CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING SUMMARY

DHCS STAKEHOLDER ADVISORY COMMITTEE (SAC)/BEHAVIORAL HEALTH-SAC (BH-SAC) JOINT MEETING SUMMARY

Date: July 24, 2024

Time: 9:30 a.m. – 3 p.m.

Type of Meeting: Hybrid

DHCS Staff Presenters: Tyler Sadwith, State Medicaid Director; Yingjia Huang, Assistant Deputy Director, Health Care Benefits and Eligibility; Drew Bedgood, Medical Consultant II, Quality and Health Equity; Ivan Bhardwaj, Chief, Medi-Cal Behavioral Health Policy; David Tian, Acting Branch Chief, Clinical Population Health Care Management; Hope Neighbor, Chief, Population Health Management; Yoshi Laing, Medical Consultant II, Population Health Management; Erica Holmes, Chief, Benefits; Paula Wilhelm, Deputy Director, Behavioral Health; Erika Cristo, Assistant Deputy Director, Behavioral Health

SAC Members in Attendance: Bill Barcellona, Michelle Cabrera, Le Ondra Clark Harvey, Eileen Cubanski, Amanda Flaum, Virginia Hedrick, Anna Leach-Proffer, Carlos Lerner, Kim Lewis, Beth Malinowski, Jarrod McNaughton, Linda Nguy, Jolie Onodero, Marina Owen, Chris Perrone, Janice Rocco, Katie Rodriguez, Al Senella, Laura Sheckler, Christine Smith, Kristen Golden Testa, Ryan Witz, William Walker

BH-SAC Membership in Attendance: Barbara Aday-Garcia, Jei Africa, Kirsten Barlow, Ken Berrick, Michelle Cabrera, Dannie Ceseña, Le Ondra Clark Harvey, Eileen Cubanski, Vitka Eisen, Brenda Grealish, Virginia Hedrick, Veronica Kelley, Linnea Koopmans, Karen Larsen, Kim Lewis, Aimee Moulin, Jolie Onodera, Deborah Pitts, Jason Robison, Al Senella, Catherine Teare, Gary Tsai, Rosemary Veniegas, Jevon Wilkes, William Walker

Additional Information: Here is the PowerPoint presentation used during the meeting. Please refer to it for additional context and details.

Introduction and Summary of Content

» The joint SAC/BH-SAC meeting addressed topics related to Medi-Cal and California's behavioral health landscape. Panel members received a Director's Update on the budget and budget solutions. The following topics were covered:

- Final Update: Year of Medi-Cal Redeterminations
- CalAIM Dashboard: Bold Goals, Behavioral Health, and Population Health Management
- Introduction of Medi-Cal Connect (Formerly the Population Health Management Service)
- Updating Medi-Cal Member Materials
- CalAIM Waiver Update: Traditional Healers and Natural Helpers
- BH-CONNECT: Incentive Programs

» The meeting concluded with a public comment period, allowing attendees to offer feedback to DHCS and panel members.

Topics Discussed

Director's Update (Budget) – *Tyler Sadwith, State Medicaid Director*: Sadwith provided panel members with the fiscal year 2024-2025 budget updates, solutions, and information about the implementation and funding components of the Behavioral Health Services Act. Proposition 1, passed by voters in March 2024, is a two-bill package (Senate Bill 326 (Eggman, Chapter 790, Statutes of 2023) and Assembly Bill 531 (Irwin, Chapter 789, Statutes of 2023)) known as Behavioral Health Transformation. Behavioral Health Transformation aims to improve access to care, increase transparency, and expand treatment capacity for Californians with significant behavioral health conditions. It includes the Behavioral Health Services Act, which updates the existing Mental Health Services Act. The Behavioral Health Services Act changes how funding is allocated to better support those with severe illnesses and substance use disorders (SUDs), emphasizes housing support, and invests in population-based programming, workforce development, and statewide outcomes. The budget includes $116.5 million in total funds to begin implementing Behavioral Health Transformation. Proposition 1 includes $3.3 billion in bonds for DHCS. The Managed Care Organization (MCO) Tax will bring back some cuts proposed in the May revision. Budget solutions include reducing costs for programs like the Behavioral Health Continuum Infrastructure Program (BHCIP), Behavioral Health Bridge Housing, and Equity and Practice Transformation Payments, sunsetting the Major Risk Medical Insurance Program by January 2025, and redirecting $79 million to other areas. For additional budget details, please see the PowerPoint. Lastly, on July 17, 2024, DHCS released the Proposition 1 Bond BHCIP Round 1: Launch Ready Request for Applications (RFA), announcing the availability of up to $3.3 billion in

