DEPARTMENT OF HEALTH CARE SERVICES

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

Hybrid Meeting
February 15, 2024
9:30 a.m. to 12:30 p.m.

SAC AND BH-SAC JOINT MEETING SUMMARY

SAC Members Attending*:* Bill Barcellona, America's Physician Groups; Doreen Bradshaw, Health Alliance of Northern California; Michelle Cabrera, County Behavioral Health Directors Association; Robert Ducay, California Hospital Association; Amanda Flaum, Kaiser Permanente; LeOndra Clark Harvey, California Council of Community Behavioral Health Agencies; Virginia Hedrick, California Consortium of Urban Indian Health; Anna Leach-Proffer, Disability Rights California; Mark LeBeau, California Rural Indian Health Board; Carlos Lerner, Children's Specialty Care Coalition; Kim Lewis, National Health Law Program; Beth Malinowski, SEIU; Jarrod McNaughton, Inland Empire Health Plan; Linda Nguy, Western Center on Law and Poverty; Jolie Onodera, California State Association of Counties; Marina Owen, Cen Cal Health; Chris Perrone, California HealthCare Foundation; Brianna Pittman- Spencer, California Dental Association; Katie Rodriguez, California Association of Public Hospitals and Health Systems; Janice Rocco, California Medical Association; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Laura Sheckler, California Primary Care Association; Kristen Golden Testa, The Children's Partnership/100% Campaign; Bill Walker, MD, Contra Costa Health Services; Ryan Witz, District Hospital Leadership Forum; Anthony Wright, Health Access California.

SAC Members Not Attending: Eileen Cubanski, County Welfare Directors Association of California; Michelle Gibbons, County Health Executives Association of California; Jolie Onodera, California State Association of Counties.

BH-SAC Members Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Kirsten Barlow, California Hospital Association; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; Vitka Eisen, HealthRIGHT 360; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Robert Harris, Service Employees Service Union; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; Virginia Hedrick, California Consortium of Urban Indian Health; Samuel Jain, Disability Rights California; Veronica Kelley, Orange County; Linnea Koopmans, Local Health Plans of California; Karen Larsen, Steinberg Institute; Kim Lewis, National Health Law Program; Hector Ramirez, Consumer Los Angeles County; Jason Robison, SHARE!, Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Meshanette Johnson-Sims, Carelon Behavioral Health; Chris Stoner- Mertz, California Alliance of Child and Family Services; Catherine Teare, California Health Care Foundation; Gary Tsai, MD, Los Angeles County; Angela Vasquez, The Children's Partnership; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Jevon Wilkes, California Coalition for Youth.

BH-SAC Members Not Attending: Jei Africa, San Mateo County Behavioral Health and Recovery Services; Ken Berrick, Seneca Family of Agencies; Dannie Cesena, California LGBT Health And Human Services Network; Jessica Cruz, NAMI; ; Eileen Cubanski, County Welfare Directors Association of California; Steve Fields, Progress Foundation; Sarah- Michael Gaston, Youth Forward; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Jolie Onodera, California State Association of Counties; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy.

DHCS Staff Attending: Michelle Baass, Sarah Brooks, Palav Babaria, Lindy Harrington, Bambi Cisneros, Tyler Sadwith, Ivan Bhardwaj, René Mollow, Yingjia Huang.

Public Attending: There were 186 members of the public attending in-person and virtually.

Welcome, Director's Opening Comments, Introduction of New Members, Roll Call, and Today's Agenda
Michelle Baass, DHCS
Slides available: https://www.dhcs.ca.gov/Pages/021524SACMeetingMaterials.aspx

Baass welcomed SAC and BH SAC members to the first meeting of 2024. She welcomed Sarah Brooks back to DHCS as the Chief Deputy Director for Health Care Programs. Baass also welcomed two new SAC members, Jason Robison of SHARE! and Ryan Witz of the District Hospital Leadership Forum.

