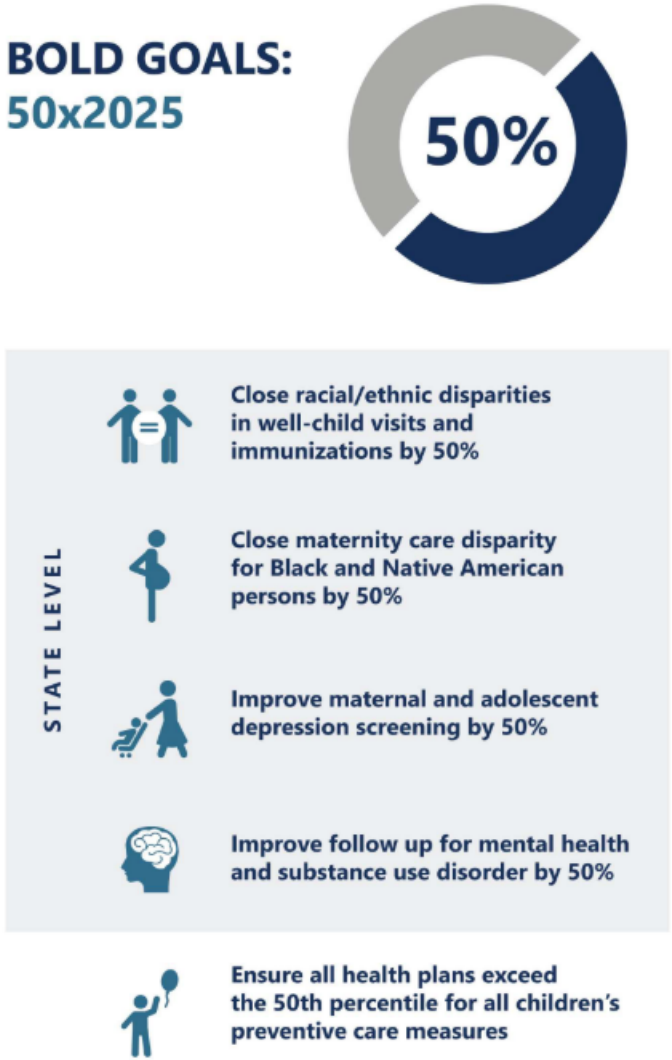
Levers to Drive Accountability

- Compliance Audits and Reviews
  - Audits and reviews verify plan compliance with applicable policy and contractual requirements.
- Corrective Action Plans
  - A structured process by which DHCS meets with a plan that is not meeting quality standards to review the plan's approach to driving improvement and progress throughout the effort.
- Liquidated Damages
  - Fines of a discrete amount that are levied against a plan that is found in breach a component of their contract.
- Sanctions
  - Financial penalties that are levied against a plan that fails to meet the quality standards set for a defined list of key quality measures based on methodology described in a Behavioral Health Information Notice or All Plan Letter.

Medi-Cal Managed Care Plans Sanctions Overview

Managed Care Accountability Sets (MCAS) Definitions MY 23

MCAS	Measures in MCAS are either reportable or held accountable to the MPL of performance goals that MCPs should exceed. The **total number of MCAS measures is 39 in MY 23.**
Minimum Performance Level (MPL)	**If MCPs fail to meet or exceed the MPL they are held to enforcement action**. The MPL is determined by DHCS for Healthcare Effectiveness Data and Information Set (HEDIS) measures as the national Medicaid 50th percentile for each measure; for non HEDIS measures, MPLs are designated as Centers for Medicare & Medicaid Services (CMS) state performance medians (national medians). MCPs are contractually required to exceed MPLs beginning in Measurement Year (MY) 24.
Report Only Measures	MCPs **must report on 21 MCAS measures** for which they will not be held to MPL or subject to enforcement actions. The number of report only measures will decrease by one in MY 24 and will be further decreased by ten report only measures in MY 25.
Accountable/Held to MPL Measures	MCPs are **held to MPL for 18 measures and subject to enforcement actions** based on their performance. Measures held to MPL in MCAS will not change from MY 23 to MY 25.



MCAS Measure Alignment

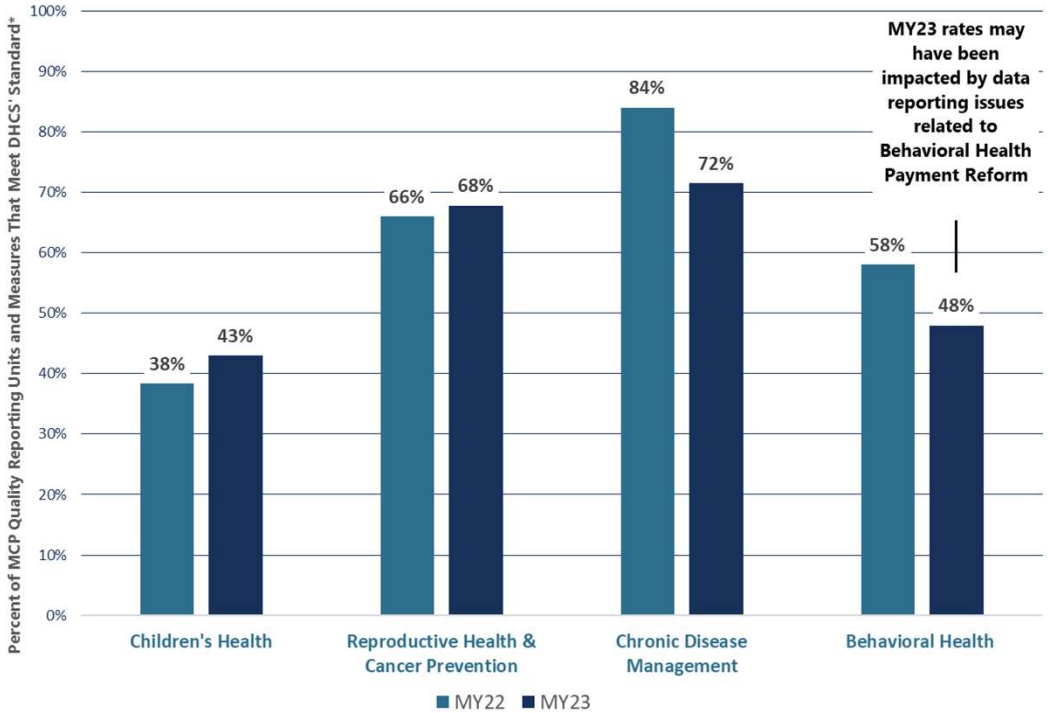
- **Children's Preventative Care**
  - Infant, child, and adolescent well-care visits.
  - Childhood and adolescent immunizations.
  - Blood lead and developmental screening.
  - Topical fluoride for children.
- **Birthing Care & Cancer Prevention**
  - Breast cancer, cervical cancer, and chlamydia screenings.
  - Prenatal and postpartum care.
  - Prenatal and postpartum depression screening.
- **Behavioral Health**
  - Follow-up after emergency department visit for mental illness.
  - Follow-up after emergency department visit for SUD.
  - Adolescent and adult depression screening and follow-up.

Domains	MY 23 Measures
Children's Health	• **WCV -** Child and Adolescent Well-Care Visits • **CIS-10 -** Childhood Immunization Status: Combination 10 • **DEV -** Developmental Screening in the First Three Years of Life • **IMA-2 -** Immunizations for Adolescents: Combination 2 • **LSC -** Lead Screening in Children • **TFL-CH -** Topical Fluoride for Children • **W30-6+ -** Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months (Six or More Visits) • **W30-2+ -** Well-Child Visits in the First 30 Months of Life – Well-Child Visits for Age 15 Months to 30 Months (Two or More Visits)
Reproductive Health & Cancer Prevention	• **BCS-E -** Breast Cancer Screening • **CCS -** Cervical Cancer Screening • **CHL -** Chlamydia Screening in Women • **PPC-Pst -** Prenatal and Postpartum Care: Postpartum Care • **PPC-Pre -** Prenatal and Postpartum Care: Timeliness of Prenatal Care
Chronic Disease Management	• **AMR -** Asthma Medication Ratio • **HBD-H9 -** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0 percent) • **CBP -** Controlling High Blood Pressure
Behavioral Health	• **FUM–30 -** Follow-up After Emergency Department Visit for Mental Illness – 30-day Follow-Up • **FUA–30 -** Follow-up After Emergency Department Visit for Substance Use – 30-day Follow-Up

Overall Quality by Domain

- Link to MCAS Fact Sheets
- To assess overall quality, DHCS evaluates if MCP Quality Reporting Units for each MCP meet or exceed the standard set for each key measure.
- Figure 1 shows the percentage of MCP Quality Reporting Units that successfully meet these standards for each health domain for MYs 2022 and 2023.

Figure 1: Overall Quality by Domain
Measurement Years (MY) 2022, 2023



Key Points by Domain

- **Children's Health Domain:** Overall improvement. There remain opportunities for improvement, particularly in enhancing coordination across delivery systems.
- **Reproductive Health & Cancer Prevention Domain:** Overall improvement. Opportunities for improvement remain, particularly in addressing disparities in access to care.
- **Chronic Disease Management:** Overall Improvement. Opportunities for improvement include enhancing care for asthma, given this was a new measure added in MY 23.
- **Behavioral Health:** Decreased compared to last year. Opportunities for improvement include enhancing care coordination and data collection across delivery systems.
  - MY 23 rates may have been impacted by data reporting issues related to Behavioral Health Payment Reform.

Key Points for Health Equity

- Statewide, Black children had rates of well child visits lower than the national median.
  - 40.8 percent of Black children received well child visits, which is below the Statewide Average of 49.5 percent.
- Statewide, timeliness of prenatal and postpartum care for Black birthing persons was worse than the national median.
  - 85.8 percent of Black birthing persons received timely prenatal care, which is below the Statewide Average of 88.0 percent.
  - 75.2 percent of American Indian and Alaska Native birthing persons had postpartum care, which is below than the Statewide Average of 82.6 percent.
- Statewide, timeliness of prenatal and postpartum care for American Indian and Alaska Native birthing persons was worse than the national median.
  - 66.7 percent of American Indian and Alaska Native birthing persons received timely prenatal care, which is below the Statewide Average of 88.0 percent.
  - 70.4 percent of American Indian and Alaska Native birthing persons had postpartum care, which is below than the Statewide Average of 82.6 percent.

