Stakeholder Advisory Committee & Behavioral Health Stakeholder Advisory Committee Meeting

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

July 2024

Webinar 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 will be able to make oral comments during the public comment period.
- For questions or comments, email: SACinquiries@dhcs.ca.gov.

Welcome, Roll Call, and Today's Agenda

Tyler Sadwith, State Medicaid Director

DHCS

Director’s Update

Tyler Sadwith, State Medicaid Director

DHCS

Budget Update

- Proposition 1 – Behavioral Health Transformation (BHT)
  - Budget includes $116.5 million total funds to begin implementation of BHT.
  - $631,000 in Behavioral Health Services Act fund included for Department of Health Care Access and Information.
  - $85 million total funds for County Behavioral Health Departments to begin administering their functions under BHT.
- Behavioral Health Infrastructure Bond Act
  - Proposition 1 included approximately $4.4 billion in bonds for DHCS.

Budget Update (Continued)

- Managed Care Organization (MCO) Tax
  - Modifications to more comprehensively account for Medicare revenue in determining the maximum aggregate tax allowable while meeting federal requirements.
  - The budget includes new rate increases effective January 1, 2025
    - Physician Emergency Department Services ($100 million)
    - Abortion Care and Family Planning ($90 million)
    - Ground Emergency Medical Transportation ($50 million)
    - Air Ambulances ($8 million)
    - Community-Based Adult Services ($8 million)
    - Congregate Living Health Facilities ($8 million)
    - Pediatric Day Health Centers ($3 million)
    - Community Health Workers to achieve 100 percent of Medicare rate

Budget Update (Continued)

- MCO Tax rate increases taking effect January 1, 2026 include:
  - Physician/Non-Physician Health Services ($753 million)
  - Private Duty Nursing ($62 million)
  - Services and Supports for FQHCs/RHCs ($50 million)
  - Continuous Coverage for Children Aged 0 through 4 ($33 million)
  - Non-Emergency Medical Transportation ($25 million)
- The budget includes $6.9 billion in 2024-25 in MCO tax funding to support existing services in the Medi-Cal program.

Budget Solutions

- **Behavioral Health Continuum Infrastructure Program** – reversion of $450.7 million General Fund one-time from the last round of the program
- **Behavioral Health Bridge Housing** – net reduction of $250 million total funding
- **Equity and Practice Transformation Payments to Providers –** reduction of $280 million one-time over multiple years of grants to providers
- Sunsetting the **Major Risk Medical Insurance Program**

Questions?

Final Update: Year of Medi-Cal Redeterminations

Yingjia Huang, Assistant Deputy Director, Health Care Benefits and Eligibility

DHCS

Where We Are

- Continuous Coverage Unwinding officially ended on May 31, 2024
- California had over 13.3 million renewals (excludes Medi-Cal members in Presumptive Eligibility, state-only, and federal SSI programs) and is the largest Medicaid caseload in the nation.
- As of June 2024, 88% or 11,625,200 of 13.3 million renewals have been completed. Most of the 12% remaining renewals are from March-May 2024, which is within the 90-day cure period.

A Year in Reflection

- Increased Auto-Renewal (Ex Parte) rates from an average 35% (June – November 2023) to an average of 66% (December 2023 to May 2024)
- Policy flexibilities allowed for a higher auto renewal rate for California's Seniors and Persons with Disabilities (Non-MAGI group) after automation of policy flexibilities
  - 3.9% (5,354 of 137,401) of all Non-MAGI were auto-renewed in Nov 2024 vs. 47% (69,715 of 148,198) in April 2024
- As of June 2024, approximately 7.8 million Californians successfully continued in coverage through the redetermination process and is one of the highest retention rates in the nation to date.
- Lower Disenrollment Rates with Policy Automation
  - A drop from 18-22% monthly disenrollment rate (June – Nov 2023) to 8-10% (Dec to May 2024)
  - Approximately 1.9 million individuals were disenrolled during the Continuous Coverage Unwinding

What We Have Learned in Outreach

- DHCS created one landing page for application and renewal information: Get Medi-Cal or Keep Your Medi-Cal which provides information for Medi-Cal members at different places in their journey
  - More than 3.1 million unique visitors to the landing page throughout the duration of the campaign.
- Targeted Messaging is Effective:
  - Development of a resource hub Keep Your Community Covered that offers a range of outreach materials to help members use and keep their coverage, totaling 6,750 total outreach assets, downloaded 17,000 times by Ambassadors and stakeholders
  - Paid media advertising: Using zip codes and income threshold to target campaign, with ad placements delivering over 1.69 billion impressions, and digital advertising garnering over 3.4 million clicks throughout the campaign.
  - Partnerships with ethnic media (approximately 70 media outlets) resulting in a total of 183 pieces of news coverage
  - Text Messaging: Most popular communication modality with our Medi-Cal members
- Community Partnership: As of June 2024, close to 8,000 DHCS Coverage Ambassadors

Questions?

CalAIM Dashboard: Bold Goals, Behavioral Health, and Population Health Management

Drew Bedgood, Medical Consultant II, Quality and Health Equity

Ivan Bhardwaj, Chief, Medi-Cal Behavioral Health Policy

David Tian, Acting Branch Chief, Clinical Population Health Care Management

DHCS

CalAIM Dashboard Overview
Goals & Objectives

- Introduction of the CalAIM Dashboard
- Review the vision of the CalAIM Dashboard
- Walkthrough of Select Initiatives
  - Bold Goals
  - Behavioral Health
  - PHM
- Live Demonstration of CalAIM Dashboard
- Next steps for CalAIM Dashboard

What is the CalAIM Dashboard?

- Portfolio of public facing data dashboards
- Intended use by all DHCS stakeholders
- Monitoring progress of CalAIM initiatives together to improve data transparency

9 initiative sites

20 interactive dashboards

Over 40 measures

Live Demonstration of CalAIM Dashboard Site

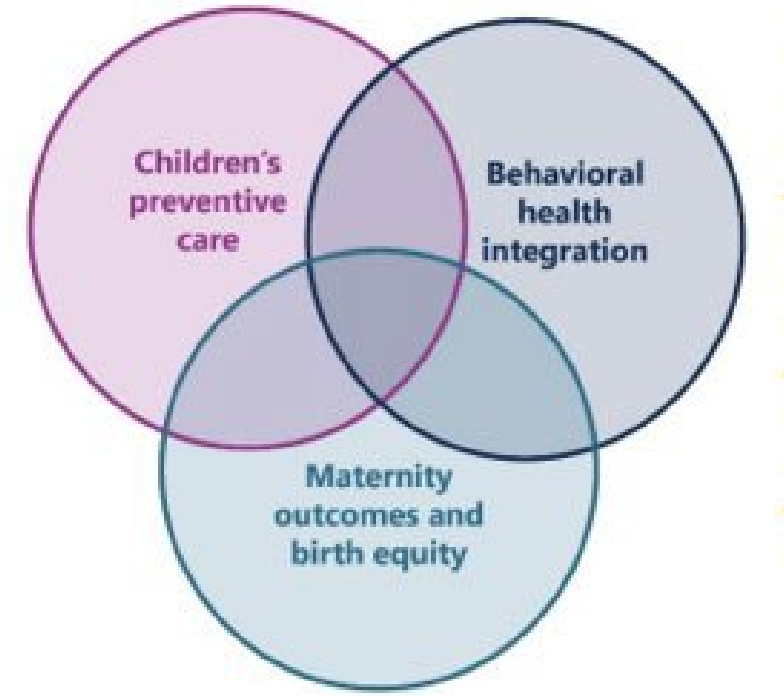
- Join us as we walk through the website together to discuss insights and main takeaways

https://calaim.dhcs.ca.gov/

Bold Goals

What Are the Bold Goals?

- Launched in 2022 with set health equity goals to achieve by the end of the year 2025
- Guided by the Health Equity Roadmap and the Comprehensive Quality Strategy



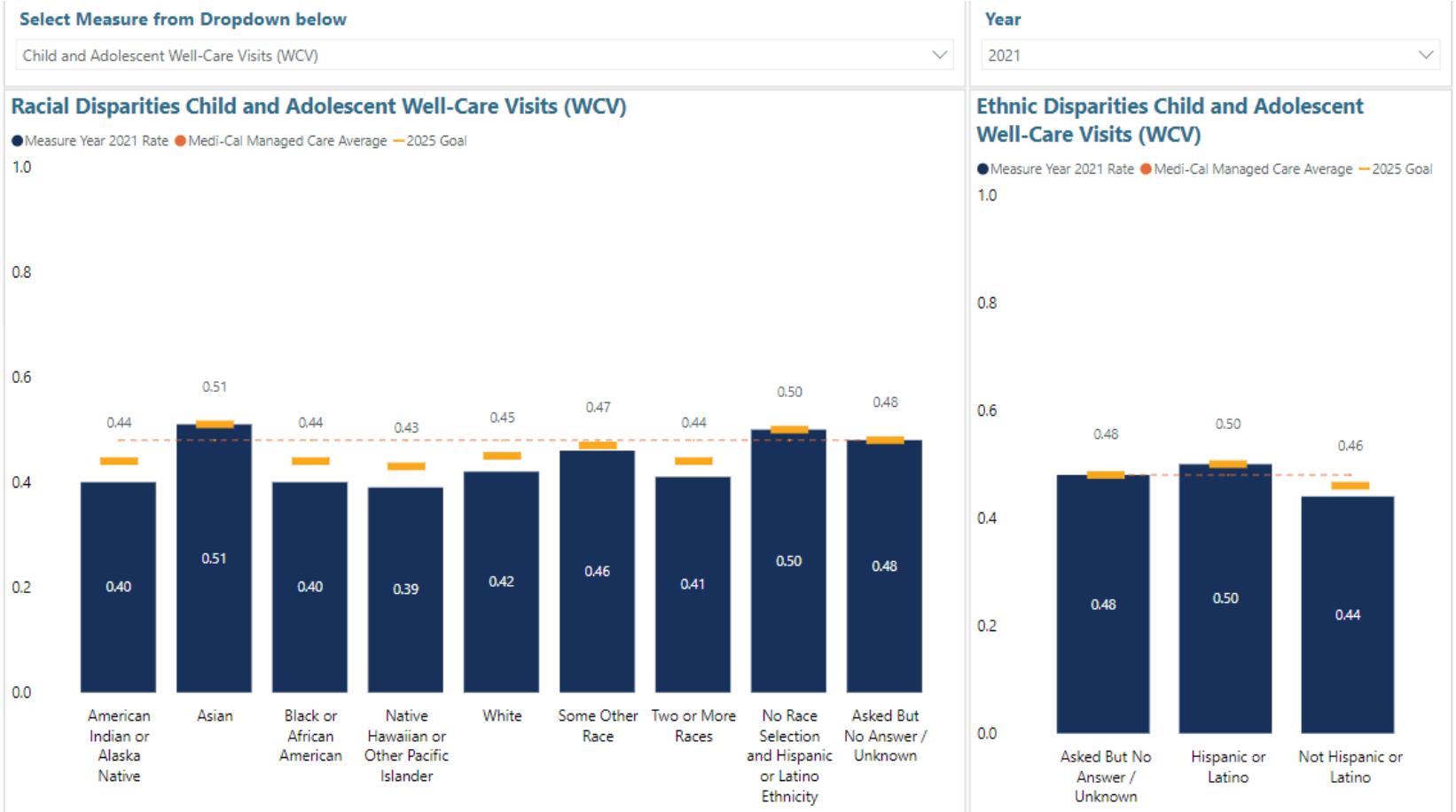
What are the Bold Goals?

- Outline DHCS' process for assessing and improving the quality of health care and services
- Quality Measures from the Medi-Cal Managed Care Accountability Set (MCAS)
- Data reported from Medi-Cal Managed Care Plans annually
  - Final reporting anticipated in Q1 2027

Insights – Bold Goals
Well Child Visit Health Equity

1st Bold Goal: Close racial/ethnic disparities in well-child visits and immunizations by 50%

- ***Medical Managed Care Average Statewide performance***: 0.48 (48%)
- ***Baseline for each category***: Ex AI or AN: 0.40 (40%)
- ***Disparity Gap***: 0.08, and closing the gap means bringing AI or AN to 0.44 (44%)



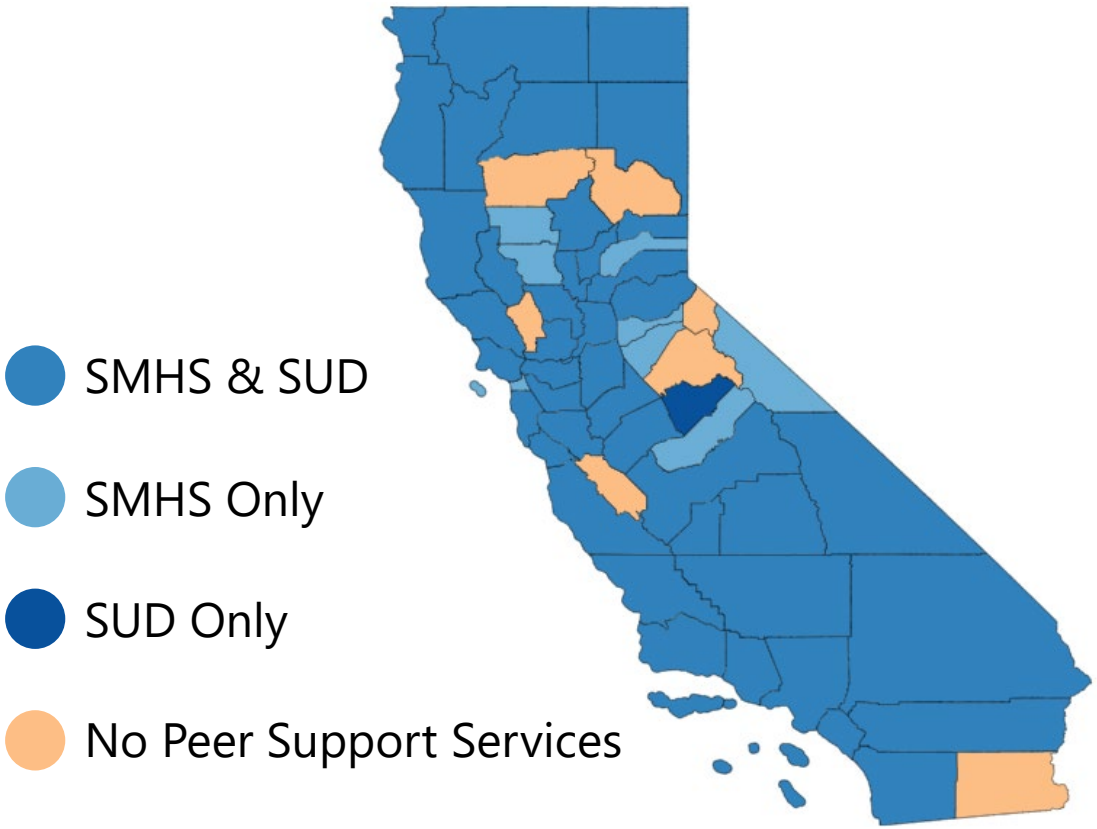
Behavioral Health

Behavioral Health: Phase I Overview

- Phase I launched in February 2024
  - Initial phase included:
    - Medi-Cal Peer Support Services
    - Recovery Incentives Program
    - Behavioral Health Quality Improvement Program (BHQIP)
    - CalAIM BH Trainings
  - Launched with “ready state” data
- Future phases will expand on existing initiatives and add new ones
  - Medi-Cal Mobile Crisis Services
  - Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment Demonstration (BH-CONNECT)

Phase I Overview: Medi-Cal Peer Support Services

Counties Offering Peer Support Services by Delivery System Type



Recovery-oriented and culturally appropriate services to promote engagement, socialization, self-sufficiency, self-advocacy, and natural supports for members seeking behavioral health treatment.