competitive grant funding. Applications are due in December 2024 and are open to counties, Tribal entities, cities, for-profit organizations, and nonprofits.

- **Discussion**
  - Members supported DHCS' decision to increase community health worker rates.
  - Members expressed satisfaction with the budget allocation for multi-year continuous coverage, but were disappointed in DHCS' decision to postpone the waiver submission. Given the policy's readiness and prior public comment, the members strongly urged immediate waiver submission, saying it would not jeopardize other pending waivers.
  - A member asked how DHCS will oversee the implementation of Behavioral Health Transformation, particularly with a large amount of funding for county infrastructure and administration. DHCS said it is creating guidelines and requirements for the Behavioral Health Services Act with input from stakeholders and workgroups. DHCS will ensure compliance through annual county reports, performance monitoring tools, audits, and enforcement authority. DHCS acknowledged that Behavioral Health Transformation is a massive transformation, and there will be an intensive transition and change management process. DHCS also plans to hire and use contractors for effective implementation and administration.
  - Members asked about the MCO Tax and how the budget would be affected if the MCO Tax ballot measure is not approved. DHCS explained the entire Budget Act, including targeted rate increases (TRI), investments in the workforce, and sustaining Medi-Cal services, would become inoperable. Any budget adjustments planned for after January 1, 2024 rely on whether the ballot initiative passes. A member also asked about ongoing discussions with the Centers for Medicare & Medicaid Services (CMS) to renew the MCP Tax and questioned whether the 6 percent threshold had been met. DHCS responded it is actively engaged with CMS to secure approval for a MCO Tax amendment, including Medicare revenue, and anticipates approval of the updated submission with the 6 percent threshold calculation.
  - A member asked about $50 million allocated for Federally Qualified Health Centers (FQHC) and Indian Health Clinics (IHC) through TRIs. DHCS said a proposal to include $50 million outside the prospective payment system (PPS) reconciliation is delayed, but under development.

- Members discussed Proposition 35, which will appear on the ballot in November. Proposition 35 proposes a permanent investment in the Medi-Cal system. Additionally, some members recommended that DHCS move forward with the waiver to ensure continuous coverage for children. Members discussed the increased investment the MCO Tax would bring and the flexibility it would offer to fund community health centers, FQHCs, and other community-based organizations.
- A member noted that programs and competitive grants, such as BHCIP, are often thought of as synonymous with county behavioral health programs. They requested data on grant recipients by county and type and information about how DHCS aligns grant programs with county behavioral health goals. DHCS said that of the $3.3 billion in BHCIP funds, it would allocate $1.47 billion to cities and counties, $30 million for Tribal entities, and $1.8 billion to a broader range of applications, such as cities, nonprofits, and for-profits. DHCS is analyzing these data to inform future decisions and pointed to a data visualization tool on the BHCIP landing page for further details.
- A member asked how DHCS expects county behavioral health leaders to support a BHCIP Round 1 project proposal. The member was worried counties might be reluctant to provide a support letter or apply for BHCIP because they don't feel they have the resources for a long-term commitment to provide services. DHCS emphasized it will not control local planning, but encourages county leaders and stakeholders to understand their county's behavioral health care continuum and use data to make informed decisions. DHCS also highlighted new funding options and flexibilities available under the Behavioral Health Services Act that counties can use.