MCAS MY 23 Sanctions Key Takeaways

- **Total MCPs sanctioned increased** from 18 (MY 22) to 20 (MY 23)
  - MCPs sanctioned in MY 23 and not in MY 22: CenCal, Santa Clara Family Health Plan, San Francisco Health Plan, and Contra Costa Health Plan.
- **Total sanction amount decreased** from $3,355,000 (MY 22) to $3,131,000 (MY 23)
  - Sanction difference is $224,000 (7.15 percent decrease).
- **Total population not served decreased** from 3,006,288 (MY 22) to 2,129,503 (MY 23)
  - Population not served decreased by 876,785 (29.16 percent decrease).
  - Eligible population decreased due to redetermination, which contributed to the decrease in the population not served.

County Behavioral Health Plan Sanctions Overview

BHAS Overview

- Behavioral Health Accountability Sets (BHAS) Quality Enforcement starts in **MY 24.**
  - **MY 22 (RY 23):** Baseline Reporting (done by DHCS)
  - **MY 23 (RY 24):**
    - *Original Expectation:* Begin enforcement actions, with County Behavioral Health Plans (BHP) expected to meet or exceed national 50th percentile or improve by 5 percent from baseline year.
    - *Revised Expectation:* Given impact of External Quality Review Organization (EQRO) transition and Behavioral Health Payment reform, **enforcement actions deferred**
  - **MY 24 (RY 25):** Anticipate use of monetary sanctions as outlined in Quality Enforcement BHIN 24-044.

Measures Reported for BHAS MY 23

Mental Health Plan (MHP) Priority Measures

#	Measure Required of MHP	Measure Acronym	Measure Steward
1	Antidepressant Medication Management, Acute	AMM - Acute	NCQA
2	Antidepressant Medication Management, Continuous	AMM - Continuous	NCQA
3	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	SAA	NCQA
4	Follow-Up After Emergency Department Visit for Mental Illness - 30 days	FUM- 30 Days	NCQA
5	Follow-Up After Hospitalization for Mental Illness - 30 Days	FUH-30 Days	NCQA
6	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics	APP	NCQA

*There were no changes in measures from MY 22 to MY 23 and no enforcement actions occurred for MY 23.

Measures Reported for BHAS MY 23

Drug Medi-Cal Organized Delivery System (DMC-ODS) Priority Measures

#	Measure Required of MHP	Measure Acronym	Measure Steward
1	Initiation of Substance Use Disorder Treatment – Initiation	IET-Initiation	NCQA
2	Initiation of Substance Use Disorder Treatment - Engagement	IET- Engagement	NCQA
3	Follow-Up After Emergency Department Visit for Substance Use - 30 Days	FUA- 30 Days	NCQA
4	Pharmacotherapy of Opioid Use Disorder	POD	NCQA
5	Use of Pharmacotherapy for Opioid Use Disorder	OUD	CMS

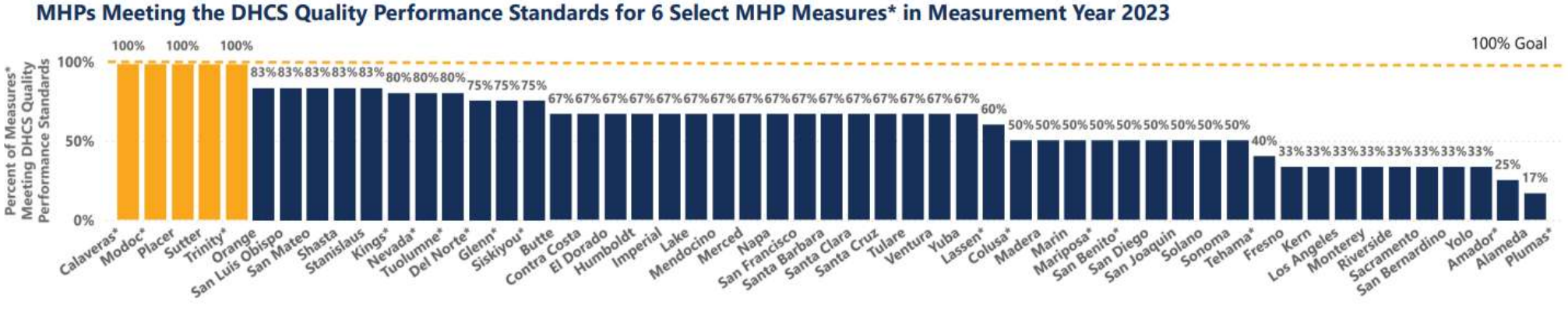
*There were no changes in measures from MY 22 to MY 23 and no enforcement actions occurred for MY 23

BHAS MY 22 to MY 23 Trends

- Counties with small measure populations
  - Necessitates data suppression - denominator not big enough to be confident of the measure rate.
  - Makes it challenging to assess the improvement in these populations.

- More robust conclusions and trending will be available once BHAS MY 23/MY 24 Performance Measure Validation is completed.

BHAS MY 22 to MY 23 Trends: MHP

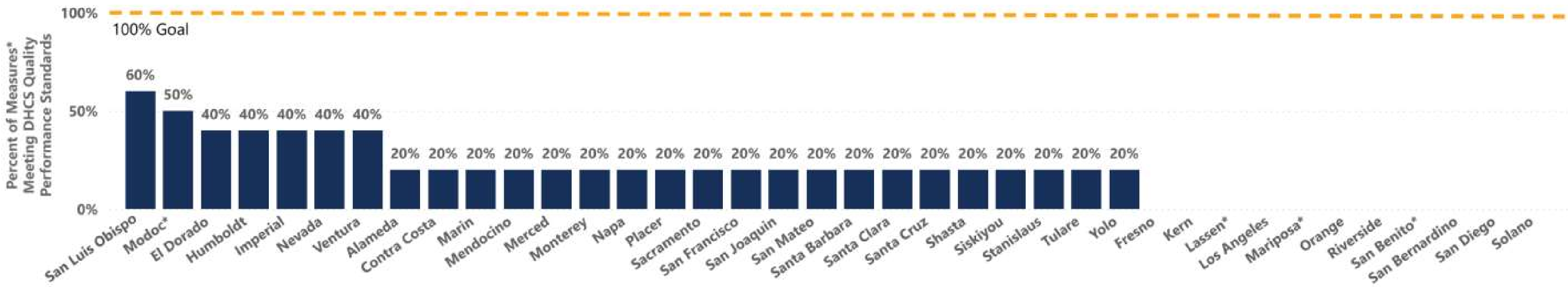


» For MHP Measures in MY 23 compared to MY 22:

- 5 BHPs were able to meet or exceed the DHCS standard on 100 percent of non-suppressed measures compared to 1 BHP in MY 22.
- 77 percent of BHPs (42 of 54) were able to meet or exceed the DHCS standard on 50 percent of non-suppressed measures compared to 80 percent (41 of 51) in MY 22.
- 65 percent of BHPs (35 of 54) were able to meet or exceed the DHCS standard on FUM-30 days compared to 80 percent (41 of 51) in MY 22.

*If any of the five measures are omitted due to very low numbers, the measure(s) are not included in calculation
**MY 23 rates may have been impacted by data reporting issues related to Behavioral Health Payment Reform.

BHAS MY 22 to MY 23 Trends: DMC-ODS



» For DMC-ODS Measures in MY 23 compared to MY 22:

- 2 DMC-ODS plans were able to meet or exceed the DHCS standard on 50 percent or more of DMC-ODS measures compared to 25 DMC-ODS plans in MY 22
- 68 percent of DMC-ODS plans (25 of 37) were able to meet of exceed the DHCS standard on OUD measure compared to 85 percent of DMC/DMC-ODS plans (47 of 55) in MY 22
  - Of note, MY 22 analysis included both DMC and DMC-ODS plans, while MY 23 analysis was focused only on DMC-ODS plans

*MY 23 rates may have been impacted by data reporting issues related to Behavioral Health Payment Reform.

Technical Assistance: Institute for Healthcare Improvement Learning Collaboratives

BHP and MCP Interventions
Inland Empire Health Plan (IEHP)/San Bernardino County

Goal

Increase FUA and FUM rates by 5 percent by June 2025 for patients visiting Arrowhead Regional Medical Center, St. Mary's, and St. Bernardine's Hospitals.

Change Ideas

- Establish CHW workflow to increase FUM/FUA follow-up rates.
- Address tracking mechanism and appointment barriers.
- Follow-up service workflow for existing clients.
- Use of screening tool to clarify roles and expectations between/within Department of Behavioral Health (DBH) and IEHP.

Children's Health Interventions

Goal

Improve the completion of well-infant visits (0-30 months) and adolescent well-visits (15-18 years old).

Change Ideas

- Define equitable & transparent, stratified, and actionable data.
- Understand provider and patient/caregiver experiences through surveys and interviews.
- Develop reliable & equitable WCV processes.
- Create asset/actor mapping & community partnerships.
- Partnering for effective education & communication.

Looking Ahead

- Maintain consistency in key clinical areas.
  - Children's Preventive Care
  - Behavioral Health Integration
  - Birthing Outcomes and Birth Equity
- Increase focus on driving quality and health equity through a VBP strategy.
- Focus on partnership and consistency across the physical health and behavioral health delivery systems.

Questions?

Break

BH-CONNECT Updates and Highlights

Paula Wilhelm, Deputy Director, Behavioral Health

Glenn Tsang, Policy Advisor, Homelessness & Housing

Susan Philip, MPP, Deputy Director, Health Care Delivery Systems

Jeff Norris, MD, Value-Based Care Payment Branch Chief, Quality and Population Health Management

Libby Abbott, Deputy Director, Health Workforce Development, Department of Health Care Access and Information (HCAI)

Sharmil Shah, MA., Psy.D, Assistant Deputy Director, Health Workforce Development, HCAI

Hovik Khosrovian, Senior Policy Advisor, HCAI

DHCS

BH-CONNECT Overview & Implementation Timeline

DHCS

Why BH-CONNECT?

- BH-CONNECT is at the center of an historic, multi-pronged initiative to **transform and improve behavioral health services for California residents living with significant behavioral health needs.**
- Prior to BH-CONNECT approval, California already had **invested nearly $15 billion in state funds** and launched **landmark policy reforms** to improve access and strengthen the continuum of care:
  - The **California Advancing and Innovating Medi-Cal** (CalAIM) includes policy and delivery system changes to transform Medi-Cal behavioral health to a more seamless system.
  - The **Children and Youth Behavioral Health Initiative** (CYBHI) is a historic investment to enhance, expand and redesign the systems that support behavioral health for children and youth.
  - The **Behavioral Health Transformation** initiative, which Californians voted to pass in March 2024 as Proposition 1, works to modernize the broader public behavioral health delivery system, improve accountability and transparency, and expand the capacity of behavioral health care facilities.
  - The **Behavioral Health Continuum Infrastructure Program** (BHCIP) and the **Behavioral Health Bridge Housing** (BHBH) Program spur investments in infrastructure and new housing settings.
  - DHCS is strengthening the behavioral health crisis care continuum, including implementing **mobile crisis services** and the **988 Suicide and Crisis Lifeline**.
- **BH-CONNECT is a linchpin for this broader effort,** offering sustainable financing for transformation initiatives through a combination of a Medicaid 1115 waiver, new SPAs and updates to state guidance.