Director's Update
Michelle Baass and Sarah Brooks, DHCS
Slides available: https://www.dhcs.ca.gov/Pages/021524SACMeetingMaterials.aspx

Baass reported on key health elements in Governor Newsom's 2024-2025 proposed budget. She noted that full scope Medi-Cal coverage to all low-income Californians ages 26–49 and the asset test elimination went live on January 1, 2024, maintaining the administration's commitment to health and the Medi-Cal program. Baass offered information on the revised budget proposal for the Managed Care Organization (MCO) Tax. DHCS will request an amendment to the existing MCO Tax approved by the Centers for Medicare & Medicaid Services (CMS) that will result in $1.5 billion additional revenue over the three-year period. She reported that phase one provider rate increases were effective in January 2024 to bring primary care, maternity care, and non-specialty behavioral health reimbursement rates to 87.5% of Medicare. She also said DHCS recently released the proposed date for phase two targeted rate increases to be January 2025. Baass commented on several proposals for new and expanded benefits, such as the new Wellness Coach benefit in the Children and Youth Behavioral Health Initiative. She also discussed possible plans to alleviate the state's fiscal situation, such as delaying the Behavioral Health Infrastructure Continuum Program (BHICP).

Questions and Comments

Nguy: The Medi-Cal expansion is great news. One missing element is the share of cost reform and multi-year continuous eligibility. We urge timely implementation of both programs. I get calls frequently from seniors and persons with disabilities asking specifically about the share of cost reform.

Baass: We appreciate the comments. There is a law that requires an assessment of the state's fiscal situation before we can move forward. We are ready if the state's fiscal situation improves.

Malinowski: We appreciate the difficult budget environment and that initiatives are moving forward that are critical to access. We are concerned about the workforce delays because they have an impact on both behavioral health and primary care access. We look forward to having a dialogue about where we

can build workforce standards into the upcoming policy paper on Medi-Cal spending, alongside the quality standards and clinic funding. I want to acknowledge the Child Health and Disability Prevention (CHDP) transition and ask for a conversation to better understand the numbers.

Brooks: Thank you for mentioning the CHDP transition. We are focused on that and committed to having additional conversations. We will reach out soon for that.

Clark-Harvey: Thanks to the administration for the continued commitment to behavioral health. I want to make sure there is an opportunity for a deeper dive discussion to learn more about the plan for implementation of targeted provider rate increases.

Baass: Online is a 20-page document outlining the provider rate increases that are part of the MCO Tax passed in last year's budget. The document specifies the different provider categories for rate increases and outlines the details. I am happy to take questions and can follow up with you offline.

Koopmans: Thank you for maintaining many of the previous commitments. On the MCO Tax, we support keeping those dollars in Medi-Cal and increasing provider rates. In reviewing the policy paper, we look forward to thinking through how we can effectively get dollars out in a way that is simple and streamlined to meet short- and long-term goals.

McNaughton: In reference to the complexity of the provider rate increases, our preliminary conversations with providers and Independent Physician Associations (IPA) indicate they are struggling with the process. Thank you for the willingness to discuss alternative options that may ease these issues.

Perrone: My question is about the announcements regarding fines to Medi-Cal managed care plans (MCPs) for quality. Having the information framed in terms of a commitment to quality and tracking managed care performance over time demonstrates DHCS' commitment to this issue. Posting the performance for behavioral health plans for the first time is also tremendous progress. The amounts of the fines seem relatively small from the perspective of some plans that receive $10 billion a year in payments. Do you think the financial incentives are enough to drive the improvements you hope to see? What is the role of financial incentives?

Baass: It's about working with MCPs to improve quality. Monetary sanctions are just one lever. It's also a lot of technical assistance, of working together to understand local needs and what will be helpful to drive quality.

Babaria: DHCS has a multi-pronged strategy. We have two learning collaboratives in partnership with MCPs and the Institute for Healthcare Improvement that are focused on children's preventive care and integrated behavioral health as core parts of the quality strategy. We have regional technical assistance that all MCPs participate in to discuss quality and equity. Quality withholds, sanctions, auto assignment, or other levers are part of the overall strategy. DHCS has other directed payment programs and has aligned those measures so providers and MCPs have more focus and synergy than in the past.

Baass continued with an update on the MCP transition, noting that 1.2 million members transitioned to a new MCP in January 2024 across 21 counties and 14 plans. Also, Kaiser became the prime MCP for 800,000 members. She reviewed the operational readiness efforts that DHCS conducted with MCPs in 2023. She also spoke about post-transition data being used to monitor the transition, such as member calls, grievances and appeals, and continuity of care (COC). She noted that DHCS is tracking the information closely and expects that the policy guidance and special requirements put in place for this transition will decrease the number of members experiencing challenges due to the transition. Baass reviewed statewide metrics on the call centers, grievances, COC, Enhanced Care Management benefit, and Community Supports services.