- Displays a map of all **51 counties** that have opted into the benefit, which accounts for **99% of the Medi-Cal population**.
- Displays a map of each county delivery system that operates Medi-Cal Peer Support Services.
- Displays counties that have not yet opted into the benefit.
- Links to the dataset used for Medi-Cal Peer Support Services data.

Phase I Overview: Recovery Incentives Program

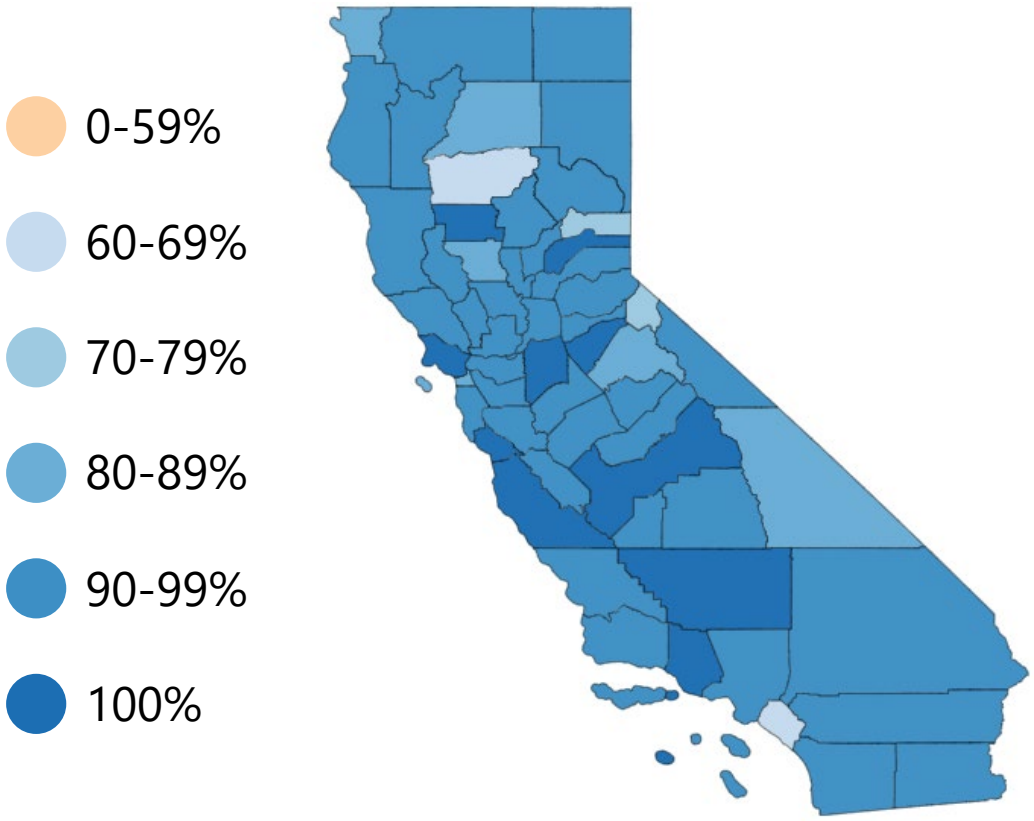
Number of Contingency Management (CM) Services County

A Contingency Management benefit, which is an evidence-based treatment that provides motivational incentives to treat individuals living with stimulant use disorder and support their path to recovery.

- More than **89%** of Medi-Cal members reside in a DMC-ODS county that has opted into the Recovery Incentives Program.
- Displays a map of all **19 counties** that are currently providing Contingency Management services.
- Displays a table of all **70+ approved** Contingency Management sites.
- Links to the master list of all approved Contingency Management sites (updated biweekly).

Phase I Overview: Behavioral Health Quality Improvement Program

County Allocations for BHQIP



An incentive payment program that helped county Behavioral Health Plans implement CalAIM behavioral health initiatives and other Administration priorities.

- Displays a map and table of incentive payments earned by county BHPs from September 2022 through March 2024 for completed program milestones and deliverables.
- Visualizes **98% of $86.6M** earned by county BHPs, as of March 2024.
- Visualizes each county Behavioral Health Plan's total and SFY allocations.
- Links to the dataset used for the BHQIP data.

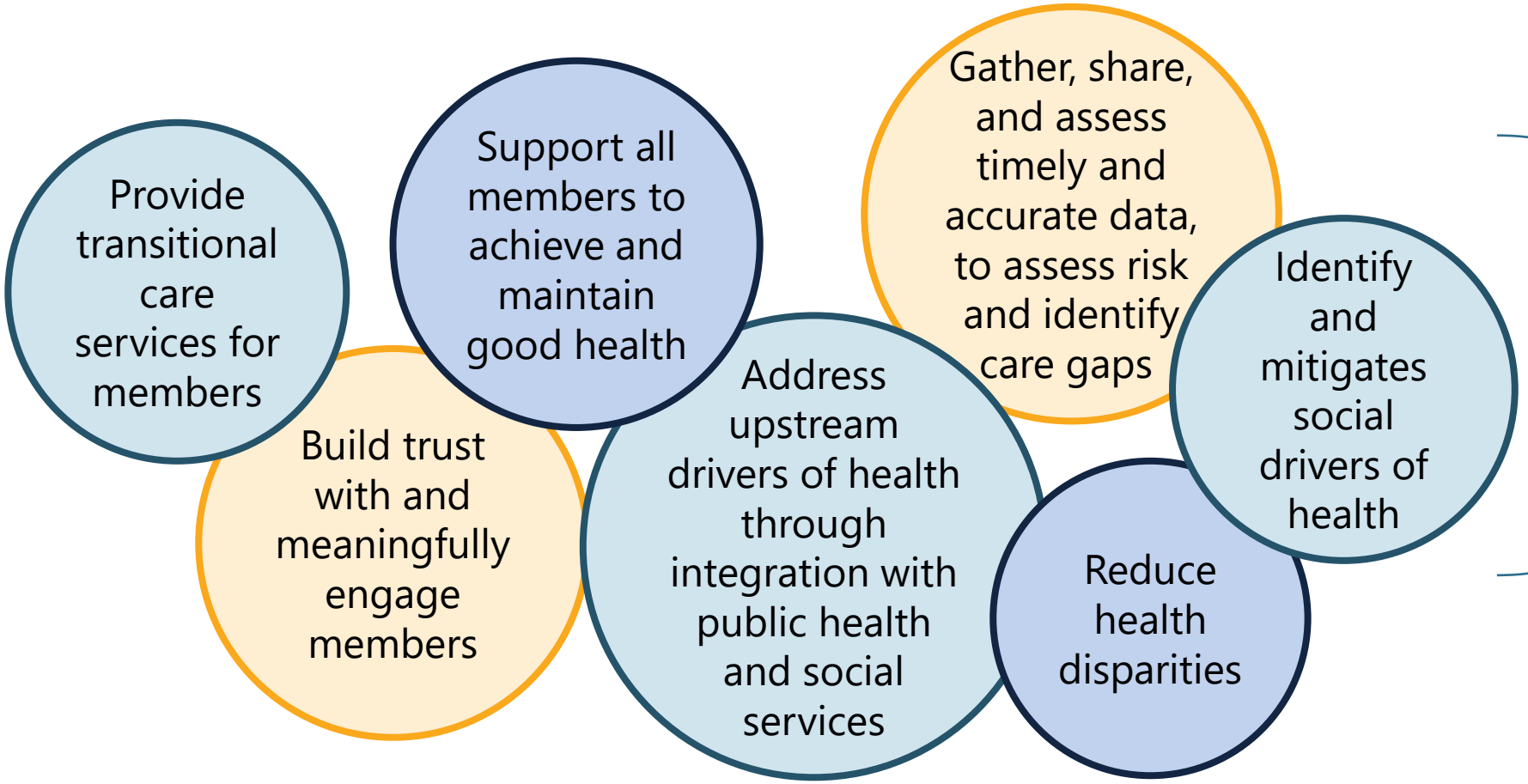
Phase I Overview: CalAIM Behavioral Health Trainings

Through a partnership with CalMHSA, DHCS administered statewide trainings to support successful implementation of CalAIM initiatives.

- Displays a table of each county and the number of:
  - Individuals utilizing the training system
  - Available and completed modules
  - Percentage of modules completed
- **34,000+** provider staff have been trained on CalAIM Behavioral Health policy updates
- **250,000+** CalAIM Behavioral Health modules completed by provider staff Statewide
- Links to the dataset used for visualization that provides granular detail on the types of completed modules.

Population Health Management

Population Health Management Program



Achieved through services and programs, including (but not limited to)

- Risk stratification, segmentation, and tiering
- Transitional Care Services
- Enhanced Care Management
- Basic Population Health Management

The DHCS CalAIM Dashboard contains performance measures data from 2021 (and soon 2022). These years are **before** the launch of PHM in 2023. Thus, the PHM section of the CalAIM Dashboard serves as a baseline prior to PHM program launch and can be followed over time to assess MCPs' PHM program impact on quality outcomes.

Current CalAIM Dashboard PHM Measures (2021 Data)

Measure	Number of emergency department visits per month for every 1,000 members (AMB-ED, lower rate is better)	Ratio of observed hospital readmissions compared to the number of expected readmissions (PCR-OR, lower is better)	Percentage of Medi-Cal members who received follow-up care within 30 days after a mental health emergency department (FUM, higher is better)
Statewide Performance	33.7	1.0	35%
Expected Impact of PHM	Through PHM, more Medi-Cal members should receive services from their primary care provider or other outpatient providers rather than ending up in the emergency department (ED). Over time, DHCS anticipates this number will decrease.	Readmissions are defined as times when a person who recently left the hospital must unexpectedly be admitted back to the hospital. PHM's Transitional Care Services policy should improve (decrease) this number.	As plans increasingly connect members to medically necessary follow up, care, or treatment related to their mental health conditions, DHCS anticipates this measure to improve (increase).

PHM section of the CalAIM Dashboard

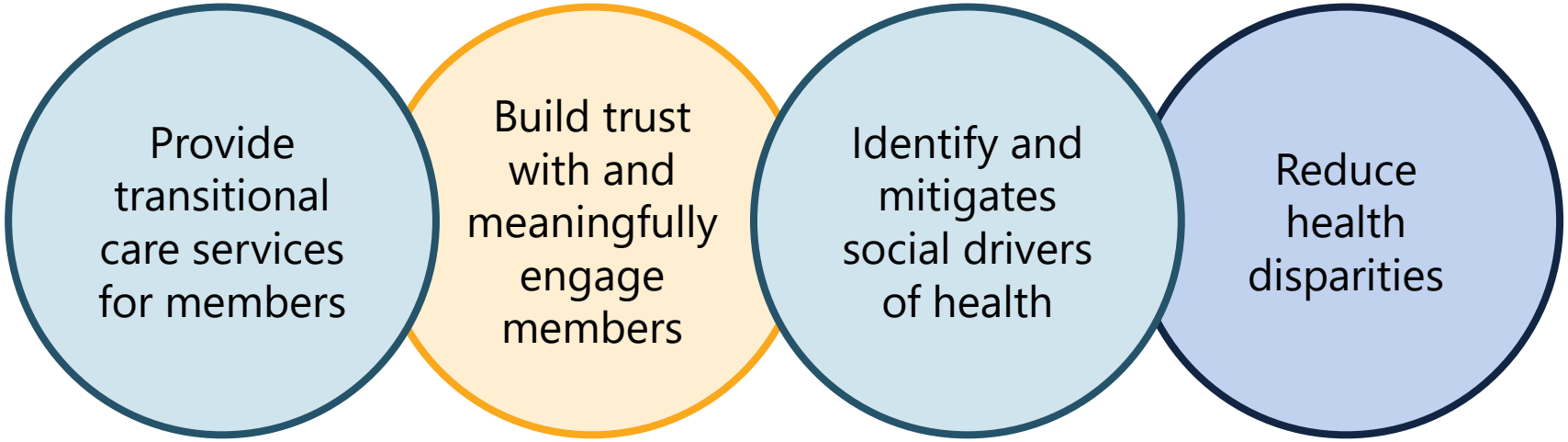
Current and Future CalAIM Dashboard PHM Measures

