DEPARTMENT OF HEALTH CARE SERVICES

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

Hybrid Meeting
May 24, 2023
9:30 a.m. to 1:30 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; LeOndra Clark Harvey, California Council of Community Behavioral Health Agencies; Amanda Flaum, Kaiser Permanente; Michelle Gibbons, County Health Executives Association of California; Trina Gonzalez, California Hospital Association; Virginia Hedrick, California Consortium of Urban Indian Health; Sherreta Lane, District Hospital Leadership Forum; Anna Leach-Proffer, Disability Rights California; 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; Cathy Senderling, County Welfare Directors Association; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Laura Sheckler, California Primary Care Association; Stephanie Sonnenshine, Central California Alliance for Health; Kristen Golden Testa, The Children's Partnership/100% Campaign; Bill Walker, MD, Contra Costa Health Services; Anthony Wright, Health Access California.

SAC Members Not Attending: Anne Donnelly, San Francisco AIDS Foundation; Sarita Mohanty, MD, SCAN Foundation; Mark LeBeau, California Rural Indian Health Board.

BH-SAC Members Attending: Jei Africa, Marin County Health Services Agency; Barbara Aday-Garcia, California Association of DUI Treatment Programs; Kristen Barlow, California Hospital Association; Ken Berrick, Seneca Family of Agencies; Michelle Cabrera, County Behavioral Health Directors Association of California; Dannie Cesena, California LGBT Health And Human Services Network; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Robert Harris, Service Employees Service Union; Virginia Hedrick, California Consortium of Urban Indian Health; Samuel Jain, Disability Rights California; Meshanette Johnson-Sims, Carelon Behavioral Health; Veronica Kelley, Orange County; Linnea Koopmans, Local Health Plans of California; Karen Larsen, Steinberg Institute; Kim Lewis, National Health Law Program; 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; Hector Ramirez, Consumer Los Angeles County; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Cathy Senderling, County Welfare Directors Association of California; Al Senella,

California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Chris Stoner-Mertz, California Alliance of Child and Family Services 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: Jessica Cruz, NAMI; Sarah-Michael Gaston, Youth Forward; Jonathan Porteus, WellSpace Health; Catherine Teare, California Health Care Foundation.

DHCS Staff Attending: Michelle Baass, Jacey Cooper, Palav Babaria, MD, René Mollow, Susan Philip, Michelle Retke, Tyler Sadwith, Erika Cristo, Lindy Harrington, Jeffrey Callison, Morgan Clair, and Clarissa Sampaga.

Public Attending: There were 220 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 Director

Baass welcomed the committees and introduced new SAC members: Katie Rodriguez, California Association of Public Hospitals and Health Systems, Dr. Carlos Lerner, Children's Specialty Care Coalition and Marina Owen, CenCal Health as well as new BH-SAC members: Samuel Jain, Disability Rights California, Dannie Cesena, California LGBT Health and Human Services Network, Meshanette Johnson-Sims, Carelon Behavioral Health, and Angela Vasquez, The Children's Partnership. Baass thanked Erica Murray of the California Association of Public Hospitals and Health Systems for her many years of service on SAC. Baass also announced Libby Harrington was appointed Assistant State Medicaid Director and Rafael Davtian as Deputy Director for Health Care Financing.

Director's Update
Michelle Baass and Jacey Cooper, DHCS
Slides available

Baass announced the Medi-Cal Member Advisory Committee (MMAC) launched and will continue to meet quarterly. She thanked the California Health Care Foundation and Lucille Packard Foundation as well as SAC member Kiran Savage-Sangwan for their support in its development. The MMAC is part of DHCS' efforts to include the perspectives of Medi-Cal members in the development of policies and programs. Everyday Impact Consulting is providing ongoing support for MMAC and will publish a report on the development process.

Baass reported on key proposals in the Governor's May Revision, including the renewal of the managed care organization (MCO) tax and Medi-Cal provider rate increases to at least 87.5 percent of Medicare for primary care, maternity care, and non-specialty mental health services. Baass also discussed budget items to modernize California's behavioral health system and the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration (formerly referred to as the California Behavioral Health Community-Based Continuum demonstration) to build out the community-based continuum of services and address behavioral health workforce. She noted that the expansion of Medi-Cal to all income-eligible adults ages 26-49 regardless of immigration status remains in the budget for implementation on January 1, 2024.

Mollow reported on the unwinding of the public health emergency (PHE) and continuous coverage. She

reviewed the timing and process for redetermination of Medi-Cal coverage and outlined outreach and communication strategies to raise awareness and support members, including a new web page, paid advertisements, and video, email, and text campaigns. Mollow reported on the Unwinding Eligibility Dashboard to begin in August 2023 that will provide a monthly data snapshot of eligible, ineligible, and pending applications.

