

Updates on the CalAIM Section 1115 and Section 1915(b) Waivers

1/14/22

Transcript

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| VISUAL | TIME AND SPEAKER | AUDIO |
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| Slide 1 | 00:00:00 – Mario S | <p>Thank you for joining today's program. We'll begin shortly. My name is Mario, and I'll be in the background answering any technical zoom questions. If you experience any difficulties during this session, please type in the Q and A and we'll respond. We encourage you to submit any questions using the same Q and A panel. During today's event live closed captioning will be available in English and in Spanish. You can find the link in the chat field.</p> <p>Today's presentation and recording will be posted in the DHCS webpage in the coming weeks.</p> <p>With that I'd like to introduce our first speaker for today Jacey Cooper. Chief deputy director of healthcare programs and state Medicaid director.</p> |

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| Sides 1-11 | 00:00:51 – Jacey Cooper | <p>Thank you so much, Mario. Thank you so much for everybody who is joining us today. Before I dig in, I just want to stop and say a huge thank you to my team here at DHCS. So many people spent thousands of hours collectively working on this waiver and just really appreciate all of the work that they put in to make this work to where it is and for us to be here excited to announce the federal approval of these waivers.</p> <p>I also want to thank many of you on the phone. You know CalAIM started with a concept paper that many of you, our counties, our plans or providers, associations, and so many stakeholders helped us to shape and form over the last few years. Even during the public health emergency. And just really appreciate many of you leaning in and helping make this what it is today. And so, thank you for all of that</p> <p>Today we will go over some background and vision items. The team will be walking you through our various 2-waiver approval both the 1915B and the 1115. And we'll talk about what's next. Because we still have some things to do when it comes to CalAIM and the waiver specifically.</p> <p>Next slide. So, a little bit more housekeeping just to make sure people are tracking. We have posted the details on our webpages at DHCS. So, you'll have both the 1115 and 1915B STCs approval letters are posted and there's quite a bit of information in the approval letter. I do want to flag that. Also, all the CalAIM state plan amendments are posted. We have a new and updated CalAIM home page. There are a number of fact sheets linked there. Information pieces that people can have at your disposal. And</p> |
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| | | <p>so, really encourage you to pull those down and look at any additional details</p> <p>Next slide. We have been talking and I think for a long time everyone has heard the three large goals of CalAIM. Not reiterating those today. One of the things we keep stressing with this CalAIM initiative it's really transforming the way we're providing care. It's really getting outside the doctor's office or the hospital getting into the community and engaging with individuals. Including some nontraditional providers that maybe historically have not played a large role in the Medicaid space. And so, we are really excited to approach CalAIM with an equitable lens really focused on whole person care, engaging new providers and really working upstream. Many of the things within CalAIM are very preventative. They're upstream in a way we haven't necessarily done before. And that will involve a lot of community engagement and having conversations with new providers, taking a new lens and really making sure we're wrapping both health and health related services around beneficiaries to meet all of their needs. Next slide</p> <p>The program overall -- and I know many of you know this -- Medicaid has a huge footprint in regards how we approach our program. More than 65% of the enrollees in our program are people of color. For some of the areas around CalAIM the percentages are even higher. If you look at the justice population, it's even higher percentages than what you see with the general population. So, really taking this approach and making sure we're taking that lens to the work we do and pushing forward. We also cover 50% of births and children in schools. And so, a lot of really important work for children and youth as we push forward with this. As well as, you know, two</p> |
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| | | <p>thirds of the long-term care facility stays are covered by Medi-Cal.</p> <p>So we have an extensive footprint throughout some of these pieces and you'll see throughout the presentation many of the proposals are really focused on some of those very vulnerable individuals, but also looking across the entire population with a preventive lens, with a wellness lens, and really going upstream in ways we have not historically done.</p> <p>You'll also see we're continuing to look at our justice involved proposal and people will talk about that later today. But at least 80% of justice-involved individuals are eligible for Medi-Cal. And we are really hoping all individuals who are eligible for Medi-Cal prior to being released can be enrolled in Medi-Cal so they can receive the appropriate services they need. A critical piece that we continue to forge forward and continue to have negotiations with CMS on is the larger in-reach package, but this one we can do regardless of that. So we're excited to continue that and move it forward. Next slide</p> <p>So here you know really wanting to focus on a number of pieces as I was mentioning advancing health equity through CalAIM is a critical piece. Meeting people where they are in life. Addressing social drivers of health and breaking down those walls of healthcare. It really focuses on a population health approach that's really prioritizing the pieces I mentioned previously.</p> <p>And the intent is to provide the full continuum of care for all individuals in Medi-Cal through birth to dignified end of life. And here many of you have heard me say with the expansion of DHCA we've expanded to individuals and adults. And some of</p> |