Brooks reported on the operational readiness assessment activities for Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) and subacute transitions, noting that there were about 4,700

members that transitioned from fee-for-service to managed care across 852 providers in the state. DHCS established a strike team to address ongoing/post-transition issues raised by stakeholders, providers, and MCPs. She reported data on the timeline for addressing issues, with 54% being resolved in less than three days and 100% being resolved in less than 10 days. Early implementation concerns included eligibility enrollment confusion for providers, reluctance among providers to sign provider agreements, the need for MCP training of providers, and operational items for specific MCPs. She described the monitoring approach and schedule and DHCS' plans for oversight and technical assistance. Brooks briefly reviewed the adult expansion for Californians ages 26-49, regardless of immigration status, implemented in January 2024 for about 700,000 members newly eligible for full scope Medi-Cal. She outlined outreach efforts and resources supporting the expansion and redeterminations.

Questions and Comments

Lewis: Is the grievance and appeal data that was presented specific to the transition or is it overarching? I noticed a high number of ombudsman calls on the COC issues, but that wasn't flagged on the grievance and appeals data. Do you track COC data separately? How should I interpret those two data sets related to the transition? I also want to comment on the transition and the importance of COC. We appreciate that you asked for ongoing feedback on how it's going, and we have been trying to capture the experience through health consumer center partners. We have seen problems with clients losing access to their providers and not being aware of COC or their right to exercise it. Also, some people don't get confirmation about whether the COC is approved, even when they request it. That is an issue that really must be addressed. There are also concerns around medical exemptions in which people are involved with specialty centers like Stanford and have had a Medi-Cal exemption for several years and they suddenly were denied starting in January because their county was part of the MCP transition. It seems that Medical Exemption Request (MER) documentation may have been overlooked in terms of how that was affected by this transition.

Brooks: The grievance and appeals data is specific to the transition and the ombudsman data overall. We do have data showing that 2.3% of member contacts to the ombudsman were specific to the transition, but the data is overall to the call center. I want to flag that COC for special populations is automatic and not something the member must request. We are tracking that and will continue to monitor MCPs. The grievance and appeals data is not granular to COC specifically. If we identify a concern with a MCP and we were to dive deeper into that concern, then we might get down to COC as the specific issue, but the rolled-up categories don't show COC specifically. I am happy to talk more with you about the MER if that would be helpful.

Wright: Is there an update on enrollment figures for the expansion regarding the total who actually have new coverage? I appreciate the close monitoring of COC and the focus on looking at surveys. People experiencing a problem may not know where to call to complain. I would love to have even anecdotal information about what you are seeing and whether there are issues surfacing that would be useful for the group to know about. We have been through previous transitions, so I am curious how the percentage of COC requests compared to those other experiences?

Baass: We are working on data on all expansion categories, although there is nothing to share today. On how COC requests compared to prior transitions, we do not have that readily available. We expect those numbers to increase given the way past transitions have worked. January is early in the transition.

Witz: Many of the district hospitals have experienced some challenges with the Intermediate Care Facility for the Developmentally Disabled (ICF/DD) transition. DHCS has been responsive when an issue is flagged. On payment, a lot of the rates haven't been finalized yet for 2023 and 2024, and we

anticipate further communication with MCPs when rates are finalized, and they go back re-adjudicate claims. I'm making the point that it's not only service issues, but also payment.

Brooks: I want to follow up on MERs from the previous question to say that I have been told all existing MERs were honored or are in place until the approved expiration date. I would like to follow up to see if there are any areas of concern that we must further review.

Robison: On the strike team information listed, the category with the largest number was "other" with 20. Are there commonalities emerging or are those other issues completely random?

Cisneros: Typically, the inquiries attributed to that category are related to the MCP long-term services liaison that is required for each MCP to help providers through this transition. It's not like the topics that were captured through the other categories.

Nguy: From the data, can you talk about your ideas for why one of the top three grievances and appeals was pharmacy, considering Medi-Cal Rx? I was surprised by the low number of provider agreements for out-of-network special population providers. Were these providers in-network for the previous MCP or were they out of network for the previous as well as the new MCP? Also, I want to offer my appreciation that this transition has been the smoothest yet.

Brooks: There could be instances where they worked under a Letter of Agreement with the prior MCP, but most would have been in-network with the prior MCP. COC provisions would kick in with the new MCP and then there could be an out-of-network situation. We are early in the transition, and it may be the COC agreements are still going through the request period.