Goals of BH-CONNECT (1 of 2)

BH-CONNECT aims to:

- **Expand the continuum of community-based services and evidence-based practices (EBPs)** available through Medi-Cal **for children, youth and adults living with mental health and substance use disorders (SUD)**.
- **Strengthen family-based services and supports** for children and youth living with significant behavioral health needs, including children and youth involved in child welfare.
- **Incentivize behavioral health plans (BHPs) to improve access, health outcomes, and invest in delivery system reforms** to better support Medi-Cal members living with significant behavioral health needs.
- **Strengthen the workforce** needed to deliver community-based behavioral health services and EBPs to members living with behavioral health needs.

Goals of BH-CONNECT (2 of 2)

- **Access federal funds for short-term stays in facility-based care**, but only for BHPs that commit to providing robust community-based services and meeting quality of care standards for such stays.
- **Promote transitions out of facility-based care** and support successful transitions to community-based care settings and community reintegration.
- **Promote improved health outcomes**, community integration, treatment and recovery for individuals who are homeless or at risk of homelessness and experiencing critical transitions.
- **Improve stability** for members going through vulnerable periods (including, but not limited to those living with significant behavioral health issues) through transitional rent services, reducing their risk of returning to institutional care or experiencing homelessness.

Key BH-CONNECT Federal Approvals

Section 1115 Demonstration Approvals

- Workforce Initiative
- Activity Funds
- Access, Reform and Outcomes Incentive Program
- Community Transition In-Reach Services
- Short-term Inpatient Psychiatric Care, including in Institutions for Mental Disease (IMDs)
- Transitional Rent

SPA Approvals

- Assertive Community Treatment (ACT)
- Forensic ACT (FACT)
- Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)
- Clubhouse Services
- Individual Placement and Support (IPS) Model of Supported Employment
- Enhanced Community Health Worker (CHW) Services

** Transitional Rent coverage will be available in the Medi-Cal Managed Care delivery system.*

Other Components of BH-CONNECT

Leveraging Existing Authorities & State-Level Guidance

- Centers of Excellence to support fidelity implementation of EBPs.
- Clarification of coverage of evidence-based child and family therapies, including Multisystemic Therapy, Functional Family Therapy, Parent-Child Interaction Therapy, and High Fidelity Wraparound.
- Initial joint child welfare/specialty mental health visit.
- County Child Welfare Liaison role within MCPs.
- Implementation of CMS milestones related to quality of care for patients of inpatient and residential facilities.

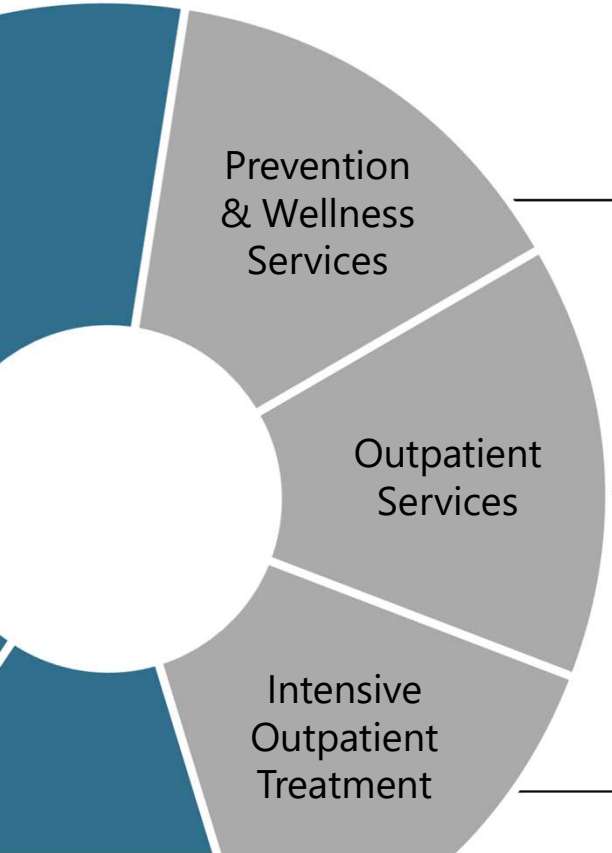
Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration

BH-CONNECT builds upon other investments to strengthen the continuum of behavioral health care in California.

- **Cross-cutting Initiatives**
- **Infrastructure Investments**
  (Behavioral Health Transformation)
- **Workforce Initiatives**
  (BH-CONNECT, Behavioral Health Transformation)
- **Statewide Incentive Programs**
  Behavioral Health Quality Improvement Program; BH-CONNECT; Access, Reform, and Outcomes Incentive Program

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration

- BH-CONNECT Initiatives*
- Existing Initiatives+



- Activity Funds*
- Children and Youth Behavioral Health Initiative; Student Behavioral Health Incentive Program; Dyadic Services; Wellness Coaches+

- Updated Access Criteria; Documentation Redesign; No Wrong Door; Payment Reform; Standardized Screening and Transition Tools; Administrative Integration+
- Justice-Involved Initiative; Contingency Management; DHCS Opioid Response+

- Clarification of Evidence-Based Therapies for Children and Families*
- Assertive Community Treatment (ACT); Forensic ACT; Coordinated Specialty Care for First-Episode Psychosis*
- Community Assistance, Recovery and Empowerment (CARE) Act+

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration

- BH-CONNECT Initiatives*
- Existing Initiatives+

- Enhanced Quality of Care in Psychiatric Hospitals and Residential Settings; Predischarge Care Coordination Services; Strategies to Decrease Lengths of Stay in Emergency Departments*

- Psychiatric Residential Treatment Facilities; Mobile Crisis Services; CA Bridge Program; CalHOPE; 988 Lifeline+

- Supported Employment; Clubhouse Services; Transitional Rent; Community Health Worker Services*
- Behavioral Health Bridge Housing+
- Enhanced Care Management; Community Supports; Traditional Healers+

- Peer Support Services+

BH-CONNECT Implementation Timeline

DHCS will implement the BH-CONNECT demonstration using a phased approach beginning January 2025. BHPs and MCPs may opt in to participate in select initiatives on a rolling basis.

January 2025 (*Demonstration Effective*)

- BHPs opt-in on a rolling basis: IMD opportunity, BH-CONNECT EBPs, Community Transition In-Reach Services
- **Launch Access, Reform and Outcomes Incentive Program** ★
- Develop guidance on evidence-based family therapies
- Identify Centers of Excellence to support training and fidelity monitoring

July 2025

- Launch Activity Funds
- **Launch Workforce Initiative** ★
- Implement initial joint child welfare/behavioral health visit
- MCPs may cover Transitional Rent as an optional benefit

January 2026

- MCPs must cover Transitional Rent as a mandatory benefit for Behavioral Health Population of Focus. Coverage for other eligible populations remain optional

December 2026

- Implement service to track availability of inpatient and crisis stabilization beds

BH-CONNECT Access, Reform and Outcomes Incentive Program

DHCS

BH-CONNECT Access, Reform and Outcomes Incentive Program Overview (1/2)

DHCS has received CMS approval for a total of $1.9 billion* over five years (2025-2029) for the Access, Reform and Outcomes Incentive Program.

- The BH-CONNECT Incentive Program will reward participating behavioral health plans (BHPs)** for demonstrating improvements in access to behavioral health services and outcomes among Medi-Cal members living with significant behavioral health needs.
- Measures were developed to align with **Behavioral Health Transformation** and address three areas of focus:

1. **Improved Access to Behavioral Health Services (up to $850M*)**
2. **Improved Health Outcomes and Quality of Life (up to $800M*)**
3. **Targeted Behavioral Health Delivery System Reforms (up to $250M*)**

**Total computable*
***Inclusive of Specialty Mental Health (SMH) Plans, Drug Medi-Cal Organized Delivery System (DMC-ODS) Plans, and plans that administer SMH and DMC-ODS services as integrated Prepaid Inpatient Health Plans.*

BH-CONNECT Access, Reform and Outcomes Incentive Program Overview (2/2)

- BH-CONNECT Incentive Program activities will begin in 2025. The first submission will be due **June 30, 2025**, with payments issued in November 2025.
- Wherever possible, DHCS will conduct the calculations for Incentive Program measures. BHPs will be responsible for developing and submitting all narrative submissions.
- Any unearned incentive payments will be placed in a high-performance pool (HPP). To the extent HPP funding is available each year, BHPs can earn payments based on demonstration of high performance.
- DHCS will release additional guidance and detailed technical specifications for all Incentive Program measures.

Participation Requirements (1 of 2)

To participate in the Incentive Program, a BHP must:

- Have completed the Targeted Managed Behavioral Healthcare Organizations (MBHO) Self-Directed Assessment with the National Committee for Quality Assurance (NCQA) by October 31, 2024, as described in BHIN 24-019.
- Submit to DHCS a commitment to participate in the Incentive Program by **March 31, 2025.***
- Maintain compliance with Incentive Program requirements, including using any earned incentive payments to support and expand Medi-Cal services and activities that benefit Medi-Cal members served by the behavioral health delivery system.

The Letter of Commitment template will be posted on the DHCS BH-CONNECT website in Q1 2025.

Participation Requirements (2 of 2)

- BHPs that participate in the Incentive Program are not required to opt in to receive Federal Financial Participation (FFP) for care provided during short-term stays in Institutions for Mental Diseases (IMDs).

- BHPs are encouraged, but not required, to implement the full suite of BH-CONNECT EBPs to participate in the Incentive Program. BHPs are required cover and implement an EBP to be eligible for incentive payment for measures related to that EBP.