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| | | <p>our beneficiaries, our benefits have not met their needs. For example, people who are experiencing homelessness.</p> <p>We have not been able to have a full continuum of care for them. And CalAIM helps us achieve some of that by adding in housing supports. By adding in recuperative care. In short-term housing. So, if somebody is diagnosed with cancer and doesn't have a home, they have a safe place to receive care and receive services. Or if they're being discharged from a hospital they have a home to go to, making sure that there's a safe place for them to recover, to receive services and to make sure that the full continuum and services be provided in our program meets the needs of all our Medi-Cal eligible individuals.</p> <p>So, really excited to push this forward and to grow from the whole person care pilots and scale them up statewide and see them expand across the state of California. Next slide.</p> <p>All right. So, the team will be walking you all through the various components. As you know CalAIM has many parts to it. It includes aligning our delivery systems, enhanced care management, community supports which is exciting, PATH and contingency management. It's where we got the authority to implement the peers. Some great pieces related to innovation around our duals population, and how we plan on integrating care for our duals and providing more coordinated care there.</p> <p>Also, our global payment program. And you'll see several other kinds of pieces that we historically have had approval for in our waivers. Some with slight changes which is great. And so, we'll walk through those, as well as all the great learnings we</p> |
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| | | <p>have from our dental transformation initiative and taking those statewide and scaling those up. The team will be walking you through all these various initiatives on this slide.</p> <p>Next slide. And as you know CalAIM is a little bit different. Historically when we come for these meetings, we're just doing an 1115 waiver update. For CalAIM we've tapped into all authorities possible to make this happen. There will be a combination of both a Section 1115 waiver, a Section 1915 (b) waiver, State plan amendment and some initiatives will be moved through our managed care contracts and APLs. There will be a little thing in the corner of each slide that breaks it down. Of course, we don't - not everybody needs to know those details. But we do want to make it clear for those who are tracking that level of detail with regard to these authorities</p> <p>So next slide. And I believe I'm going to be turning it over to Susan to take over the slides from here. Susan.</p> |
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| <p>Slides 11-13</p> | <p>00:09:16 – Susan Philip</p> | <p>Hi everyone. My name is Susan Phillip, Deputy Director for healthcare delivery systems. So as many of you know and as Jacey alluded to one of the core goals of CalAIM is to standardize, streamline, and really align across delivery systems. So, we have transitioned all four delivery systems. Medi-Cal managed care, dental managed care, specialty mental health services, and drug organized Medi-Cal organized delivery systems -- all four of those -- consolidated them into one 1915B waiver. So, this allows us to streamline policies relevant to managed care under one waiver.</p> <p>So, first under Medi-Cal managed care we are standardizing benefits and enrollment. We are eliminating variation in Medi-Cal managed care enrollment so that Medi-Cal beneficiaries have access to the same set of benefits regardless of county they reside or eligibility category. And then in terms of benefits, there are a couple that I wanted to point out. Major organ transplant benefits were carved into managed care effective January 1, 2022. Just a couple of weeks ago went live. And then institutional long-term care services will be carved in effective January 1, 2023.</p> <p>So, now a couple of examples how we're streamlining benefits. In terms of behavioral health there are payment reform efforts. The goal of these efforts is to really tie reimbursement more closely with outcome and quality and not just cost. A big part of that initiative is to transition to a new coding system. And this will allow for more standardized claiming and reporting of services, which you know will ultimately help us better monitor performance</p> <p>Next slide. So, one thing I wanted to mention during the waiver negotiations, CMS really emphasized our</p> |
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| | | <p>efforts across the country to improve monitoring and oversight of managed care delivery systems. And, of course, ensuring accountability in our delivery systems is an important DHCS goal. So, you'll see in the STC requirements to implement robust monitoring and oversight. Programs focused on access to and availability of services. Quality of care, and financial accountability both within and across the managed care delivery systems.</p> <p>Couple of examples. Part of that effort there's a focus on member experience. So, to really focus on that we'll continue to engage stakeholders, advocates, and members through our stakeholder advisory committee and other forums. Another piece of that is consumer advisory committees. Managed care plans currently are required to have consumer advisory committees. DHCS will undertake a new effort where we will have members from those consumer advisory committees join a newly formed statewide member advisory committee.</p> <p>So, we'll look forward to implementing that. And the department will also be conducting consumer satisfaction surveys on an annual basis. And this aligns with national committee for quality assurance requirements or NCQA. And the department will conduct them directly through 2026. And then in 2026 plans will be directly conducting the surveys themselves.</p> <p>In terms of network adequacy and access that is a major component. There's a big emphasis on that in the waiver terms and conditions. So, you know, there's a big emphasis specifically not just to look at network adequacy across plans or the prime contractor if you will, but there's also an emphasis now to look at the delegated plan level. So, we are really going to be building up requirements to ensure</p> |
