Stakeholder Advisory Committee and Behavioral Health Stakeholder Advisory Committee Hybrid Meeting

May 24, 2023

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Webinar Tips

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

Director's Update

Michelle Baass, Director, and Jacey Cooper, Chief Deputy Director for Health Care Programs and State Medicaid Director

DHCS

May Revision

Governor's May Revision

- The May Revision for the proposed fiscal year (FY) 2023-24 budget includes $156 billion in total funds for DHCS.
- The May Revision updates new and current proposals:
  - Managed Care Organization (MCO) Tax
  - Medi-Cal provider rate increases
  - Modernization of California's behavioral health system
  - Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) demonstration (formerly referred to as the California Behavioral Health Community-Based Continuum (CalBH-CBC) demonstration)
  - Expansion of Medi-Cal to Undocumented Individuals

May Revision (Continued)

- The budget includes the renewal of the MCO Tax, effective April 1, 2023, nine months earlier than planned at Governor's January Budget.
  - This results in an additional $3.7 billion General Fund revenue compared to the Governor's Budget.
  - The state's net benefit will bring an additional $19.4 billion to support the Medi-Cal program, improving access, quality, and equity.
- The budget proposes to use the additional revenue of $2.5 billion to achieve a balanced budget in FY 2023-24.
- Remaining funds will be used to support Medi-Cal investments over an eight-to-ten-year period.
- Effective January 1, 2024, DHCS proposes rate increases to at least 87.5 percent of Medicare for primary care, maternity care, and non-specialty mental health services.

May Revision (Continued)

- The budget includes $40 million total funds to begin the modernization of California's behavioral health system.
- Modernization of three key areas:
  - Mental Health Services Act
  - Accountability and access to behavioral health services
  - General obligation bond to establish the Behavioral Health Infrastructure (BHI) Act and Grant Program

May Revision (Continued)

- The budget includes $6 billion over five years to implement BH-CONNECT, effective January 1, 2024.
- The budget adds a new Workforce Initiative to the waiver, $480 million a year for the five years ($2.4 billion total funding), to strengthen the pipeline of behavioral health professionals, including improving short-term recruitment and retention efforts.
- DHCS will seek approval of a Medicaid Section 1115 demonstration waiver in summer 2023.

May Revision (Continued)

- The May Revision expands full scope Medi-Cal Eligibility to all income eligible adults ages 26-49, regardless of immigration status, on January 1, 2024.
- As of March 2023, there are 347,163 individuals enrolled under the Older Adult Expansion policy, 128,825 enrolled under the Young Adult Expansion, and 158,701 enrolled under Medi-Cal for All Children.

Unwinding of COVID-19 PHE and the Continuous Coverage Requirements

Continuous Coverage Unwinding

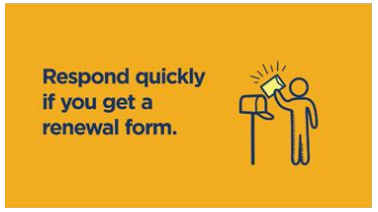
- Counties resumed the Medi-Cal redetermination process on April 1, 2023, for Medi-Cal members who have a June redetermination month.

- The first set of disenrollments due to redeterminations will occur in June 2023, with an effective date of July 1, 2023.

Continuous Coverage Unwinding (Continued)

- DHCS began emailing/texting Medi-Cal members during the week of May 8.
- **Enhanced Landing Page:** KeepMediCalCoverage.org
- Paid advertising is live statewide in 19 languages across digital, radio and out-of-home platforms.
- New "Stay Covered/Take Care" videos (30, 15, 6 seconds each) now available for partner use as part of Unwinding Toolkits.

"Stay Covered"



English

Spanish

Hmong

Japanese

"Take Care"

English

Spanish

Continuous Coverage Unwinding Data Dashboards

- The DHCS Unwinding Eligibility Dashboard will publish monthly with statewide and county-level data:
  - Total Enrollment
  - Application Snapshots:
    - Determined Eligible/Ineligible
    - Pending
    - Received
- Redetermination Snapshot
- Discontinuances (to be published in August 2023 for the June 2023 eligibility month)
- DHCS to post all unwinding dashboards and federal submissions of unwinding data on the Medi-Cal Enrollment webpage.

Health Plan Quality Measures and Sanctions

Palav Babaria, MD, Deputy Director and Chief Quality and Medical Officer, Quality and Population Health Management, DHCS

DHCS

Domains	Measures (MY 2023)
Child & Adolescent Preventative Health	• Child and Adolescent Well-Care Visits (WCV)* • Childhood Immunization Status: Combination 10 (CIS-10)* • Developmental Screening in the First Three Years of Life (DEV) • Immunizations for Adolescents: Combination 2 (IMA-2)* • Lead screening in Children (LSC) • Topical Fluoride for Children (TFL-CH) • Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months (W30)* • Well-Child Visits in the First 30 Month of Life - Well-Child Visits for Age 15 Months - 30 Months (W30)*
Reproductive Health	• Chlamydia Screening in Women (CHL) • Prenatal and Postpartum Care: Postpartum Care (PPC-Pst)* • Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)* • Postpartum Depression Screening and Follow Up (PDS-E) • Prenatal Depression Screening and Follow Up (PND-E) • Prenatal Immunization Status (PRS-E)

Domains	Measures (MY 2023)
Behavioral Health	• Follow-Up After Emergency Department (ED) Visit for Mental Illness – 30 days (FUM)* • Follow-Up After ED Visit for Substance Abuse – 30 days (FUA)* • Depression Remission or Response for Adolescents and Adults (DRR-E) • Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)* • Pharmacotherapy for Opioid Use Disorder (POD)*
Chronic Diseases	• Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC-H9)* • Controlling High Blood Pressure (CBP)* • Asthma Medication Ratio (AMR)*
Cancer Prevention	• Breast Cancer Screening (BCS)*—ECDS/Admin • Cervical Cancer Screening (CCS) • Colorectal Cancer Screening (COL)*

Specific Measures

Infant, child, and adolescent well-child visits
Childhood and adolescent vaccinations

Prenatal and postpartum visits
C-section rates

Prenatal and postpartum depression screening
Adolescent depression screening and follow up

Follow up after ED visit for SUD within 30 days
Depression screening and follow up for adults
Initiation and engagement of alcohol and SUD treatment

Infant, child, and adolescent well-child visits
Childhood and adolescent vaccinations
Blood lead and developmental screening
Chlamydia screening for adolescents

BOLD GOALS: 50x2025

STATE LEVEL

Close racial/ethnic disparities in well-child visits and immunizations by 50%

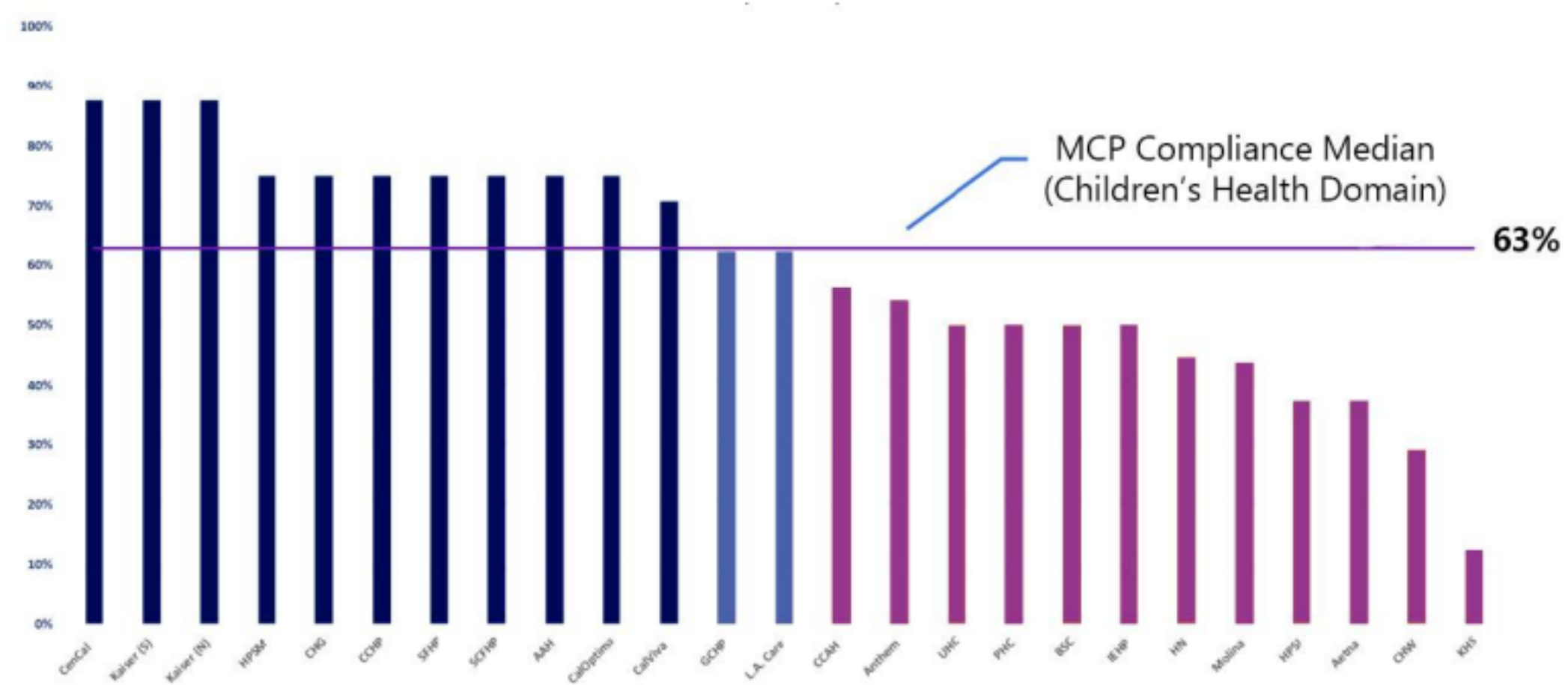
Close maternity care disparity for Black and Native American persons by 50%