Mollow: On the pharmacy question, there are medications that remain the responsibility of the MCP, such as those administered by physicians. I presume these were medications that are the responsibility of the MCP versus the outpatient pharmacy. We would have to review further to know.

LeBeau: I appreciate the research topics the strike team is looking at and want to suggest another topic for consideration. Beginning in 2024, all MCPs must hire a tribal liaison to address issues with tribal health programs and clinics. As we look at partnership issues, perhaps this topic can be included in monitoring to know how many MCPs have hired the liaison.

Brooks: We issued an All Plan Letter (APL) in early February and have all MCPs post their tribal liaison to the portal to verify they have a liaison. That is the way we are monitoring initially. I will talk to the team about how we can ensure the information is updated regularly.

Stoner-Mertz: I'm interested in the level of detail we will be able to see. For example, when a member is moving from one plan to another, is there the opportunity for the MCP to take issue with the COC because of rates? It seemed there was a difference in the rate that was paid by one plan versus another, and that could result in an issue with COC.

Sangwan-Savage: Have you looked at the data on grievances and appeals and ombudsman calls for transition related issues by primary language and limited English proficiency (LEP)? This population is significant and may fall through the cracks with a transition. Can you confirm if LEP are considered a special population?

Brooks: We have not reviewed the data in that way. I will look at whether the data on transitions allows for this analysis.

Baass: I can confirm that LEP is not a special population in the final policy.

Owen: I applaud creating the strike team for the ICF/DD transition. Is there is an opportunity for learning collaboratives among the liaisons? The County Organized Health System (COHS) plans have worked with this special provider population since the inception of managed care and if there is an opportunity to support peer exchange, we always appreciate that.

Baass: I think that is a great suggestion. I will take that back. It could be useful for awareness, as we

have a foster care liaison requirement, tribal liaison requirement, and long-term care liaison requirement for MCPs, and learning could be useful.

Baass continued with the Director's Update, providing information on the DHCS response to the California State Auditor report on barriers to timely access to behavioral health services for children. Baass spoke to the administration's commitment to this issue through multiple efforts, including the Master Plan for Kids' Mental Health, Children and Youth Behavioral Health Initiative (CYBHI), and the DHCS Comprehensive Quality Strategy framework. She offered highlights of DHCS efforts, including updated materials on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and requirements for MCPs to train providers, a dedicated web page, the birthing care pathway, California Advancing and Innovating Medi-Cal (CalAIM), and the many changes in behavioral health to improve access, invest in primary care, and encourage MCPs to include parents and youth in Community Advisory Committees (CAC). The DHCS response included timelines and outlined strategies for monitoring compliance.

Questions and Comments

Savage-Sangwan: Can you provide a link to the state work plan for access improvement submitted to CMS?

Baass: Yes. https://www.dhcs.ca.gov/provgovpart/Documents/State-Work-Plan-for-Access-Improvement-for-CMS.pdf

Cabrera: In the past, there were differences in the monitoring for specialty mental health (SMH) and non-specialty mental health (NSMH) network standards. One of the audit recommendations was for DHCS to implement a policy outlining when a plan's non-compliance justifies penalties. Will DHCS publish MCP standards publicly? The screening and transition tool has helped with directing members appropriately to MCPs for NSMH services. What standards exist for MCPs regarding informing communities about the existence of those NSMH benefits that mirror the community engagement requirements of behavioral health plans?

Baass: I will have to follow up on whether the new standards for compliance will be public for MCPs.

Brooks: MCPs have requirements related to community engagement, such as the CAC, as well as various documents with educational information, such as the member handbook. Would MCPs here want to comment?

Owen: There is ongoing partnership on this. We convene regular opportunities for education and input from behavioral health providers to improve MCP process. We have taken care to include representatives on the CAC to make sure educational programs are effective. We have outbound navigation from our call centers and have a behavioral health call center team specific to pediatric services, so there is a dedicated group of individuals that know the needs of this population. We have frequent meetings with our county partners because patients do transition back and forth between the two delivery systems.

Flaum: Kaiser operates similarly to what was just described. We are very explicit with our medical groups about benefits and services, as well as offering education and training for call centers so they can appropriately triage and support members who may have questions about the benefit. As already mentioned, we maintain a close connection and collaboration with county partners.