» **Current**

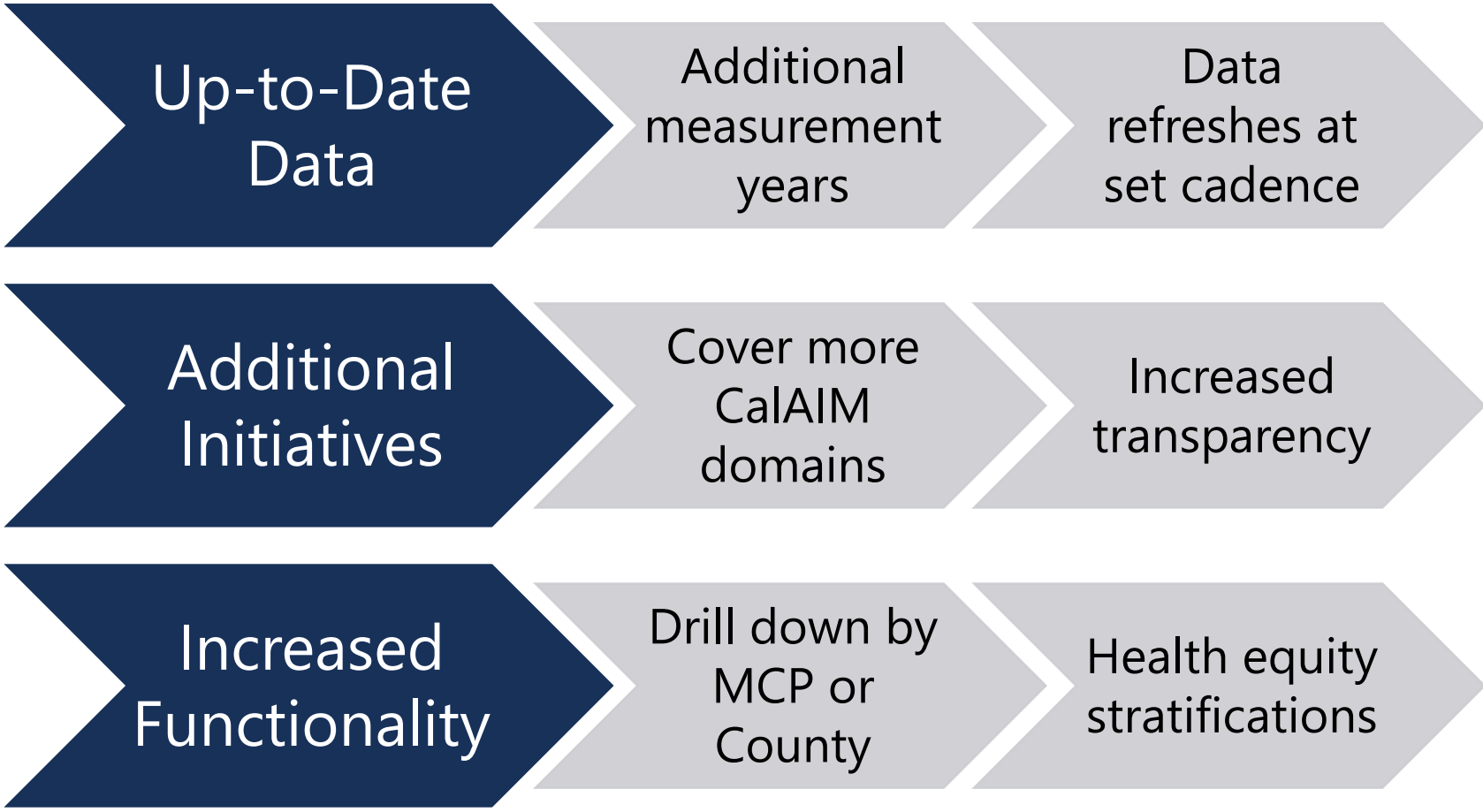
- Number of emergency department visits per month for every 1,000 members
- Rate of observed hospital readmissions compared to the number of expected readmissions
- Percentage of Medi-Cal members who received follow-up care within 30 days after a mental health emergency department visit

» **Anticipated Future Additions**

- Number of unique Medi-Cal members receiving the community health worker benefit
- Number of hospital discharges with outpatient follow-up within 7 days
- Percentage of Medi-Cal members who received follow-up care within 30 days after a substance use disorder related emergency department visit



CalAIM Dashboard Next Steps



Discussion and/or Questions?

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

Introduction of Medi-Cal Connect

(formerly the Population Health Management Service)

Hope Neighbor, Chief, Population Health Management

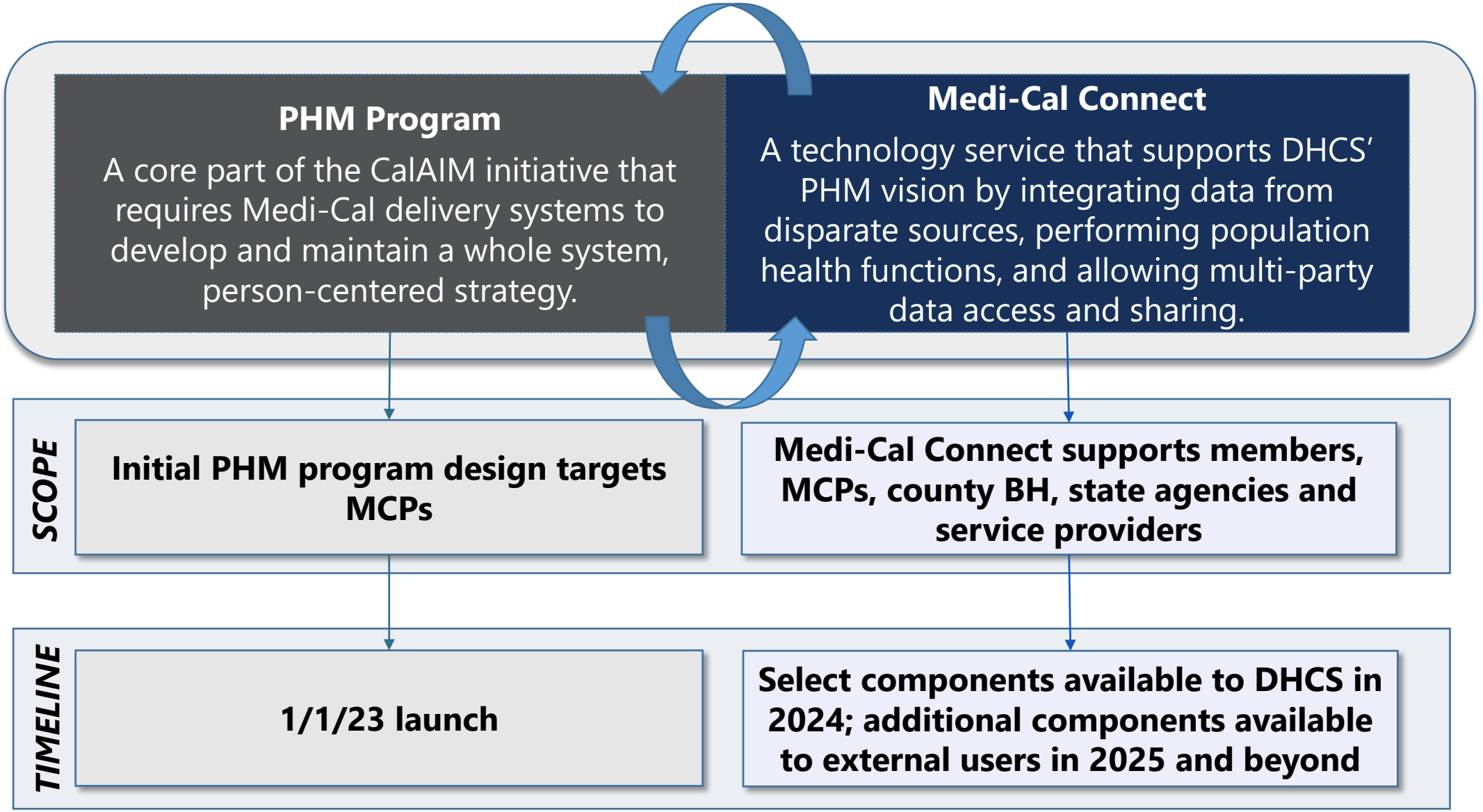
Yoshi Laing, Medical Consultant II, Population Health Management

DHCS

Objectives

- Understand vision, objectives, and current status of DHCS' Medi-Cal Connect (the PHM Service)
- Value propositions for users
  - Release timeline
  - Stakeholder engagement plan
- Discuss your questions and concerns regarding implementation

The PHM Program and Medi-Cal Connect



Vision for Medi-Cal Connect

- To provide a data-driven business solution that supports whole-person care by integrating information from trusted partners to support population health functions and allow for multi-party data access and sharing.

Objectives of Medi-Cal Connect

Member Experience

- User-friendly tool
- Navigate benefits
- Streamline access to services
- Enable self-service updates

Whole Person Care

- View member's risks & unmet needs
- Standardized risk stratification
- Actionable insights

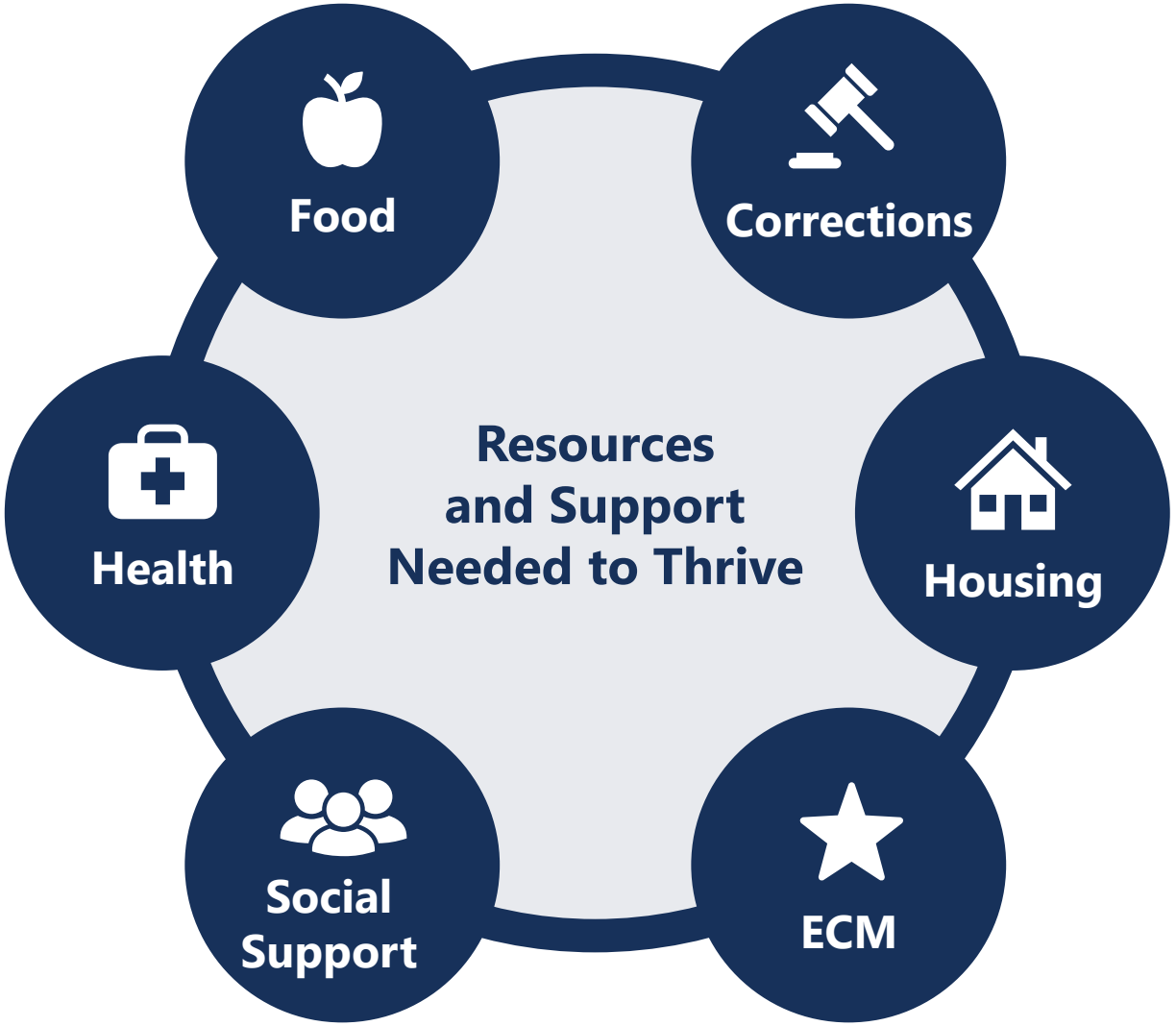
Population Level Insights

- Enable data aggregation, analytics & sharing
- Understand population-level health trends

Informed Policymaking

- Strengthen DHCS' oversight & policy decisions
- Drive improved health equity & quality of care

Medi-Cal Connect Will Support Whole Person Care



- Whole Person Care combines physical health, behavioral health, and social services to improve member health and well-being
- Medi-Cal Connect will support whole-person care by creating an easy-to-access platform, empowering members to:
  - Navigate benefits
  - Close gaps in services
  - Update contact information

Medi-Cal Connect

What it is..

- Enables members to effectively assess potential eligibility for services and conveniently update their contact information.
- Guides members toward appropriate health and social service programs.
- Offers a platform for service providers to view member care plans and share information with relevant parties (e.g., care managers, plans).
- Serves as a centralized repository for hosting comprehensive health and social resource information.

What it isn’t…

- A tool that pulls data from electronic health records.
- A tool for making real-time patient-related decisions.
- A fully functioning care management system.

Privacy, Security & Consent

Considerations	Key Project Approach Examples
Privacy	• User profiles have role-based access • Analytics developed with the minimum necessary data • Comparative analytics will be anonymized to ensure member privacy
Security	• Robust verification security tooling and audits at each release • DHCS's independent security audits have identified 0 major findings • Gainwell's monitoring system ensures active compliance with NIST controls
Consent	• Default consent is based on Medi-Cal permissions at time of enrollment • Members will be able to add/subtract permissions as part of the member release

Release Roadmap & Users

Release 1 *(Q3 2024)*

For DHCS Power Users

- Initial release focused on Service's fundamental requirement: support activation of analytic capabilities for DHCS
- Three initial dashboards:
  - Quality Measures
  - Condition Prevalence & Quality of Care
  - Health Equity

Release 2 *(Q4 2024)*

For all DHCS Users

- Evolve R1 capabilities based on DHCS Feedback
- Additional dashboards

Release 3 *(Q2 2025)*

For MCPs, MHPs, State Partners and Agencies

- Two ways R3 users can interact with data: API or portal with dashboards
- Risk Stratification, Segmentation & Tiering (RSST)
- Collection and sharing of: screening & assessments, care plans, and member contact & demographic information

Release Roadmap & Users Cont…

Release 4 *(Q3 2025)*

For Other Delivery Partners

- Deliver R1-R3 capabilities to support Local County Partners, PHM Program Services & Supports, Healthcare Delivery Partners (HDPs), Other Medi-Cal Delivery Systems, and Tribal Partners

Release 5 *(Q1 2026)*

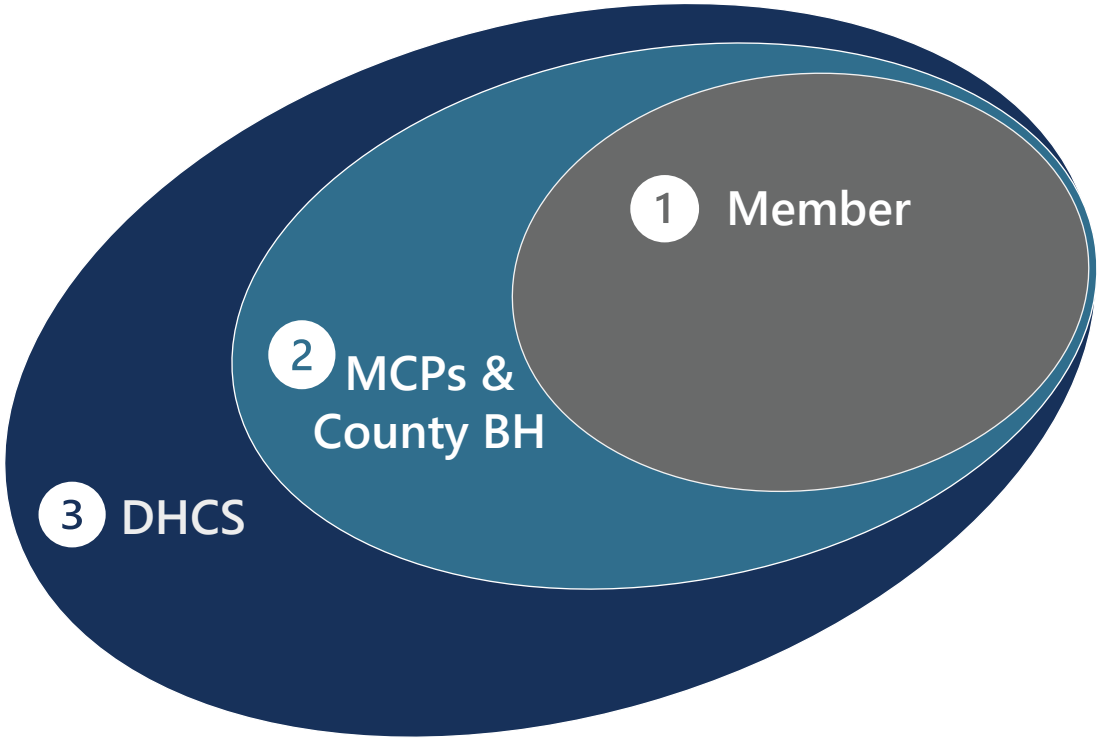
For Members

- Evolve R1 – R4 capabilities
- Deliver novel capabilities to support Members

Quarterly Releases

- Regularly scheduled maintenance releases to ensure continued Medi-Cal Connect operations and availability
- Potential to add additional data sets and functionality