Improve maternal and adolescent depression screening by 50%

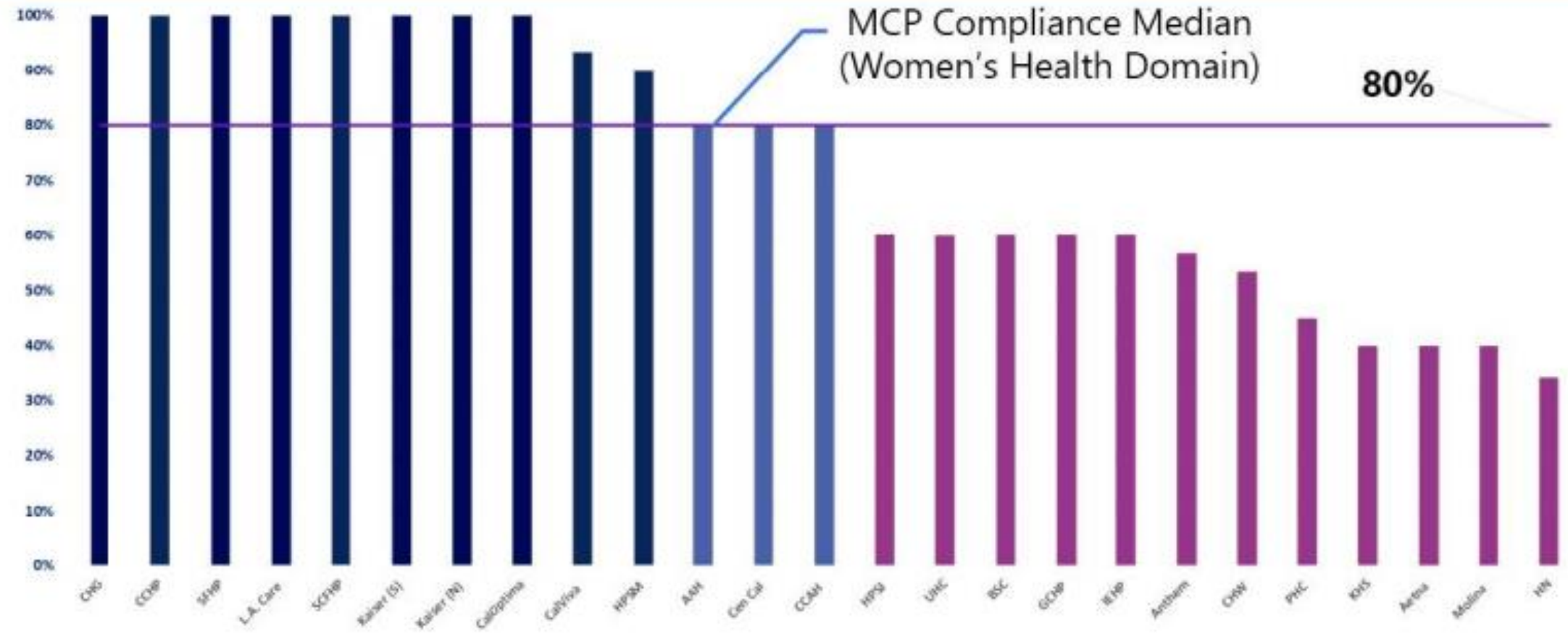
Improve follow up for mental health and substance use disorder by 50%

Ensure all health plans exceed the 50th percentile for all children's preventive care measures

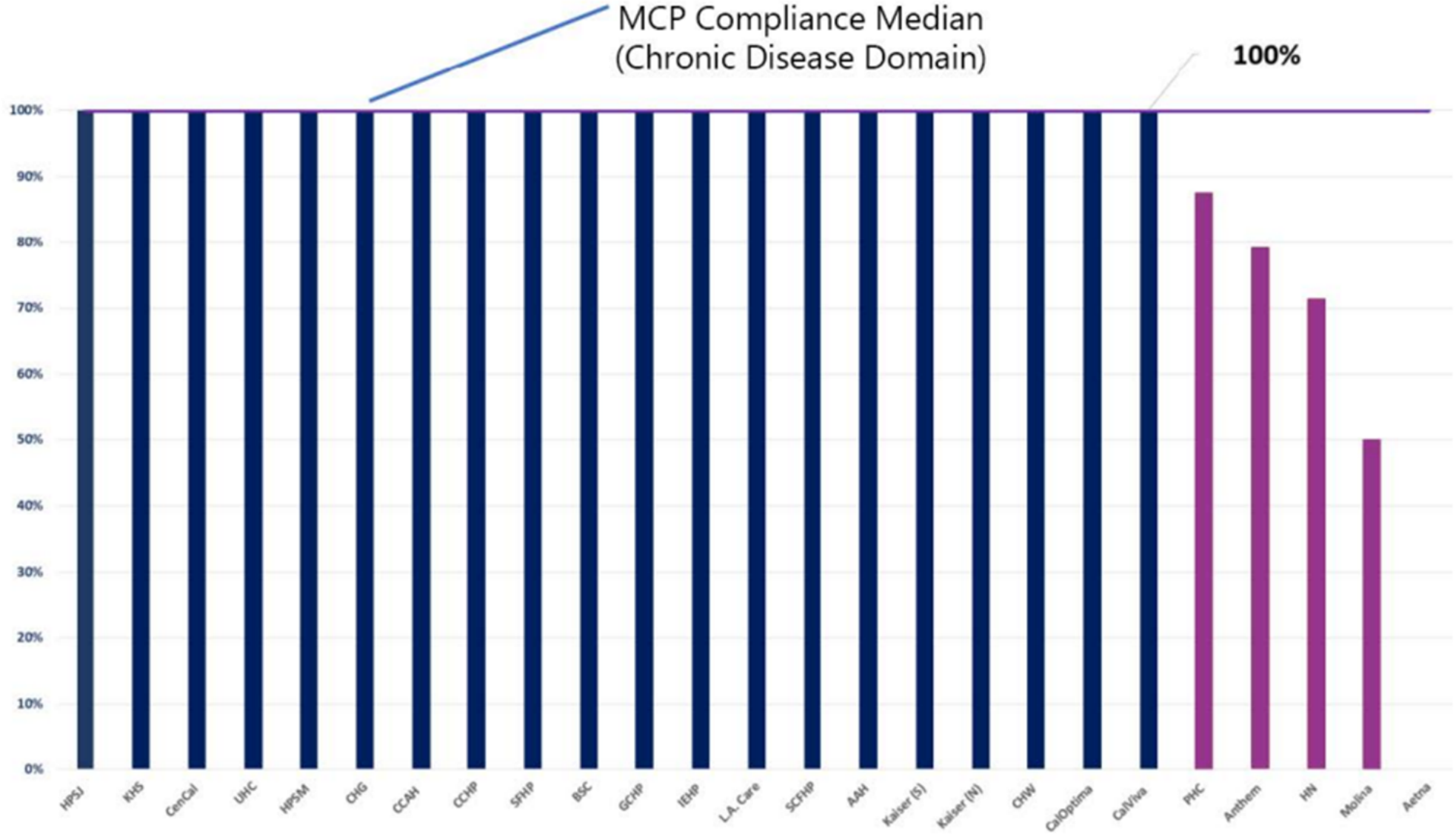
MCPS MEETING THE DHCS STANDARD FOR CHILDREN'S DOMAIN MEASURES IN MEASUREMENT YEAR (MY) 2021



MCPS MEETING THE DHCS STANDARD FOR WOMEN'S DOMAIN MEASURES IN MEASUREMENT YEAR (MY) 2021



MCPs MEETING THE DHCS STANDARD FOR CHRONIC DISEASE DOMAIN MEASURES IN MEASUREMENT YEAR (MY) 2021



Tiers*	All Plans	Green Tier	Orange Tier	Red Tier
Triggers	N/A	One (1) measure below the minimum performance level (MPL), per domain	Two (2) or more measures below the MPL in any one (1) domain	Three (3) or more measures in two (2) or more domains
Quality Improvement requirements	• 2 performance improvement plans (PIPs) • Quarterly regional collaborative calls • Actively engage and collaborate across delivery systems to improve quality measures	• Plan Do Study Act (PDSA) *Max of 3 PDSAs across domains for each managed care plan (MCP)*	• PDSA • Strengths, Weaknesses, Opportunities, Threats (SWOT) *Max of 1 SWOT on any domain and 2 PDSAs for remaining triggered domains*	• Quality Improvement MCP assessment and Strategic Plan • Executive leadership meeting every four (4) months • NC meetings prior to executive meetings
Enforcement Action	Sanctions are applicable to all MCPs that performed below the MPL on quality performance measures.			

Closer look at QI Efforts

- Regionalization: working toward a regional model aligning quality improvement (QI) work within specific regions that share similar demographics and access barriers.
  - Currently have quarterly collaborative calls for each region for a more in-depth discussion.
- PDSA: measure-specific interventions with a goal outcome to raise rates for the measure.
- SWOT: domain-specific with a multi-intervention method that allows for broader, farther-reaching QI process.
- Corrective Action Plan (CAP): QI Assessment, program-wide internal look at infrastructure/barriers impacting quality improvement stagnation for Medi-Cal members.

	First Violation Under Sanction	Second Violation Under Sanction	Third Violation Under Sanction	Comments
Monetary Sanctions	Up to $25,000 per violation	Up to $50,000 per violation without evidence of improvement	Up to $100,000 per violation without evidence of improvement	Based on WIC 14197.7(f)(1) Factors
Non-monetary Sanctions	• Temporarily suspension orders: -Adjusting auto-assignment algorithm to funnel enrollment into other MCPs within the RU not under a CAP -Suspend MCP marketing activities -Require MCP to temporarily suspend specific personnel and/or subcontractor -Require MCPs to ensure subcontractors cease certain activities including referrals, assignment of eligible members, and reporting	• Continued temporary suspension orders • MCP Personnel assessment and/or termination: -Require MCP to terminate specified personnel and/or subcontractor -MCP must assess executive roles or Governing Board operations (for COHS)	• Imposition of temporary management: -DHCS may impose temporary management if continued egregious conduct by MCP -DHCS can consider termination of the contract between a MCP and DHCS	Based on WIC 14197.7(d)(1)-(5) Factors

Questions?