Approved Measure Set (1/2)

Measure Area
Area of Focus: Improved Access to Specialty Behavioral Health Services
1. Improve Penetration and Engagement in Specialty BH Services
2. Improve Performance on Timely Access Standards for Specialty BH Services
3. Increase Utilization of EBPs for Adults (ACT, FACT, CSC for FEP, IPS Supported Employment, CHW Services, Peer Support Services, Clubhouse Services)*
4. Increase Utilization of EBPs for Children, Youth and Adolescents (MST, PCIT, FFT, HFW)
5. Increase Utilization of Enhanced Care Management (ECM)
Area of Focus: Improved Health Outcomes and Quality of Life
6. Pharmacotherapy for Opioid Use Disorder (POD)
7. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
8. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
9. Improve Patient-Reported Quality of Life (QOL)
10. Improve Health Outcomes and QOL Among Members Receiving ACT, CSC for FEP, and IPS Supported Employment (ED Visits, Hospital Admissions, Homelessness, Justice Involvement, School/Work Involvement, QOL)*

**Measure available to BHPs that opt in to specific BH-CONNECT EBPs only.*

Approved Measure Set (2/2)

Measure Area
Area of Focus: Targeted Behavioral Health Delivery System Reforms
11. Receive Approval of Plan to Address County-Specific Behavioral Health Delivery System Gaps
12. Reduce County-Specific Quality Improvement Gaps Identified in NCQA MBHO Assessment
13. Demonstrate Improved Data Sharing for the Behavioral Health Population
14. Improve Identification and Outreach to Member Population Eligible for Specialty Behavioral Health Services
15. Increase Capacity to Deliver Crisis Services

Program Accountability

A share of total Incentive Program funding will be at risk in years 3-5 based on aggregated performance across all participating BHPs on three key measures. One measure will be drawn from each area of focus.

Aggregated performance on each measure will be weighted and added to create an overall aggregate score, namely the State's Program Accountability Score.

Funding at Risk by DY

DY	Percent of Total Funding at Risk
DY 1	0 percent
DY 2	0 percent
DY 3	5 percent
DY 4	10 percent
DY 5	20 percent

Program Accountability Measures

Area of Focus	Score Weight	Program Accountability Measure
Improved Access to BH Services	45 percent	Improve Penetration in SMHS
Improved Health Outcomes and QOL	42 percent	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
Targeted BH Delivery System Reforms	13 percent	Demonstrate Improved Data Sharing for the Behavioral Health Population
Total	**100 percent**	

Key Dates for Incentive Program Participation

45 BHPs completed a self-directed assessment on NCQA's MBHO Standards as a condition of Incentive Program participation

September 30, 2024

Q1 2025

DHCS releases:

- Incentive Program BHIN
- Form for commitment to participate
- Instructions for Submission 1

Submission 1: Plan to address gaps identified in the NCQA MBHO assessment

June 30, 2025

BH-CONNECT Workforce Initiative

DHCS

Workforce Initiative (1/2)

The Workforce Initiative will support the training, recruitment and retention of behavioral health practitioners to provide services across the continuum of care. Recipients of workforce funding will commit to serving Medi-Cal members living with significant behavioral health needs for 2-4 years.

Between 2025 and 2029, in partnership with the Department of Healthcare Access and Information (HCAI), DHCS will invest up to $1.9 billion in five workforce programs:

1. **Medi-Cal Behavioral Health Student Loan Repayment Program**
   - Licensed, prescribing behavioral health practitioners are eligible for up to $240,000 in loan repayment.
   - Non-prescribing licensed or associate level pre-licensure practitioners are eligible for up to $180,000.
   - Non-licensed, non-prescribing practitioners including Counselors, Community Health Workers, Peer Support Specialists and Wellness Coaches are eligible for up to $120,000.
2. **Medi-Cal Behavioral Health Scholarship Program**
   - Individuals participating in educational programs to become licensed, prescribing behavioral health practitioners are eligible for up to $240,000 in scholarship funding.
   - Individuals participating in educational programs to become non-prescribing licensed practitioners are eligible for up to $180,000.
   - Individuals participating in educational programs to become non-prescribing, non-licensed practitioners are eligible for up to $120,000.

Workforce Initiative (2/2)

3. **Medi-Cal Behavioral Health Recruitment and Retention Program**
   - Eligible "safety net" settings* may receive funding to:
     - Provide recruitment bonuses of up to $20,000 and retention bonuses of up to $4,000 each.
     - Provide bonuses of up to $50,000 per individual to support students completing required training in advance of their final year of education.
     - Provide up to $1,500 per practitioner to cover licensing or certification fees.
     - Support supervision hours of pre-licensure or pre-certificate practitioners (up to $35,000 per year).
     - Cover backfill costs to support behavioral health practitioners receiving training in EBPs (between $250 and $750 per practitioner per day).
4. **Medi-Cal Behavioral Health Community-Based Provider Training Program**
   - Training programs may receive up to $10,000 per individual to train Alcohol or Other Drug Counselors, Community Health Workers and Peer Support Specialists.
5. **Medi-Cal Behavioral Health Residency Training Program**
   - Residency and fellowship programs can receive up to $250,000 per slot per year to expand residencies or fellowships.

** Eligible settings include rural hospitals with 30 percent Medi-Cal and/or uninsured population and other hospitals and behavioral health settings with a 40 percent or higher Medi-Cal and/or uninsured population.*

Transitional Rent

Transitional Rent

MCPs will begin to cover Transitional Rent as a new Community Supports service.

- MCPs will provide up to 6 months of Transitional Rent for transitioning populations who meet certain clinical criteria and who are experiencing or at risk of homelessness, reducing their risk of returning to institutional care or experiencing homelessness.
- This benefit will be available for up to 6 months per household per demonstration period.

Transitional Rent Eligibility Criteria

Eligible high-need members enrolled in a MCP may be eligible for up to 6 months of Transitional Rent if they meet the following criteria:

1	+	2	+	3

Meet Clinical Risk Factors	Experiencing or at Risk of Homelessness (Social Risk Factor)	Meet Criteria for Specified "Transitional Populations"
» Meet the access criteria for Medi-Cal Specialty Mental Health Services (SMHS), or » Meet the access criteria for DMC, or » Meet the access criteria for DMC-ODS services, or » Have one or more serious chronic physical health conditions, or » Pregnant to 12-months postpartum, or » Have physical, intellectual, or developmental disabilities	» As defined by US Department of Housing and Urban Development's (HUD) current definition as codified at 24 Code of Federal Regulations (CFR) part 91.5, with certain modifications	» Transitioning out of an institutional or congregate residential setting, or » Transitioning out of a carceral setting, or » Transitioning out of interim setting, or » Transitioning out of recuperative care or short-term post-hospitalization housing, or » Transitioning out of foster care, or » Unsheltered homeless, or » Eligible for Full Service Partnership (FSP)

Transitional Rent Implementation Timeline

California will take a phased approach to implementation.

Key Dates	Original Timeline	Updated Timeline
January 1, 2025	MCP optional go-live 1	
July 1, 2025	MCP optional go-live 2	**Optional go-live for MCPs on 7/1/2025** MCPs going live 7/1/25 can choose to go live for: » The Behavioral Health POF that must go live 1/1/26, and/or » Additional populations within Transitional Rent-eligible populations – if choosing this option, must continue offering to this population.
January 1, 2026	**Mandatory launch for all MCPs**	**Phase 1: Mandatory launch for all MCPs to cover Transitional Rent for Behavioral Health POF** » MCPs may also choose to cover additional populations within the overall Transitional Rent-eligible populations.
July 1, 2026 (BHSA go-live)		
January 1, 2027		**Future phase-in of additional populations TBD**

Bridge from Transitional Rent to BHSA Housing Interventions (1 of 2)

Transitional Rent can serve as a bridge to long-term housing for members living with significant behavioral health needs, such as through connections to BHSA Housing Interventions.

Bridging Transitional Rent and BHSA Housing Interventions

- **DHCS recognizes that county behavioral health is a critical access point for Transitional Rent for members living with significant behavioral health needs** (i.e., many members within the Transitional Rent Behavioral Health POF.
- **DHCS expects MCPs and county behavioral health will collaborate** to ensure that members living with significant behavioral health needs are smoothly transitioned from Transitional Rent to BHSA-funded services.
- **DHCS will release streamlined authorization procedures and referral processes** to support MCP coordination with county behavioral health.

Bridge from Transitional Rent to BHSA Housing Interventions (2 of 2)

Overview of BHSA Housing Interventions

- Delivered via county behavioral health, effective 7/1/26.
- Interventions available to both BHSA-eligible Medi-Cal members (as long as not supplanting a Medi-Cal service) and non-Medi-Cal individuals.
- Counties will receive funding for Housing Interventions that aim to place and sustain individuals living with significant behavioral health needs in permanent housing settings.
- Housing Interventions include, but are not limited to, rental subsidies, operating subsidies, landlord outreach and mitigation funds, participant assistance funds, and capital development funding.

Updates to Community Supports with Room and Board Components

Updated Time Limits for Community Supports with Room and Board Components (1/2)

In December 2024, CMS released a new "Health-Related Social Needs (HRSN) Framework" that outlines the latest period of coverage for short-term recuperative care and short-term post-transition housing. Updates to the duration limits for short-term recuperative care and short-term post-transition housing will ensure Medi-Cal members are able to access these services for a longer period, if medically necessary.

By aligning with CMS' framework, the state is permitted to increase the duration of coverage for two specific housing-related community supports:

- **Recuperative care (known in the new demonstration as "Short Term Recuperative Care"):** Eligible members can receive this service for up to 6 months per 12-month period (rather than 90 days per the five-year demonstration).
- **Short-term Post-Hospitalization Housing (known in the new demonstration as "Short Term Post-Transition housing"):** Eligible members can receive this service for up to 6 months per 12-month period (rather than 6 months per the five-year demonstration).

Updated Time Limits for Community Supports with Room and Board Components (2/2)

In addition to the new time limits for the individual services, CMS is imposing new limits across the Community Supports with Room and Board components.

Service	Service Limits	Limits across the Services ("stacking")
Recuperative Care (includes clinical services with room and board)	» 6-month limit per rolling 12-month period (per member)	» 6-month limit per rolling 12-month period (per member) also applies across <u>all three</u> housing interventions with room/board components.
Short-Term Post Hospitalization Housing (STPHH) (includes clinical services with room and board)	» 6-month limit per rolling 12-month period (per member)	
Transitional Rent (room and board only)	» One 6-month service per 5-year demonstration (per household)	

*Note: These limits do **not** apply to Housing Deposits, Housing Transition Navigation, or Housing Tenancy Sustaining Services.*

Flexible Housing Subsidy Pools

Flex Pools: Core Principles

Flexible Housing Subsidy Pools ("Flex Pools") are a model for centrally administering rental assistance and coordinating related housing supports in a way that helps people who are experiencing or at risk of homelessness enter and maintain stable long-term housing.