Lewis: How is DHCS evaluating improved access to SMH services? Aside from aligning access standards, which is important, is there more DHCS is doing to evaluate the overall effectiveness or

success of that transition?

Baass: We will discuss this in a few minutes as part of the CalAIM and behavioral health performance monitoring report key findings.

Vasquez: Related to the question about outreach and education from the plans about NSMH, I want to highlight that there is legislation requiring DHCS to develop an outreach and education plan for and with the MCPs around NSMH. We have been in conversation about a legislative response to the California State Auditor's report and would like to connect with DHCS to develop solutions to work on timely access. I'll reach out offline.

Baass: We look forward to it.

Ducay: What is the status of the independent access findings for each delivery system required under the waiver?

Harrington: We have done the initial analysis and submitted an initial report to CMS. We will continue to update that reporting. I don't have it available today, but we can follow up.

Status of Medi-Cal Redeterminations
René Mollow and Yingjia Huang, DHCS
Slides available: https://www.dhcs.ca.gov/Pages/021524SACMeetingMaterials.aspx

Huang provided an update on the status of Medi-Cal redeterminations. She announced that CMS is extending all federal waivers and flexibilities under the continuous coverage unwinding until December 2024. She reported on four months of redetermination data that offer a better picture of how many people were reinstated during the 90-day cure period and how the overall enrollment numbers look. She commented that overall disenrollment numbers are slightly higher than the preliminary numbers that were previously posted. Efforts to increase the ex parte rates were successful in raising the auto-renewal rate from 36% in November to 66% in December 2023, and the disenrollment rates were significantly lower for December, at 8.7%. She commented that December seems to be an inflection point, and DHCS hopes to continue this momentum.

She also shared that in partnership with the California Health Care Foundation (CHCF), DHCS implemented a disenrollment survey to members who were procedurally disenrolled. Initial data represent 1,200 responses from individuals procedurally terminated with a disenrollment date effective November 1. The survey will continue for six months and will expand to the 19 threshold languages. General themes include not receiving the renewal packet, having difficulty completing it, long county call center wait times, and packets not being sent out in language they selected. She explained that DHCS is working to achieve quick wins from the information, such as a process to direct individuals from county call lines to health enrollment navigators in the field.

Questions and Comments

Witz: It is good news that more members are retaining coverage. The original estimates were that 2-3 million would lose coverage. Can you share updated estimates as to what is expected? Is the tech transition impacting this?

Huang: It's too early to identify clear trends with only one month of data following the automation.

Golden-Testa: Can you say more about why the disenrollment rate went up after the 90-day reinstatement period? It seems like 4-5% is a big jump. Can you clarify the information about directing individuals to navigators; is that to help with call center wait times?

Huang: On the change in disenrollment data, we never tracked the data in this way prior to unwinding so we don’t know if this increase after the 90-day period has happened before or not. The rate on June 30

was 21% disenrollment. We knew the data in June was preliminary and that 35% of redeterminations were still in process. At the 90-day refresh, the 21% disenrollment rate increased to 24%, and when we examined the data, we noted that the procedurally terminated group decreased. They may have provided information to be restored during the cure period or may have been over income and disenrolled. The 3% increase may be a result of ineligibility due to other reasons and not procedural terminations. We will have more analysis as time goes forward. On the second question, we know counties are going through multiple transitions, including system migration, so to help with wait times, we have a process in place to redirect calls to local health enrollment navigators instead of having applicants wait on the phone.

Nguy: We are pleased with ex parte rate for December that is retaining coverage for so many. Even with this improvement, we urge DHCS to pause procedural discontinuance and continue all flexibilities.

Lewis: The CHCF survey results confirm the concerns about how high the procedural terminations have been. Hopefully, some people will get back on coverage during the 90-day cure period, but there are concerns about individuals not receiving their redetermination packets, turning it in and not hearing from the county, or not being able to reach the county to get information needed to complete it. Also, navigators shouldn't necessarily be the ones who must field the lack of county resources. We must reduce that procedural termination number, so they don't have to get back on coverage after losing it.

Huang: The survey is one source of the information we're receiving, and it offers real time feedback, insight, and a good qualitative understanding. As we have additional months of data, we will have more information to go on. DHCS is committed to continuing to investigate and troubleshoot.

Wright: Can you say more about which specific flexibilities are increasing the ex parte rates? Is there a plan to respond to the survey data with additional notices or other outreach? Why did the number of redeterminations due in December increase to 1.25 million?