Medi-Cal Managed Care Plan Contract: 2024 Readiness and Transition Planning

Susan Philip, Deputy Director, Health Care Delivery Systems, DHCS, and Michelle Retke, Chief, Managed Care Operations, DHCS

DHCS

2024 MCP Operational Readiness and Transition Planning

Contract Deliverable Review

All MCPs are subject to operational readiness for 2024 which entails a full review of readiness deliverables:

1. MCPs in counties with no changes
2. MCPs in counties subject to county plan model changes
3. MCPs (commercial) that are directly contracted with DHCS

- Approximately 236 Deliverables per Managed Care Plan
- Of the 236 Deliverables, 74 are considered key deliverables that are required to be approved prior to September 1, 2023, as part of the Go/No-Go decision of a MCP going live for January 1, 2024.
- Key deliverables pertain to specific domains, including network adequacy and access, delegation oversight, continuity of care, CalAIM (Enhanced Care Management (ECM)/Community Supports)

Contract Deliverable Review

- Operational Readiness Contract Deliverables
  - 2,918 deliverables has been submitted
  - 2,682 deliverables has been approved
- Key Operational Readiness Deliverables
  - 1,304 key operational deliverables has been submitted
  - 1,185 deliverables has been approved
- Deliverables pending approval are either with DHCS for review or with the MCP for follow up as needed.
- Overall, MCP's have been timely on submitting deliverables. DHCS has processes in place to work with MCP's if deliverables are delayed or if deliverables submitted need additional information added to them for an approval.

2024 MCP Contract Provisions Delayed until 2025

- Closed Loop Referrals, including Community Resource Directory and provider referral tracking
- Emergency Preparedness & Response
- Certain MOUs with other parties
- School-Based Services

2024 MCP Transition Policy Guide:
Expectations specific to the 2024 Transition

Purpose

- The Policy Guide will include **guidance related to the January 1, 2024, transition of Medi-Cal MCPs**
- The Policy Guide will function as a **requirements document** for MCPs' transition activity, **incorporating links to existing, applicable All Plan Letters (APLs), as well as new MCP requirements**
- The Policy Guide will afford DHCS a nimble approach to **respond to feasibility challenges and issues impacting members, providers, and MCPs**

Target Audience

- **MCP staff impacted by the January 1, 2024, transition, either as an exiting MCP or a new MCP** will be the primary user of this Policy Guide
- The Policy Guide will also offer an **organized, reference source for DHCS staff** charged with monitoring and oversight of the transition.

Policy Content

- **It is envisioned that the Policy Guide would contain requirements related to the following transition topics:**
  - Member enrollment
  - Continuity of care
  - Data transfer
  - Payment and program transitions
  - Post-transition monitoring and related reporting requirements
  - *Other topics pertinent to the transition, such as incentive program participation/ obligations after January 1, 2024*
- **Out of scope:** Internal DHCS policies, Operational Readiness

DHCS released the Policy Guide in May and expects quarterly updates thereafter.

Policy Guide Outline

DHCS anticipates including the below topics in the forthcoming Policy Guide.

- Table of Contents
- Updates from Prior Version
- Introduction
  - Context
  - Purpose, Scope, Audience
- Key Definitions
- Member Enrollment
  - Noticing
  - Enrollment policies for new Medi-Cal members during transition period
  - Enrollment policies for members transitioning from exiting plans
  - Other Kaiser-related enrollment policies
  - Other enrollment policies
- Continuity of Care
  - Context
  - Special populations
  - Continuity of care for providers
  - Continuity of care for covered services
  - Continuity of care coordination and management information
  - Additional continuity of care protections for all members of exiting MCPs
- Transition policy for ECM *(tentative for Q2 release)*
- Transition policy for Community Supports *(tentative for Q2 release)*
- Data Transfer:
  - From exiting plan to DHCS
  - From DHCS to receiving plans
  - Plan-to-plan
- Payment and Program transitions
  - Incentive Payment Plan (IPP) intersection
  - Housing and Homelessness Incentive Program (HHIP)
  - Providing Access and Transforming Health (PATH)
  - Acute care payment responsibility
  - Network development incentives/considerations
  - PHM Health Risk Assessments (HRA) timing
- Post-Transition monitoring and related reporting requirements
- Appendix
  - General definitions

Items within these sections will be ready for release in Q2

The Q2 release will indicate anticipated timeline for subsequent releases for these items

Go-Live Assessment

Conducting deep dive of “high priority” MCPs

- Is the managed care plan entering a new market?
- Will the managed care plan take on substantially new number of members?
- Consideration of other factors which may pose a potential risk to go-live

CalAIM Update

Jacey Cooper, Chief Deputy Director for Health Care Programs and State Medicaid Director,

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

Palav Babaria, MD, Deputy Director & Chief Quality and Medical Officer, Quality and Population Health Management, DHCS

DHCS

Upcoming ECM Milestones

July 2023

ECM launches in all counties for the Children and Youth POFs, which include:

- Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition
- Children and Youth Involved in Child Welfare

January 2024

ECM launches in all counties for:

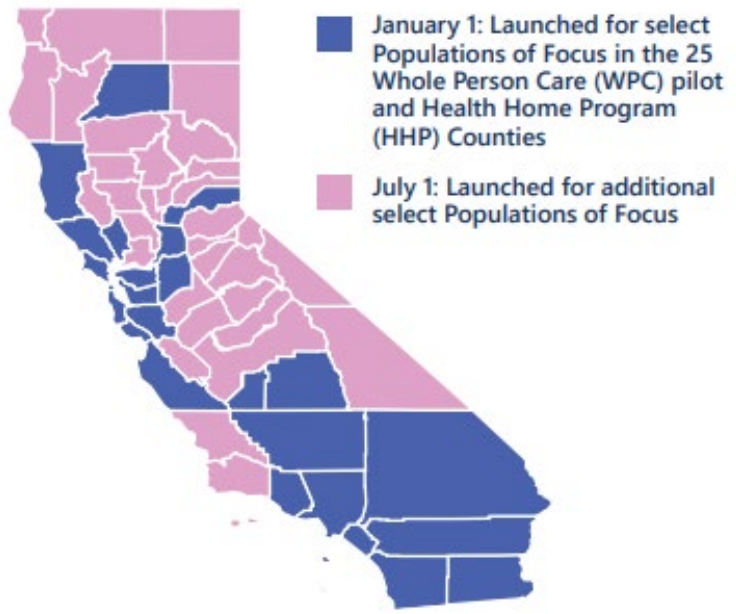
- Individuals Transitioning from Incarceration
- Birth Equity Population of Focus

Approach for Children and Youth PoFs

- ECM will provide whole-child care management **above and beyond** what is provided by the pre-existing programs.
- ECM serves as the **single point of accountability** to ensure coordination across multiple systems/programs – the **"air traffic control"** role.
- The person, organization, or entity that already knows the child best becomes the lead care manager through ECM.
- ECM does **not take away funding from existing care management programs**; other programs' care managers can choose to enroll as an ECM provider and receive **additional** reimbursement for ECM from MCPs.

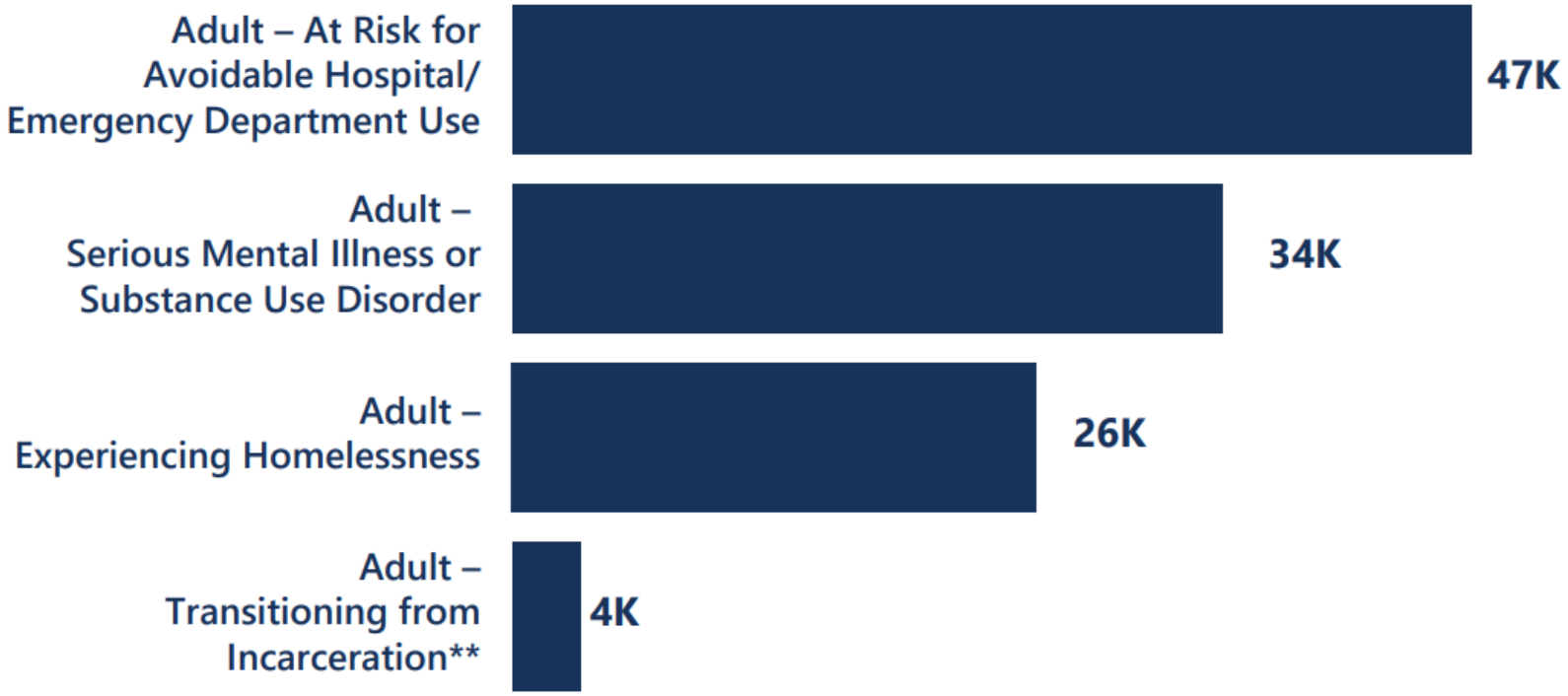
ECM: Early Implementation Data (Q1 – Q3 2022)

ECM Expanded Statewide in 2022



88,115 total members were enrolled in ECM in January through September 2022.