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| | | <p>that access standards are being met at the delegated level.</p> <p>CMS is also requiring that we have monitoring oversight assessment -- a monitoring oversight assessment plan in place. We'll need to submit that plan how we're planning to approach this to CMS by June.</p> <p>And as part of that effort we will be required to have an independent assessment of each delivery system. For managed care plans there's going to be a requirement that we compare plan networks, not just in Medi-Cal but also across other lines of business such as Medicare and commercial plans. So that will be a new undertaking.</p> <p>There is also a set of reporting requirements for various domains such as grievances and appeals et cetera. Those reporting domains will be standardized since we are required to use CMS's templates. So you know a number of these domains and updated elements are ones that plans already are reporting but there will be some updates in terms of templates and DHCS will be providing additional guidance and details about these templates and methods for reporting in the next little while. So, stay tuned guidance is forthcoming there. Believe the next slide is for Lindy.</p> |
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| Slide 13 | 00:14:39 – Lindy Harrington | <p>Thank you so much Susan. So, carrying on in that same vein additional requirements around oversight and accountability. The special provision did include additional requirements around our oversight of medical loss ratios. So, under existing requirements all Medi-Cal managed care plan and dental managed care plans currently report their MLR information to the state today. Our dental managed care plans are currently subject to [indiscernible] if they're MLR falls below the 85%. And managed care plans will be subject to that remittance beginning in calendar year 2024 under existing regulations -- under existing requirements. However, what's been added through these standard terms and conditions is requirements beginning with calendar year 2023, all fully or partially sub delegated plans and subcontractors will be required to report their MLR. And the fully Medi-Cal managed care delegated plan and subcontractors will be required to provide a remittance if they do not meet that minimum MLR.</p> <p>In order to achieve those required changes, we will be developing a plan with stakeholders that will outline the key deliverables and timelines necessary to meet those requirements. And that is due to CMS in July of 2022. And, finally, we will in 2028 be conducting a 5-year retrospective audit of that MLR reporting and remittance requirement</p> <p>And with that I will pass it back to Susan.</p> |
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| <p>Slides 14 - 18</p> | <p>00:16:32 – Susan Philip</p> | <p>Thanks Lindy. I'm going to touch on enhanced care management as well as community supports. Many of you are aware of the enhanced care management benefit or ECM. As a reminder ECM is a new statewide Medi-Cal benefit providing intensive care management to address clinical and non-clinical needs of our most high needs members and we're really attempting to do that through managed care and intensive high touch services.</p> <p>So, it is intended to use ECM providers who are in the community and have experiences in working with the populations of focus. ECM is as you know builds on the successes of whole person care and health home programs under the previous waiver, scaling the care management approach through managed care across the state.</p> <p>So, we began January 1, 2022. As Jacey mentioned before, I also want to thank everyone who is on the call who very instrumental in supporting us in the launch of the effort and the plans and providers and really appreciate the efforts for us to go live in January. So right now, we are focused on ensuring that the implementation is smooth through 2022 and we're phasing ECM in through 2023 for other populations of focus.</p> <p>So, we can go to community supports, which is the next slide. Okay. So, community supports refers to 14 new services proposed by DHCS. Again, designed to address social drivers of health and health equity. These are also we're referring to them as in lieu of services. So, we're excited to say that all 14 community supports are approved. Twelve are approved in the 1915 (b). And two are approved</p> |
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| | | <p>in the 1115. And those two are short-term post hospitalization housing and recuperative care</p> <p>And this is mostly because these two community supports are largely related to housing. So, the next slide we have the list of the 14 approved community supports. I will note that again these are services that plans are encouraged to but not required to offer. We did go live January 1, 2022. And 25 out of 26 managed care plans who have expressed interest have gone live by July 1 of 2022. All managed care plans will be offering community supports. And we will also be including all 58 counties.</p> <p>The community supports that have quite a lot of take up include medically tailored meals, asthma remediation and the housing package. So, we can go to the next slide</p> <p>So, I do want to point out there are specific requirements in the STCs as it relates to community supports. The main point I want to make is that for all of 14 community supports, either at the plan or provider level documentation is required for medical appropriateness as part of the utilization management review.</p> <p>DHCS will be updating our guidance on this and make sure that that is clear in our guidance as well as including other relevant items from the STCs. So do look for that, okay? Turn back over to Lindy.</p> |