Final Update: Year of Medi-Cal Redetermination – *Yingjia Huang, Assistant Deputy Director, Health Care Benefits and Eligibility:* The continuous coverage unwinding officially ended on May 31, 2024. California had 13.3 million renewals and has the largest Medicaid caseload in the nation; this excludes Medi-Cal members in Presumptive Eligibility, state-only, and federal Supplemental Security Income (SSI) programs. As of June 2024, 88 percent of renewals have been completed, with the remaining 12 percent still being processed at the county level. The auto-renewal (ex parte) rate increased to an average of 66 percent. Automation and policy flexibilities allowed for a higher auto renewal rate for California's seniors and people with disabilities. California has the highest caseload, but one of the lowest disenrollment rates in the nation.

DHCS shared the successes it experienced in its outreach approach. All departmental initiatives were member-centric and user-tested to ensure effectiveness. DHCS plans to continue working with counties and posting data publicly, allowing the community to track renewals. The data are posted on the DHCS website to ensure transparency.

- **Discussion**
  - Members asked about the potential extension of federal flexibilities to June 2025. DHCS confirmed this possibility until June 30, 2025, but is still evaluating it internally.
  - Members asked about other outreach strategies DHCS found effective in addition to the text messaging campaign. DHCS said it utilized the following paid media campaigns: in-language commercials, radio advertisements, and school partnerships to distribute materials. DHCS highlighted its effort to convey information through diverse sources and underscored the email campaign was particularly successful and had high engagement.
  - Members gave positive feedback on the redetermination process and encouraged extending flexibilities. They found the text messaging campaign particularly effective at the county level and were pleased with performance metrics, including increased ex parte numbers.
  - A member recommended utilizing data from disenrollment surveys to address reported issues. Specifically, the member suggested focusing on concerns related to missing renewal packages and extended wait times for renewal assistance.
  - A member expressed appreciation for a decreasing disenrollment rate and concern over the high procedural termination rate. DHCS identified this as a critical focus area following the unwinding period. Data collection post unwinding is underway and should be publicly available soon. DHCS plans to analyze the data, review the application workflow and renewal packet, and work with Covered California to optimize the Medi-Cal/joint application experience.
  - A member asked when DHCS would determine which of the 17 flexibilities will be implemented. DHCS said a timeframe is not yet available, as some flexibilities don't require federal approval and others will be assessed after reviewing post-unwinding data. DHCS aims to finish processing the remaining 12 percent of renewal cases by the end of the year. Coverage continues for these members during the renewal process.

- **CalAIM Dashboard: Bold Goals, Behavioral Health, and Population Health Management – *Drew Bedgood, Medical Consultant II, Quality and Health Equity; Ivan Bhardwaj, Chief, Medi-Cal Behavioral Health Policy; David Tian, Acting Branch Chief, Clinical Population Health Care Management*:** The CalAIM dashboard is a public-facing data resource for DHCS stakeholders. It currently features nine initiatives, 20 interactive dashboards, and more than 40 measures, including clinical quality, utilization, and funding. Launched in 2022, the Bold Goals outline health equity objectives to be achieved by 2025, focusing on children's preventive care, behavioral health, and maternity outcomes in birth equity. The behavioral health dashboard, launched in February 2024, includes data and initiatives, such as Medi-Cal Peer Support Services, the Recovery Incentives Program, the Behavioral Health Quality Improvement Program, and CalAIM Behavioral Health Trainings. DHCS plans to expand dashboard initiatives and functionality over time. DHCS also uses the dashboard to monitor Population Health Management (PHM) efforts. PHM provides various types of support for members, including transitional care, health disparities reduction, and engaging members in addressing social drivers of health.
- **Discussion**
  - A member emphasized the need for frequently updated data to support quality improvement efforts. The member also requested data disaggregation beyond just the county level. DHCS clarified that the current dashboard focuses on telling the story of CalAIM rather than real-time performance metrics. DHCS shared the challenges of data cleaning requirements for public-facing dashboards and described future improvements with the help of the upcoming Data Exchange Framework. Finally, the member advised that this information should be explicitly communicated on the dashboard for transparency.
  - A member was worried about potential negative interpretations of dashboard data, such as blaming specific municipalities for poor performance, and questioned how this data might be interpreted. DHCS understands this and hopes these dashboards will be seen as a method of improving overall outcomes rather than assigning blame. This is an opportunity for the state to leverage the programs in place, help decrease stigma when seeking care at the emergency department, improve follow-up services, and enhance community education. DHCS will consider feedback and work on deliberately framing dashboard communication to be impactful.