Cumulative Enrollment by Top 4 Populations of Focus*

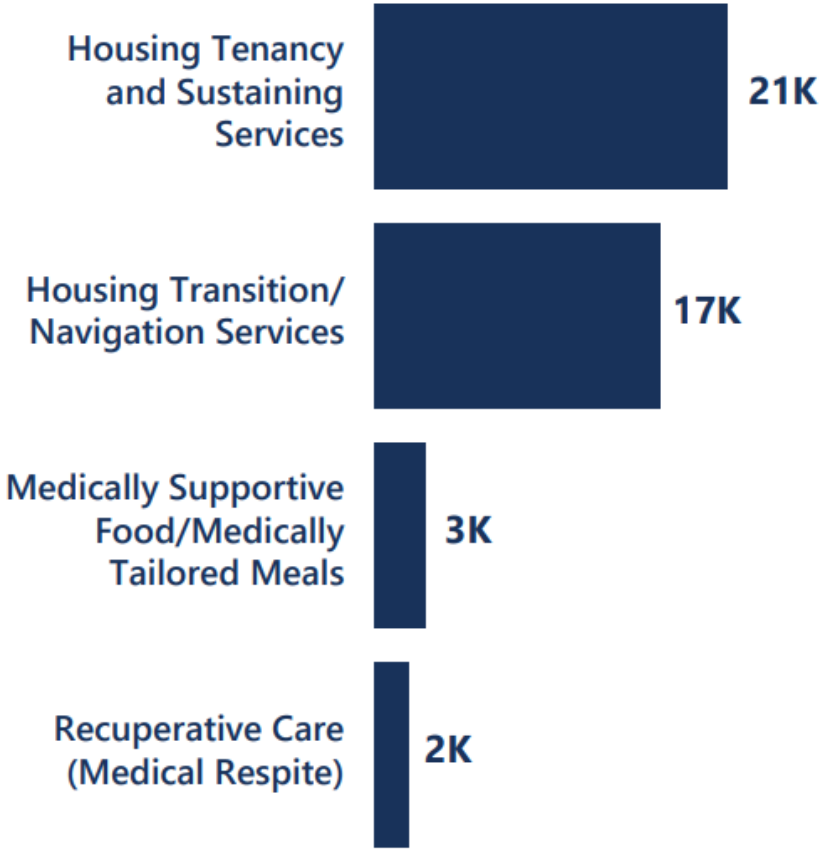


* ECM enrollees may be categorized under multiple PoFs.

** This Population of Focus is live only in select WPC counties, not statewide.

Community Supports: Early Implementation Data (Q1 – Q3 2022)

Cumulative Utilization for Top 4 Community Supports Services*



27,213 members received at least one Community Support service in January through September 2022.

DHCS is working with MCPs to enable more widespread provision of services to members, including those with the most complex challenges affecting health, such as homelessness and unstable and unsafe housing.

* Members may receive more than one Community Supports service.

ECM and Community Supports

Early Implementation Data (Q1 – Q3 2022)

The number of members receiving ECM and/or Community Supports is expected to continue to grow as more providers contract with MCPs to deliver services, providers develop their capacity, and members and their families learn about and connect to these services.

Cumulative ECM Providers to Date
As of:

March 2022	June 2022	September 2022
692	759	956

The total number of providers that were contracted to provide ECM in 2022 **increased by 38%** from the end of Q1 to the end of Q3.

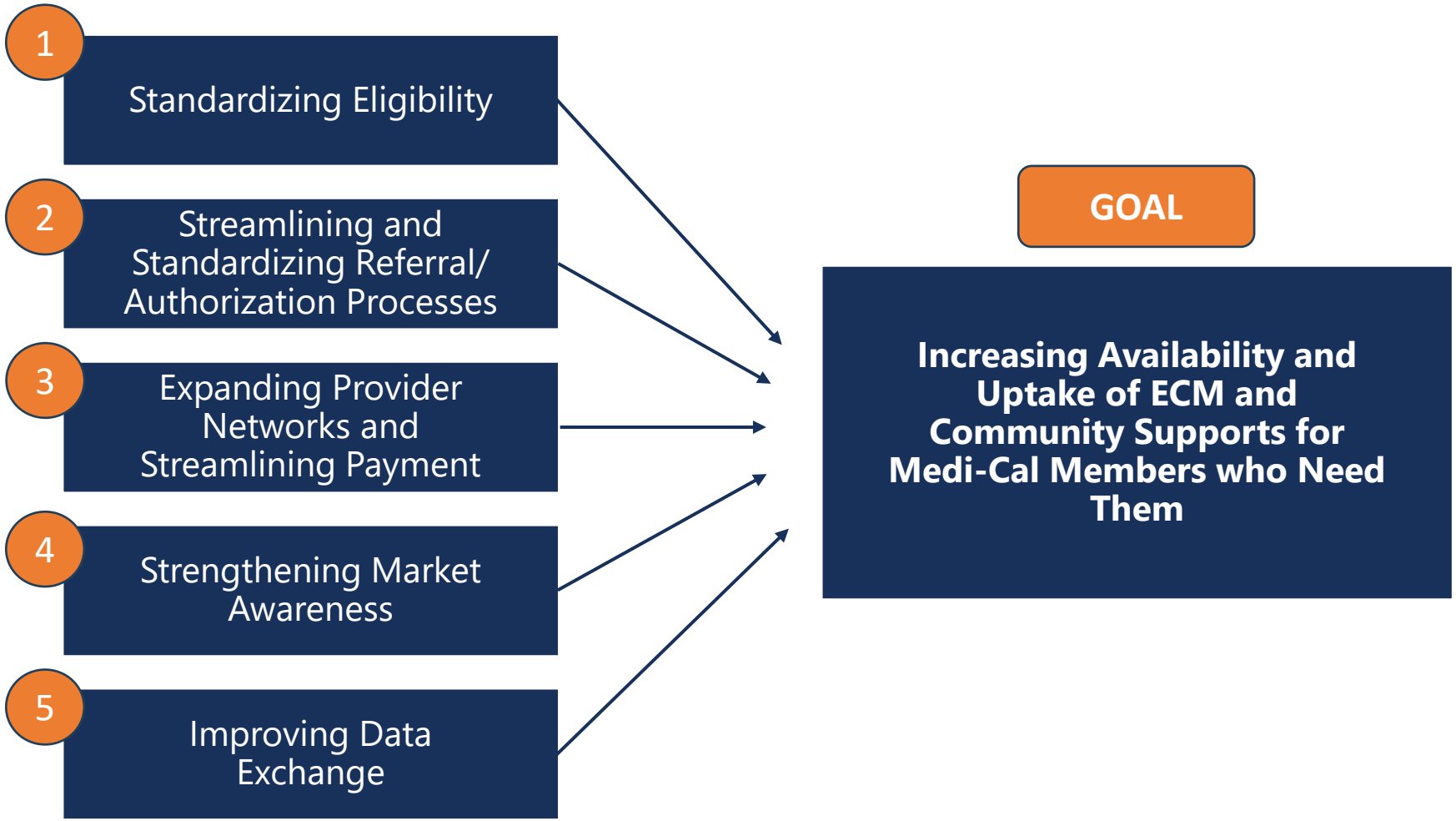
Cumulative Community Supports Providers to Date
As of:

March 2022	June 2022	September 2022
722	850	1,212

The total number of providers that were contracted to provide Community Supports in 2022 **increased by 68%** from the end of Q1 to the end of Q3.

To learn more, view ECM and Community Supports Fact Sheet for Q1-Q3 2022 Data.

Increasing Uptake of ECM and Community Supports in Response to Data and Feedback



Dual Special Needs Plans (D-SNPs) Policy Updates

- **On January 1, 2023**, Medicare Medi-Cal (Medi-Medi) Plans launched in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
  - Medi-Medi Plan enrollment was approximately 230,000 in April 2023, compared to 113,000 in Cal MediConnect in December 2022.
  - Of the 230,000 Medi-Medi Plan members in April, approximately 20 percent were under age 65.
- **In 2024**, Medi-Medi Plans will be available in five additional counties: Fresno, Kings, Madera, Sacramento, and Tulare.
  - DHCS is working with local stakeholders in those five counties on outreach and collaboration to prepare for the launch of the Medi-Medi Plans.
- Medi-Cal plans in all counties will have Medi-Medi Plans **no later than 2026.**
- DHCS is making key updates for 2024 for the D-SNP State Medicaid Agency Contract (SMAC) and Policy Guide:
  - Require all D-SNPs to include ECM, palliative care, and dementia care in their Models of Care.
  - Add requirements for D-SNPs regarding coordination of dental benefits across Medicare and Medi-Cal.

Public Comment

Next Meeting, Next Steps, and Adjourn

Break

Behavioral Health Stakeholder Advisory Committee Hybrid Meeting

May 24, 2023

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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

Tyler Sadwith, Deputy Director, Behavioral Health, DHCS

DHCS

The CalBH-CBC Demonstration is now the BH-CONNECT Waiver

DHCS is renaming the California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration. The name is new, but the vision, objectives, and approach remain the same.

CalBH-CBC Demonstration → **BH-CONNECT Waiver**

The new name, the **Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment** (BH-CONNECT) waiver, emphasizes DHCS' commitment to providing a robust continuum of community-based behavioral health care and improving access, equity, and quality for Medi-Cal members with mental health needs, particularly populations experiencing disparities in behavioral health care and outcomes.

Section 1115 BH-CONNECT Waiver: Vision and Objectives

DHCS' vision for the BH-CONNECT waiver is to ensure a robust continuum of community-based behavioral health care services is available to all Medi-Cal members living with SMI and SED.