Questions and Comments

Nguy: Related to the dashboard, can DHCS provide preliminary, real-time data on discontinuances? The 45-day lag is a long time to wait.

Mollow: DHCS receives a massive amount of information each month and it takes time to prepare it for publication. We will report what we can in real-time and share the caveats in the data. Also, if someone is discontinued from coverage, there is a 90-day cure period. We will report back to SAC and take comments once the dashboard is active.

Cooper: One additional clarification is that we will be doing mapping on the discontinuance reasons across systems beginning in June and it will take additional time to categorize the data accurately. Beginning in August, this data will be posted monthly.

Nguy: We appreciate the toolkits although we haven't been able to find any of the videos via the links. Could the videos be shared in some other way?

Cooper: Thank you for letting us know and we will take that back.

Bradshaw: I want to highlight the workforce shortages in county eligibility departments, and how this may impact Medi-Cal redetermination. In Shasta County, one-third of the eligibility worker positions are vacant, coupled with a county strike. As a health care community, what can we do to ensure members maintain coverage?

Cooper: We are tracking those events, including the strike. We will be posting all data by county to track differences across counties.

Lerner: Are there projections or DHCS goals for member retention during this process?

Cooper: Yes, DHCS estimates that 1.8 – 2.8 million members will no longer need Medi-Cal. The data indicates many people have other coverage. We surmise they may have lost employment during COVID, received Medi-Cal coverage, and then regained employment and employer-based coverage. In addition, people will transition to Medicare or no longer need Medi-Cal. Our focus is to make sure anyone who needs coverage maintains it via Medi-Cal or Covered California.

Wright: Can you clarify that the rate increase is ongoing and not just for one year? Also, I appreciate this is over multiple years, how much funding remains for additional investment later?

Cooper: Correct, the rate increase is ongoing. In addition, if Medicare rates increase, DHCS will align to the adjustment in future years. We will propose a larger rate augmentation for 2025. There is approximately $10-11 billion in general fund (GF) allocation, not including the federal share.

Wright: Will the dashboard include reporting for the population in the COVID-19 Medi-Cal aid code and how they are connecting to other coverage?

Cooper: We are not tracking the COVID aid code population separately. All populations received Medi-Cal applications and information on Covered California. As you remember, before determining people eligible for the COVID-19 aid code, screening included the fact that they didn't need Medi-Cal, therefore we expect eligibility will be very low for that aid code.

Wright: Will there be any survey of members who are discontinued to know if they have employer-based coverage, Medicare, or Covered California?

Cooper: It would be interesting to have a survey to follow up. We will track individuals who move from Medi-Cal to Covered California. We will report those who do not respond and, although many of them may have other coverage, we will not have that information. The reporting will indicate they did not respond and provide a discontinuance reason.

Golden-Testa: On the budget update, what percentage of the MCO tax is going into the rate increases and what percentage of the amount for rate increases is for the 2024 rate increases?

Cooper: There is $32 billion overall in the MCO tax and the state's net benefit is about $19.4 billion. There is $8.3 billion to support the Medi-Cal program to avoid reductions in benefits and services during the budget shortfall. The remaining $11.1 billion will go into rate increases. Of that amount, $721 million is for rate augmentations in the January 2024 budget for costs through calendar year 2026. The remaining $10.3 billion is for costs in the out years. The result is that 57.2 percent of the net benefit will be going towards rate increases.

Golden-Testa: On the unwinding, were the text messages that went out in May targeted to individuals up for renewal in June or was it to every member? Will you do targeted messages?

Mollow: The text messages sent in May were to all members.

Cooper: We will follow up on the question related to targeted messages.

Lewis: It's exciting to see the investment in Medi-Cal through the MCO tax. On the unwinding, are you tracking the wait times on calls or the time it takes to get help from the counties?

Mollow: We report out on the call times for the state-level call centers that were set up for the Affordable Care Act, but not the county-specific call centers.

Lewis: In other states, like Florida, there are huge numbers of people disenrolled for administrative reasons, which is concerning. We encourage you to track individuals terminated for administrative reasons that re-enroll. Is that something that will be reported in the data?

Cooper: During COVID-19, we published detailed monthly enrollment reports that included information on Medi-Cal churn. We now have good data analytics on anyone leaving Medi-Cal and returning within 12 months and anyone who was historically enrolled and returns. That will continue to be published every month alongside the new data. We will be able to see if there are any trends related to churn, both for the 12 months short-term churn and long-term churn in Medi-Cal. There will be standard discontinuance reasons to be posted beginning in August.

Mollow: The top five discontinuance reasons are the ones to be published.

Vasquez: In the May revision, can you provide detail on the $40 million modernization of the Mental Health Services Act? Are there policy documents on the vision for this reform?