- Members gave positive feedback on the dashboards, but expressed concerns about data accuracy, specifically substance use data, due to the discontinuance of supplemental data from DHCS to managed care plans. A member highlighted the importance of data completeness rather than performance. DHCS acknowledged this and explained there are data delays and changes, including within behavioral health payment reform and payment codes.
- A member asked about tracking peer certification implementation, including workforce expansion and service delivery models in participating counties. DHCS indicated plans to build upon existing modalities, identify relevant metrics, and share CalAIM's story.
- A member asked for details about how data are reported and what follow up is expected, especially for emergency department visits. DHCS explained referrals from the emergency department are not limited to the county behavioral health provider network and are specific to Medi-Cal members. Generally, members must live in a county and be enrolled in a managed care plan for a certain period, and follow-up procedures are flexible.

- **Introduction of Medi-Cal Connect (formerly the Population Health Management Service) – *Hope Neighbor, Chief, Population Health Management; Yoshi Laing, Medical Consultant II, Population Health Management*:** Medi-Cal Connect is a new platform designed to integrate data, such as public health, social services, and housing data, from trusted partners across the state to enable whole-person care for Medi-Cal members. The platform will provide functionality to multiple groups of users, including Medi-Cal members, DHCS, Medi-Cal managed care plans, state partners, and providers. Members will have a personalized portal to help them easily navigate benefits, streamline access to services, and update their contact information. DHCS will be able to leverage aggregated data to analyze member health across the state and to support DHCS' work with managed care plans to target interventions. Managed care plans will be able to access these data via a dashboard or Application Programming Interface (API). Medi-Cal Connect will also incorporate a novel Risk Stratification, Segmentation, & Tiering algorithm and limited care management functions. Still, it will not pull data from Electronic Health Records (EHR) to support real-time clinical decisions. The first release went live on July 25 for a limited number of DHCS users. The next four releases will provide access to Medi-Cal managed care plans, state partners, health care delivery partners, providers, and members. DHCS is committed to user engagement through webinars, working

sessions, and advisory committees to inform platform development. Finally, a mock-up of the Quality Measures dashboard was presented, demonstrating internal data visualization capabilities, unlike CalAIM, which is public facing.

- **Discussion**
  - Members asked what the data will show and if it will be shared externally to aid system-level analysis to drive decisions. DHCS is still exploring options for sharing data beyond the users listed above.
  - A member asked if providers would receive access to the portal. DHCS clarified that providers contracted with DHCS would have access to the portal and be subject to compliance requirements.
  - A member asked about artificial intelligence (AI) integration, portal connectivity with others, such as BenefitsCal, and member access. DHCS is exploring whether this system will connect with other portals, such as BenefitsCal. Regarding AI, the RSST algorithm will utilize machine learning, but there is no current plan to use large language models like ChatGPT. This portal is meant to help members understand their benefits and where to find those services.

- **Updating Medi-Cal Member Materials – *Erica Holmes, Chief, Benefits*:** DHCS developed an infographic to help simplify the Medi-Cal appeal, grievance, and fair hearing processes for members. The infographic uses a clear, step-by-step approach with "yes" or "no" questions to help members navigate each process. This user-friendly resource aims to make these complex procedures easier to understand. DHCS presented the infographic and received feedback from the Medi-Cal Member Advisory Committee (MMAC). The recommended changes will be incorporated into the final version. The infographic is being reviewed for readability, accessibility, and format options. DHCS is also in the beginning stages of developing an informational brochure. This brochure will outline available behavioral health services, including mild and moderate benefits, specialty mental health and SUD services, and member rights. DHCS aims to finalize the brochure by July 2025.
- **Discussion**
  - Members emphasized the importance of considering Medi-Cal member reading levels and exploring alternative communication channels and media beyond traditional brochures. DHCS shared its commitment to developing

culturally competent, appropriate, and readable materials and exploring various media options to maximize reach.