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| <p>Slides 18 - 20</p> | <p>00:20:48 – Lindy Harrington</p> | <p>Thank you so much. So, the next program that we want to talk about is Providing Access and Transforming Health or PATH support. So, we received federal authority for \$1.44 billion total receivables for the PATH support. This program is meant to provide a flexible source of new funding to maintain, build, and scale the capacity necessary to really ensure we have successful implementation of CalAIM. We're looking to support a huge transition from a pilot program as enhancement care management and community support services are scaled up and implemented statewide. We're looking to support a diverse array of stakeholders participating in CalAIM, including community-based organizations, counties, private organizations, providers, and stakeholders as they prepare for this implementation. And really looking to advance health equity by investing in providers, communities, community-based organizations, and other entities that support historically underserved and under resourced populations. Go to the next slide.</p> <p>And we're really looking to do this under multiple key initiatives. So the first initiative is really a time-limited initiative to support and sustain existing whole person care pilot services that have converted to community supports and that we have managed care plans within that community that have committed to cover those services. And this cover those services through the transition but no later than January of 2024. And you will see an application process and funding anticipated to begin in quarter 1 of 2022 – so this quarter. And this is really going to be funding only for existing whole person care lead entities, so this is not a bucket that's broadly available.</p> |
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| | | <p>However, as we move into our next bucket these would be more broadly available initiatives. With all applications processes and funding in Quarter 3 of 2022. So, the first is really looking to provide technical assistance to providers, community-based organizations, county agencies, public hospitals, tribes and others. The second is funding to support collaborative training and implementation efforts among managed care plans and all those providers that I just spoke about in order to promote readiness for enhanced care management and community supports.</p> <p>The next initiative is really looking at enabling the transition, expansion and development of capacity infrastructure for providers, community-based organizations, county agencies, public hospitals, tribes, and others to provide enhanced care management and community support. So really looking to build out that network of available providers to provide these services</p> <p>And then finally we will have an initiative to provide funding for [indiscernible] and IT investment among our justice-involved stakeholders to really support the implementation of prerelease Medi-Cal eligibility and enrollment processes.</p> <p>Next slide. Here we've provided a breakdown of funding and how we anticipate those funds will be broken down amongst the initiatives. So, we have \$1.2 billion over the five years for those initiatives that are services during transition and delivery system and innovation. And \$151 million for justice involved planning and implementation.</p> <p>I do want no note that to the extent that any of the funds associated with PATH are not fully expended or allocated each year we do have the authority</p> |
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| | | <p>under PATH to reallocate across those initiatives subject to our overall expenditure limit. And did also want to flag that CMS is continuing to consider additional PATH funds to further support our justice involved initiative. And with that I'm turning it over to Tyler this time.</p> |
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| <p>Slides 18 - 23</p> | <p>00:25:13 – Tyler Sadwith</p> | <p>Good morning everybody. My name is Tyler Sadwith, assistant deputy director of behavioral health. And I'd like to touch on a few CalAIM components related to substance abuse disorder. So, under CalAIM, DHCS is using a combination of federal Medicaid authorities to continue the drug Medi-Cal Organized Delivery System or the DMC-ODS for short. Also, to add coverage for several new substance use disorder treatment services under Medi-Cal. So, specifically, under CalAIM, DHCS aligned DMC-ODS with other managed care delivery systems. So, the federal waiver provides the authorities necessary to deliver DMC-ODS services in a managed care environment where the counties that opt into the DMC-ODS function as managed care plans. These are integrated into the section 1915B waiver program that DHCS is using now to operate other managed care programs.</p> <p>In addition, we received approval from CMS for a state plan amendment to relocate the DMC-ODS services from the 1115 waiver into the Medi-Cal state plan. So that the DMC-ODS services are now covered under the state plan and in conjunction with the 1915B waiver these are available in the 37 counties and hopefully more that opt into the DMC-ODS.</p> <p>We are continuing to use the 1115 to receive the expenditure authority that we need to draw down federal Medicaid funding for services provided to DMC-ODS beneficiaries who receive short-term residential or inpatient SUD treatment in facilities that are institutions for mental diseases or IMDs for short. Otherwise these would not be coverable under Medi-Cal due to the IMD exclusion. I highlight that DHCS issued a behavioral health information notice (No. 21075) in December that describes the</p> |
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| | | <p>programmatic standards and requirements that were previously described in the STCs. So, that information notice describes most of the DMC-ODS program, including the policy updates that were made to the 1-year extension of the 1115 last year.</p> <p>Under CalAIM we're covering two new notable benefits for substance use disorder. First, we're using the 1115 to cover contingency management for DMC-ODS counties that opt into providing that service. We're really excited about this. This approval makes California the first state in the nation to cover contingency management under Medicaid. We've also added peer support specialist services as a new service. This will be a county option where both DMC and DMC-ODS counties will have the opportunity to cover peer support specialist services beginning July 1st, 2022 at the earliest.</p> <p>We could move to the next slide. So, as I mentioned CMS approved our request to cover contingency management as an optional service so that DMC-ODS counties can elect to cover it. We are thrilled to begin piloting this evidence-based intervention which again makes us the first state to cover this service. So just as background, contingency management is the most effective treatment for stimulant use disorder. It has a really robust evidence based that demonstrates it leads to reductions and cessation of stimulant use as well as increased retention and treatment. The intervention consists of providing motivational incentives for meeting treatment goals, which here are nonuse of stimulants as evidence by urine drug screens. The motivational incentives are in essence gift cards of low retail value provided during a set duration of time such as a 24-week period of treatment.</p> |