Coordination and centralization maximize efficiency and outcomes

Housing-focused with supportive services

Help is person-centered and honors choice

Deep collaboration among key partners

Core Functions of Flex Pool Administration and Operation

A Flex Pool is designed to centrally administer rental assistance and coordinate related housing supports:

1. Coordinating and braiding funding streams
2. Acting as a fiscal intermediary between funders and landlords, on behalf of participants
3. Identifying, securing, and supporting a portfolio of units for participants
4. Coordinating with providers of housing supportive services to support participants

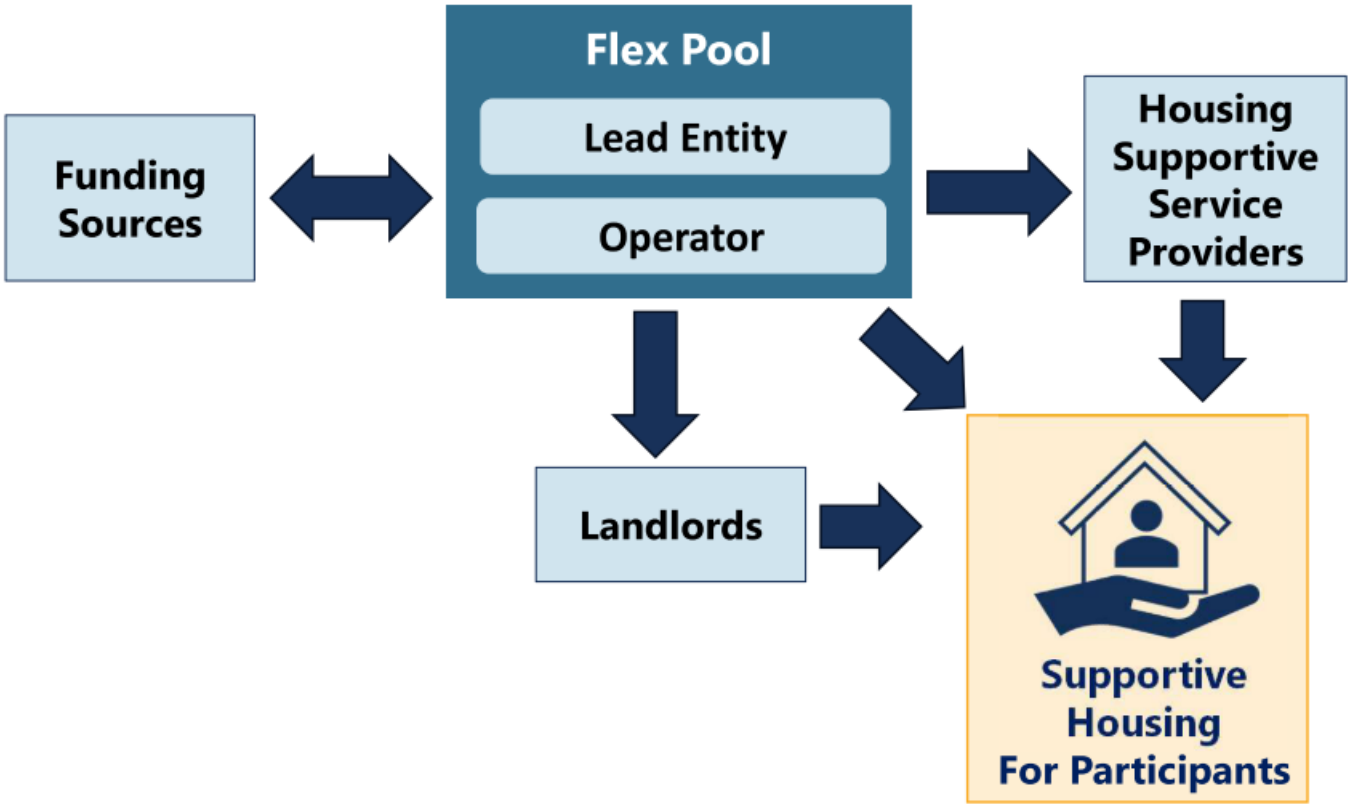
Often performed by Lead Entity

» The entity that plays the role of convener and "system driver"—identifies, aggregates, and administers funding sources, likely also a funder, and contracts with the Operator

Often performed by Operator

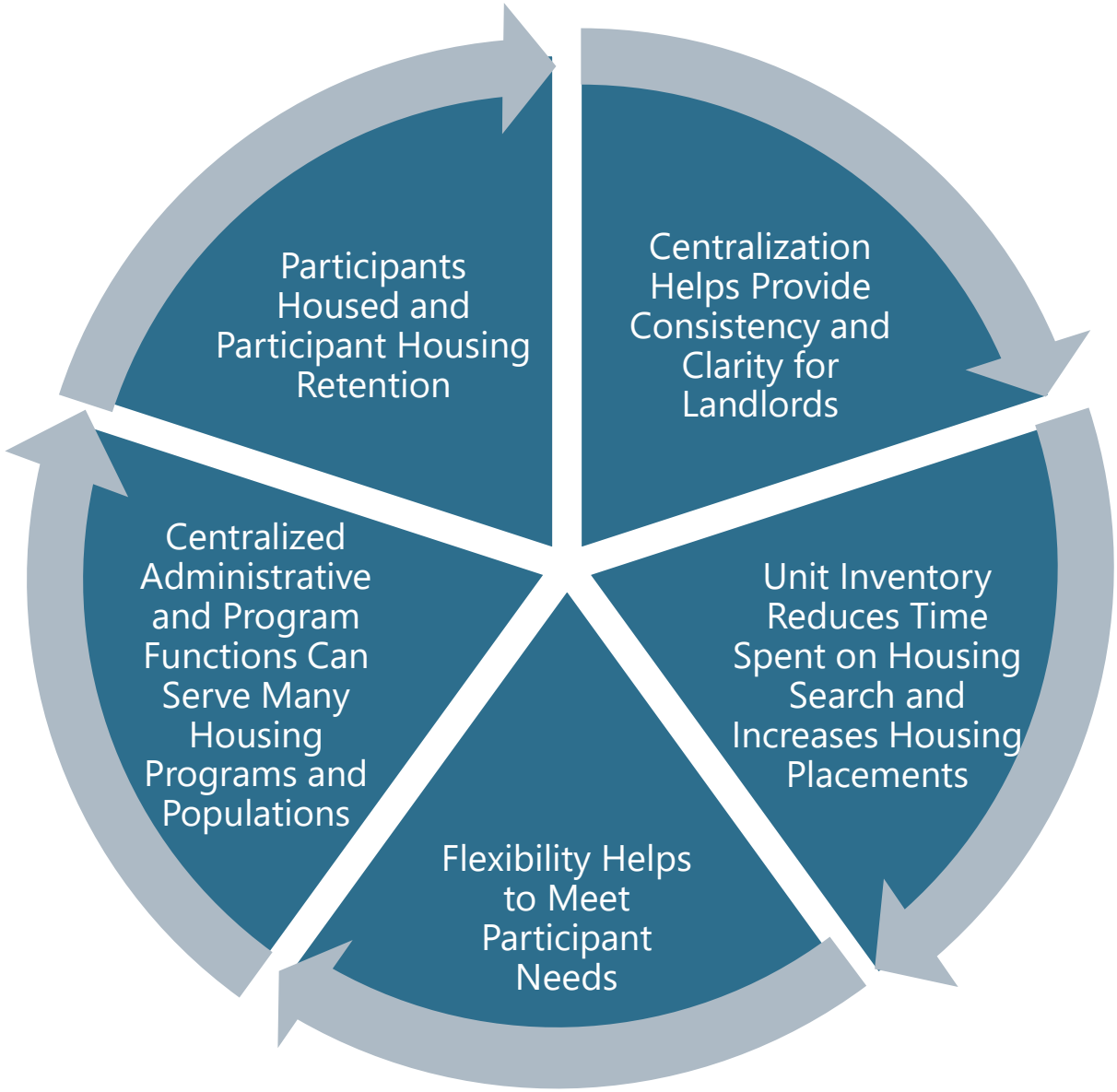
» The entity responsible for keeping the day-to-day operations of the Flex Pool running smoothly and delivering excellent customer service to landlords, participants, and the Lead Entity

Flex Pool Model and Key Roles



Intended Value of a Flex Pool

- **Efficiently and effectively administer rental subsidies** within a complex, multi-program funding environment.
- Creates a **seamless experience** for landlords, participants being served, and housing supportive services provider.
- **County behavioral health departments administering BHSA Housing Interventions and MCPs covering Transitional Rent** benefit from the value delivered to landlords, participants, and supportive services providers.



Questions?

Long-Term Services and Supports (LTSS) Dashboard

Anastasia Dodson, Deputy Director, Office of Medicare Innovation and Integration

DHCS

Agenda

- Introduction and Background on LTSS
- Goals and Development of LTSS Dashboard
- LTSS Dashboard Releases
- Live Demonstration
- Questions

Introduction and Background on LTSS

DHCS developed the LTSS dashboard under the data transparency initiative of the Home and Community-Based Services (HCBS) Spending Plan.

Medi-Cal LTSS provide critical services that support older adults and people with disabilities. Services include, but are not limited to:

- **Institutional Care**
  - Skilled Nursing Facilities (SNF)
  - Adult and Pediatric Subacute Care Facilities
  - Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD)

- **HCBS**
  - "HCBS Select" in Dashboard: In-Home Supportive Services (IHSS), Assisted Living Waiver (ALW), Home and Community Based Alternatives (HCBA) Waiver, Multipurpose Senior Services Program (MSSP), Community Based Adult Services (CBAS), and California Community Transitions (CCT).
  - "HCBS All" in Dashboard includes HCBS Select and the following: Regional Center Services and related programs for persons with developmental disabilities; Medi-Cal home health.

Goals of LTSS Dashboard

- Increase access to accurate, timely, and meaningful data.
- Improve Medi-Cal transparency related to LTSS utilization and health equity, particularly across multiple programs.
- Inform partners, members, and the public on efforts to expand, enhance, and improve the quality of LTSS in all home, community, and congregate settings.

Development of LTSS Dashboard: Collaboration

DHCS developed the initial and revised versions of the dashboard in collaboration with:

- State partners such as California Department of Aging (CDA), CDSS, and California Department of Developmental Services (DDS).
- Stakeholders, such as Justice in Aging, The SCAN Foundation, California Health Care Foundation, and others.

Development of LTSS Dashboard: Data Sources

Data sources include:

- DHCS Medi-Cal claims data
- DHCS Medi-Cal enrollment data
- CDSS Case Management, Information, and Payrolling System (CMIPS) for IHSS
- DDS enrollment data for Regional Center programs
- CDA enrollment data for Multipurpose Senior Services Program (MSSP) and Community-Based Adult Services (CBAS)

Development of LTSS Dashboard: Data Variances

Data variances are when the LTSS Dashboard results do not match other published data, primarily on other state websites.