- A member expressed appreciation for DHCS' efforts to obtain Medi-Cal member feedback when creating these important documents.

- **CalAIM Waiver Update: Traditional Healers and Natural Helpers – *Tyler Sadwith, State Medicaid Director; Paula Wilhelm, Deputy Director, Behavioral Health*:** DHCS submitted a request to CMS to cover Traditional Healer and Natural Helper Services in the Drug Medi-Cal Organized Delivery System (DMC-ODS), which will expand access to culturally based SUD treatment services for American Indian and Alaska Native Medi-Cal members. This request was initially made in 2017 and again in 2021 as part of the CalAIM waiver application. The DMC-ODS covers 96 percent of Medi-Cal members in 39 counties. DHCS is requesting that CMS expand access to Traditional Healer and Natural Helper Services for American Indians, particularly those with high overdose rates. CMS is expected to approve this amendment by late summer or early fall 2024. Initially limited to Indian Health Services (IHS) facilities and Tribal 638 Providers, CMS has confirmed coverage of Urban Indian organizations. CMS and DHCS have adopted a broad framework for Traditional Healer and Natural Helper Services, recognizing the diversity of tribal practices. Provider qualification will be determined by Indian Health Care Providers (IHCPs), and reimbursement will vary based on provider status and facility type. Eligible practitioners can bill at the all-inclusive rate, while others will receive a separate fee-for-service rate. To offer these services, IHCPs must enroll in Medi-Cal and deliver at least one DMC-ODS evidence-based practice.
- **Discussion**
  - A member suggested replacing the term "music therapy" with "music as a healing practice" to strengthen the credibility of the service and profession. DHCS explained the terminology was derived from Tribal partner input and offered to relay member feedback to partners. The member also asked about eligibility for other providers serving a non-Native American population. DHCS clarified that the current focus is on IHCPs. DHCS explained both state and federal partners are relying on participating providers and traditional healers to decide what is culturally centered.
  - Multiple members shared appreciation for this benefit. A member sought clarification on the potential implications of this benefit leading to the coverage of other community-defined practices. DHCS shared that it had

conversations with Tribal partners and looked at how some of these services could be covered through existing benefits. While the current focus is on Traditional Health Care Practices, the experiences gained could inform future efforts to expand coverage for other practices.

- A member emphasized the need for SUD treatment, particularly Medications for Addiction Treatment (MAT) in conjunction with traditional healing services. DHCS explained that the Tribal MAT Project, which provided funding and technical assistance opportunities, has supported IHCPs to learn more about MAT services. DHCS acknowledged the challenge of offering a new service in a clinic and outlined ongoing efforts to increase MAT availability in Tribal communities.
- A member inquired about DHCS' role in the credentialing process. DHCS explained it is still being negotiated with CMS, but will primarily be handled by IHCPs.
- A member shared Urban Indian organizations are working on developing a standardized process to credential providers and would be happy to assist Tribal health partners. The member also said American Indian and Alaskan Native populations continue to have the highest rate of health disparities, especially regarding SUD treatment. They noted it is important to be careful how some of the existing covered DMC-ODS services are characterized, especially in communities with deep disparities, since the gold standard program often mentioned is not always successful for them. Lastly, the member advocated for limiting traditional healing services to the IHCP network to prevent cultural commodification.