Cooper: We are working to finalize the Budget Change Proposal and will make it public. At a high level, the financing is needed for extensive planning. One element tied to the proposal is data systems. There are 12 different behavioral health data systems across programs, and it is extremely administratively burdensome for counties and the state. As we go to enhanced reporting, there is a need to upgrade those systems.

Rodriquez: I want to highlight the importance of the MCO tax in preserving and improving access for patients through the 21 public health care systems, mostly county-owned and operated. They serve everyone and ensure patients are seen in the appropriate setting, whether that is trauma or burn care or primary and specialty care. We operate over 100 federally qualified health centers (FQHCs), and train over half of the doctors in California. Because of this outsized role, the services provided by public health care systems should be prioritized in the MCO tax discussions. We look forward to working with the Administration, Legislature, and stakeholders so that public health system funding is stabilized.

McNaughton: The Inland Empire Alliance, made up of two counties and medical societies, Loma Linda, and the health plan, are excited about the MCO tax and want to see it prioritized for the Medi-Cal program over the GF. We are advocates of an equity adjustment for regions with a very low population-to-provider ratio. We did a study with a health system in our region and found that for every 10 to 15 miles inland from the coast, we must pay a premium. The hospitals are subsidizing physicians and struggling to get providers in remote areas. We would love to see a disparity equity adjustment in the calculation for the MCO tax on top of Medicare to get providers to go into communities in desperate need.

Cooper: We agree. The 87.5 percent rate proposed for 2024 is the foundation. There was not time for the appropriate analytics in this year and we are looking to 2025 for augmentations using an equity lens.

Ramirez: Mental Health Services Act (MHSA) funding and services are blended with federal financing and there are federal requirements such as accessibility and non-discrimination for Medicare that do not seem to operate in MHSA. I want to recommend that we strengthen the enforcement of state and federal regulations for MHSA, particularly for accessibility, and work on equity, particularly given the shortage of workforce. Community members are doing the work and we need to strengthen the partnerships and reduce friction at the state and county levels. The workforce in county agencies feel frustrated when they must follow state and federal laws and state agencies are not. The Americans with Disabilities Act (ADA) is a 30-year-old federal law, yet MHSA services are not ADA-compliant or culturally appropriate for Latino or Native American communities.

Health Plan Quality Measures and Sanctions
Palav Babaria, MD, DHCS
Slides available

Babaria provided an update on managed care plan (MCP) accountability measures for 2023. The results for 2023 will be reported in summer 2024, approximately six months following the end of the reporting year. She noted that measures that are also health equity measures require stratification by race and ethnicity. DHCS is working on a methodology for MCP accountability to equity improvements in addition to overall performance. Babaria reviewed the overall results for clinical quality domains. Some measures have larger sample sizes, such as depression screening for adults and adolescents as well as maternity populations and are drawn from the electronic

health record. Babaria noted the focus on three clinical areas, maternity care and birth equity, children's preventative care, and integrated behavioral health, are linked to the Bold Goals campaign and integrated into programs and policies. Babaria offered information about the tier classification for plans, the follow up actions by DHCS, and noted there were financial sanctions applied for all orange- and red-tier plans. Babaria reviewed quality improvement activities by DHCS with plans.

Questions and Comments

Vasquez: Is DHCS tracking members with long COVID and associated post-viral illness? There are provider codes for this condition. Many low-income people of color are not accessing providers who can assess or treat long COVID symptoms. Data indicates that 20 percent of US adults experience symptoms up to six months after COVID infection.

Babaria: We acknowledge there are issues with long COVID and disparities in access given the medical and clinical expertise to diagnose and treat long COVID is concentrated in certain areas, such as academic centers, and otherwise not widely available because it is new. We can take that back to look at in terms of clinical access. California Department of Public Health has a team working on long COVID and we align our efforts with them. For the Managed Care Accountability Set (MCAS), the measures we choose are national measures that are validated and have benchmarks and the measures usually take multiple years to develop. As far as I know, there are no great nationally validated measures for long COVID, and it is something that needs development in the years to come.

Gibbons: Some measures are not nimble to the public health challenges in our state. For example, I appreciate seeing the measure on chlamydia, but we know that syphilis and congenital syphilis is currently impacting women and their births. Similarly, on maternal mortality, care is a factor, but systemic racism and implicit bias within the healthcare system also are drivers of maternal mortality. We are not able to see if someone is cared for in a manner that would address those issues through these measures. How might we think through whether measures can be nimble or if not the measures, where we can monitor and course correct?

Cooper: It might be useful to talk through the population health performance indicators. They don't address all of those topics. Also, DHCS is launching a birth equity project and will be engaging in extensive stakeholder engagement to close maternity disparities. We want it to be informed by both a clinical workgroup as well as direct member voices. We won't make substantive changes before going through this process. We are focused on closing disparities that we see in the data.