Huang: Something I didn't speak to is that New York shared their experience on survey design that led us to add a comment at the end of the survey to encourage respondents to visit the Keep Your Medi-Cal website. On the flexibilities, the increased ex parte rates resulted from three waivers, two of those waivers relate to the 100% income attestation being automated, when previously it was done by hand. The third waiver on stable income really helped with the non-MAGI population and that is also part of the increase in December. This helped with the aged, blind, and disabled population group because we did not have to send a packet to renew them. The reason that December traditionally has higher numbers of total redeterminations is because that is open enrollment for Covered California.

Wright: Now that we have the new flexibilities, can we retroactively apply them? I appreciate directing applicants to navigators to ease call center waits. Since this is big barrier, would DHCS consider surge capacity for call centers as it has done other times?

Huang: We'll continue to track best practices and improvements and report back on this.

CalAIM Behavioral Health Key Findings from Preliminary Implementation Feedback Report
*Tyler Sadwith and Ivan B*hardwaj*, DHCS*
Slides available: https://www.dhcs.ca.gov/Pages/021524SACMeetingMaterials.aspx

Sadwith provided key themes of the *Feedback Report* that assessed early implementation of CalAIM behavioral health initiatives to improve the performance of the behavioral health delivery system carve out. The report is based on surveys, interviews, and other data from implementation partners, including MCPs, county MHPs, consumer representatives, and provider organizations, including peer run organizations. He clarified that the report does not include analysis of claims data or service utilization data from claims. Sadwith provided context for each initiative included in the report: Access Criteria for SMH, No Wrong Door Policy, Screening and Transition of Care Tools, and Medi-Cal Peer Support Services. He offered overall findings emerging from the data, including improved coordination, better access to care, and implementation challenges.

Bhardwaj reported data on the overall themes from participants. He reviewed input from participants which indicated that improved coordination results from increased information sharing and referral workflows, although work flows are also an ongoing challenge. He reported that fewer barriers to care resulted from increasing access for youth, increasing the speed of member engagement in services, and accomplishing smoother transitions into services for members in crisis. Bhardwaj followed the overall themes with more detailed information on the reported successes and challenges related to each initiative. He ended with a discussion question for stakeholder input: How should DHCS best approach technical assistance, resource development, and policy improvement in the areas identified?

Questions and Comments

Ramirez: Across the presentations today, there has been a lack of focus on how people with disabilities struggle to access mental health services. For people with disabilities, the no wrong door approach doesn't take into consideration the accommodations that we need and are entitled to as a protected class. I also want to highlight that other members and I proposed that Hispanic and other non-English speaking populations should be a targeted population because of the significant disparities we have had with accessing services in a timely manner and receiving quality services. While we have seen an increase in access, staff are so overworked that requesting accommodations has become very controversial and retaliatory, creating further stigma and barriers. I am excited about the incredible access to care that we have and want to uplift the continued impacts that people with disabilities, including a significant number of Latino residents, face over and over while trying to take care of ourselves.

McNaughton: We recently received audit survey results, and an interesting finding on our audit is that we don't have mechanisms to detect over-utilization of behavioral health treatment services. I know that may be an issue of potential fraud, waste, and abuse, as well as stewardship of dollars. We need open access as much as possible – a no wrong door policy. I ask that DHCS look at what's happening on the audit front that offer more alignment between audits and policy.

Kelley: I want to put the peer support information in context from one county's perspective. We have recruited peers from wellness centers and clubhouses. There's hesitancy to leave the county system and move into the health care system. When we change one system, it impacts other systems. Prior to the pandemic, we recommended that the Community Mental Health Equity Project providers shift to outreaching to peers, instead of doing technical assistance on equity to counties. They are closer to the ground and have a different relationship with community than government does.

Robison: On the peer support, it looks like preliminary data is focused on county utilization. Is there any data from MCPs that implemented peer services?

Sadwith: Peer support services are limited to county mental health or recovery services and is not a benefit of MCPs. Individuals with lived experience are encouraged as community health workers and potentially other services covered under MCPs, but that wouldn't be tracked as a peer support service.

Stoner-Mertz: I am pleased to see the surveying on implementation of these initiatives. I have not heard from any member of the California Alliance of Child and Family Services that they were surveyed. I welcome the opportunity to partner with you to survey our providers because we are hearing very different things about access, as well as issues about screening tools and multiple assessments. We would love to participate more actively.