- **California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment Demonstration (BH-CONNECT): Incentive Programs – *Paula Wilhelm, Deputy Director, Behavioral Health; Erika Cristo, Assistant Deputy Director, Behavioral Health*:** DHCS is actively working to implement BH-CONNECT, a statewide initiative to improve Medi-Cal member access to behavioral health services. DHCS is negotiating proposal details with CMS, aiming for partial implementation in 2025. BH-CONNECT's incentive program supports county behavioral health plans in strengthening managed care performance, adopting evidence-based service models, and improving member outcomes, especially for high-risk populations experiencing disparities. Three categories of incentive payment will be offered: statewide, evidence-based practice (EBP), and

cross-sector. All county behavioral health plans can participate in the statewide incentive pool by completing a targeted managed care organization assessment in collaboration with the National Committee for Quality Assurance. CMS provided feedback on the proposed measures and requested a focus on population health goals for members with behavioral health conditions, expansion of crisis services, member access, and timely access to care.

- **Discussion**
  - A member emphasized the importance of integrating primary care and general health access into the current discussion. They expressed alignment with certain CMS requirements, particularly those related to health access issues. The member inquired about a stakeholder process involving providers. DHCS responded by highlighting the involvement of the BH-SAC and CalAIM behavioral workgroups in gathering feedback, as well as conducting one-on-one interviews with teams that have worked on various BH-CONNECT EBPs.
  - A member questioned the absence of SUD-focused EBPs in the incentive program. DHCS explained the statewide programs are addressing SUD measures, such as MAT access. DHCS explained the EBP pool is centered around mental health, and CMS suggested exploring incentives for co-occurring care. The member also identified county transfer requests as a significant barrier to timely care access. DHCS clarified that once county residency is updated, the new county is responsible for coverage. Finally, the member proposed additional measures, such as follow-up visits and streamlined continuum movement, to improve access.
  - Another member pointed out that DHCS didn't include youth homeless prevention centers (YHPC) and schools. The member stated that California does not have many YHPCs, but they are crucial to consider.
  - A member was disappointed that the federal focus seemed to be shifting from outcome measures to access/process measures, arguing access does not guarantee quality care. They advocated specifically for maintaining outcome measures. DHCS clarified it is proposing to keep those measures, but is being asked to reduce rebalance and add some access measures.
  - A member said their county behavioral health plan has the most rigorous timely access to care standards in Medi-Cal in terms of the types of measures and the evaluation process of those measures. Members expressed

appreciation to DHCS for investing in EBPs, but emphasized the importance of adequate reimbursement so the return on investment is appropriate.

- A member highlighted the challenges faced by highly mobile youth, emphasizing the need for consistent care and timely access. A member suggested considering activity stipends to support peer groups for the youth population. (Note: Activity funds for youth are also proposed under BH-CONNECT).
- A member inquired about the inclusion of Community Supports in statewide measures. DHCS clarified that the proposed measure focused on referrals to Enhanced Care Management to support engagement in specialty mental health and SUD services, with incentives directed toward counties.
- A member stressed that social support is crucial for well-being, particularly for vulnerable groups. They pointed out the need to measure social support and connect individuals with self-help support groups.
- A member agreed with CMS' focus on access to care, citing reports of significant access challenges, including long waitlists for behavioral health services. The member emphasized having timely access standards are great, but ineffective in addressing these issues.

- **Public Comment:** During the public comment period, attendees were allowed to voice their concerns and offer feedback to DHCS and panel members.
  - Selena Liu Raphael from The California Alliance of Child and Family Services raised concerns about the implementation of EBPs. It was noted that substantial upfront costs, including infrastructure development, staff training, and program initiation, may hinder EBP expansion. They suggested that funding disbursements be aligned with implementation timelines to support organizations during this critical phase. Regarding peer support services, Raphael expressed enthusiasm for the 52 participating counties, but sought data on the number of peer specialists, their distribution, and reimbursement rates. They expressed concern that low reimbursement rates might impact the recruitment and retention of peer specialists. Finally, a member inquired about recent data on the reenrollment rates of 18 to 21-year-olds to assess progress since previous reports indicated low procedural reenrollment numbers.