Three Priority User Groups



VALUE PROPOSITIONS

1
- » Exchange info via direct, reliable communication channel
  - Ex: Update contact info
- » Easily navigate Medi-Cal and related services

2
- » Fill data and tool gaps (APIs & dashboards) to strengthen PHM per policy guide. E.g.:
  - Accurate contact info
  - Standard screenings & assessments
  - Automated, standardized member risk scoring and tiering

3
- » Analyze, monitor, and improve population health programs
- » Generate insights to inform policy development and reporting

Quality Measures Dashboard Mock-up with Synthetic Data

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Period Type: Calendar Year

Period Name: 2024-12 2024

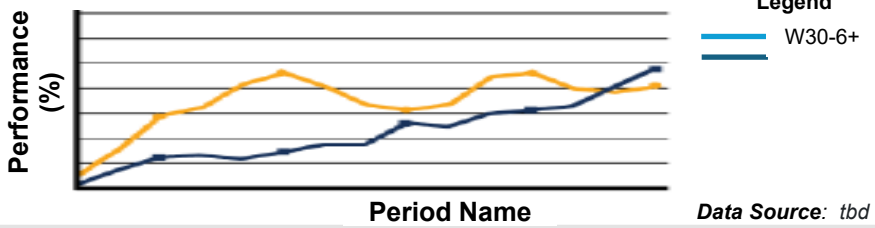
32 Measures at or above Target

34 Measures below Target

Initiative (filter one at a time)

Bold Goals – Children's Preventive Care

Six or More Well-Child Visits Over Time



***Data Source**: tbd*

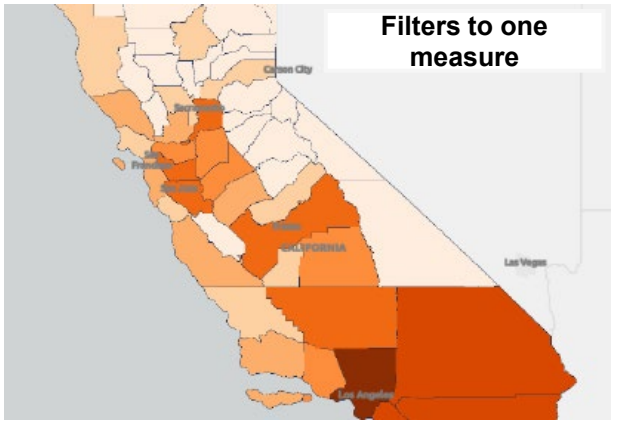
Overall Performance by Measure

Select a measure to populate the map on the right.

Measure	Performance	Target 1	Numerator	Denominator	To Target
W30-6+	67.0%	50%	33	66,732	
W30-2+	57.5%	50%	356	66,732	
IMA-2	34.0%	50%	351	52,753	
CIS-10	20.2%	50%	4,241	48,171	
WCV	59.5%	50%	23,154	35,886	
PPC-Post	17.9%	50%	0	31,821	
PPC-Pre	28.2%	50%	10,402	20,692	
PDS-E-DS	63.0%	50%	4,445	18,938	
PND-E-DS	77.9%	50%	5,566	18,938	
IET-ENG	7.9%	50%	4,452	18,938	
DSF-E-DS	23.5%	50%	15,832	18,728	
FUA-30	7.7%	50%	5,409	17,591	
	21.4%				

***Data Source**: tbd*

Six or More Well-Child Visits by County



***Data Source**: tbd*

Quality Measures Dashboard Mock-up with Synthetic Data

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Period Type: Calendar Year

Period Name: 2023-12 2023

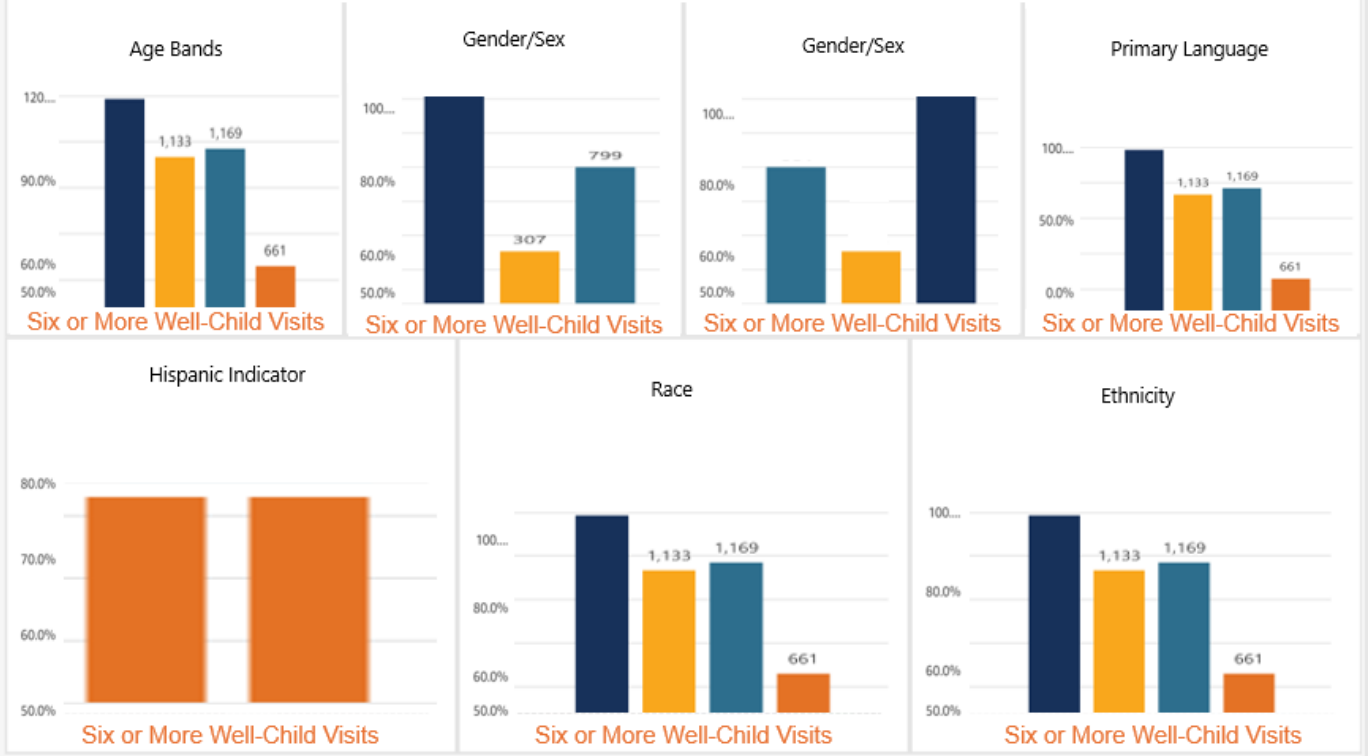
Initiative (filter one at a time): Bold Goals: Children's Preventive Care

Measure (Click to filter)

Measure	Performance	To Target
W30-6+	67.0%	
W30-2+	57.5%	
IMA-2	34.0%	
CIS-10	20.2%	
WCV	59.5%	
PPC-Post	17.9%	
PPC-Pre	28.2%	
PDS-E-DS	63.0%	
PND-E-DS	77.9%	
IET-ENG	7.9%	
DSF-E-DS	23.5%	
FUA-30	7.7%	
	21.4%	

Data Source: tbd

Six or More Well-Child Visits by Select Demographic Characteristics



Quality Measures Dashboard Mock-up with Synthetic Data

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Period Type: Calendar Year

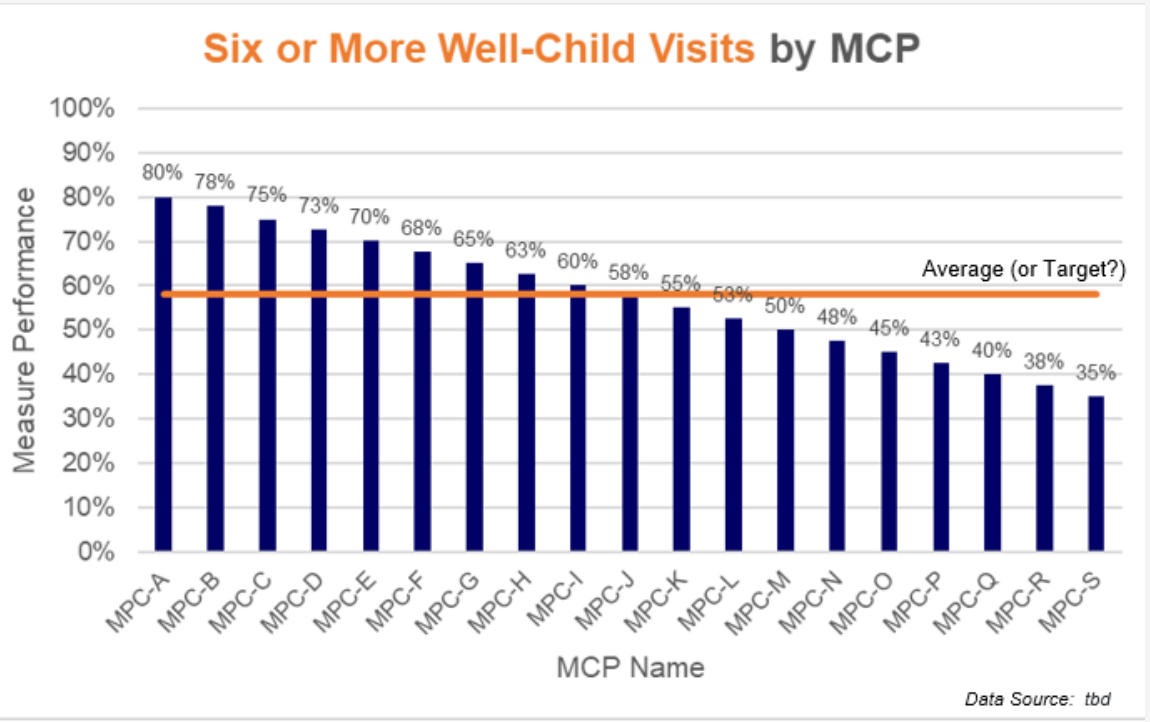
Period Name: 2023-12 2023

Initiative (filter one at a time): Bold Goals: Children's Preventive Care

Measure (Click to filter)

Measure	Performance	To Target
W30-6+	67.0%	
W30-2+	57.5%	
IMA-2	34.0%	
CIS-10	20.2%	
WCV	59.5%	
PPC-Post	17.9%	
PPC-Pre	28.2%	
PDS-E-DS	63.0%	
PND-E-DS	77.9%	
IET-ENG	7.9%	
DSF-E-DS	23.5%	
FUA-30	7.7%	

Data Source: tbd



User and stakeholder engagement

PURPOSE

- Engage target stakeholders to integrate their needs into PHM Service configuration and to ensure its use by stakeholder group

5 STAKEHOLDER GROUPS

1. Tribes and Tribal Partners
2. MCPs and county BH
3. State Partners and Agencies
4. Members
5. HDPs

2 ENGAGEMENT COMPONENTS

- 1: Engagement for **configuration**
- 2: Engagement to drive **adoption** (currently scoped for DHCS, MCPs, county BH, HDPs and Business Partners)

Early Adopter Engagement Types

Webinars

- High level
- Progress check-in

Small Groups & Working Sessions

- Understand stakeholder needs
- Configure capabilities

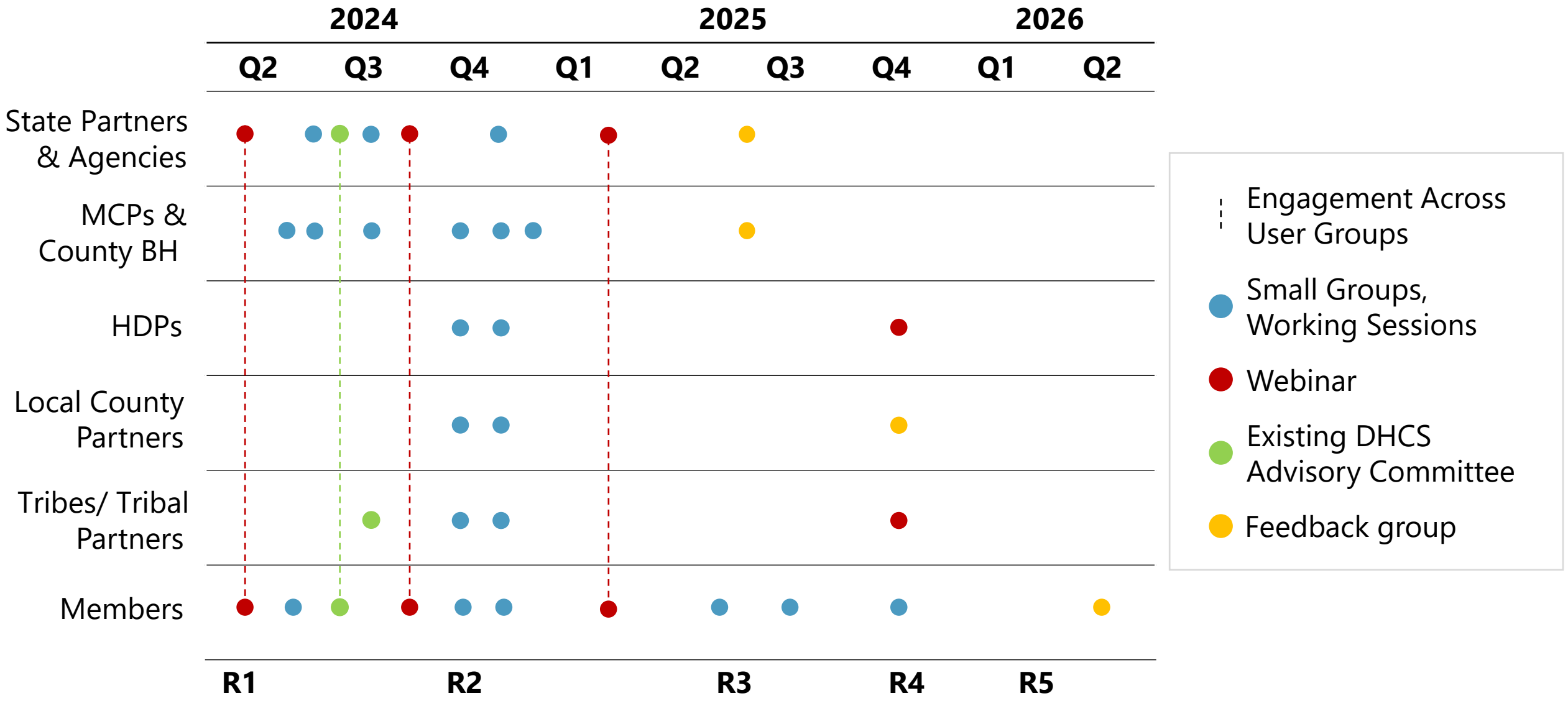
Existing DHCS Advisory Committees

- Gather high level feedback

Feedback Groups

- Discuss feedback post-release

Illustrative Schedule for User Engagement



Questions?