Babaria: DHCS recognizes the maternal morbidity crisis nationwide and in California includes severe persistent racial and ethnic disparities for Black, Native American, and Pacific Islander populations. We are developing a multiprong strategy to address this that will begin soon. There is broad recognition that the measures do not include information on the quality of care and there are national efforts with the National Quality Forum to improve and accelerate measure development in the maternity space. Usually, it is a multi-year process to develop, test, and validate measures. We align with National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services (CMS) measures because those are what DHCS and health plans track and report. The MCAS and sanctions process will never be as nimble as you suggest is needed. However, we recognize the need for that and have developed a Population Health Management (PHM) monitoring program, in addition to the standard quality measures that I reviewed, as a series of process measures and key performance indicators that we intend to be nimbler. They are not necessarily to be used to sanction health plans, yet they are important

trends we are watching. I would like to follow up on the syphilis measure because that may be an area where we can develop a deeper dive that doesn't require the rigid structure of a formalized measure. We are building out dashboards both for internal DHCS use as well as public dissemination and will speak to that in the future.

Koopmans: I look forward to continued conversation about establishing a process to reevaluate the measures as well as which should be accountable. There is a challenge in having an ever growing measure list. I appreciate the acknowledgement that as we add accountable measures, we look at what may be shifted to report only or removed altogether based on performance. On the equity standards, the stratification results in many different measures and a measure set of 40 quickly becomes multiples of that number. MCP medical officers' input is that interventions for subpopulations must be very targeted to the subpopulation and that leads to the usefulness of a holistic review of the measures and priorities established in the comprehensive quality strategy. We hope for more transparency from DHCS about the framework for next year. We don't have a good understanding of what was considered in arriving at the dollar amounts. It's important to consider both achievement and improvement. It means something very different to reach the MPL in the Central Valley than it does in a higher-resource community. We want to have the same standard and be reaching for that, although the oversight and enforcement should have a more nuanced approach. Can you explain more about the groupings of measures for the plans? Is the median reflective of an aggregated score of all HEDIS measures?

Babaria: For example, looking at the child measures, they are an aggregate of all the measures in the children's domain. The data displayed combines the immunization metric, well-child visits, infant well-child metrics, etc. The slides depict those measures that exceeded the MPL and those that did not meet the MPL. The median depicts where the state is on that measure. We are committed to continuously refining and improving the precision of how we enforce accountability. We learned a lot from this first round of quality accountability sanctions and are committed to being as transparent as possible moving forward with the next round of sanctions. We recognize that there are structural inequities across the state and are working to account for that in quality measurement work.

Perrone: You spoke to the expectations and penalties for not meeting the minimum standards, but can you also update us on the program to support plans to improve over time toward higher scores that includes factors for quality and equity in the rates?

Babaria: For 2023 capitated payments, we included adjustments based on historical data in counties with more than one plan. We will use a different methodology going forward across the state. Equity was not incorporated in 2023 because we don't have final stratified data yet.

McNaughton: We appreciate you taking time for an in-person visit to the Inland Empire to meet with providers. I am a fan of sanctions to keep plans accountable. On the equity adjustment, it is important to consider risk adjustments for different regions and even within a region because there may be a unique member mix. I would caution DHCS about reporting this in this time of transition and leadership change that could pose a challenge in recruitment.

Babaria: Thank you. We will need the input of all our partners to figure out the way forward.

Cesena: Thank you for sharing information about the discussions in different regions. Related to measures, do discussions with MCPs include information about members from a local plan that have to travel out of the area to receive access to care? LGBTQ and Two-Spirit native folks can't find providers willing to treat them in some regions because of bias and take an entire day or two

off work to travel to get access to care. Often, they will not travel for access to care unless they are extremely sick and do not receive the preventive care they should. Are there discussions or measures of that?

Babaria: Yes, this comes up frequently in regional calls. There is a lot to be done to improve the quality of care and the data collection to know which populations have unique needs. We have diverse members that need services delivered in different ways and by different types of providers. As we launch our PHM program monitoring approach, quality and process measures will be stratified by language, race and ethnicity, age, sexual orientation, and gender identity for the dashboard. There is a revised PHM policy guide online with additional details.

Wright: I appreciate the focus on improvements through multiple avenues, corrective action plans (CAPs), working with the plan, and sanctions. Are the financial sanctions before, concurrent or after the CAPs and other efforts? Also, the chart mentions "per violation." What is the metric of violation?

Babaria: Starting with measurement year 2021, the financial sanctions were concurrent with the technical assistance and CAPs and there were universal sanctions for all orange- and red-tier plans for the measures that were below MPL. We look at it measure by measure for the reporting units. If a plan is in multiple regions, there are different rates for each reporting unit and adjustment factors for the member impact. There are also adjustments for improvements to acknowledge progress.