Data variances can occur because of:

- Reporting timeframe: Annual, monthly, point in time
- Data collection: Calendar year versus waiver year
- Data suppression
- Data exclusion
- Data deduplication

Important Note: Most utilization data on the LTSS Dashboard is "ever utilized" in a year, rather than point in time displayed by other sources, such as CDSS.

LTSS Dashboard Releases

Initial launch (12/12/22)

- First iteration available via CalHHS Open Data Portal
- Data includes 2017-2021
- 40 enrollment and utilization measures

Update (12/15/23)

- Added 2022 data and updated all other years
- Added 16 new enrollment and utilization measures
- Upgraded data visualization capabilities
- Incorporated interactive data functionalities

Update (12/27/24)

- Added cost, quality, and length of stay measures
- Added demographics, including dual eligibility status
- Improved visualization and analysis capabilities
- Refreshed data

Live Demonstration of LTSS Dashboard

- Join us as we walk through the website together to discuss insights and main takeaways:

Webpage:

https://www.dhcs.ca.gov/dataandstats/dashboards/Pages/LTSS-Dashboard.aspx

Questions?

Contact us at LTSSdashboard@dhcs.ca.gov with any questions.

Related Data Sources and Dashboards

- CDA – Master Plan for Aging Data Dashboard on Aging, https://letsgethealthy.ca.gov/mpa-data-dashboard-for-aging/
- DDS – Caseload and Regional Center Data, https://www.dds.ca.gov/transparency/facts-stats/
- DHCS – Dashboards Initiative, https://www.dhcs.ca.gov/provgovpart/Pages/DHCSDashboardInitiative.aspx
- DHCS – Cal MediConnect and Dual Eligible Special Needs Plans (D-SNP) Dashboard, https://www.dhcs.ca.gov/Pages/Cal_MediConnectDashboard.aspx
- CDSS – IHSS Program Data, https://www.cdss.ca.gov/inforesources/ihss/program-data
- CalHHS, Open Data Portal – Long-Term Care Facilities Annual Utilization Data, https://data.chhs.ca.gov/dataset/long-term-care-facilities-annual-utilization-data
- Medicaid – LTSS Data, Long Term Services & Supports | Medicaid
- The SCAN Foundation and AARP – LTSS State Scorecard, http://www.longtermscorecard.org/

Questions?

Public Comment

Final Comments and Adjourn

Upcoming 2025 Meeting Dates

» May 21, 2025

Thank You!

DHCS

Appendix

Appendix: Birthing Care Pathway

Appendix: Policies DHCS Has Implemented/Is Implementing

Provider Access and MCP Oversight and Monitoring (1 of 4)

Problem Statements

- **Limited racial and ethnic diversity of maternity care providers** in Medi-Cal today.
- Members face **delays in obtaining breast pumps.**
- **Smoother hospital discharges are needed after birth.**

Policy Solutions	Status
Leverage CalHealthCares education **loan repayment program** to build pipeline and increase diversity of OB/GYN and family medicine workforce.	In Progress
Streamline requirements and improve access to a range of **high-quality breast pumps**.	In Progress
Create guidance and/or technical assistance for MCPs on supporting pregnant and postpartum members **transferring to different care settings and levels of care**.	In Progress

Provider Access and MCP Oversight and Monitoring (2 of 4)

Problem Statements

- Members and providers are often **unaware of the full array of available maternity care services.**

Policy Solutions	Status
Create and enhance **member-facing communications materials** and outreach strategies on perinatal Medi-Cal benefits and provider types to bolster awareness during and after pregnancy.	In Progress
Issue a **standing recommendation for doula services** for all pregnant and postpartum Medi-Cal members to increase access to doula services and launch a **Doula Directory** for use by Medi-Cal members, providers, and MCPs to identify doulas in their community/network.	Completed
Establish a **Doula Implementation Stakeholder Workgroup** comprised of doulas, Black birthing justice experts, Tribal representatives, local health departments, advocates, and provider associations to inform DHCS' doula benefit design and reimbursement approach.	In Progress

Member-Facing Fact Sheets

Doctors, Midwives, and Doulas:

Finding the Right Care Team for Your Pregnancy

Medi-Cal

Do you think you might be pregnant? Choose your care team early to help you navigate your pregnancy and birthing journey. Medi-Cal pays for medical professionals (like doctors and midwives), doulas, and other care providers to help with your needs.

Who They Are:	What They Do:
DOCTORS, like OB-GYNS and some Family Doctors Medical professionals who help with every part of pregnancy, including prenatal checkups, childbirth, and postpartum care.	» Specialize in maternal health, providing checkups, tests, and prescriptions » Monitor high-risk pregnancies » Usually deliver babies in hospitals » Can perform surgeries (like C-sections)
MIDWIVES Specially trained health professionals who care for people with healthy, low-risk pregnancies—including prenatal checkups, childbirth, and postpartum care. Some midwives are also nurses.	» Provide prenatal checkups, advice, and emotional support » Support personalized approaches to pregnancy and childbirth » Can deliver babies in hospitals, birth centers, or at home » Do not perform surgeries (like C-sections)
DOULAS Birth workers who help with physical, emotional, and non-medical support before, during, and after birth. They do not provide medical treatment or deliver babies.	» Teach you about pregnancy, childbirth, and caring for a newborn » Empower you and help you speak up for what you want during pregnancy and childbirth » Provide breathing, relaxation, and other support during childbirth

Ready to support a healthy pregnancy and start your baby's journey off strong?

Scan the QR code or visit **https://www.dhcs.ca.gov/services/Pages/Maternal-Perinatal.aspx** to learn more about picking the right care team for you and your family.

Services for Pregnant People and New Parents

Medi-Cal

If you have Medi-Cal and are pregnant or just had a baby, you have access to free health care and services to keep you and your baby healthy and safe.

Medi-Cal Programs and Services

Health Care
Medi-Cal covers health care for you and your baby—from pregnancy until at least one year postpartum. That includes labor and delivery, doctor visits, hospital stays, emergency care, medical supplies, medications, family planning, dental, vision, and more.

Care Coordination
Get help managing your health care before and after your baby is born, including follow up doctor's visits, rides to the doctor, and specialty care referrals.

Mental Health & Addiction
Talk to a therapist and get help for common issues like postpartum depression or anxiety, mental health needs, or alcohol and drug treatment.

Classes for Health, Childbirth & Parenting
Learn how to stay healthy during pregnancy, make a birth plan, and take care of your new baby.

Breastfeeding & Nutrition
Get help with breastfeeding coaching, free breast pumps, nutrition counseling, and vitamins.

Community Supports
If you qualify, you can get help with housing, healthy food, and other needs along with your health care.

American Indian Maternal Support Services
American Indian mothers can get health care, education, emotional support, and home visits before and after having a baby.

Other Programs and Services

Paid Family Leave
Get up to eight weeks of paid leave for each parent to care for your family within a 12-month period.

Women, Infants, and Children
Get healthy foods, breastfeeding help, and checkups for you and your baby.

CalFresh
For members who want to add to their budget to put healthy and nutritious food on the table.

Black Infant Health
Black pregnant and postpartum people can get both one-on-one and group help.

Ready to support a healthy pregnancy and start your baby's journey off strong?

Scan the QR code or visit **www.dhcs.ca.gov/services/Pages/Maternal-Perinatal.aspx** to explore these free services and find the right support for you and your family.

Provider Access and MCP Oversight and Monitoring (3 of 4)

Problem Statements

- Members and providers are often **unaware of the full array of available maternity care services.**

Policy Solutions	Status
Survey MCPs on promising practices to promote covered perinatal benefits among members and providers and reduce administrative burden for providers.	In Progress
Consolidate and update Medi-Cal perinatal policies through a single All Plan Letter (APL) and update provider manuals **to clearly define perinatal benefits and provider enrollment requirements** for midwives, birth centers, and doulas. Encourage MCPs to incentivize network providers to offer group perinatal care models to members.	Not Started

Provider Access and MCP Oversight and Monitoring (4 of 4)

Problem Statements

- Medi-Cal provider enrollment requirements created **potential barriers for midwives participating in Medi-Cal.**
- **Downstream subcontracting arrangements** can create barriers to perinatal services.

Policy Solutions	Status
Remove administrative barriers to Medi-Cal provider enrollment and reimbursement requirements **for midwives** by ensuring alignment with state licensing and scope of practice requirements.	Completed
Clarify MCP **network adequacy requirements for CNMs, LMs, and FBCs** as mandatory provider types and strengthen thresholds that must be met.	In Progress
Enhance oversight of network agreements and/or delegated arrangements for maternity/perinatal care services to ensure covered benefits are clearly outlined.	In Progress

Behavioral Health and Trauma-Informed Care (1 of 2)

Problem Statements

- Members face **challenges accessing timely behavioral health care** with limited mental health providers who accept Medi-Cal, are taking new patients, and have perinatal experience.

Policy Solutions	Status
Raise awareness of Children and Youth Behavioral Health Initiative (CYBHI) ongoing investments to **provide behavioral health services to children and their parents**.	Completed
Review MCP and behavioral health contracts to identify opportunities for **strengthening existing language to ensure pregnant and postpartum members have access to qualified behavioral health providers**.	Not Started

Behavioral Health and Trauma-Informed Care (2 of 2)

Problem Statements

- Some providers are **confused around how long a pregnant or postpartum member can receive residential substance use disorder (SUD) treatment.**
- **Trauma can negatively impact a member's physical and mental health outcomes,** relationships with health care providers, and adherence to treatment.

Policy Solutions	Status
Reinforce communication of **existing Medi-Cal coverage policy of no maximum stay** (e.g., 60 days) **for members** – including pregnant and postpartum members – **receiving residential SUD treatment**.	Completed
Update and disseminate SUD Perinatal Practice Guidelines for providers that deliver SUD treatment to pregnant and parenting women.	Completed
Reframe services in a trauma-informed context, acknowledging how care needs to be delivered to pregnant and postpartum members who are experiencing or have experienced Adverse Childhood Experiences (ACEs), IPV, community violence, and racism.	Not Started

Risk Stratification and Assessment

Problem Statements

- **Lack of standardization for how MCPs use risk stratification algorithms,** employ risk tiers, and connect members to services.
- **IPV screening is inconsistent** with limited follow-up care or support.