As part of CalAIM, California committed to pursuing a Section 1115 demonstration to enhance the continuum of community-based services to support adults with serious mental illness (SMI) and children and youth with serious emotional disturbance (SED). The objectives of BH-CONNECT include:

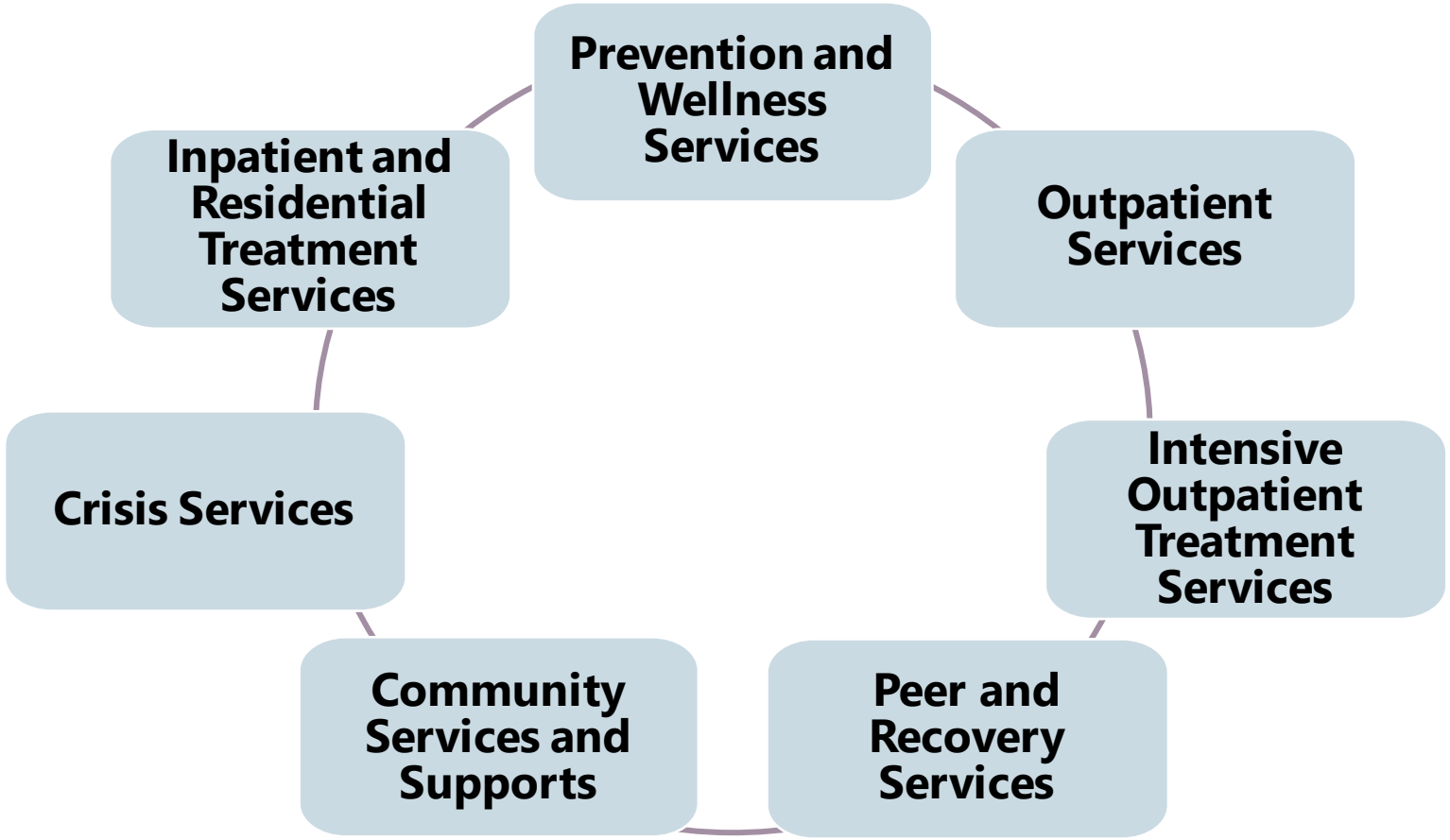
1. **Amplify the state's ongoing investments** in behavioral health and further strengthen the continuum of community-based care.
2. **Meet the specific mental health needs** of children, individuals who are justice-involved, and individuals experiencing or at risk of homelessness.
3. **Ensure care provided in facility-based settings** is high-quality and time-limited.

Demonstration: Approach

- **Strengthen the statewide continuum of community-based services** and evidence-based practices available through Medi-Cal, leveraging concurrent funding initiatives, including clarifying coverage requirements for evidence-based practices for children and youth.
- **Support statewide practice transformations** and improvements in the county-administered behavioral health system to better enable counties and providers to strengthen the continuum of community-based services; improve the quality of care delivered in residential and inpatient settings; and strengthen transitions from these settings to the community.
- **Improve statewide county accountability** for meeting service improvement requirements and implementing new benefits through incentives, robust technical assistance, and oversight.
- **Establish a county option to enhance community-based services** through coverage of evidence-based practices that reduce the need for facility-based care and improve outcomes.
- **Establish a county option to receive federal financial participation (FFP) for services provided during short-term stays in an Institution for Mental Disease (IMD)**, contingent upon counties meeting robust accountability requirements; ensuring that care is provided in a facility-based setting only when medically necessary and in a clinically appropriate manner; offering a robust array of enhanced community-based services; and reinvesting new Medi-Cal funding into community-based care.

Demonstration: Continuum of Care

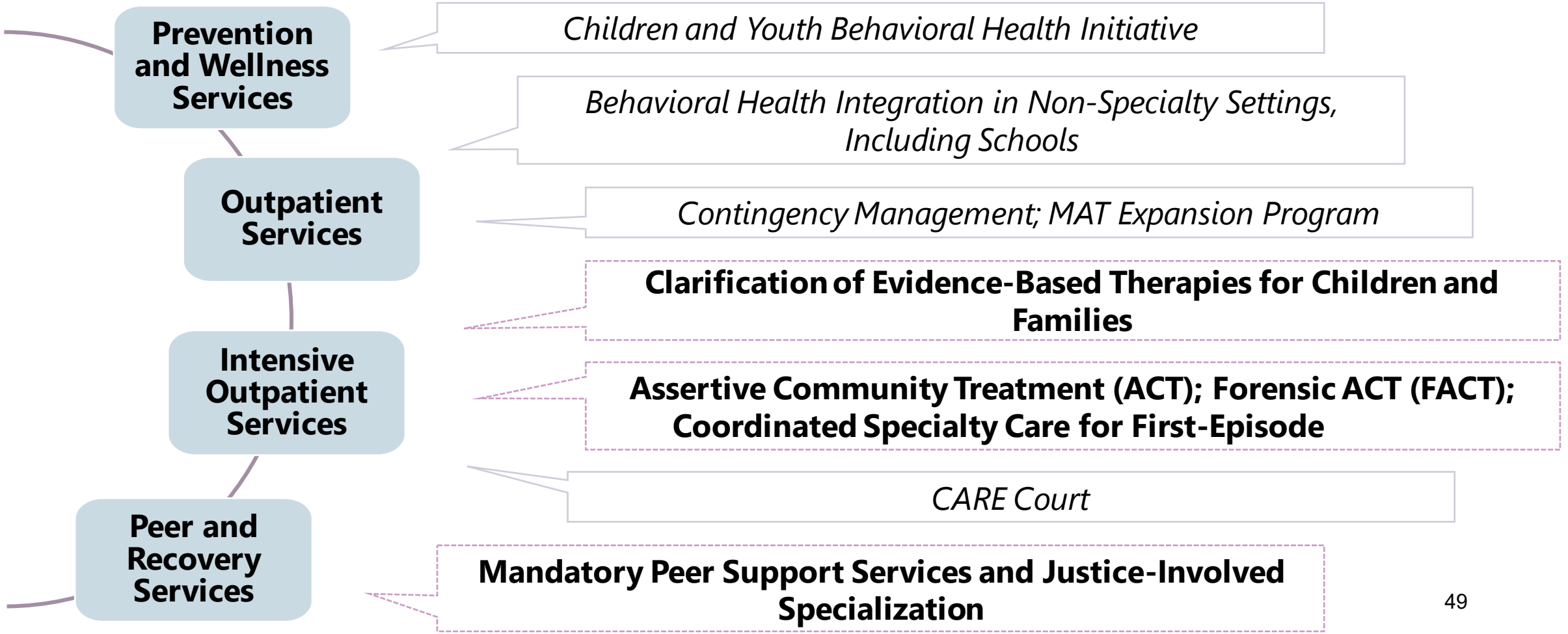
The demonstration is designed to complement and amplify the state's existing initiatives to build out the continuum of care for individuals living with SMI and SED.



In the following slides, proposed BH-CONNECT initiatives are in **bold**; existing initiatives are *italicized*.

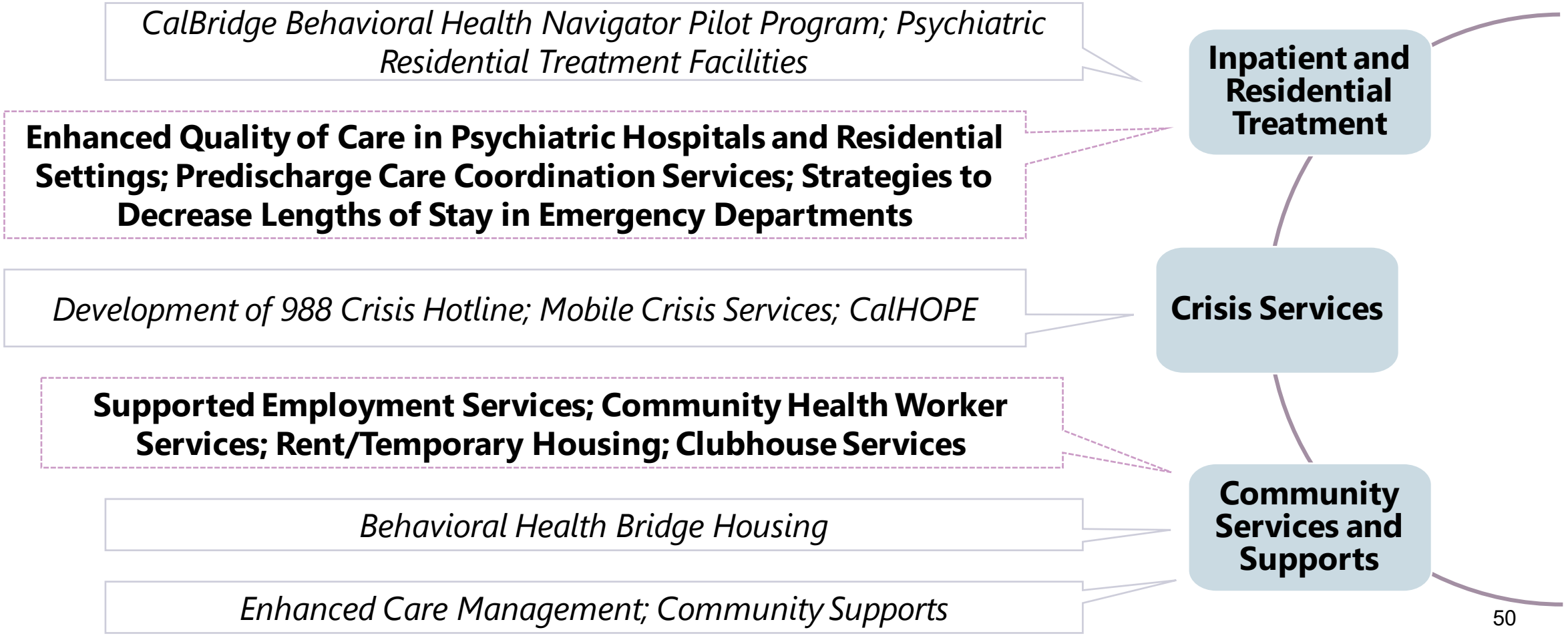
Demonstration: Continuum of Care (1/2)

The demonstration is designed to complement and amplify the state's existing initiatives to build out the continuum of care for individuals living with SMI and SED.