Break

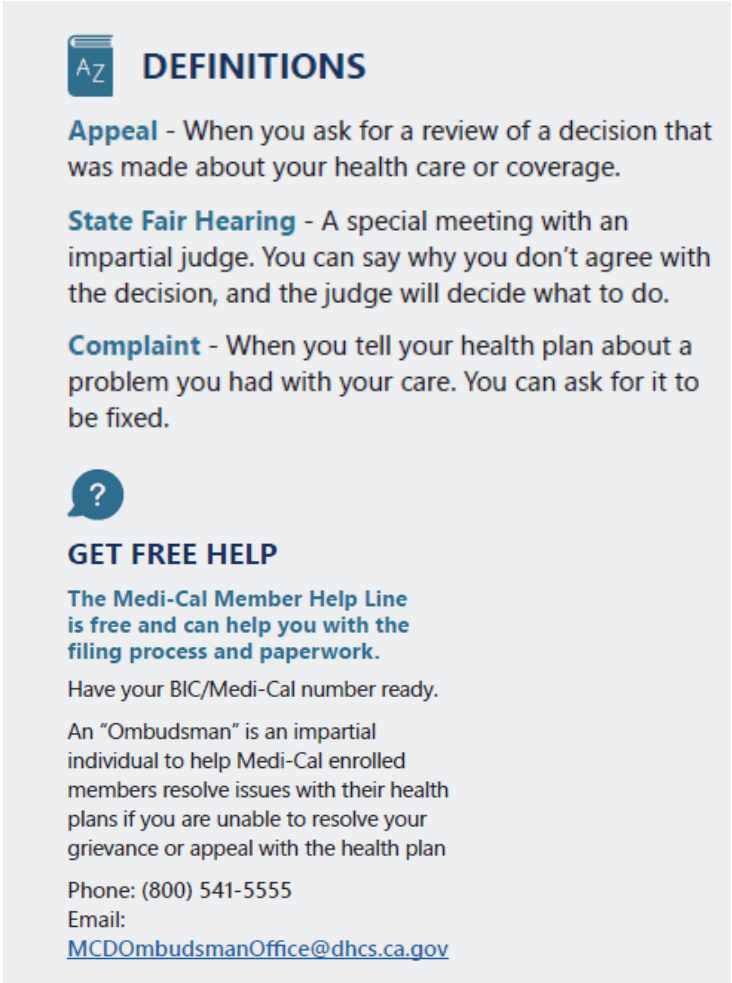
Updating Medi-Cal Member Materials

Erica Holmes, Chief, Health Care Benefits and Eligibility

DHCS

Appeal, Grievance & Fair Hearing Process Infographic

- The Department has developed an infographic to help Medi-Cal members better understand Medi-Cal appeal, grievance, and fair hearing processes in an easy-to-read, visual format.
  - The infographic covers both fee-for-service and managed care delivery system processes for non-specialty mental health services.
  - The infographic covers county behavioral health processes for specialty mental health and substance use disorder services.
  - The infographic provides basic definitions and contact information for Medi-Cal members who need additional assistance.



DEFINITIONS

Appeal - When you ask for a review of a decision that was made about your health care or coverage.

State Fair Hearing - A special meeting with an impartial judge. You can say why you don't agree with the decision, and the judge will decide what to do.

Complaint - When you tell your health plan about a problem you had with your care. You can ask for it to be fixed.

GET FREE HELP

The Medi-Cal Member Help Line is free and can help you with the filing process and paperwork.

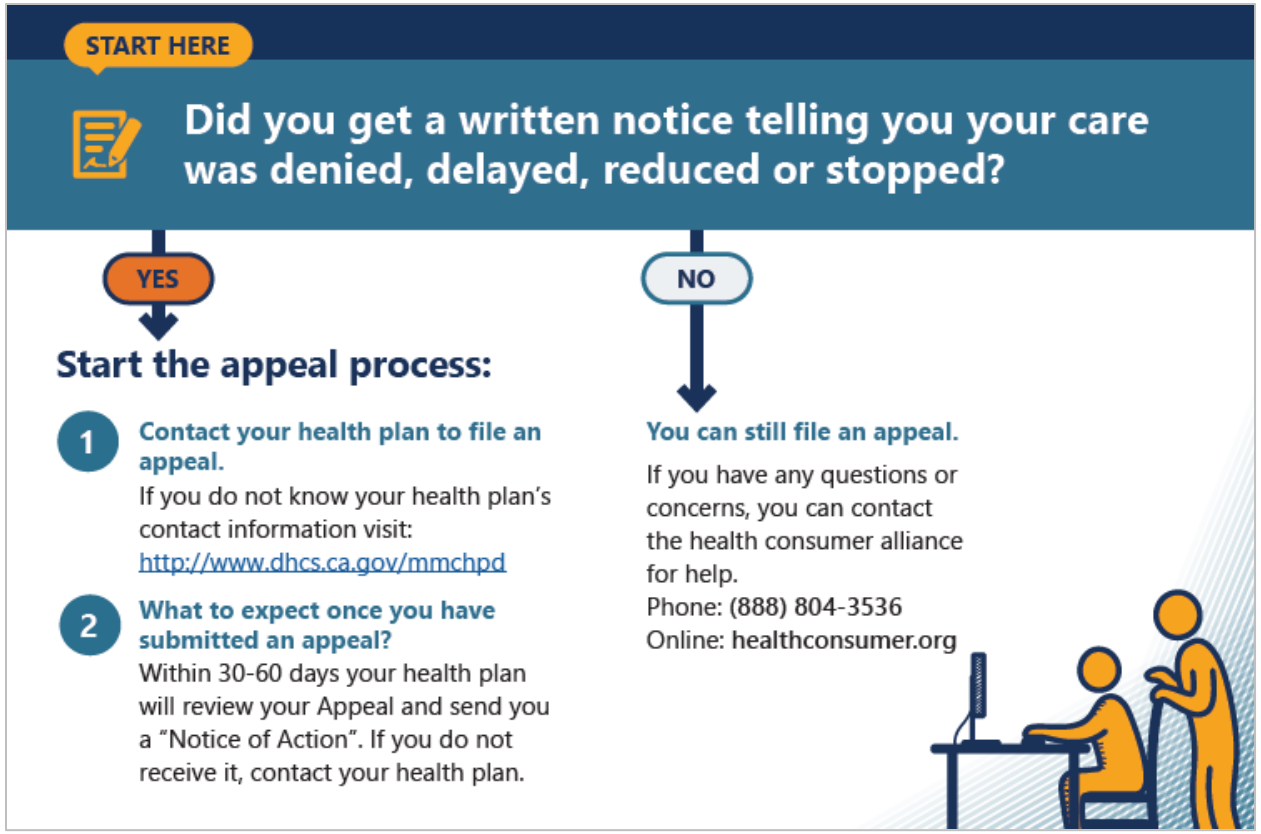
Have your BIC/Medi-Cal number ready.

An "Ombudsman" is an impartial individual to help Medi-Cal enrolled members resolve issues with their health plans if you are unable to resolve your grievance or appeal with the health plan

Phone: (800) 541-5555
Email:
MCDOmbudsmanOffice@dhcs.ca.gov

Appeal, Grievance & Fair Hearing Process Infographic (Cont.)

- The infographic utilizes a flow chart approach with "yes" and "no" questions that enable the Medi-Cal members to more easily navigate and understand the different steps in each process.
- In developing this infographic, DHCS already sought feedback from Medi-Cal members via May 15, 2024 Medi-Cal Member Advisory Committee Meeting (MMAC).



Appeal, Grievance & Fair Hearing Process Infographic (Cont.)

- Examples of the Medi-Cal member feedback from the MMAC included the following:
  - Most liked the infographic, specifically highlighting the overall "flow" and helpfulness of the "yes/no" chart with logical steps.
  - Some liked the bold use of colors to draw attention, whereas others thought the colors were a bit distracting.
  - Some asked for clarification about what an "ombudsman" is and how they can be helpful.
  - Some asked questions about the readability and accessibility of the document, including the use of certain words and assistive technologies such as screen readers.
  - Some asked for clarification around the applicability of these materials to dually eligible members and those with private insurance as well.
  - Some asked for additional acknowledgments that Medi-Cal members' concerns would be taken seriously and not subject them to stereotyping or discrimination.
- DHCS is currently working to review and incorporate that feedback for inclusion in the brochure.

Behavioral Health Information Brochure

- In addition, DHCS is developing a brochure to explain behavioral health services for people who have Medi-Cal and serve as a helpful guide for understanding and accessing behavioral health care included within Medi-Cal coverage. The brochure will include:
  - Behavioral health services covered by Medi-Cal, including non-specialty mental health, specialty mental health, and substance use disorder services.
  - Medi-Cal member rights.
  - What county behavioral health delivery systems are and what services they provide.
  - Explain what to do if Medi-Cal members have questions and/or problems getting behavioral health services.
- DHCS has engaged an external vendor to assist in the development, design, and implementation of the brochure.
- DHCS plans to seek stakeholder comment on the brochure once a draft has been completed and is aiming to finalize by July 2025.

Questions?

Contact us at Medi-Cal.Benefits@dhcs.ca.gov

CalAIM Waiver Update: Traditional Healers & Natural Helpers

Tyler Sadwith, State Medicaid Director

Paula Wilhelm, Deputy Director, Behavioral Health

DHCS

Background: Traditional Healer/Natural Helper Services in the Drug Medi-Cal Organized Delivery System (DMC-ODS) (1 of 2)

- *In 2021, DHCS requested to amend the CalAIM Section 1115 demonstration to receive federal funding to provide Traditional Healer and Natural Helper Services to DMC-ODS beneficiaries.*

Key Points from the CalAIM 1115 Application Submitted in June 2021:

- Requested Section 1115 expenditure authority for Traditional Healer and Natural Helper Services, which allows federal Medicaid matching funds for these services
- Provided by Indian Health Care Providers (IHCPs)
- To DMC-ODS beneficiaries
- From January 1, 2022, through December 31, 2026

Background: Traditional Healer/Natural Helper Services in DMC-ODS (2 of 2)

Key Points from the CalAIM 1115 Application Submitted in June 2021:

- As part of CalAIM's focus on advancing health equity, DHCS is seeking expenditure authority to allow federal reimbursement for DMC-ODS services provided by traditional healers and natural helpers.
- The purpose of this request is to provide culturally appropriate options and improve access to SUD treatment for American Indians and Alaska Natives receiving SUD treatment services through IHCPs.
- For American Indians and Alaska Natives, traditional healing practices are a fundamental element of Indian health care that helps patients achieve wellness and healing and restores emotional balance and one's relationship with the environment
- Medi-Cal recognizes that reimbursement for these services to address SUD in a manner that retains the sanctity of these ancient practices is critical.

Background: Tribal and Urban Indian Community-Defined Best Practices (TUICDBP) Program

Overview of Program

- *The TUICDBP program is a grant funding and technical assistance opportunity for Tribal and Urban Indian health programs.*
- TUICDBP supports the implementation and integration of culturally-validated traditional healing and recovery practices for SUD into clinical services serving Tribes and Urban Indian populations.
- Grantees support:
  - Identification of types and purposes of California Native traditional healing practices
  - Development of approaches for blending the identified traditional healing practices within the conventional substance use prevention, treatment, and recovery service spectrum
  - Implementation of blended approaches into Tribal and Urban Indian SUD services
- Time period: February 28, 2023 to June 30, 2024
- Number of Awardees: 23 awardees
- Evaluation available upon request

Current Status of California's Request

- *CMS aims to approve DHCS' Traditional Healers and Natural Helpers demonstration amendment (originally proposed in 2017) by late Summer or early Fall of 2024.*

- Since 2017, DHCS has requested to cover Traditional Healer and Natural Helper Services under the Drug Medi-Cal Organized Delivery System (DMC-ODS).
  - In 2020, DHCS submitted a second request to CMS
  - In 2021, DHCS submitted a third request to CMS
- In April 2024, CMS hosted an All-Tribes Consultation Webinar on Medicaid coverage of traditional health care practices where it shared the initial national framework that it will use to approve Traditional Healer and Natural Helper requests across four states (California, New Mexico, Arizona, Oregon). (See next slide)
- DHCS has solicited direction and input from tribal partners on the design and implementation of traditional health care practices and aims to identify any updates needed to the waiver request language developed together to date.

CMS' Framework on Traditional Healers and Natural Helpers (1 of 2)

- *CMS released its initial framework of Medicaid requirements for Traditional Healers and Natural Helper services in April to guide coverage of different tribal practices. Additional details are forthcoming.*

- **Eligible beneficiaries:** Eligible beneficiaries would include any Medicaid beneficiary eligible to receive services by or through Indian Health Service (IHS) or tribal facilities. Non-American Indian/Alaska Native (AI/AN) individuals can also receive these services, like all other services, by or through IHS or tribal facilities.

- **Traditional Health Care Practices:** Covered services (in alignment with the Indian Health Care Improvement Act) would need to be delivered by or through IHS or tribal facilities, and include practices provided in the community. Practices would be reimbursed at 100% federal match for AI/AN individuals who receive services through IHS or tribal facilities. [1]

[1] As defined in federal guidance, Urban Indian Organizations (UIOs) will not be eligible to receive 100% federal matching funds for the provision of THCPs. The American Rescue Plan Act included an allowance for states to claim 100% federal match for services provided through UIOs that expired in March 2023.