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| | | <p>These modest motivational incentives are central to contingency management. They're based on the best scientific evidence available for treating stimulant use disorder. And importantly they're not an inducement to use other medical services. The department has been partnering with national experts, counties, providers, training partners to design the implementation of this benefit. We're providing robust technical assistance and supports to counties that seek to participate, as well as ongoing and initial training to county staff to targeted TA for providers readiness reviews and fidelity reviews for every provider.</p> <p>We're also developing clear oversight and monitoring guidelines to ensure the integrity of the benefit. We're developing an auditing tool that counties can use to monitor the service and importantly we're contracting with a single centralized vendor that will track, manage, and distribute the incentives themselves. The goal is to ensure we have strong guardrails in place to protect against fraud waste and abuse. So, under our 1115 this is structured as a pilot program which will allow the state to evaluate and assess the effectiveness of the contingency management benefit before determining whether it should be available statewide pending the necessary budgetary and statutory authorities. So, the pilot will run from July 2022 through March 2024.</p> <p>Next slide. We also received approval from CMS to cover peer support specialist services in drug Medi-Cal in the DMC-ODS program, as well as in the specialty mental health services effective July 1st. So consistent with SB803 these services will be covered on an optional basis by counties where they voluntarily elect to cover it. The service descriptions</p> |
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| | | <p>for the peer support services reflect extensive stakeholder input and engagement. In essence they are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths with the goal of preventing relapse and empowering beneficiaries.</p> <p>There are three service components: educational skill building groups, engagement, and therapeutic activities. These services will be delivered by peer support specialists who are individuals with a state approved Medi-Cal peer support specialist certification. In July, DHCS published a behavioral health information notice that describes the standards for Medi-Cal peer support specialist certification programs. These services will be delivered under the direction of a behavioral health professional and counties and providers can also choose to use peer support specialist supervisors to provide supervision and supports to peer support specialists. And with that I'll turn it over to my colleague Anastasia.</p> |
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| Slide 24 | 00:32:55 – Anastasia Dodson | <p>Hi good afternoon. So, the changes that are included in the 1115 waiver around dual eligibles are in line with the discussions that we have had with stakeholders and with all of you over the course of 2021. And in essence it is that to provide a more integrated experience for dual eligible, if a Medicare plan choice beneficiary chooses a Medicare advantage or D-SNP plan then their Medi-Cal plan choice will align with that Medicare choice. And this is in effect already in 2022 so that in counties where -- so this would be two plan or certain GMC counties where beneficiaries have a choice in their Medi-Cal plans -- then their Medi-Cal plan will align with their Medicare plan. And that's an important way that we are designing the policy overall for DSNP exclusively aligned enrollment, as well is to have the same plan across the same set of benefits for the beneficiary.</p> <p>And then in 2023, again the 1115 includes authority around alignment that we need to establish our exclusively aligned enrollment DSNP model. And the [indiscernible] beneficiaries will automatically transition to that DSNP model in January 1st, 2023. And based on the model of having one plan manage intensive coordination and other components that we've been working on with CMS to improve care coordination such as integrated member materials, working toward integrated appeals and grievances and the exclusively aligned D-SNPs starting in the CCI counties in 2023 and then expanding that model to other counties in future years.</p> <p>And again, that's the same policy we've been talking about with all of you for several months. All right. I'll pass it on to Lindy.</p> |
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| Slide 25 | 00:35:10 – Lindy Harrington | <p>Thanks Anastasia. So we are excited to be able to announce the extension or the authority that we received to renew our global payment program which was a statewide pool funding established in our Medi-Cal 2022 waiver to provide care for the uninsured population that it served by the state public hospital system. This approval also included the ability to include our uncompensated care pool funding at the original level that we had received for the \$472 million annually retroactive back to July of 2020. A great investment in our public hospital system.</p> <p>The global payment program will continue to support services provided for the uninsured through value-based methodology, awarding points for encouraging preventive and primary care with a renewed focus on addressing social needs and responding to the impact of systemic racism and inequities. And over the next 90 days the department will continue to work with CMS to develop new evaluations to reflect the evolving focus to advance health equity through the global payment program health equity monitoring and metric protocol.</p> <p>And with that I will pass it over to Aaron.</p> |