Demonstration: Continuum of Care (2/2)

The demonstration is designed to complement and amplify the state's existing initiatives to build out the continuum of care for individuals living with SMI and SED.



Update: Timeline for Opt-In Counties (1/2)

	Concept Paper Proposal	Proposed Updated Timeline

Upon Go-Live (*rolling basis*)	» Participate in the opt-in county incentive program
	» Meet county accountability requirements
	» Meet CMS accreditation and emergency department (ED) strategy requirements
	» Begin providing:
	  » Assertive Community Treatment (ACT)
	  » Peer support services, including justice-involved specialization
		» Participate in the opt-in county incentive program
		» Meet county accountability requirements
		» Meet CMS accreditation and ED strategy requirements
		» Begin providing:
		  » Peer support services, including justice-involved specialization
		  » Community Health Worker (CHW) services
		» Complete preliminary ACT fidelity assessment from Centers of Excellence
		» Begin participating in training and technical assistance for ACT/FACT offered through Centers of Excellence

Within Six Months of Go-Live	*n/a*	» Close gaps in ACT fidelity assessment from Centers of Excellence and submit progress update

Demonstration: Timeline for Opt-In Counties (2/2)

	Concept Paper Proposal	Proposed Updated Timeline
Within One Year of Go-Live	*n/a*	» Fully implement ACT » Begin providing: » Rent/Temporary Housing

Within Two Years of Go-Live	» Begin providing:
	  » CHW services
	  » FACT
	  » Supported Employment
	  » Coordination Specialty Care for First Episode Psychosis
	  » Rent/temporary housing
		» Begin providing:
		  » FACT
		  » Coordination Specialty Care for First Episode Psychosis

Within Three Years of Go-Live	*n/a*	» Begin providing: » Supported Employment

BH-CONNECT: Cross-Sector Incentive Program Background and Request for Stakeholder Input

Cross-Sector Incentive Program: Background and Connection to Statewide Activities for Children and Youth

The BH-CONNECT Cross-Sector Incentive Program is part of a broad set of activities being proposed to strengthen care and improve outcomes for California's most vulnerable children and youth.

DHCS will use the BH-CONNECT demonstration to make targeted improvements to care for children and youth statewide, including:

- **Cross-sector incentive program** to reward managed care plans (MCPs), County Mental Health Plans (MHPs), and child welfare agencies for meeting specified measures related to care for children and youth in the child welfare system.
- **Activity stipends** for children/youth involved in child welfare to promote social/emotional well-being.
- **Centers of Excellence** to support implementation of evidence-based practices for children, youth, and adults.

In parallel with the BH-CONNECT demonstration, DHCS is making other statewide changes to strengthen services for children and youth that do not require waiver expenditure authority, including:

- **Clarification of coverage** of specific evidence-based practices for children and youth Multisystemic Therapy (MST), Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT).
- **Alignment of the Child and Adolescent Needs and Strengths (CANS) tool** to ensure both child welfare and behavioral health providers are using the same CANS tool.
- **Initial Behavioral Health Assessment** during a joint home visit by behavioral health and child welfare systems.
- **Foster Care Liaison Role** requirement within MCPs.

DHCS is requesting stakeholder input in the early phases of development of the Cross-Sector Incentive Program.

For Discussion: Cross-Sector Incentive Program Details and Design Principles

Program Details

Eligible Participants: MCPs, MHPs, child welfare services (CWS)

Population Addressed: Children and youth receiving foster care, at risk of receiving foster care, transitioning out of foster care, and/or eligible for the Adoption Assistance Program

Objective: Incentivize activities to improve the physical, behavioral health, and health-related social outcomes of children and youth being served by these systems. Such activities may include cross-sector collaboration, implementation of children and youth-related components of BH-CONNECT, and alignment with children and youth-related efforts across DHCS, among others.

Example metric focus areas outlined on next slide

Guiding Design Principles

- ✓ **Emphasize up-front planning and multi-system collaboration** to ensure systems are well-prepared to demonstrate performance improvement in later program periods
- ✓ **Align program requirements with existing efforts and leverage existing data** where possible to minimize burden
- ✓ **Reward participating systems for going "above and beyond"** existing requirements across the state and for engaging in new initiatives to achieve outcome improvements

Cross-Sector Incentive Program: High-Level Program Measurement Timeline

Initial program metrics may focus on planning, infrastructure development, and establishment of baseline data on systems' quality performance. Throughout the course of the program, metrics may shift to be more outcomes- and performance-based.

High-Level Cross-Sector Incentive Program Measurement Timeline

Program Year 1	Program Year 2	Program Year 3	Program Year 4
Measurement Period 1	Measurement Period 2	Measurement Period 3	Measurement Period 4

Metrics may shift to be more performance-based as the program goes on

EXAMPLE Metric Focus Areas

Process Metrics (Focus Early in Program)	**Outcome Metrics** (Focus Later in Program)
» Alignment of CANS tool across systems/programs » Standardization of county ECM requirements (e.g., MCP contracting and reporting templates) » Cross-sector coordination (e.g., AB 2083 Children and Youth System of Care implementation, MCPs joining Interagency Leadership Team, etc.)	» Improvement of SUD-related outcomes » Reduction in average time to permanency » Reduction in residential/inpatient length of stay (LOS) and/or placements » Reduction of use of restraints in facilities » Increase in use of community-based care (e.g.HFW, IHBS)

Cross-Sector Incentive Program: Call for Stakeholder Input

Guiding Questions for Stakeholders

- What **current challenges** have the greatest impact on MCPs', MHPs', and/or CWS' ability to care for the population addressed by this program?
- What would **effective cross-sector collaboration** look like between MCPs, MHPs, and CWS to deliver care for this population? What is the most important role for each system to play?
- What **outcome(s)** would best demonstrate "success"?
- Which **quality metrics** would best measure progress toward program objectives?

DHCS welcomes input submitted to BH-CONNECT@dhcs.ca.gov

Demonstration: Next Steps

DHCS is committed to working with stakeholders to ensure the BH-CONNECT demonstration is aligned with the needs of Medi-Cal members living with SMI/SED across the state

- **Behavioral Health Workgroup Webinar.** DHCS will hold a CalAIM Behavioral Health Workgroup webinar on Thursday, June 8, from1-2:30 pm PDT, during which more detail on the BH-CONNECT demonstration application will be provided. Learn more: https://www.dhcs.ca.gov/provgovpart/Pages/bhworkgroup.aspx
- **Public Comment.** DHCS intends to release the BH-CONNECT demonstration application for public comment in late June/early July 2023.
- **Submission of Application and Implementation Plan to CMS.** DHCS intends to submit the final BH-CONNECT demonstration application and implementation plan to CMS in fall 2023, following stakeholder review, BH-CONNECT webinar sessions, and incorporating feedback received during public comment.
- **Additional Information.** Learn more: https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx

Appendix

Demonstration: Components (1/2)

In identifying the key elements of the demonstration, DHCS dedicated particular attention to the needs of populations disproportionately impacted by behavioral health conditions.

Strengthen Statewide Continuum of Community-Based Services

- ✓ Clarify Coverage of Evidence-Based Practices (MST, FFT, PCIT)
- ✓ Cross-Sector Incentive Pool
- ✓ Activity Stipends
- ✓ Initial Behavioral Health Assessment
- ✓ Foster Care Liaison Role

Support Statewide Practice Transformations

- ✓ Centers of Excellence
- ✓ Statewide Incentive Program
- ✓ Workforce Initiative
- ✓ Statewide Tools to Connect Beneficiaries Living with SMI/SED to Appropriate Care
- ✓ Promotion and Standardization of Quality of Care in Residential and Inpatient Settings

Improve Statewide County Accountability for Medi-Cal Services

- ✓ Transparent Monitoring Approach
- ✓ Establishment of Key Performance Expectations and Accountability Standards in County MHP Contract
- ✓ Streamlined Performance Review Process

Demonstration: Components (2/2)

In identifying the key elements of the demonstration, DHCS dedicated particular attention to the needs of populations disproportionately impacted by behavioral health conditions.

County Option to Enhance Community-Based Services

- ✓ ACT
- ✓ FACT
- ✓ Supported Employment
- ✓ Coordinated Specialty Care for First Episode Psychosis
- ✓ CHW Services
- ✓ Rent Services
- ✓ Clubhouse Services

County Option to Receive FFP for Short-Term Stays in IMDs

- ✓ FFP for Short Term Stays in IMDs
- ✓ Requirement to Provide Enhanced Community-Based Services for Members Living with SMI/SED
- ✓ Incentive Program for Opt-In Counties
- ✓ Other CMS Requirements

Behavioral Health Payment Reform

Jacob Lam, Assistant Deputy Director, Health Care Financing, DHCS

Brian Fitzgerald, Chief, Local Governmental Financing, DHCS

Gary Tsai, Los Angeles County Department of Public Health

DHCS

Overview

- The CalAIM Behavioral Health Payment Reform initiative seeks to move counties away from cost-based reimbursement to better enable counties and providers to deliver value-based care that improves quality of life for Medi-Cal-members.