Barlow: I agree with the importance of hearing from providers about how coordination of care works to access services between the two systems. I am pleased you included peers. They are hearing directly from consumers about the realities of how transitions of care and no wrong door are going, and that is valuable input. It seems this was a survey of perceptions from plan leadership. Hospitals' role is with an acute episode of mental health or drug/alcohol, and we experience significant difficulty trying to coordinate care and transition individuals from different levels of care, particularly out of the emergency room. We continue to need to clarify that, along with stabilization and post stabilization. We want to work with DHCS to ensure people get effective care.

Sadwith: Just for context, in this report, we were focused on implementation of targeted policies that may not play into those transition issues. We did reach out to three consumer organizations in addition to a peer run organization and other provider groups. We agree there is a need to improve referrals and access to care.

Savage-Sangwan: In reference to the discussion question, I encourage DHCS to put equity at the top of the list of topics. The presentation didn't include evaluation of racial equity and how these tools impact that. We know there are significant racial and language disparities in who receives services and who is receiving quality services. There have been some missed opportunities with the initiatives and policy changes. For example, screening and transition of care tools is not just a translation issue, but it's also about testing in language, culture, and communities. DHCS only had budget dollars for field testing in English. On peer certification, the data show only 4% of peers speak Spanish, and the Spanish-language exam was posted online very late. I flag these things to consider where we can do better on equity.

Sadwith: We agree and acknowledge that the translations for the tools and certification exams trailed English. When we analyze claims data, we are interested in looking at racial inequities.

Lewis: I hope the data analysis will have an equity focus. I agree with comments that advocates are not seeing the improvement we hoped for reflected here. Additional analysis and a deeper dive talking to the advocacy community is important. It is important to dive into specific populations, like foster youth. Also, I want to highlight that the role of CHWs is important, and we must utilize those resources to ensure better access.

Jain: The peer support benefit is an optional benefit. We are hearing that peer support organizations are losing their contracts, and it is unclear if this is an anticipation or Proposition 1, which, if passed, would eliminate a lot of the money available for these services. Peer services are critical to the system and a key piece in recovery. It's also concerning this is happening alongside the significant work shortages in behavioral health. What is the thinking about this piece of our behavioral workforce?

Sadwith: With the new peer support benefit in Medi-Cal, we must think about both peers as the rendering provider and peer run organizations as the backbone for this service. Some counties are embedding peers directly into clinic-based operations. We are interested in facilitating dialogue with county partners to ensure that peer run organizations can participate in Medi-Cal, not only receive funding through MHSA. There are grant opportunities through the Behavioral Health Workforce Development Initiative with significant funding to peer run organizations across the state to set up the infrastructure for Medi-Cal contracting, billing documentation, etcetera. We know it's not easy, but it is important to keep at it so that peer run organizations, in addition to peers themselves, are able to scale up in Medi-Cal.

Veniegas: I urge all of us to think about the minimum number of questions, so we don't inadvertently cause distress among young people going through assessments. There's some good data on how to ask about substance use and an article in the Journal of the American Medical Association about how asking about substance use can uncover symptoms of mental health stress. With one to two questions

on substance use, we may open the opportunity, then focus on the screenings. I serve on the health disparities panel for the Patient-Centered Outcomes Research Institute. They are looking at research to shorten measures for behavioral health needs for youth. I am happy to make an introduction to the research team advancing trauma and substance use screening measures.
Cabrera: Not all people with lived experience can be peer support specialists. There is a defined scope of work, and they are not synonymous with community health workers. Just to underscore the point made earlier, peer run organizations are oftentimes almost entirely funded through the MHSA. We are helping organizations get the training and support that they need to be able to bill Medi-Cal, which could benefit from additional support, such as Community Mental Health Equity Project (CMHEP) mentioned earlier. On the screening and transition of care tools, we have concerns about the ages 0 to 5 population who have seen a drop off in referrals to our access line, which we think has to do with the screening tool design. We hope that we can have an iterative review of these tools and continuously make improvements. I think there is interest in re-looking at the Sacramento tool.

Sadwith: DHCS has affirmed in Frequently Asked Questions (FAQs) that plans and providers can use clinical assessment tools they developed to make a clinical determination about which system is best to serve a member and whether a member must transition fully to the other delivery system or have concurrent services from both systems. DHCS policy refers to transitions of care tools to capture standardized clinical information for accomplishing referrals. The transition of care tool is not a clinical tool to determine if a transition is needed.