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| <p>Slides 26 - 28</p> | <p>00:36:38 – Aaron Toyama</p> | <p>Hello everybody. My name is Aaron and I am the Senior Advisor with the Department of Health Care Services. And I'll touch on a few final details on the waivers as it stands today before we get into what's ahead of us. So as mentioned earlier our 1115 waiver does include some provisions that carryover from our previous Medi-Cal 2020 waiver. These include coverage for out of state former foster care youth up to the age 26. It also includes our community-based adult services program with technical changes that allow for some greater flexibility for remote services under certain circumstances.</p> <p>And it also includes chiropractic services for Indian health service and tribal facilities. So, again, carryovers from the previous waiver now in the CalAIM 1115 waiver. Next slide please.</p> <p>In addition, as is typical with 1115 demonstrations, there are also some robust evaluation requirements that the department is held to. The evaluation will need to include research questions and hypotheses that will test the impact of CalAIM on enrollee access to care, quality of care, health outcomes in addition to reductions in health disparities and advancement of health equity.</p> <p>These will include programmatic areas such as [indiscernible] delivery systems. Also, the effectiveness of contingency management. Also, our enhanced care management supports and as it relates to PATH funding. And then also health outcomes, reductions and appropriate utilization and reductions in inpatient long-term care. So again, with this 1115 there will be an evaluation with all these elements. Next slide please.</p> |
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| | | <p>And, also, as mentioned earlier in the presentation there are a few policies from our Medi-Cal 2020 1115 demonstration that are continuing but doing so under the state plan authority. So, these include the preventive dental benefits and dental pay for performance which were formerly under the dental transformation initiative with the previous waiver. And it also includes coverage for low income pregnant individuals with incomes up to 138% of federal poverty level. So previous waiver initiatives that are moving into state plan authority in the new year.</p> <p>And I believe that's it. So now I will turn it over to Tyler.</p> |
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| Slides 29 - 33 | 00:39:34 – Tyler Sadwith | <p>Thank you, Aaron. I think we'd like to at this point just touch on several components of CalAIM that we continue to engage CMS on and that we look to engaging CMS on later this year. We can go on to the next slide. Thank you.</p> <p>So, the CalAIM justice initiative is an innovative program of CalAIM. In essence it is designed to better meet the needs of Medi-Cal eligible individuals who are preparing to return to the community from state prisons, county jails and youth correctional facilities. Unfortunately, CMS did not approve this request in their comprehensive approval. But CMS did signal in their approval letter that they are interested in supporting DHCS on this proposal and we continue to have productive discussions with CMS on this piece. And so, just taking a step back -- as many of you may know there is a federal prohibition on using Medicaid funding to deliver care to inmates of a public institution such as prison and jails. As part of the CalAIM application, DHCS requested federal expenditure authority to cover a targeted set of Medi-Cal services to Medi-Cal eligible justice-involved populations during a 90-day period prior to release.</p> <p>The goal is really to provide initial stabilization for conditions that may have decompensated during incarceration. Whether it be a medical condition like diabetes or behavioral health condition like mental illness and to provide really targeted and intensive care management with a core goal of supporting successful reentry into the community through facilitated referrals and warm handoffs to community-based providers so that, especially in the first several weeks upon release, those individuals are receiving the healthcare services that they need. The individuals that are proposed to be included in</p> |
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| | | <p>this initiative include all Medi-Cal eligible youth, as well as those Medi-Cal eligible adults who have a chronic condition that would benefit from in-reach services. I think you can see some of those healthcare needs listed here on this slide.</p> <p>And again, the targeted set of services that are listed on this slide that we're proposing to cover really are designed to meet that initial stabilization and care transition needs for this population. To support this work, we are requesting PATH funding from CMS to help with initial capacity building including in prisons, in county jails, in youth correctional facilities. We recognize there's a tremendous level of effort required to implement the functions and processes to carry out the 90-day pre-release services -- for example hiring staff, IT infrastructure and system changes, workforce training and developing policies and procedures.</p> <p>I do want to be clear that the statutory requirement for county jails and youth correctional facilities to assist individuals eligible for Medi-Cal with submitting an application for and enrolling in Medi-Cal by January 1st, 2023 remains in effect. And that is not impacted by CMS's review of this particular proposal. But we continue to work with CMS seeking approval in early 2022 for this CalAIM initiative that covers targeted services during a 90-day period with an implementation timeline of 2023.</p> <p>We can move to the next slide. DHCS continues to engage CMS on our long-standing proposal to cover services delivered by traditional healers and natural helpers under the DMC-ODS program. We are really committed to securing approval from CMS on this request as we recognize that in order to meet the treatment and recovery needs of American Indian and Alaska native individuals with substance</p> |