Policy Solutions	Status
Develop a risk stratification, segmentation, and tiering (RSST) process in Medi-Cal Connect to identify pregnant and postpartum members who are high risk. The RSST will identify members who may benefit from connections to additional social support and clinical care.	In Progress
Incorporate IPV screening as part of Medi-Cal assessments performed by providers and clinical care managers.	Not Started

Medi-Cal Maternity Care Payment Redesign (1 of 2)

Problem Statements

- Partners explained that **Medi-Cal's reimbursement rates for licensed and non-licensed maternity care providers are not high enough** to incentivize participation in Medi-Cal.
- The existing FQHC and rural health clinic (RHC) reimbursement methodology **does not incentivize clinics to provide dyadic services.**

Policy Solutions	Status
Increase rates for maternity care providers and enhance supplemental payments for Labor-and-Delivery (L&D) and hospital-based birthing center services.	In Progress
Expand Quality Incentive Pool (QIP) for Designated Public Hospitals (DPH) and District and Municipal Public Hospitals (DMPH).	Completed
Strengthen implementation of dyadic services by establishing an alternative payment methodology (APM) allowing FQHCs, RHCs, and Tribal Health Programs (THP) to be reimbursed for dyadic services at the Medi-Cal fee-for-service (FFS) reimbursement rate in addition to the FQHC/RHCs' Prospective Payment System (PPS) reimbursement rate and THPs' All-Inclusive Rate (AIR) for an eligible visit.	In Progress

Medi-Cal Maternity Care Payment Redesign (2 of 2)

Problem Statements

- FBCs and midwives providing home births face **challenges being recognized and reimbursed for their birthing approaches.**
- Providers are not incentivized to **appropriately transfer a patient to a higher level of care** based on their needs.

Policy Solutions	Status
Redesign how Medi-Cal pays for maternity care services to create a new birthing care payment model that rewards value-based care, incentivizes best practices for pregnant and postpartum members, and supports the goals of the Birthing Care Pathway.	In Progress
Develop billing/reimbursement guidance for Medi-Cal providers as well as MCPs and their subcontractors on LM services, including home births, and FBC services.	Not Started

Care Management and Social Drivers of Health (1 of 3)

Problem Statements

- **Homelessness and housing insecurity** contribute to adverse maternal and infant outcomes.

Policy Solutions	Status
Encourage utilization of Transitional Rent under the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 waiver demonstration as a Community Supports service **for eligible Medi-Cal members** – i.e., those who (1) meet one or more of the qualifying clinical risk factors (e.g., pregnancy and up to 12 months postpartum), are (2) experiencing or at risk of homelessness, and (3) fall within one or more of the transitioning populations (e.g., transitioning out of a hospital after giving birth).	In Progress
Encourage **MCPs to consider working with facilities that offer rooming in with short-term post-hospitalization stays** to provide Recuperative Care (medical respite) or Short-Term Post-Hospitalization Housing to members experiencing homelessness and who meet clinical criteria.	Not Started

Care Management and Social Drivers of Health (2 of 3)

Problem Statements

- **ECM and Community Supports providers** serving pregnant and postpartum members **need perinatal expertise.**
- Some **members are unaware of what ECM and Community Supports cover** and how they can find out if they are eligible.

Policy Solutions	Status
Conduct outreach to **WIC, home visitors, CBOs, and county behavioral health and nutrition services providers with perinatal expertise** to become ECM providers.	In Progress
Encourage **MCPs to build partnerships with IPV CBOs** to serve as ECM and Community Supports providers.	Not Started
Encourage **MCPs to partner with housing providers that meet the needs of perinatal populations** from pregnancy through 12 months postpartum **to serve as ECM and Community Supports providers**.	Not Started

Care Management and Social Drivers of Health (3 of 3)

Problem Statements

- Providers need **technical assistance, support, and educational materials around the ECM Birth Equity Population of Focus** (POF) as well as **education on which Community Supports can best support** their patients.

Policy Solutions	Status
Expand ECM referral pathways, particularly from social services and behavioral health providers, for pregnant and postpartum members.	In Progress
Leverage **Providing Access and Transforming Health (PATH)** to support ECM Birth Equity providers by providing technical assistance and prioritize ECM Birth Equity providers for **Capacity and Infrastructure, Transition, Expansion, and Development (CITED) Initiative awards**.	Completed

Perinatal Care for Justice-Involved Individuals

Problem Statements

- While some jails provide medications for opioid use disorder (MOUD) during pregnancy, many individuals are **abruptly discontinued** from these medications postpartum.

Policy Solutions	Status
Ensure pregnant and postpartum individuals are **enrolled in Medi-Cal pre-release**.	Completed
Ensure eligible pregnant and postpartum individuals **receive 90-day pre-release services**.	In Progress
Encourage **connection to ECM upon release**.	In Progress

Data and Quality (1 of 2)

Problem Statements

- California **does not have a statewide technology platform for maternity care providers, programs, and MCPs to easily and safely share patient data** and help members manage their medical, behavioral, and social needs.
- Eligibility and enrollment **data sharing across public benefits and programs are inconsistent** in California causing gaps in care and service delivery.

Policy Solutions	Status
Leverage Medi-Cal Connect to support whole person care and provide population insights by **safely sharing integrated health care and social data and insights about members among providers, delivery systems, programs, and state agencies** that support Medi-Cal members.	In Progress
Leverage learnings from pilot programs aimed at **cross-enrolling Medi-Cal members into crucial safety net supports** upon pregnancy through 12 months postpartum to inform strategies to facilitate cross-enrollment and the ongoing rollout of Medi-Cal Connect.	In Progress

Data and Quality (2 of 2)

Problem Statements

- **Maternity care quality metrics** that are used for MCP quality improvement and accountability processes **are limited.**

Policy Solutions	Status
Identify opportunities to **leverage and integrate existing California maternity data centers with Medi-Cal data** to more comprehensively measure and monitor birth outcomes.	In Progress
Create **key performance indicators to track the efficacy of maternity care** and monitor adherence to Birthing Care Pathway policies.	Not Started

State Agency Partnerships (1 of 2)

Problem Statements

- California's **home visiting programs** are not coordinated across state agencies, causing a **lack of member awareness and underutilization.**
- Low-income individuals in California are less likely to take advantage of the state's **Paid Family Leave (PFL) program.**

Policy Solutions	Status
Collaborate with California Department of Public Health (CDPH), California Department of Social Services (CDSS), and MCPs to **promote home visiting for Medi-Cal members** and ensure eligible members can access home visiting programs.	In Progress
Partner with the Employment Development Department (EDD) and Legal Aid at Work (LAAW) to **develop a resource guide for perinatal providers** on how their pregnant and postpartum patients can **access the state's PFL and State Disability Insurance (SDI) programs**.	In Progress

State Agency Partnerships (2 of 2)

Problem Statements

- Lack of **access** and links to **risk-appropriate care.**
- **Siloed** services, programs, and interventions.

Policy Solutions	Status
Partner with CDPH, Office of the California Surgeon General (OSG), and California Maternal Quality Care Collaborative (CMQCC) to develop the **statewide Maternal Health Strategic Plan.**	In Progress
Leverage the Family First Prevention Services Act (FFPSA) to **support SUD and mental health treatment** services for pregnant and postpartum individuals at risk of child welfare involvement.	In Progress
Continue to support the OSG Strong Start & Beyond movement through participation in the **Perinatal Advisory Group (PAG)**.	In Progress

Appendix: Strategic Opportunities for Further Exploration

Provider Access and MCP Oversight and Monitoring (1 of 2)

Problem Statements

- **Access issues persist** despite MCPs meeting existing Medi-Cal network adequacy standards.
- **Significant racial and ethnic disparities** in maternal health outcomes persist.

Potential Opportunities

- **Strengthen oversight and monitoring of network adequacy standards for maternal providers**, including adopting an appropriate threshold for accepting Alternative Access Standards (AAS) requests.
- Require MCPs to participate in a **joint performance improvement project (PIP)** in which all MCPs are required to participate, focused on **reducing disparities for Black, American Indian/Alaska Native, and Pacific Islander** pregnant and postpartum members.

Provider Access and MCP Oversight and Monitoring (2 of 2)

Problem Statements

- Many perinatal providers **lack the training to conduct IPV screening.**
- Only physicians, registered nurses, and dieticians working under the supervision of a physician can provide **lactation services** in Medi-Cal today.

Potential Opportunities

- Require MCPs to **incorporate IPV training into required network provider training** and **promote universal IPV education** in health care settings.
- Update lactation policy to **recognize International Board Certified Lactation Consultants (IBCLC) and Certified Lactation Counselors (CLC) as a provider type** that can bill Medi-Cal.

Behavioral Health (1 of 2)

Problem Statements

- Members face **challenges accessing behavioral health providers** that have perinatal training and appointment availability.

Potential Opportunities

- Develop **statewide perinatal behavioral health consultation line** for maternal providers and therapists without perinatal training to receive consultations from qualified mental health and SUD providers with perinatal expertise for pregnant and postpartum members living with behavioral health needs.
- Support implementation of **perinatal workforce training on trauma-informed, culturally relevant crisis care** and integration of county behavioral health services into obstetric provider practices for pregnant members living with SUD or serious mental health needs.
- Support CBOs serving pregnant and postpartum individuals living with behavioral health needs by providing counties with a **list of proposed uses for Behavioral Health Services Act (BHSA) funds** that address gaps identified for this population.

Behavioral Health (2 of 2)

Problem Statements

- Parents must be allowed to **stay with their infants** while undergoing **treatment for neonatal abstinence syndrome (NAS).**

Potential Opportunities

- Support postpartum members to **stay in the hospital with their newborns (e.g., rooming in) while the newborn is being treated for NAS/Neonatal Opioid Withdrawal Syndrome (NOWS)** and not be discharged until their newborn is discharged.

Maternal Care Models and Access (1 of 2)

Problem Statements

- **Limited oversight of** the **CPSP and insufficient data to track utilization** of CPSP services.
- **Separate CPSP provider enrollment process** with CDPH is burdensome.
- Existing CPSP payment structure for FQHCs/RHCs **encourages clinics to maximize service volume** over reducing member burden.

Potential Opportunities

- **Enhance the delivery of comprehensive perinatal services** across the FFS delivery system and Medi-Cal MCPs, including:
  - Aligning with the most recent clinical guidelines.
  - Updating benefit delivery structure.
  - Improving state oversight with data-driven monitoring.
  - Modernizing the payment and billing code structure.

Maternal Care Models and Access (2 of 2)

Problem Statements

- There is **no perinatal specialization for CHWs.**
- **More racially concordant providers**, including midwives, are needed.
- **Short-term housing solutions** are needed for high-risk pregnant members to be closer to risk-appropriate care.

Potential Opportunities

- Develop **perinatal specialization for CHWs.**
- Develop **loan repayment program** to increase diversity and rural representation of **midwives**.
- Provide **short-term housing for high-risk pregnant members** who live in remote counties that is near hospitals equipped to care for complex maternal and fetal medical conditions and obstetric complications.