Moulin: Are the financial sanctions applied for a subpopulation? If the plan was below a metric for a subgroup, would they be fined $25,000? And do we think that $25,000 is enough of an incentive to develop a specific targeted intervention for a subgroup to meet a specific metric?

Babaria: I will take that back. We haven't implemented the subgroups yet and those are the discussions we are having as we develop the approach to equity and accountability. We know from experience with the equity targets in the Quality Incentive Program hospital-directed payment program that we will not close the gap by targeting global quality improvement. To close disparity gaps takes focused, intentional community-based partnerships and approaches, which take time. More to come on how to approach equity.

Cooper: It's an important point because we don't want a plan to forego improvements because the sanction is too low to be a factor. The dollar amounts for sanctions are in state statute and would require statutory change.

Ramirez: I invite you to use person-centered equity standards to fix the system for people most impacted. Financial incentives are good, but not enough considering the consequences of not getting care. As a two-spirited person living in Los Angeles County, I must go all the way to San Francisco to get two-spirit services. Similarly, I invite you to utilize a person-centered equity approach for accessibility for the disabled population. Instead of using a punitive approach, utilize a restorative approach because ultimately, our communities are the ones that are paying the price and by utilizing a restorative approach, you don't further disenfranchise communities. Also, a restorative approach could involve the community members impacted in the restorative process. As I listen to workers who left, many of them did so because things were hard, not because they were complicated. We know that when people have safe work environments, that helps worker retention and further improves the system. Utilizing a variety of options from punitive to restorative is necessary to fix the problems. The measures should have stakeholder engagement and participation including people not served appropriately to evaluate and come up with solutions.

Babaria: We agree. Today we are speaking about punitive approaches, but the Comprehensive Quality Strategy includes a two-pronged approach. The punitive approach is helpful to ensure a minimum standard is met. But punitive approaches don't achieve excellence above the 90th percentile, which is our goal. All plans are hiring Chief Health Equity Officers as a requirement for the new contracts. They are excited to address these long-standing disparities and I'm confident we will get there. The DHCS Chief Health Equity Officer, Dr. Pamela Riley, with funding from the California Health Care Foundation will be launching the health equity roadmap listening tour to engage communities and members and center their voices and perspectives our work.

Owen: I want to highlight that the regional work groups are very valuable, and I agree with Hector's comments that providing technical assistance to assess the barriers at the local level and then implement interventions through the PDSA process is also valuable. I am pleased about the DHCS birth equity project. We participate in the national health equity collaborative. How will MCPs be involved in the DHCS effort?

Babaria: DHCS will launch working groups and solicit MCP representation. There are also engagement opportunities through quality improvement regional collaboratives.

Owen: Is DHCS looking at quality and health equity as integrated programs? Currently, health equity officers are convened separately, and integration could be valuable.

Babaria: We agree. There is no conversation about quality that doesn't include health equity. I encourage you to integrate your teams locally as well. One trend is that plans that create multidisciplinary teams at the highest levels combining data, contracting, access, and provider networks with quality and health equity efforts have accelerated transformation results.

Savage-Sangwan: I appreciate the map of scores and sanctions and the color-code systems to simplify what we are driving toward. Do the sanctions collected go into the GF?

Cooper: We will use the sanctions for learning collaboratives and other technical assistance for plans and for DHCS to improve systems and close equity gaps.

Savage-Sangwan: I encourage finding a way to engage members directly to understand the member experience. Are the scores factored into the plan readiness for 2024?

Cooper: No, the plans wouldn’t be able to move that fast. We have signaled the importance of quality and equity and that it will be a factor in any future decisions related to plan partners.

Lerner: The quality improvement and PDSAs with the plans have not percolated to frontline providers. Is there sufficient representation from frontline providers in quality efforts to figure out how to meet member needs.

Babaria: We are in a period of evolution and currently the regional and technical assistance calls are between DHCS and plans. We are on track to launch a statewide learning collaborative in late 2023/early 2024 supported by Institute for Healthcare Improvement to scale lessons learned from the CMS infant well-child visit learning collaborative. We are thinking through how to involve providers. Also, the Health Equity and Practice Transformation payments program will launch soon and is an opportunity to work more directly with primary care providers.

Baass: DHCS is working to do more direct communication with providers about all Medi-Cal

initiatives.

Lewis: Are behavioral health measures MCP-centric? How will you track aspects that happen via the carved-out mental health and behavioral health delivery systems?

Babaria: As we work toward a seamless experience for members, we reinforce member centeredness through the measures and the accountability. Many, although not all, of the behavioral health measures are also in the behavioral health MCAS. Some of the services may be with Non-Specialty Mental Health Providers and some with County Behavioral Health. Neither MCPs nor counties have the full data set for reporting. There is no way to report on them or to improve quality on these rates without working in an integrated way.