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| | | <p>misuse or substance use disorder needs it's really critical that these services be culturally centered and be reflective of traditional practices, cultures, languages, and values that are specific to the tribal community.</p> <p>So just as background DHCS initially requested to cover these services in 2017. We submitted an additional request in 2020. We submitted our third request in 2021. And CMS has neither approved nor denied any of these requests. So, the request is still pending with CMS and we look forward to engaging with our federal partners so we can receive Medicaid funding for these critical and healing approaches.</p> <p>Thank you, and I think the final update to the CalAIM 1115 waiver is we expect to submit an amendment to the waiver late summer or fall of 2022 related to the federal opportunity for serious mental illness and serious emotional disturbance waiver or the SMI/ SED waiver opportunity.</p> <p>So, in essence, this program would be the mental health equivalent of the DMC-ODS. So just as the DMC-ODS program allows counties to participate in an optional basis to receive federal Medicaid funding for residential and inpatient SED treatment provided in IMDs, this opportunity would allow counties to participate in a program to receive federal Medicaid funding for residential and inpatient psychiatric services and mental health services provided in an IMD.</p> <p>So, like the DMC-ODS program there are several programmatic and delivery system and quality of care requirements that CMS will require DHCS and the counties to meet. These are described in the state Medicaid director letter that is linked on this slide. And they're focused sort of at their core on</p> |
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| | | <p>ensuring any services provided in IMDs are part of a broader continuum of care. That they're interwoven with access to crisis services and they're part of overarching efforts to increase access in engagement to community-based mental health care. There are initial requirements such as accreditation and the use of an evidence-based patient assessment tool to determine level of care and length of stay. So, I think it's really helpful to understand this is not simply an IMD waiver but rather an opportunity to introduce a few benefit and service delivery reforms that are necessary to meet CMS's requirements for approval.</p> <p>This is also an opportunity to really expand on the existing efforts to build out California's continuum of care such as through the B chip program and as identified in the report that DHCS published earlier this week entitled assessing the continuum of care for behavioral services in California. We look forward to engaging stakeholders on the design and the planning efforts for this waiver application.</p> <p>And with that, I think we are ready for some questions and answers.</p> |
| N/A – Q & A | 00:47:32 – Allison Orris | <p>Questions have been coming in through the chat. And unless you want to do any housekeeping before I just start asking questions. I realized I just jumped in.</p> |
| N/A – Q & A | 00:47:46 – Emma P | <p>No, thank you.</p> |
| N/A – Q & A | 00:47:47 – Allison Orris | <p>So, please do keep sending questions and we'll use the time we've got. But wanted to start with a couple of questions for Lindy. We got one question about whether PATH supports are going to go through managed care plans or from the state directly.</p> |

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| N/A – Q & A | 00:48:06 – Lindy Harrington | The intention is for the PATH supports will go through the state directly. We are currently looking to contract with a third-party administrator to assist us in the administration of these PATH funds. |
| N/A – Q & A | 00:48:26 – Allison Orris | Thank you. So, then we've gotten a couple of questions about community supports. And to start with a big picture question, I'm going to bump it to Jacey to address the question about the implementation with respect to a couple of the community supports being approved under the 1115 waiver and how that will impact the treatment of community supports from a contract and reporting perspective. |
| N/A – Q & A | 00:48:54 – Jacey Cooper | Thank you, Allison. So, as you see on slide 16. I just want to also emphasize: All 14 community supports were approved by CMS. It's just that 12 were approved in the 1915B and two were approved in the 1115. So, I know there's been a question or two on that. But, also, then like Allison was framing up the question -- they will be treated the same. Even though we needed different federal authority to get the different types of community supports approved, they will all be treated the same. They will be built into the managed care plans' capitation rate. Managed care plans will continue to provide them if they're medically appropriate and cost effective. They will all be included in the managed care plan contract. And all the rules, requirements, and expectations will be the same across all 14 community supports regardless whether it's in the 1115 or the 1915B. Hopefully that answers the questions, Allison. |

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| N/A – Q & A | 00:49:58 – Allison Orris | Thanks Jacey. Lindy, one question that came in is regarding the capitation rates for community support payments. And the question is, "Are plans required to offer all benefits or are you going to tailor capitation payments according to which community supports are offered?" |
| N/A – Q & A | 00:50:19 – Lindy Harrington | Plans are not required to offer all 14 community support services. And the latest plan selections are available on the DHCS website. We can provide the link to that. Once the admin data begins to flow into rate development in the coming year, we will only consider cost of the services that the plans elected to provide. So really the impact on payments will be based on the election of a given community support. |
| N/A – Q & A | 00:50:51 – Allison Orris | Thank you. And then staying on community supports for a moment, Susan, a question for you about whether there's a list of providers who are ECM or community supports providers. And the questioner was wondering if providers would contract fully with the managed care plans or if DHCS is also maintaining a list of those providers as well. |
| N/A – Q & A | 00:51:16 – Susan Philip | Managed care plans are required to build a network of ECM providers and providers for the community supports they do provide, and they are required to ensure that the providers they are contracting with are included in the provider directories. So, I want to make that clear. And because there's, you know, a little bit of ramp-up time needed to build the network and fully understand who's in the network, we are making that requirement effective as of July 1st, 2022. So those provider directories would be available through the managed care plan. |