CMS' Framework on Traditional Healers and Natural Helpers (2 of 2)

- *CMS released its initial framework of Medicaid requirements for Traditional Healers and Natural Helper services in April to guide coverage of different tribal practices. Additional details are forthcoming.*

- **Providers/Practitioners:** Providers of services would need to be employed or contracted by IHS or tribal facilities, and would not have to undergo additional state licensing or credentialing requirements beyond what is already in place. [1]
- **Reimbursement and Infrastructure:** CMS will consider infrastructure funding to states, which can facilitate system updates, staff training, and development of processes to ensure compliance.
- **Evaluation:** Post approval evaluations are expected to assess beneficiary awareness and understanding of traditional health care practices; reasons for receiving these services; access to, cost of, and utilization of services; quality and experience of care and beneficiary physical and behavioral health outcomes.

[1] CMS indicated UIOs will be included in CMS' framework. Providers and practitioners employed or contracted by UIOs would be eligible to provide Traditional Health Care Practices. Additional detail from CMS is forthcoming.

California's Proposed Approach

- *DHCS intends to request several changes to CMS' framework to better meet the needs of Medi-Cal members receiving Traditional Healer and Natural Helper services.*

- **Eligible beneficiaries:** Medi-Cal members receiving care through DMC-ODS to promote treatment of substance use disorders (SUDs).
- **Providers/Practitioners:** Inclusion of UIOs as eligible providers.
- **Reimbursement:** Requesting Traditional Healer and Natural Helper services be reimbursed consistent with DHCS' existing policy for DMC-ODS services; see BHIN 22-053.

Service Descriptions Developed in Partnership with Tribes and Indian Health Care Providers (IHCPs)

- Traditional Healers may use an **array of interventions including, music therapy (such as traditional music and songs, dancing, drumming), spirituality (such as ceremonies, rituals, herbal remedies) and other integrative approaches.**
- Natural Helpers may assist with **navigational support, psychosocial skill building, self-management, and trauma support** to individuals that restore the health of those DMC-ODS beneficiaries receiving care at IHCP.

DHCS partnered with Tribes to develop draft service descriptions of Traditional Healer and Natural Helper Services and will work to ensure that these descriptions are coverable under the Demonstration.

Individual Provider Qualifications (1 of 2)

- *In partnership with Tribes, DHCS also developed preliminary qualification requirements for individuals who will offer Traditional Healer and Natural Helper services through IHCPs and will work to ensure they are retained under the Demonstration.*

- A **Traditional Healer** would be a person currently recognized as a spiritual leader and in good standing with his/her Native American Tribe, Nation, Band or Rancheria, and with two years of experience as a recognized Native American spiritual leader practicing in a setting recognized by his/her Native American Tribe, Nation, Band or Rancheria who is contracted or employed by the IHCP. A Traditional Healer would be a person with knowledge, skills and practices based on the theories, beliefs, and experiences which are accepted by that Indian community as handed down through the generations and which can be established through the collective knowledge of the elders of that Indian community.

Individual Provider Qualifications (2 of 2)

- *In partnership with Tribes, DHCS also developed preliminary qualification requirements for individuals who will offer Traditional Healer and Natural Helper services through IHCPs and will work to ensure they are retained under the Demonstration.*

- **Natural Helpers** would be health advisors contracted or employed by the IHCP who seek to deliver health, recovery, and social supports in the context of Tribal cultures. Natural Helpers could be spiritual leaders, elected officials, paraprofessionals and others who are trusted members of his/her Native American Tribe, Nation, Band or Rancheria.
- IHCPs seeking reimbursement for Natural Helpers and/or Traditional Healers would **develop and document credentialing (e.g., recognition and endorsement) policies consistent with the minimum requirements above.**

Provider Organization Qualifications

- **IHCPs that offer Traditional Healer/Natural Helper services will need to enroll in Medi-Cal** (if not already enrolled).
- **DHCS AOD Certification & Residential Program Licensure:** Assesses a program's capacity to provide safe and clinically appropriate specialty substance use disorder services (outpatient or residential)
  - IHCPs are exempt from state AOD certification/licensure, consistent with federal law (25 U.S.C. Section1647a) if they attest they meet all applicable standards.

In general, DMC-ODS Provider organizations are required to obtain DMC certification/Medi-Cal enrollment and Alcohol or Drug Abuse (AOD) certification for outpatient programs or AOD licensure for residential programs.

Provider Organization Qualifications: Additional SUD Services

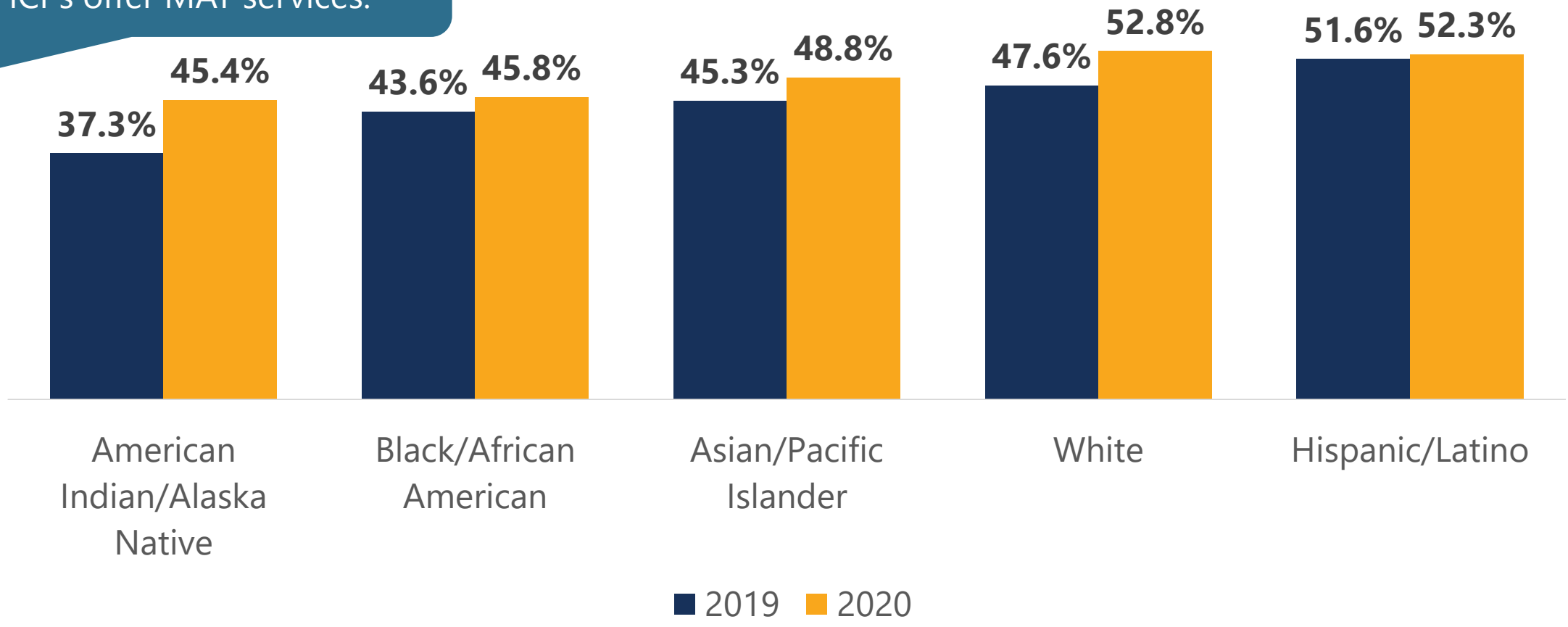
- *DHCS proposes that IHCPs that offer Traditional Healer and Natural Helper Services provide and/or refer members to additional services to promote the treatment of SUDs.*
- DHCS will not require each individual practitioner of Traditional Healing to fulfill these requirements. **However, at the organizational level, IHCPs will need to have policies and procedures in place to ensure members can access these additional services.**

DHCS seeks to ensure that members who access Traditional Healer and Natural Helper Services receive the following additional services as needed:

- **Comprehensive ASAM assessments** to identify other SUD treatment needs, consistent with DHCS' DMC-ODS policy.
- **Medications for addiction treatment (MAT).** Assessments and access to clinically appropriate MAT, consistent with DHCS' MAT access policy for all SUD provider organizations – see BHIN 23-054
- **Care coordination** to access other SUD treatment and Medi-Cal services more broadly

Medi-Cal MAT Prescribing for Opioid Use Disorder by Race/Ethnicity, 2020

As of June 2024, 9 out of 49 IHCPs offer MAT services.



Source: UCLA ISAP, Tribal MAT Data Analytics Performance Measure Report, September 2023.

Provider Organization Qualifications for IHCPs: Evidence-Based Practices *(1 of 2)*

DMC-ODS Evidence-Based Practices

- **Motivational Interviewing** – a member-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment
- **Cognitive-Behavioral Therapy** – based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned
- **Relapse Prevention** – a behavioral self-control program that teaches individuals with SUD how to anticipate and cope with the potential for relapse; can be used as a stand-alone substance use treatment program or as a recovery services program to sustain gains achieved during initial SUD treatment

Other DMC-ODS providers are required to implement at least two of the evidence-based treatment practices (EBPs) described below. DHCS has proposed to require IHCPs that offer Traditional Healer and Natural Helper Services to offer these EBPs as well.

Provider Organization Qualifications for IHCPs: Evidence-Based Practices *(2 of 2)*

DMC-ODS Evidence-Based Practices

- **Trauma-Informed Treatment** – services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice, and control
- **Psycho-Education** – designed to educate members about substance abuse and related behaviors and consequences; provides information designed to have a direct application to members' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist members in recovery, develop an understanding of the process of recovery, and prompt people using substances to act on their own behalf

Other DMC-ODS providers are required to implement at least two of the evidence-based treatment practices (EBPs) described below. DHCS has proposed to require IHCPs that offer Traditional Healer and Natural Helper Services to offer these EBPs as well.

Questions?

BH CONNECT: Incentive Programs

Paula Wilhelm, Deputy Director, Behavioral Health

Erika Cristo, Assistant Deputy Director, Behavioral Health

DHCS

BH-CONNECT Status Updates

DHCS

BH-CONNECT Section 1115 Demonstration Submission Updates

Public Comment Period

(August 2023)

Response to Public Comment

(August-October 2023)

Submission of 1115 Application to CMS

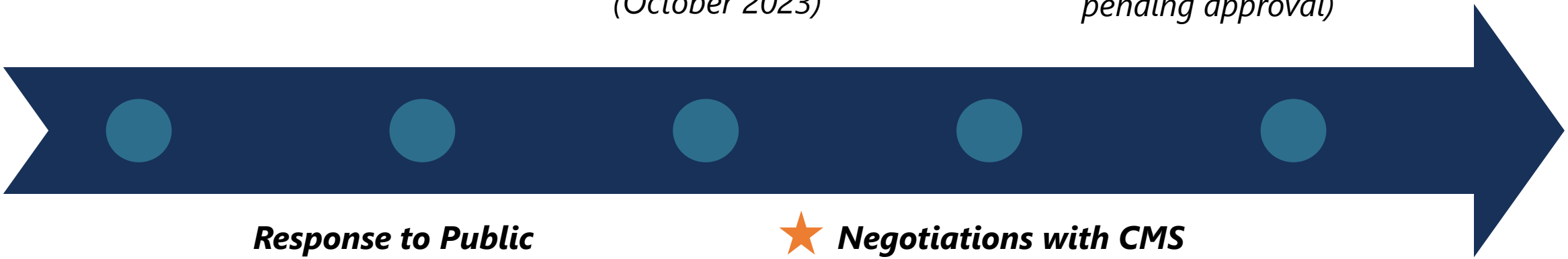
(October 2023)

★ ***Negotiations with CMS***

(October 2023-December 2024)

BH-CONNECT Go-Live

(beginning January 2025, pending approval)



Find the BH-CONNECT Section 1115 demonstration application and public hearing materials posted on https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx

Key Goals

To expand access, reform California's behavioral health delivery system, and improve health outcomes for individuals with significant BH needs

Focus on the priority populations that have historically experienced the greatest disparities in access to care, including Californians experiencing homelessness, those with justice system involvement, and children and youth

Expand the continuum of community-based services and EBPs available for members living with significant behavioral health needs

Strengthen coverage of services and supports to address health-related social needs such as employment and housing

Improve access to high-quality behavioral health services, including through foundational investments in the workforce and enhanced accountability and oversight

California Investments in Behavioral Health

*(*non-exhaustive list)*

State investments in infrastructure and workforce

- BH-CONNECT workforce initiative and Centers of Excellence *($200M state funds)*
- Behavioral Health Continuum Infrastructure Program investments *($2.2B)*
- Children and Youth Behavioral Health Initiative *($4.6B)*
- Behavioral Health Bridge Housing Program *($1.5B)*
- Behavioral Health Transformation infrastructure investments *($6.4B forthcoming)*

Build out a comprehensive continuum of care

- BH-CONNECT EBPs, including ACT, Supported Employment, CSC for FEP, Clubhouse Services (county option), and EBPs for children and youth (statewide)
- Contingency Management
- Mobile Crisis Services
- Peer Support Services
- Community Health Worker Services
- Strengthening FSP programs under the BHSA to require evidence-based fidelity models aligned with BH-CONNECT

Increase access to care and bolster system capacity

- "No Wrong Door" policy
- Trauma-informed access criteria for mental health services
- Standardized screening and transition of care tools
- Streamlining BH documentation requirements
- New oversight and accountability strategies to promote network adequacy and access to care (*see following slides*)

BH-CONNECT Incentive Program Update

DHCS

Overarching Goals of BH-CONNECT Incentive Program

- **The BH-CONNECT incentive program is a key "carrot"** that DHCS is using to drive behavioral health delivery system reform. The incentive program aligns with the overall goals of BH-CONNECT and DHCS' broad behavioral health reforms, and has three specific goals:

1

Strengthen county BHPs' **managed care performance and quality improvement capabilities.**

2

Implement and scale new **evidence-based service models with fidelity.**

3

Improve member outcomes, especially for **high-risk populations experiencing disparities.**

BH-CONNECT Incentive Program Components

- To achieve the goals of the BH-CONNECT incentive program, DHCS proposes making incentive payments in three key areas:

Statewide Incentives
$1.5B

- Strengthen county BHPs' managed care performance, quality improvement capabilities, improve outcomes, and reduce disparities for Medi-Cal members with significant behavioral health needs

EBP Incentives

$1B

- Drive widespread, high-fidelity implementation of ACT, Supported Employment, and Coordinated Specialty Care, and improve specified outcomes for members receiving those EBPs

Cross-Sector Incentives

$250M

- Improve outcomes among children and youth involved in child welfare and living with behavioral health needs through enhanced coordination among jointly responsible agencies

Focus on Health Equity

The BH-CONNECT incentive program is designed to support **broader population health management and health equity goals.**

Across all program components, DHCS will:

- **Focus measures on the total eligible population** (rather than just the population utilizing services) wherever possible.
- Align statewide incentive measures with **relevant measures from CMS' forthcoming Health Equity Measure Slate.**
- **Require counties to stratify data** based on the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.