Lewis: There isn't comparable data on fee-for-service (FFS) access. Although it would be mostly access and utilization, can we do more to educate people about how that system is working?

Babaria: For some measures, we have an analysis. As we launch the PHM program, it will include all data, not just managed care and that will answer some questions about gaps or issues to address for the FFS population.

Cooper: Overall, we see higher quality in managed care across most measures and cost is more balanced across aid codes in managed care. That is a reason DHCS is focused on managed care expansion. By January 2024, 99.5 percent of members will be in managed care where there are better outcomes, better quality, and better cost. Clearly, there are still improvements to make but we believe managed care is the best delivery system for our members.

Bradshaw: There are high health inequities in rural communities. They are often poorer, less educated, and have fewer resources, access to food, transportation, housing, et cetera. In a recent comparison of demographic and economic indicators between urban and rural, data indicated 9 percent of urban residents had three or more challenging indicators and that was over 30 percent for rural residents. It is more challenging to meet the quality indicators because of the populations we serve as well as the workforce shortages. Is there consideration of adjustments to the quality benchmarks or a different approach in rural communities?

Babaria: Yes, rural challenges surface in every implementation and quality and health equity discussion. The regional collaboratives have surfaced those unique needs and we are looking to scale creative approaches, like mobile clinics and telehealth, more effectively for rural areas.

2024 Health Plan Contract Implementation and Health Plan Transitions
Susan Philip, and Michelle Retke, DHCS
Slides available

Philip provided information about the MCP readiness process, and the four operational readiness and transition areas for launch of 2024 MCP contracts. She reviewed contract readiness deliverables and noted the key deliverables in critical domains that must be reviewed before a go/no-go decision for startup in 2024. Philip offered a status update on the process, such as the number of deliverables submitted and approved, and next steps. Implementation of some provisions, such as closed-loop referrals and school-based services, are delayed to 2025 to allow for additional readiness. Philip reported on MCP transition policy to ensure members do not experience disruptions with the change in MCP contracts. Continuity of Care (CoC) requirements were the first aspect of the policy guide released and member enrollment will follow shortly. There is a deep-dive assessment for MCPs with risk, such as MCPs entering a new market or a

substantial membership change.

McNaughton: Behind the scenes, how is DHCS working with the survey team to onboard the teams conducting future audits to the new contracts?

Philip: There is ongoing work between the Quality Monitoring Division and the Audit and Investigations teams to align survey tools with the updated contract.

Cooper: There is usually a lag between the time something goes live and when it is added to the audit tool. Changes probably wouldn't happen in 2024, but in the subsequent year.

Pittman-Spencer: Does the delay in closed loop referrals include dental? Can you speak more to enforcing dental requirements with MCPs?

Philip: Yes, the delay includes dental. More time is required for providers to ramp up capabilities and for policy guidance as well.

Cooper: We are not removing the current and longstanding requirement for MCPs to do dental referrals, only delaying the closed-loop referral element.

Barlow: When will the updated version of the boilerplate be available? When we last checked in to clarify emergency department responsibility for MCPs versus MHPs during a psychiatric crisis, we were told that CMS was reviewing an updated version of the boilerplate.

Retke: The boilerplate version on the website is the most current. The existing boilerplate is all-encompassing and we are no longer posting separate County Organized Health System or Geographic Managed Care versions.

Cooper: We will take that back. Typically, the team waits to post a new version after CMS approves the contract and CMS is far behind on these approvals. We will work to get approval or send you that version directly.

Leach Proffer: Thank you strengthening CoC requirements. For people with disabilities and specialized healthcare needs, the ability to continue seeing specialists and have access to equipment is the largest concern with any change like this. Given that this is a large transition, we recommend more than a 90-day extension to ensure needs are met; more like six months would be a reasonable timeline for plans to develop relationships and contracts with new DME providers.

Philip: I appreciate the comment. One item to highlight is that we are identifying the members who are transitioning about two months in advance and providing member-specific data to ensure continuity. There are limitations to how early we can identify transitioning members .

Wright: In the data, is there a concern about the distinction between what was submitted vs approved, given there is a difference of 200 between the two? What is the no-go option?

Cooper: As you heard, there are many items that must be filed. Some are more critical to the decision than others in terms of readiness to provide the needed care. We need to decide within a certain timeframe to send notices to members. We are looking at contingency plans for outstanding issues. The big concern would be with any plans entering a new market. We have ongoing reports internally on the status and can come back with more information. We hope all MCPs will meet the go-live readiness for their areas.

Wright: Is there further clarity on how members will be distributed between the two MCPs in Los Angeles that are subcontracting?