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| N/A – Q & A | 00:51:56 – Allison Orris | Great. Thank you. And then to go back to Lindy for a moment. A question about the medical loss ratio requirements. And for delegated entities in particular. And whether those downstream organizations must calculate MLR for just their Medi-Cal services or whether the global MLR will apply. |
| N/A – Q & A | 00:52:19 – Lindy Harrington | The requirement is we will need to be having those delegated entities reporting on their Medi-Cal related medical loss ratios. That will need to be reported. |
| N/A – Q & A | 00:52:35 – Allison Orris | Great. Next, I want to go to Tyler. We've gotten questions about whether specialty mental health under managed care is still only for lower level or not seriously emotionally disturbed enrollees. Can you talk a little bit about that? |

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| N/A – Q & A | 00:52:52 – Tyler Sadwith | <p>Happy to. Thanks, Allison. I think this is a great question that we didn't highlight today because it wasn't part of the CalAIM approval from CMS. DHCS has been issuing and developing guidance to provide more information about the CalAIM policies related to specialty mental health services that are delivered by the counties, non-specialty mental health services that are delivered by managed care plans, and the interaction between the two which are sort of described as our [indiscernible] policies.</p> <p>So, in December, DHCS issued guidance that really updates the medical necessity and access criteria to specialty mental health services that are delivered through the county mental health plans. And we're currently developing guidance and we look forward to receiving feedback from stakeholders on what we call the no wrong door policies.</p> <p>So, under no wrong door, the goal is for beneficiaries to receive needed mental health services regardless of where they initially seek care. So, the goal is to really improve the performance of the overall behavioral health system and Medi-Cal where fee-for-service providers or managed care plan providers deliver a set of non-specialty mental health services and the counties deliver specialty mental health services. And so, the draft guidance that we seek to issue soon will clarify the criteria for individuals to receive non-specialty mental health services. It will clarify what those specialty mental health services are, which are currently described in our welfare and institutions code. And it will clarify a few important policies such as allowing mental health services in both delivery systems to be covered during the assessment period even when there's no diagnosis that has been made yet. Really to ensure</p> |
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| | | beneficiaries don't face barriers to accessing the mental health care that they need. |
| N/A – Q & A | 00:54:58 – Allison Orris | Great. Thank you, Tyler. So, with our couple of minutes left, we have several questions for Lindy. Curious if you can talk a little bit more about the timelines for PATH funding recognizing that this is also in progress as we implement. |
| N/A – Q & A | 00:55:22 – Lindy Harrington | Sure. I think for the broader buckets I think you will see for the first bucket of funding - transition of whole person care - we'll see additional guidance coming out in this quarter. For the other PATH initiatives, we will be providing additional information around the rules and expectations around that funding in the next few quarters with the expectation of applications being released in quarter 3 of 2022. |
| N/A – Q & A | 00:55:58 – Allison Orris | Great. And, similarly, Lindy -- oops, sorry there's a question Susan's ready to answer. Go ahead. |
| N/A – Q & A | 00:56:37 – Susan Philip | There's a question regarding community support. I touched on the STC requirements related to medical appropriateness documentation. We do currently have quite a bit of guidance in our policy guide related to documentation that is required, but we will be further developing guidance to track to the STCs. And so that will be forthcoming. |
| N/A – Q & A | 00:56:37 – Jacey Cooper | As you can see in STCs it really allows for documenting the way things happen in healthcare today. For example, the provider reviews and determines that yes, it is medically appropriate. They put the request into the managed care plan. It's documented. And then really from the managed care plan point of view, through the UM or utilization management process, of deeming it medically appropriate as well. The team will be working to get that guidance out but just want to make sure people are tracking in that kind of context. |

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| N/A – Q & A | 00:57:17 – Allison Orris | Wonderful. So, I think that we are almost at time. I know Lindy maybe I'll just give you a quick minute on next steps for GPP. A question came in about planning there too. |
| N/A – Q & A | 00:57:32 – Lindy Harrington | Sure. So, we will be coordinating with CMS and working with CMS to fully flesh out the adjustments and the updates to the global payment program. And really, working on that focus on equity. And really this is around adding additional services that qualify for reimbursement under the global payment program, and services that we think will have an equity impact. For example, bringing in some of these services that you received approval for through the waiver and making those available under the global payment program for our continuing uninsured population. |
| N/A – Q & A | 00:58:19 – Allison Orris | Thank you. So, I know we're almost out of time. I will just note because we also got a question about this that the slides will be posted on the CalAIM website. But we'll turn it to Jacey for the last word. |
| N/A – Q & A | 00:58:30 – Jacey Cooper | Thank you, Allison. I'm going to punt to Michelle Baass, our director, to close us out. |
| N/A – Q & A | 00:58:36 – Michelle Baass | I just want to close on the same note that we opened which is really a place of gratitude for your partnership over the last few years as we've developed CalAIM. I want to echo my extreme gratitude for all our DHCS team and your hard work and dedication to really develop policies that are going to help so many Californians. And then finally to our state Medicaid Director, Jacey Cooper, thank you to her amazing leadership and dedication with CalAIM. So just wanted to say thank you to everybody and look forward to future conversations. Thank you. |