Statewide Incentive Measures

Overview: Statewide Incentive Payments

Funding: $1.513B

Overarching Goal #1:
Strengthen county BHPs' managed care performance and quality improvement capabilities.

Overarching Goal #3:
Improve member outcomes, especially for high-risk populations experiencing disparities.

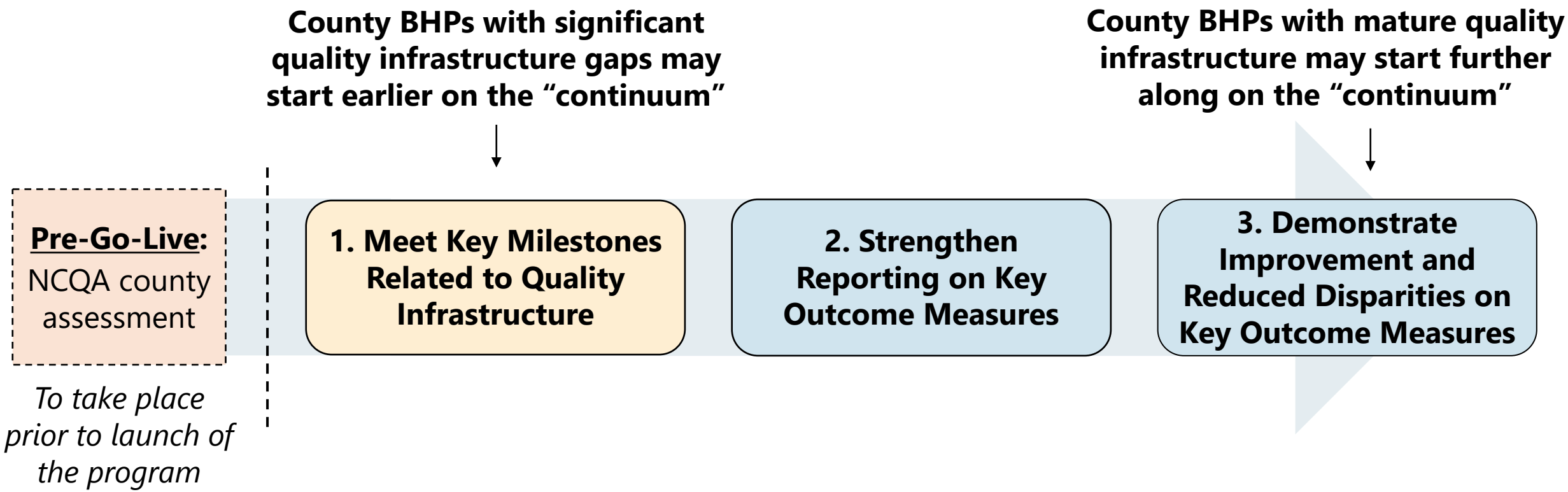
» Statewide incentives will reward county BHPs for meeting:

- **Process measures** informed by findings from a targeted Managed Behavioral Healthcare Organization (MBHO) self-directed assessment ("county assessment") delivered in partnership with the National Committee for Quality Assurance (NCQA).
- **Outcome measures** to assess improved health outcomes among members living with significant behavioral health needs, aligned with existing national and DHCS initiatives (e.g., CMS Core Set, DHCS Behavioral Health Accountability Set (BHAS).

To be eligible to receive statewide incentive payments, county BHPs must complete the NCQA targeted MBHP self-assessment

Funding: $1.513B

Overview: Statewide Incentive Payments



Funding: $1.513B

Proposed Statewide Incentive Measures (1 of 3)

Process measures will be developed based on county assessment learnings and incentivize county BHPs to improve their performance as managed care plans by strengthening their quality improvement capabilities. Measures may address, but are not limited to:

- Closure of County-Specific Gaps Identified in the NCQA MBHO Assessment
- Data-Driven Quality Improvement
- Improved Identification and Outreach to Eligible Member Population
- Improved Identification of Member Disparities

DHCS is currently developing statewide incentive measures informed by DHCS' Comprehensive Quality Strategy/Behavioral Health Accountability Set (BHAS) and learnings from the county assessment.

Funding: $1.513B

Proposed Statewide Incentive Measures (2 of 3)

Included in the BHAS:

- Pharmacotherapy of Opioid Use Disorder (POD)
- Follow-Up After Emergency Department Visit for Substance Use (FUA)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

DHCS is currently developing statewide incentive measures informed by DHCS' Comprehensive Quality Strategy/Behavioral Health Accountability Set (BHAS) and learnings from the county assessment.

Funding: $1.513B

Proposed Statewide Incentive Measures (3 of 3)

Not included in the BHAS:

- Member Experience of Care (*but measured by DHCS**)
- Member Quality of Life (QOL)**
- Access to Evidence-Based Practices for Children, Youth and Adolescents
- Engagement in Enhanced Care Management (ECM) and Community Supports

**See BHIN 24-009 on CPS requirements for MHPs & BHIN 24-026 on TPS requirements for DMC-ODS plans.*

***DHCS will continue to engage stakeholders and experts on QOL measurement tools.*

DHCS is currently developing statewide incentive measures informed by DHCS' Comprehensive Quality Strategy/Behavioral Health Accountability Set (BHAS) and learnings from the county assessment.

EBP Incentive Measures

Overview: EBP Incentive Payments

Funding: $1.08B

Overarching Goal #2: Implement and scale new evidence-based service models with fidelity.

Overarching Goal #3: Improve member outcomes, especially for high-risk populations experiencing disparities.

» County BHPs will earn incentives for:

- **Process measures** related to fidelity implementation, scaling, and utilization of BH-CONNECT EBPs; and
- **Outcome measures** related to improved outcomes among members receiving specific BH-CONNECT EBPs (ACT/FACT, CSC for FEP, and Supported Employment).

To be eligible to receive EBP incentive payments, county BHPs must:

✓ Complete the NCQA targeted MBHO self-directed assessment;

✓ Commit to participating in the statewide incentives; and

✓ Agree to implement a full suite of BH-CONNECT EBPs (see next slide).

x County BHPs are <u>not</u> required to receive funding for short-term stays in Institutions for Mental Disease (IMDs) to receive EBP incentives

Funding: $1.08B

Overview: EBP Incentive Payments

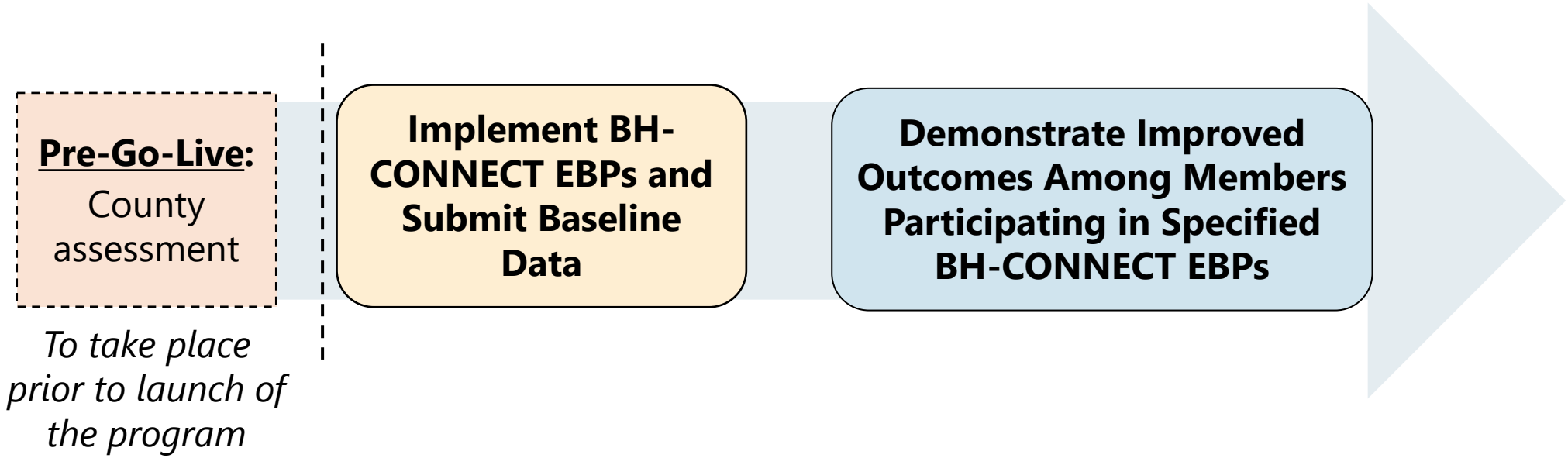
County BHPs that seek to earn EBP incentives will be required to implement a full suite of BH-CONNECT services, with the exception of Clubhouse Services.

BH-CONNECT EBPs/Community-Based Services	
Assertive Community Treatment (ACT) / Forensic ACT (FACT)	**Required to receive EBP incentives**
Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)	
Supported Employment	
Community Health Worker (CHW) Services	
Peer Support Services, including Forensic Specialization	
Clubhouse Services	

Funding: $1.08B

Overview: EBP Incentive Payments

Measures will progress from process measures in early program years to outcome measures in later program years:



= Planning activities = Process measures = Outcome measures

Funding: $1.08B

Proposed EBP Incentive Measures

Some EBP incentive measures will support fidelity implementation and scaling of key BH-CONNECT EBPs, while most will focus on improved outcomes among the members receiving each EBP. DHCS is currently developing EBP incentive measures informed by analysis of the evidence base and interviews with national and state experts.

Process measures may address activities related to:

- Completion of an Implementation Plan for Participation in BH-CONNECT
- Member Engagement in Specified EBPs (e.g., ACT/FACT, CSC for FEP, Supported Employment)
- Utilization of Specified EBPs (e.g., Peer Support Services, CHW Services)
- **The EBP incentive program is anticipated to launch in 2025, concurrent with the implementation of the BH-CONNECT EBPs.**

Proposed EBP Incentive Measures

Some EBP incentive measures will support fidelity implementation and scaling of key BH-CONNECT EBPs, while most will focus on improved outcomes among the members receiving each EBP. DHCS is currently developing EBP incentive measures informed by analysis of the evidence base and interviews with national and state experts.

Outcome measures may address outcomes such as:

- Reduction in emergency department visits
- Reduction in hospitalizations
- Reduction in homelessness
- Reduction in justice involvement
- Improved quality of life
- Improved work/school involvement

**Specific measures may vary by EBP.*

- **The EBP incentive program is anticipated to launch in 2025, concurrent with the implementation of the BH-CONNECT EBPs.**

Cross-Sector Incentive Measures

Overview: Cross-Sector Incentive Payments

Funding: $250M

Overarching Goal #3: Improve member outcomes, especially for high-risk populations experiencing disparities.

Mental health plans (MHPs), managed care plans (MCPs), and child welfare agencies (CWAs) may earn incentives for:

- **Improving key outcomes** for children and youth with complex needs.
- **Enhancing and strengthening coordination** among multiple service systems.
- Cross-sector incentives will build upon, but not duplicate, existing county-level initiatives and agreements across the three systems **that are jointly responsible** for supporting this vulnerable population.

To be eligible to receive cross-sector incentive payments:

✓ Counties must submit a joint letter from the MHP, CWA and MCP(s) in that county that explains:

- How MCPs will actively participate in the county-level System of Care alongside MHPs and CWAs.
- How all three entities will actively share data, including through establishing new data sharing agreements when needed.

Existing Investments & Programs for the Child Welfare Population

Existing Services and Supports

- Key specialty and non-specialty behavioral health services, including but not limited to Respite Services (Community Supports), Intensive Home-Based Services, Therapeutic Foster Care, Therapeutic Behavioral Services, Enhanced Care Management (ECM), and Intensive Care Coordination (ICC)
- California Wraparound (county option)
- Child and Family Teams (CFT)
- Work done through the county-level System of Care with behavioral health needs involved in child welfare.

Cross-sector incentives will build upon, but not duplicate, existing county-level initiatives and agreements the State has developed to improve care for children and youth with behavioral health needs involved in child welfare.

Existing Investments & Programs for the Child Welfare Population

New initiatives to further support this population:

- Activity Funds (pending CMS approval)
- Implementation of County Child Welfare Liaison role within MCPs
- Implementation of Joint Behavioral Health Assessment at Entry Point into Child Welfare
- Alignment of Child and Adolescent Needs and Strengths (CANS) tool
- Clarifying coverage of High-Fidelity Wraparound (HFW), Multisystemic Therapy (MST), Functional Family Therapy (FFT) and Parent-Child Interaction Therapy (PCIT) under Medi-Cal
- CDSS Foster Care Rate Reform Proposal with behavioral health needs involved in child welfare.

Cross-sector incentives will build upon, but not duplicate, existing county-level initiatives and agreements the State has developed to improve care for children and youth with behavioral health needs involved in child welfare.

Preliminary Cross-Sector Incentive Measure Areas

Cross-sector incentive measures are designed to build upon existing agreements and reward MHPs, MCPs, and CWAs for effective coordination to improve health outcomes for child welfare-involved youth.

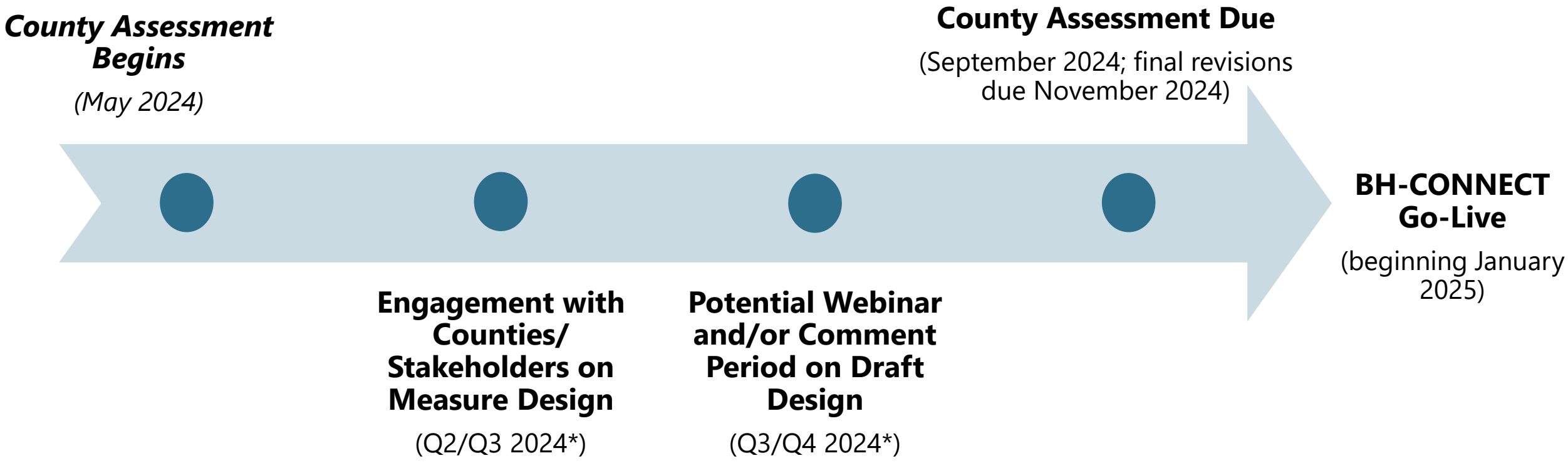
Specific outcomes measures are still under development, but may include:

- Rapid receipt of initial joint behavioral health assessment
- Improved access to key preventive services
- Increase in utilization of intensive in-home services
- Decrease in emergency department visits
- Decrease in out-of-home placements

DHCS is actively engaging with key stakeholders on the development of the cross-sector incentive measures.