Cooper: In Los Angeles, we will look at HealthNet and Molina regarding readiness for transition.

Baass: We are also looking at provider overlap and trying to transition from HealthNet to Molina with provider continuity.

Wright: Will DHCS provide the process by which some folks are staying with Molina and others will transition? How are people choosing?

Baass: We can walk through an enrollment scenario at a future meeting.

Wright: It is unique, but there are a lot of members. Finally, are there provisions for anticipating challenges with augmented call center capacity to handle any individual problems?

Cooper: The top issues for go/no-go include CoC, network adequacy, and member services, including making sure MCPs have the capacity to answer all of those calls and direct someone who needs a CoC request to the right place.

Retke: For the state call center capacity, there are Ombudsman and Health Care Options teams. As state staff, the Ombudsman employees go through extensive training and receive frequent updates. There is flexibility with the Health Care Options enrollment broker team to ramp up when large transitions happen. And both the call center staff and the enrollment service representatives in the field receive training and join the Ombudsman team for topics, such as dual eligible beneficiaries.

Lewis: One challenge with CoC is the complexity. It's hard for people changing plans to know if their services will be prior authorized or are still covered. We know from other transitions that members get billed by providers due to changes in provider contracts. We are concerned that there is no automatic protection for members for 30 or 60 days, regardless of whether the provider has an agreement, so the provider will be paid by the new plan or FFS and cannot go after the member. Some of this is in the CoC plan, but it is not as robust as I am recommending. I also have a question about notices. The new notices are for members moving from one plan to another but there is no notice for those folks moving from FFS to managed care or new options of plans coming online where they may choose to change, such as Kaiser.

Philip: On CoC, the intent is to ensure that for vulnerable and individuals with complex conditions, the continuity is presumptive. That is included in the COC policy guide, so if additional clarification is needed, please let us know.

Retke: The 2024 notices will be going out for comment in June.

Koopmans: Thank you to the DHCS team for working with local plans on operational readiness. On CoC, there is a shared interest in not having any member disruptions. Our greatest concern on CoC is how critical it will be to have data at the right time and in the right format. Despite excellent policy, if the data is not able to be used, the transition will not be smooth.

Philip: We are using the experience from the exit of a MCP in San Diego as a small-use case to inform the data elements and improve the transition.

Gonzalez: It may be challenging in the first months. How is DHCS planning to track the transitions overall and how can providers engage? One of our key concerns is post-discharge issues and unfortunately, December and January tend to be high hospitalization periods.

Owen: Operational readiness has been clear and organized. It has catalyzed readiness, expedited clarifications within the contract and policy guidance, and enhanced the implementation for quality and equity. My emphasis would be to ask for clarity from DHCS on the low-priority plans that are not subject to the go/no-go. With 77 percent of the deliverables approved, we are ready to begin implementing and it would help to have clarity if there are additional processes or a site visit so we can implement policies that have been approved.

Cooper: We will follow up to make sure plans know which category they are in.

Perrone: I can assume from the budget that rate increases are about 13 percent for FFS. Does that seem about right to bring primary care providers to 87.5 percent of Medicare? It is harder to know what the numbers may be in MCPs. We hear MCPs pay more than FFS. How much do you expect the increase to be to physicians contracting through MCPs?

Cooper: It will vary by category. Most MCPs already pay about 80-90 percent of Medicare to primary care providers so the increase will be more noticeable on the FFS side. There are some primary care codes where MCPs are paying lower. It is a different story for OB where both FFS and MCPs are about 60 percent of Medicare and is where the largest impact will be. On non-specialty mental health, it really varies. There are some that are low and will increase to reach 87.5 percent of Medicare and others that were added in more recent years and have a higher rate.

Perrone: It sounds like for maternity care, this is a significant increase. Also, that the long-term certainty is important to drive changes. It is less clear how significant this will be in primary care. I'm wondering if MCP representatives would comment on how significant this is to providers.

McNaughton: It varies. For behavioral health, our rates are higher now than Medicare to ensure access. Primary care is also close to 100 percent Medicare already. We raised rates in these areas previously. In some specialties, such as anesthesia, there will be bigger increases for providers.

Owen: Our experience is similar in that primary care and behavioral health are already higher and the major impact will be in specialty provider rates.

Cooper: We are trying to raise all boats. Some plans are lower than the average and some, as you hear, are higher. This effort will standardize and mandate that the rates get to the provider.

Perrone: Will the MCPs receive rate increases?

Cooper: We don't build capitation rates from the FFS schedule. It is built from what the MCP pays providers. If they pay more, it's built in. In this case, it won't take two years to build that into rates because it is a new mandated rate MCPs must pay.

McNaughton: The Medicare rate structure is different for every single hospital and different for each region, even within the state. When you look at how CMS puts all that together and what we are trying to benchmark on the state side, you really must look at an equity approach.