Equity and Practice Transformation (EPT) Provider Directed Payment Program
Palav Babaria, MD, DHCS
Slides available: https://www.dhcs.ca.gov/Pages/021524SACMeetingMaterials.aspx

Babaria reported on the launch of the Practice Transformation Directed Payment program, a five-year, $700 million program to close gaps in preventive services and chronic disease management and recenter primary care as the backbone of the health care system. Practices were selected from hundreds of applications to work on specific milestones to support a multi-year transformation to address population health and health equity and implement evidenced-based practices. The 211 practices selected are eligible to earn a maximum of $387 million in incentive payments over five years and were selected with a priority for those serving Healthy Places Index (HPI) quartiles one and two and an emphasis on small independent practices. Practices also were selected based on alignment with DHCS strategic priorities, such as children, birthing populations, tribal partners, and integrated behavioral health. The Population Health Learning Center will provide technical assistance and learning collaborative support, centering equity, and co-design as principles. There will likely be a second cohort in the future.

Questions and Comments

Koopmans: It's exciting to see this program launch. We look forward to more conversations about the role of the plans to support practices and providers. Many of us were surprised about who wasn't selected and that fewer than a third of the total applicants were selected. Can you share the thinking behind the selection process? Was the quality of the applications not what you expected? Did you want more focus on something that you didn't see in the applicants not selected?

Babaria: I should have mentioned that the scoring process was in partnership with health plans and the applications went to both DHCS and MCPs. MCPs used a common scoring tool for consistency statewide. The program is being administered in collaboration with MCPs. Applicants were strong. We had to draw a scoring cutoff, so the practices that were selected had higher aggregate scores than the practices that were not selected. We wanted to reserve funds for a second cohort for two reasons. One, we received significant feedback from our tribal partners that the timeline was not enough time for them

to work with the MCPs to put together an application. From the health equity perspective, many of the disparities disproportionately affect both tribal providers and others serving disproportionate numbers of tribal Medi-Cal members. For the second round, I hope we have a longer timeline for engagement with specific populations that were underrepresented.

Koopmans: I think in part because the application process was done collaboratively, that's why there was a surprise about the outcome. The focus on tribal partners is a helpful insight and something that I'll share with members.

McNaughton: Since only about 10% of providers in the Inland Empire who applied were selected, it would be helpful for round two to have clarification on the high number of points awarded for optional activities. That wasn't clear at the beginning. If our providers had been aware of those priorities in advance, that might have helped the way they developed applications.

Babaria: The optional activities were weighted with the clinical priorities and the Comprehensive Quality Strategy, which hopefully is not a surprise to anyone. Another advantage of the second cohort is to modify and refine the approach and messaging and identify where we didn't have enough representation from certain geographies and populations to address those gaps.

Savage-Sangwan: I appreciate the update. You talked about providers that serve tribal members and I'm curious about your thinking on the other racial populations that experience severe disparities, such as Black and Pacific Islanders. Those populations are not picked up well in the HPI because they're smaller and dispersed. What is the thinking about having providers serving those populations also receive funding?

Babaria: In the planning process, we prioritized those populations and worked with MCPs to focus on providers that disproportionately serve Black, Indigenous, and People of Color (BIPOC) communities, lesbian, gay, bisexual, transgender, and queer communities, tribal populations, etcetera. We are still digesting the data from the planning payments and will share the outcomes of the incentive program that was to get smaller providers to apply.

Witz: When do you envision the second cohort process to begin?

Babaria: We are aiming for next year, but there is no decision yet.

Public Comment

Stacie Hiramoto, Racial and Ethnic Mental Health Disparities Coalition: I want to echo and support the comments of Kiran Savage-Sangwan that focused on asking for your presentations to address equity issues. Particularly, I was interested in the CalAIM and the consumer support report, as well as all the others. We would really appreciate that because when I read high-level documents, they always talk about how reducing disparities will be one of the priorities. So, if you could just put those things in your report. Thank you so much.

Next Meeting, Next Steps and Adjourn
Michelle Baass, DHCS

Baass noted that hybrid meetings will continue through 2024. Meeting dates for the remainder of the year are:

- Wednesday, May 29, 2024
- Wednesday, July 24, 2024
- Wednesday, October 16, 2024