Provider Resources

Problem Statements

- **Additional Medi-Cal provider education is needed on the programs and services for which** pregnant and postpartum members may be eligible.

Potential Opportunities

- Require MCPs to **augment provider training requirements to include a focus on Medi-Cal perinatal benefits, perinatal mental health, and SUD.**

Data and Quality

Problem Statements

- There is a **need for additional maternity care quality metrics** beyond those currently tracked.
- DHCS does not currently require reporting on **patient-reported measures around access and patient experience** for perinatal care and services.

Potential Opportunities

- Develop **technical workgroup to advise** on perinatal health and birth outcome **quality measures.**
- Identify quality metrics and require reporting **on patient-reported outcome measures (PROM)** around access and patient experience for perinatal care and services.

State Agency Partnerships (1 of 3)

Problem Statements

- **Members and providers may be unaware of which birth setting would be best suited** based on their level of risk during pregnancy.
- Members are also often **unaware of the impact their current health has on pregnancy outcomes** until they attend their first prenatal appointment.

Potential Opportunities

- Partner with CDPH to **require birthing hospitals to have a verified ACOG Levels of Maternal Care designation.**
- Partner with OSG to promote community education and **pregnancy risk awareness.**

State Agency Partnerships (2 of 3)

Problem Statements

- Low-income individuals in California are **less likely to take advantage** of the state's **PFL program.**
- California faces **maternal health care workforce shortages** across multiple provider types.
- **None** of California's **home visiting programs** are available **statewide**, and each has **differing eligibility criteria.**

Potential Opportunities

- Explore options to **obtain data from EDD to improve outreach** to pregnant and postpartum Medi-Cal members **about the state's PFL and SDI programs**.
- Coordinate with the California Department of Health Care Access and Information (HCAI) to fund **workforce development strategies for perinatal providers**.
- Collaborate with CDPH, CDSS, and MCPs to **provide at least one voluntary home visit to every newly pregnant Medi-Cal member** and develop a standard to identify members who would benefit from more than one home visit in the prenatal and postpartum periods.

State Agency Partnerships (3 of 3)

Problem Statements

- **Stigma around SUD treatment** results in many members **forgoing necessary care for fear of prosecution or child protective services involvement.**

Potential Opportunities

- Examine opportunities to partner with state agencies to **protect pregnant and postpartum individuals from prosecution** for drug-related offenses that may be initiated after they seek SUD treatment.
- Partner with CDSS to **educate health care partners on child welfare policy nuances** that may inadvertently require or permit revoking custody from the parent due to use of medications for SUD treatment and consider modifications to the policies.
- Collaborate with CDSS on **training for labor and delivery clinical care teams and child welfare case managers about perinatal SUDs** to reduce stigma, misinformation, and barriers to treatment.

Appendix: Medi-Cal MCP and County Behavioral Health Plan Quality Ratings for 2023

DHCS

Changes to MCAS MY 23 Measures from MY 22 Measures (1 of 2)

MCPs & RUs

- Total number of MCPs
  - MY 23: 24
  - MY 22: 25
- Total number of RUs
  - MY 23: 55
  - MY 22: 56

Measure Type Methodology Changes

- Breast Cancer Screening (BCS was adjusted to BCS-E).
  - National Committee for Quality Assurance (NCQA) & Health Services Advisory Group (HSAG) recommend against dual reporting of admin and Electronic Clinical Data Systems (ECDS) methods.
  - BCS-E was calculated using ECDS methodology.
  - MCPs held to MPL derived from MY 22 50th percentile of admin measurement of BCS.

Changes to MCAS MY 23 Measures from MY 22 Measures (2 of 2)

Transitioned from Report Only to Accountable

Two new measures held to MPL in the Children's Domain:

- Developmental Screening in the First Three Years of Life (**DEV**)
  - Report only in MY 20-22
- Topical Fluoride for Children (**TFL-CH**)
  - Report only in MY 22

One new measure held to MPL in the Chronic Disease Management Domain:

- Asthma Medication Ratio (AMR)
  - Held to MPL in MY 20
  - Report only in MY 21-22
  - Related to Medi-Cal Rx transition
- Total measures held to MPL increased from 15 to 18

Reporting Units are defined as the smallest geographic boundary from which network adequacy ratios are determined and MCP quality performance measure rates and incentive programs are based). A reporting unit may be a single county or an aggregate of counties with less populated areas.

Finalized Policy Changes for MY 23

- **Severity Factor:** Break down the Severity Factor category "Minimal Violation" range of 1.00 percent to 5.99 percent into two smaller ranges:
  - 1.00 percent - 2.99 percent
  - 3.00 percent - 5.99 percent

- **FUM/FUA:** MCPs will not be held to MPL on FUM/FUA measures for MY 23.

- **TFL-CH:** MCPs will be held to MPL for TFL-CH with potential for waiving/reducing sanctions if they provide sufficient documentation in the meet and confer process.

Methodology Overview

» The overall methodology remains largely **unchanged** from MY 22.

$$\sum\left[\left(\textbf{severity violation factor}\right) \times (\text{trending factor}) \times (\text{population not served}) \times [1-(\text{HPI impact reduction})]\right]$$

- **Severity** – percentage point difference between MCP's measure rate and MPL **(adjusted in MY 23).**
- **Trending** – percentage point difference between MCP's measure rate in current MY compared to prior MY.
- **Population not served** – number of affected members who did not receive service based on numerators and denominators submitted with MCAS reporting.
- **Healthy Places Index (HPI)** – reduction accounting for MCPs serving members in underserved zip codes.

Quality Enforcement Action Tier Triggers for MY 23

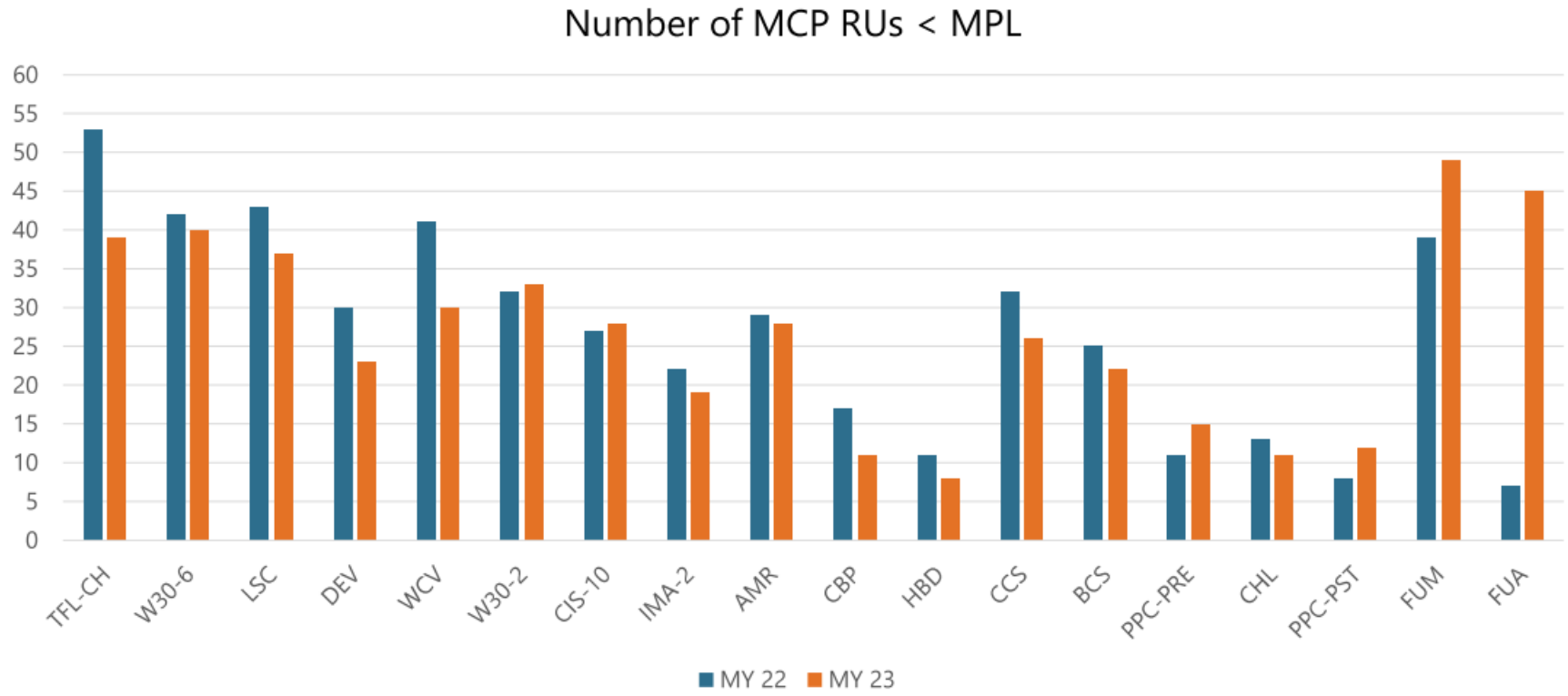
Enforcement Tier	Tier 1	Tier 2	Tier 3
MY 23 Triggers (per MPL/domain)	**One (1)** measure below MPL in any **one (1)** domain	**Two (2)** or more measures below MPL in any **one (1)** domain	**Three (3)** or more measures in **two (2)** or more domains
Enforcement Action	Not subject to monetary sanctions	Subject to monetary sanctions	Subject to monetary sanctions

- MCPs requiring Corrective Action Plans (CAPs) for two consecutive years are subject to doubling of their sanction total per violation.
- CAPs are issued for plans in Tier 3 (red tier).

Comparison: MY 22 to MY 23 MCAS Measures Key Takeaways

- **Improvement is defined as less RUs below the MPL.**
  - 12/18 measures saw improvement: W30-6, WCV, IMA-2, CBP, LSC, HBD, CCS, BCS, CHL, DEV, AMR, and TFL-CH.
  - 6/18 measures saw decreases in performance: W30-2, CIS-10, FUM and FUA , PPC-PRE, PPC-PST.
  - **Statewide** improvement in TFL-CH, DEV, and LSC; however, CIS-10, AMR, and FUM-30 show downward trends .
- One MCP achieved all MPLs, including FUM and FUA: Health Plan of San Mateo.

Comparison: MY 22 to MY 23 Overview on MCAS Measures that Failed to Meet MPLs



- Number of RUs declined from 56 in MY 22 to 55 in MY 23
- DEV, TFL-CH, AMR were not held to MPL for MY 22, but MCPs still had to report on their performance rates