Key Milestones: BH-CONNECT Incentive Program

Measure design for all three components of the incentive program is underway. DHCS anticipates sharing draft measure set materials with counties for review in summer/fall 2024.



**Timing tentative; exact dates will be confirmed in future communications.*

Discussion Prompts

- How do you recommend DHCS measure timely access to care, in addition to appointment wait time standards?
- What additional key access measures should DHCS consider, if any? For example:
  - SMHS/DMC-ODS penetration rates
  - Engagement measures such as 5+ SMHS visits
  - What others?
- What are the most important services to strengthen via the EBP incentive measures, in addition to the new BH-CONNECT EBPs? For example:
  - Mobile crisis
  - Other crisis services (e.g., crisis intervention, crisis stabilization)
  - Co-occurring mental health and SUD care
  - What others?

Questions?

Public Comment

Next Steps and Adjourn

Upcoming 2024 Meeting Dates

- Wednesday, October 16

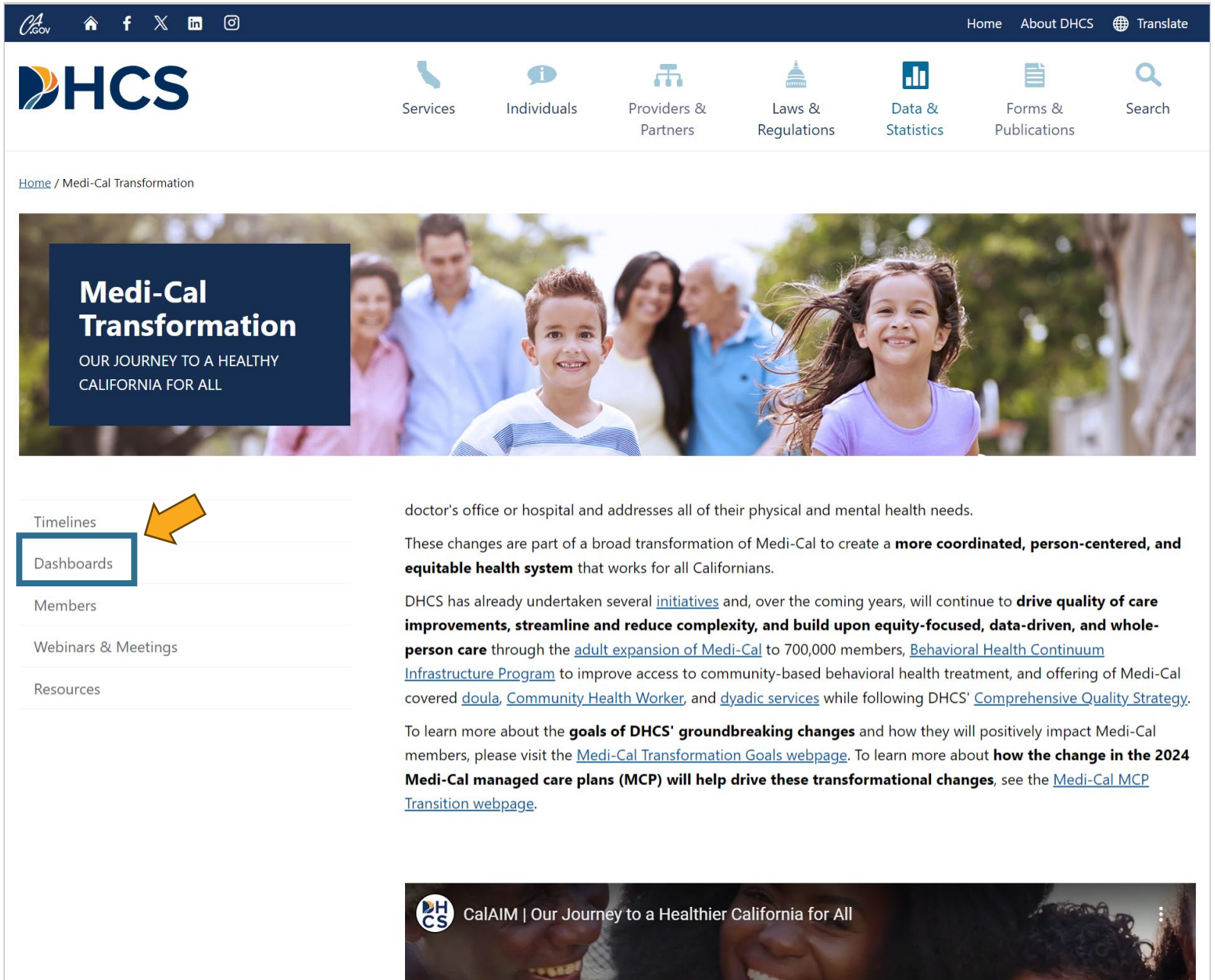
Thank You!

DHCS

Appendix

Walkthrough

- Link added to Medi-Cal Transformation homepage to navigate to the dashboard site



Landing Page

- Overview of CalAIM

Landing Page

- Navigate to specific CalAIM initiative page

Bold Goals

- Initiative description
- Key highlights

DHCS Medi-Cal Transformation

Overview | Initiatives | DHCS CalAIM Home | Contact

CalAIM Bold Goals: 50x2025

The Bold Goals: 50x2025 initiative was launched in 2022 as a focused campaign to improve the quality and equity of care in DHCS' three focus areas outlined in its Comprehensive Quality Strategy: children's preventive care, behavioral health integration, and maternity care.

Each Bold Goal is evaluated by a collection of individual quality measures that all share an emphasis on health equity, most of which are found in the Medi-Cal Managed Care Accountability Sets (MCAS) of quality metrics that Medi-Cal managed care plans (MCPs) report on annually.

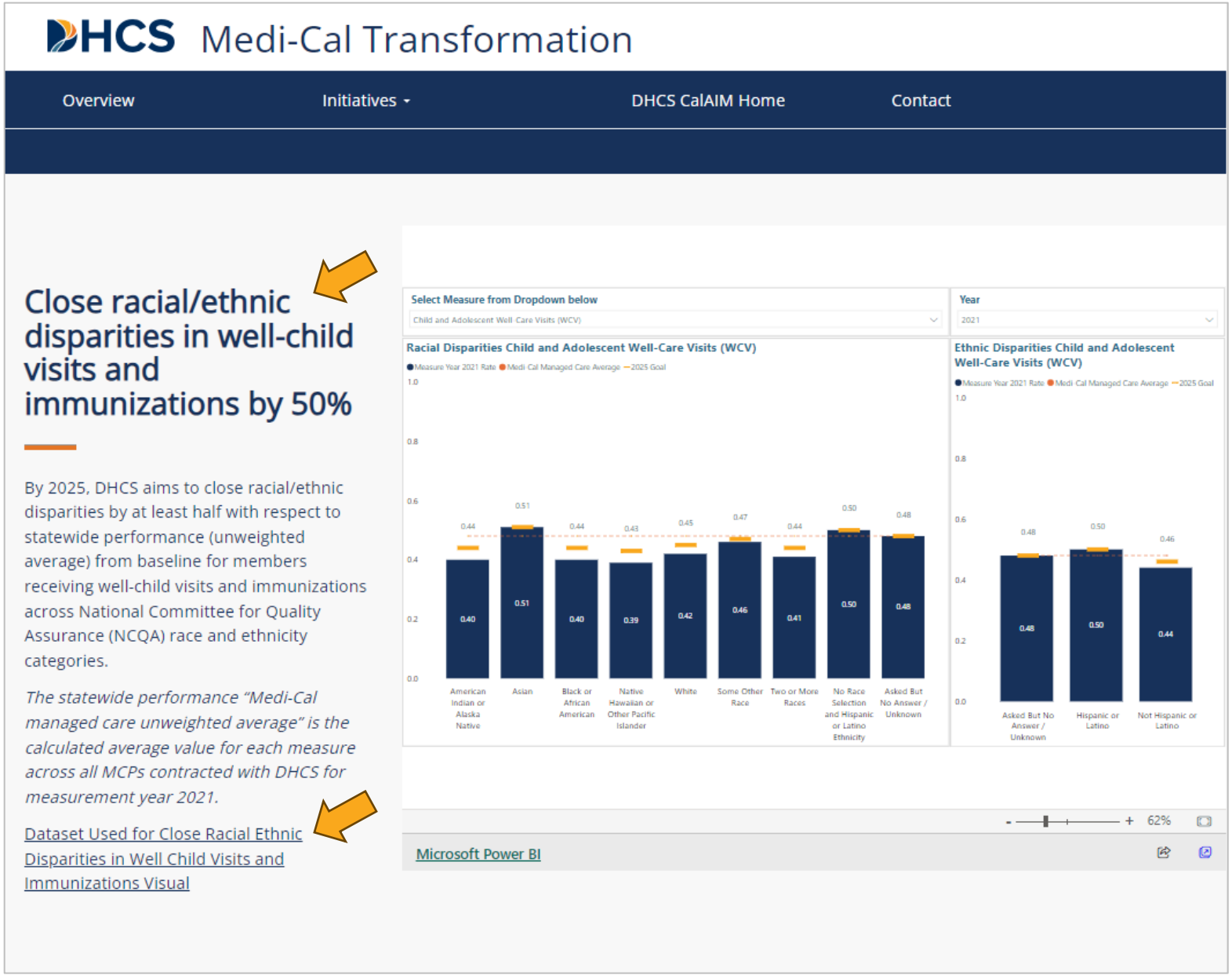
As data becomes available, stakeholders will be able to monitor yearly trends, at the state and regional level, over time from our baseline measurement year to achieve DHCS' vision of reducing certain health care disparities by 50 percent by 2025 and improving overall care by 50 percent.

Bold Goals

Close racial/ethnic disparities in well-child visits and immunizations by 50%	Close maternity care disparity for Black and Native American persons by 50%	Improve maternal and adolescent depression screening by 50%	Improve follow up for mental health and substance use disorder by 50%	Ensure all MCPs exceed the 50th percentile for all children's preventive care measures

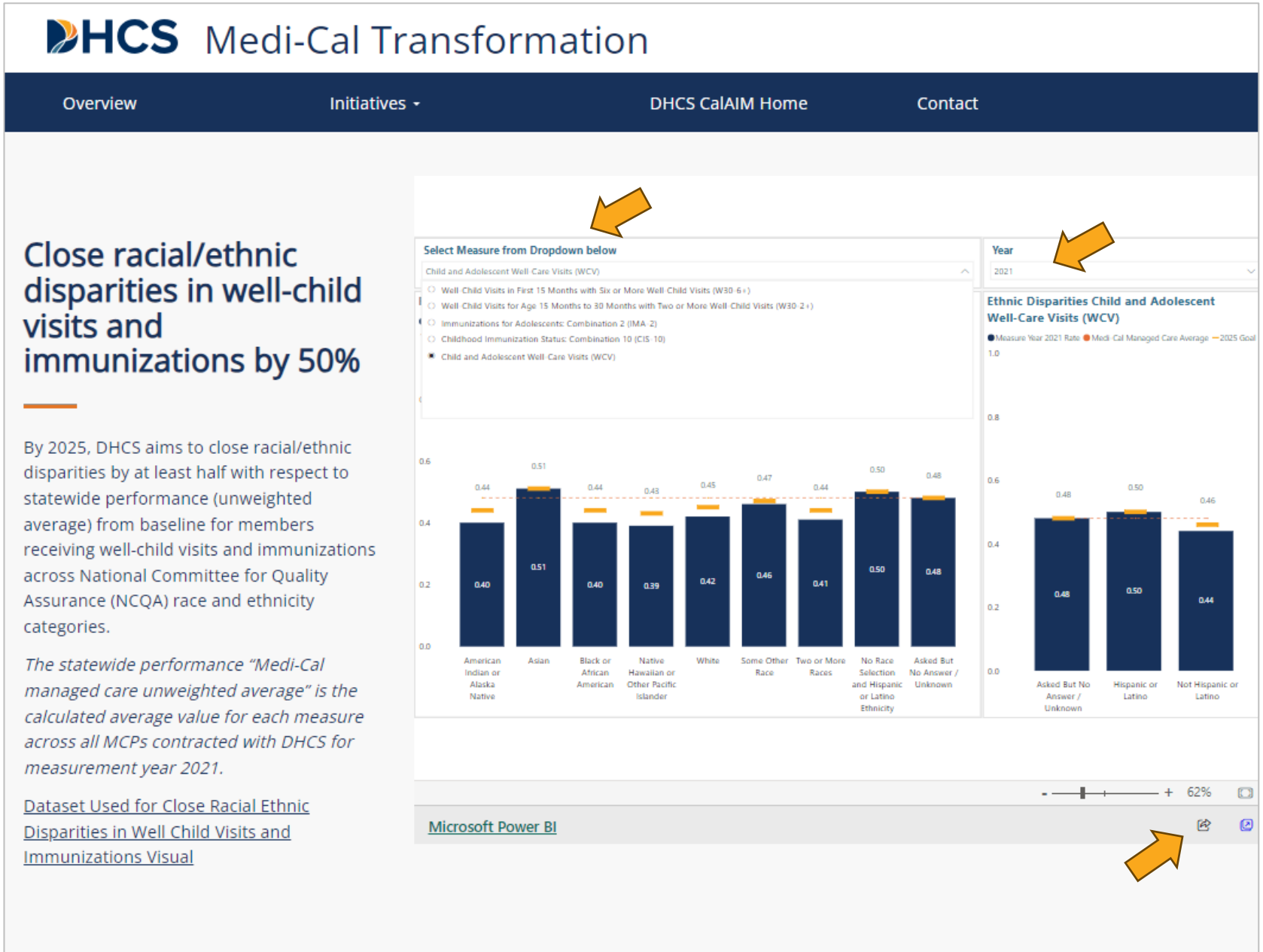
Bold Goals

- Accompanying narrative
  - Describes the dashboard
  - Link to dataset



Bold Goals

- Interactive dashboard
  - Select quality measure
  - Select year
- Share or embed the dashboard



Bold Goals

- Visualization
  - Stratifications by region
- Accompanying narrative
  - Link to region definitions
- Resources
- Contact