- **Go Live:** July 1, 2023.

The Three Transitions of Payment Reform

1. **Reimbursement Structure:** End cost-based reimbursement and implement fee-for-service payments to county BH plans.

   Goals: Simplify county BH plan payments and reduce administrative burden for the state, counties, and providers. Develop rates sufficient to attract and maintain an adequate network of qualified specialty providers.

2. **Financing Mechanism:** Transition to Intergovernmental Transfers (IGTs) to finance Medi-Cal county BH plan payments.

   Goal: Enable county BH plans to continue providing the non-federal cost share for Medi-Cal services without certified public expenditures and cost-based reimbursement.

3. **Providing Billing:** Transition from HCPCS II to CPT coding.

   Goals: Improve reporting and support data-driven decision making by disaggregating data on specialty behavioral health services. Align with other health care delivery systems and comply with CMS requirements for all state Medicaid programs to adopt CPT codes where appropriate.

Reimbursement Structure

» **End cost-based reimbursement and implement FFS payments to county BH plans.**

Present Cost-Based Reimbursement	Future FFS Reimbursement
• County BH plans claim federal reimbursement on an interim basis for each service rendered. • Counties and contracted providers submit annual cost reports subject to audit, reconciliation, and cost settlement. • Plan reimbursement is limited to cost. Provider payments are negotiated with county BH plans.	• County BH plans claim FFS reimbursements at rates established in BH plan fee schedule. • Plans negotiate payment terms and rates with subcontracted providers. • Plan reimbursement for each service is final, with no additional settlement to cost for county BH plans.

Financing Mechanism

» **Transition to IGTs to finance Medi-Cal county BH plan payments.**

Present Certified Public Expenditures (CPEs)	Future Intergovernmental Transfers (IGTs)
• County BH plans purchase specialty services and attest to expenditures of non-federal share under a CPE protocol. • CPE-based financing is based on actual costs incurred and requires cost reporting, audit, and settlement to finalize federal reimbursement to county BH plans.	• Reimbursement is claimed via the fee schedule with the county share transferred by the county to the state. • Sources of non-federal share available to county BH plans and eligible for use as IGTs (including Realignment and MHSA funds) do not change.

Provider Billing

» **Transition from HCPCS II to CPT coding.**

Present HCPCS Level II – All Services	Future CPT/HCPCS Level I Where Applicable
• HCPCS Level II codes are highly flexible; a variety of activities may be captured by the same code, making detailed analysis of services rendered a challenge. • HCPCS Level II codes can be used by any provider (licensed or non-licensed).	• CPT codes: more detailed and nationally standardized definitions for each code and allows the payer more information on practitioner type. • Some HCPCS Level II codes will be retained for those behavioral health providers and services not captured by CPT codes.

Coding Guidance and Technical Assistance (TA)

- DHCS released coding guidance and updated billing manuals in August 2022 via BHIN 22-046.
- DHCS contracted with CalMHSA to offer trainings and TA materials.
  - Short-Doyle Medi-Cal CPT Code Reference Guides:
    - Specialty Mental Health (SMHS)
    - Drug Medi-Cal (DMC)
    - Drug Medi-Cal Organized Delivery System (DMC-ODS)
  - Trainings:
    - Introductions to CPT Codes
    - Optimization of CPT Codes for the Majority of Behavioral Health Services

Rate Setting

- DHCS established SMHS, DMC-ODS, and DMC fee schedules **by service type**.
- Rates are **county-specific** and will be **updated annually.**
- DHCS used **multiple inputs** to develop the fee schedules, such as:
  - Provider cost surveys
  - County submitted cost reports
  - Short-Doyle claims data
  - Vacancy and labor adjustments
- For further information, see BHIN 23-017.

Key Rate Information

- Inpatient professional fees must be billed separately using the county outpatient fee schedule
- Inpatient administrative day rate development will remain the same
  - One statewide rate published annually
- Administrative, Utilization Review/Quality Assurance (UR/QA) and Mental Health Medi-Cal Administrative Activities (MAA) will remain as a CPE methodology for FY 2023-24
  - DHCS will work to simplify the reporting process

Key Rate Information (Continued)

- Rate setting methodologies designed to encompass travel and documentation time.
  - No longer claimed and reimbursed separately from the client service.
- Most rates/services are under outpatient service category.
  - Rates are displayed as hourly and by practitioner type.
  - Payments for services will be based on increments of “face-to-face” time that correspond to the CPT or HCPCS code claimed.

What Stays Constant

- Payment Reform does not change:
  - Provider contracts and reimbursement will continue to be negotiated with counties.
    - The new fee schedules are for county BH plan reimbursement (not provider reimbursement).
  - Counties will continue to rely on the same sources of non-federal share.
    - The new payment model does not add non-federal share or change allowable sources.
  - Coding transition does not change benefits definitions or covered services.

Next Steps

» May – June 2023

- CMS engagement and SPA approval.
  - SPA 23-0015 submitted in April.
- DHCS-county testing of updated claiming system.
- Track county readiness and provide TA in coordination with County Behavioral Health Directors Association (CBHDA) and California Mental Health Services Authority (CalMHSA).

» July 2023 and Beyond

- July 1: Payment Reform Go Live!
- Monitor impacts to counties, providers, and Medi-Cal members.
- Use learnings to inform potential rate adjustments and next phases of payment reform.

Guidance and Resources

- CalAIM Behavioral Health website
- CalMHSA's Learning Management System
- BHIN 23-017: Specialty Mental Health Services and Drug Medi-Cal Services Rates, April 2023
- BHIN 23-013: Readiness Check List, March 2023
- BHIN 22-046: Coding & Billing Guidance, August 2022
- IGT Frequently Asked Questions (FAQ), February 2023
- Payment Reform Fact Sheet, December 2022
- **Email: bhpaymentreform@dhcs.ca.gov**

Overview of the Los Angeles County Specialty SUD System's Approach to Payment Reform

Gary Tsai, M.D.
Director
Division of Substance Abuse Prevention and Control (DPH-SAPC)
Los Angeles County Department of Public Health

DPH-SAPC's Key Goals for the Early Years of Payment Reform

- **Rates for the Future**
  - To set rates and establish capacity-building and incentive funds that support the desired system of the future and not just to support the system of today.
- **Facilitating Smooth Transition Away from Reliance on Costs to FFS**
  - Specialty SUD systems have operated via a cost-based mindset for decades, and the shift to FFS will require adapting practices, use of data, and focuses to prioritize service delivery and volume essential evolution to successfully transition to value-based reimbursement (VBR).
- **Establishing Incentive Payments as a Driver of Practice Change**
  - To train its provider network to have their practices be influenced by financial incentives precursor to VBR.

IMPORTANT NOTES:

- *This payment reform rate setting approach is specific to the specialty SUD system in LA County.*
- *DPH-SAPC is entirely contracted out (no county-operated sites).*

County of Los Angeles Public Health
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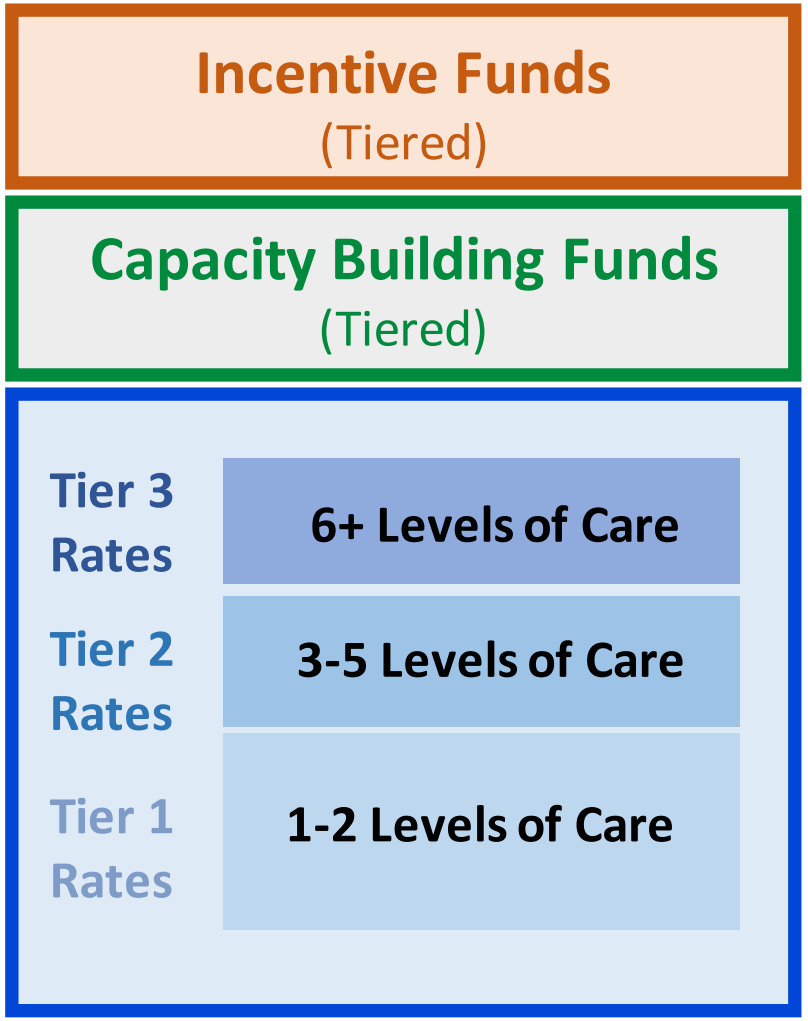
DPH-SAPC's Payment Reform Rate Structure

Tiered:

1. Base Rates
2. Capacity Building Funds
3. Incentive Funds



County of Los Angeles Public Health
Substance Abuse Prevention and Control

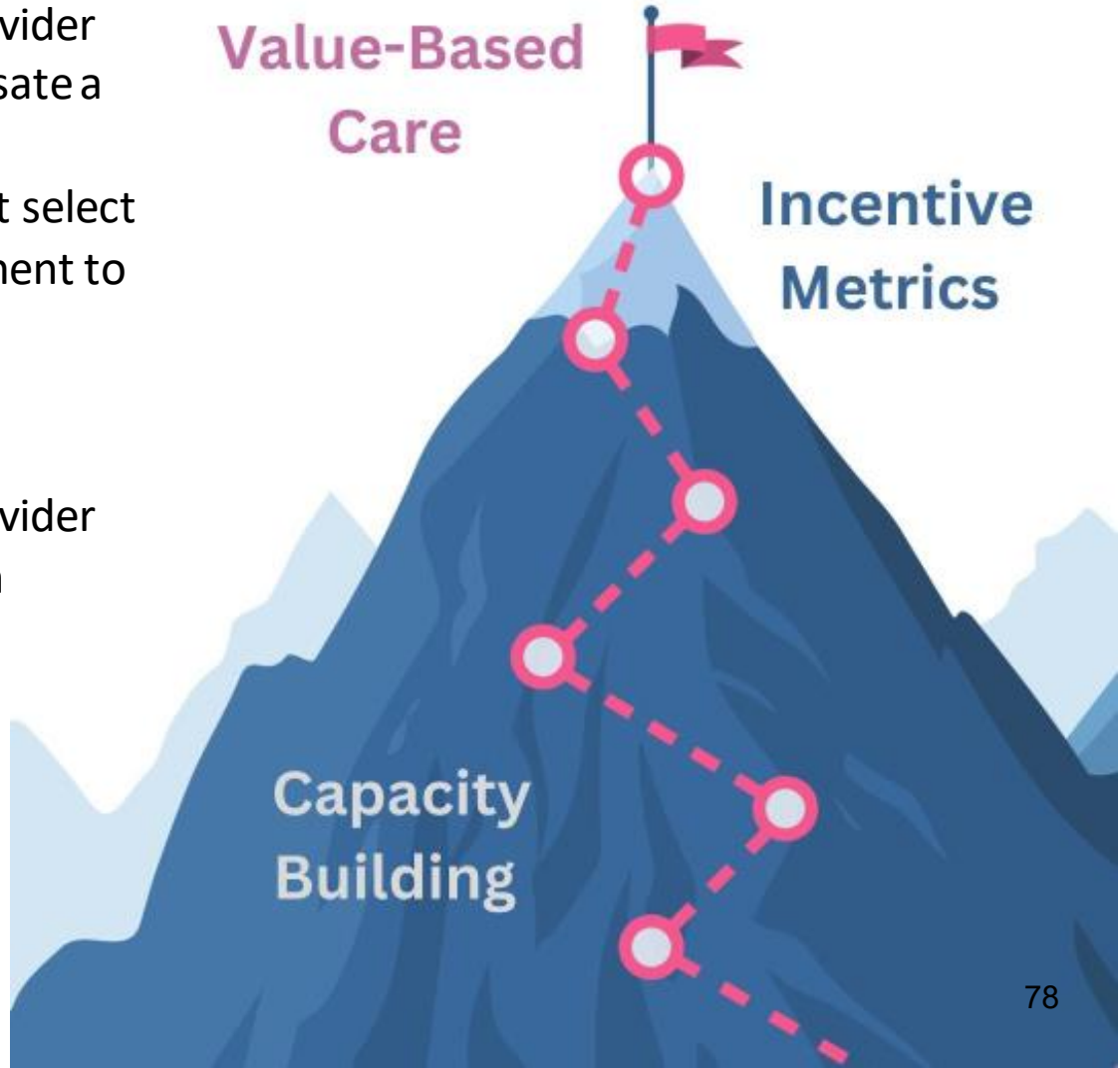
Preparing for Value-Based Reimbursement

What is capacity building?

- Funds that LA County DPH-SAPC will pay an SUD treatment provider either in advance as start-up funds or after the fact to compensate a treatment provider for completing a shared aim.
- Capacity building is designed to help prepare providers to meet select incentive metrics and maximize a supplemental incentive payment to prepare for value-based reimbursement.

What are incentives?

- Funds that LA County DPH-SAPC will pay an SUD treatment provider after achieving a performance metric in order to draw down an incentive payment.
- The funds can be used to reinvest in the program as needed, including to support activities associated with the metric.



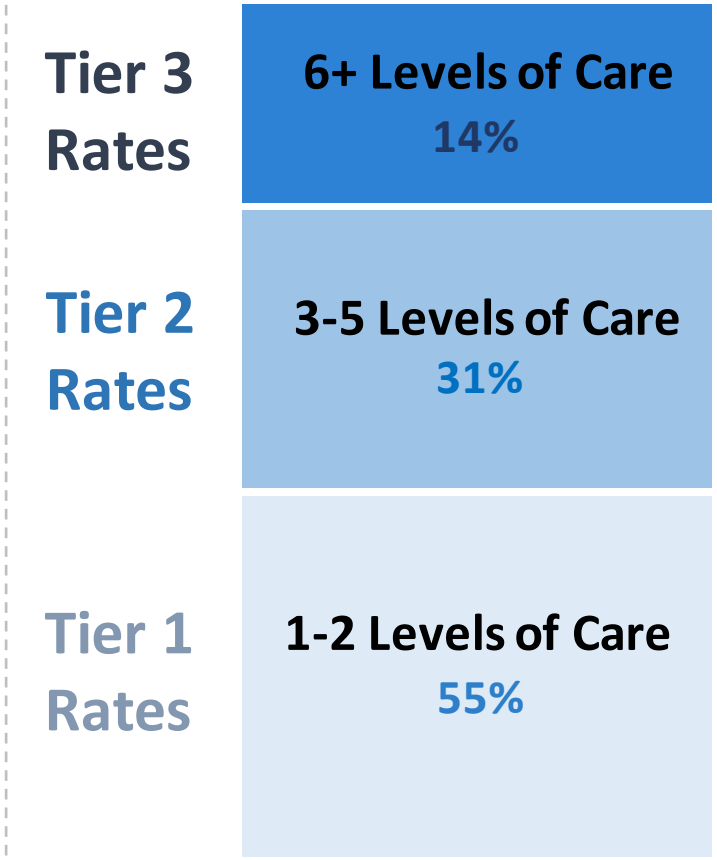
County of Los Angeles Public Health
Substance Abuse Prevention and Control

LA County DPH-SAPC's Payment Reform Approach

Tiered:

1. **Base Rates**
2. Capacity Building Funds
3. Incentive Funds

- **Foundational Overview**
  - **DPH-SAPC developed tiered, actuarially-sound rates based on the number of levels of care at an agency** to facilitate the development of continuums of care within agencies to improve client access and care coordination.
    - Tier 1: 1 - 2 levels of care
    - Tier 2: 3 - 5 levels of care
    - Tier 3: 6+ levels of care
      - LOC based on DPH-SAPC contract and demonstrated service utilization
  - **Accreditation** (e.g., Joint Commission, CARF) count as a level of care with respect to the ability to move up Tiers.
  - **Eligibility for moving up Tiers** will occur annually prior to the beginning of the FY.



County of Los Angeles Public Health
Substance Abuse Prevention and Control

LA County DPH-SAPC's Payment Reform Approach

Tiered:

1. **Base Rates**
2. Capacity Building Funds
3. Incentive Funds

- **Foundational Overview** (continued)
  - DPH-SAPC's rates for all levels of care are higher (market basket inflator + inflator for inflation + inflator for quality) than current rates under Tier 1.*
  - Non-Residential and Non-OTP settings → Tier 2 & 3 rates are ~5% and ~8% higher than Tier 1 rates, respectively.
  - Residential (including Residential Withdrawal Management) settings → Tier 2 & 3 rates are ~9% and ~11% higher than Tier 1 rates, respectively.
  - Opioid Treatment Program (OTP) settings → Generally a 10% increase in dosing rates, with DPH-SAPC covering more than 100% of DHCS' rates for all medications except methadone

    *In instances when the state's rates came in lower than DPH-SAPC's current rates (inpatient and residential withdrawal management rates), DPH-SAPC is using margins from the outpatient rates that came in higher than current rates to cover those gaps so that all of our payment reform rates are above our current rates.

County of Los Angeles Public Health
Substance Abuse Prevention and Control

LA County DPH-SAPC's Payment Reform Approach

Tiered:

1. Base Rates
2. **Capacity Building Funds**
3. Incentive Funds

- **Foundational Overview**
  - DPH-SAPC's capacity building funds are funding that provider agencies can opt-in to that are designed to prepare agencies for value-based reimbursement in the future.
- **Capacity building funding focus categories:**

Workforce Development (recruitment, retention, and training)	**Access to Care – Reaching the 95%** (*items are required to be deemed an "R95 Champion" to be eligible for incentive payment)	**Fiscal Operations** (revenue and expenditure management)
Agency Workforce Survey	Enhancing Outreach & Engagement	Accounting System
Staff Survey	Optimizing Field-Based Services	Revenue/Expenditure Training & Tool
Sustainability Plan	*Optimizing 30-60 Day Engagement Policy	
Tuition/Paid Time	*Low Barrier Admission & Discharge Policies	
Certification	Customer Walk-Through Analysis for Low Barrier Care	
	Bidirectional Referrals Between Harm Reduction & Treatment	

LA County DPH-SAPC's Payment Reform Approach

Tiered:

1. Base Rates
2. Capacity Building Funds
3. **Incentive Funds**

- **Foundational Overview**
  - DPH-SAPC's incentive funds are funding that provider agencies receive after achieving specified quality benchmarks to shape care delivery and prepare agencies for value-based reimbursement in the future.
- **Incentive funding focus categories:**

Incentive Categories	Incentive Metrics
Workforce Development (training & supervision)	At least 40% of SUD counselor workforce is certified
	LPHA-to-SUD counselor ratio of at least 1:15
Access to Care – Reaching the 95%	Meet eligibility to become an "R95 Champion"
Medications for Addiction Treatment (MAT)	At least 50% OUD/AUD patients receive MAT education/MAT services
	At least 50% patients receive naloxone
Care Coordination	At least 75% of patient have ROI for information sharing
	At least 30% of patients referred to another LOC post-discharge
Enhanced Data Reporting	At least 30% of CalOMS admission and discharge records agency-wide within the fiscal year are submitted timely and are 100% complete

Public Comment

Next Meeting, Next Steps, and Adjourn