Cooper: The rate increases will also apply to nurse practitioners and physician assistants.

CalAIM Update
Jacey Cooper, Susan Philip and Palav Babaria, MD, DHCS
Slides available

Babaria reviewed Enhanced Care Management (ECM) milestones and implementation. She reported that the children's population of focus for ECM will launch in July 2023 to provide whole-child navigation beyond what is currently provided. In January 2024, ECM will launch for individuals transitioning from incarceration and birth equity populations of focus. Babaria also reported on early ECM implementation data for the top four populations of focus. She noted that, from January – June 2023, ECM was live only in counties that previously had Whole Person Care (WPC) or Health Home pilots and since July 2023, ECM has been statewide. Over 88,000 members are enrolled in ECM statewide, and enrollment is expected to continue to ramp up.

Philip reported on ECM and Community Supports (CS) providers and DHCS efforts with MCPs to increase take-up. About 27,000 members received at least one CS, the majority receiving housing-related services in counties transitioning from previous WPC. Cooper walked through a logic model developed from input in listening sessions. The goal is to increase uptake of ECM and CS for members in need of CS through new and revised policies to standardize eligibility, streamline referrals, expand providers, improve data exchange, and raise awareness.

Philip provided updates on Dual Special Needs Plans (D-SNP). Plans launched in seven counties in January 2023 and will launch in five additional counties in 2024. By 2026, all counties will have D-SNP plans. Philip highlighted policy updates related to this expansion which include requirements for D-SNPs to include ECM, palliative care, and dementia care in their model of care submissions as well as coordinate dental benefits across Medicare and Medi-Cal.

Questions and Comments

Barcellona: To be successful in ECM, physicians need to have admits, discharges, and transfer (ADT) information from hospitals and know when patients visit the emergency room. We need DHCS support in accomplishing this so that Quality Improvement Organizations (QIO) can implement this on behalf of independent physicians.

Cooper: We are supportive of ADT data feeds from all the entities who are required to do that and ensuring this flows through contracts with MCPs as well.

Gibbons: We have heard from counties and local health departments a desire for standardization across the multiple plans, including billing and authorization and appreciate DHCS is working on that. Is there a report that provides the penetration of providers and the service they offer by geography for ECM and CS?

Cooper: MCPs are required to include this in the provider directories and manuals. Teams need to be community-based, so their office address isn't as pertinent. Let me take that back to see how we could represent that accurately.

Barlow: I want to echo the implementation difficulties flagged by hospitals. Emergency room staff are having challenges connecting frequent users with complex conditions into ECM. At the ground level, there is still confusion for challenging cases such as significant behavioral health conditions.

For example, I'm being asked to assist in a rural county where an individual has been in a medical surgical bed for six months. He has bipolar disorder and needs a long-term care facility. There is confusion about who should follow up and how to accomplish the vision of having one person to coordinate care for all the providers in a patient's life.

Cooper: ECM providers are tailored to specific population needs. ECM for transitioning home from a long-term care facility is very different than ECM for individuals experiencing homelessness or severe mental health conditions. We hope to see more contracts between MCPs and County Behavioral Health. Full Service Partnerships (FSP) vary by county and that has made it challenging to offer clarity about how ECM and FSP fit together. Under BH-CONNECT, we are focusing on through-put from emergency rooms to placements which is another reason MCPs and county BH partnership is important.

Baass: We are working to pull together MHSA and other planning processes to form a cohesive approach. BH-CONNECT is a three-year planning process and we hope to expand that to all the partners of the community-based mental health delivery system. More to come on that.

Barlow: Who at DHCS is best to talk through individual cases that are forming a pattern so I can help hospitals understand whom to turn to?

Baass: Through the children and youth system of care, the state has a technical assistance team that triages situations.

Cooper: For ECM, the point of contact at the state is with Palav Babaria, Chief Quality Officer.

Moulin: ECM is exactly what the population needs, however the logistics make it hard to navigate. For example, the person who needs ECM is likely to come in nights and weekends and will be hard to contact, so having prior authorization and referral to another provider is challenging and may result in losing the opportunity again and again. Is there a thought about co-locating ECM staff in the emergency room or creating conditional eligibility for individuals intended for ECM?

Cooper: More and more plans are moving to presumptive eligibility, especially where the case is clear-cut. I agree that having staff connected to the emergency department is a best practice. DHCS has been paying for embedded navigators in hospitals through Cal Bridge and that may be a great liaison to ECM. We will take this back.

McNaughton: We hold joint operating meetings with hospitals to dig into the details of what is working or not. Sharing data has proven helpful to get people enrolled in ECM teams. It is a great idea to embed ECM workers in the emergency department.

Cooper: MCPs have the full ability to embed ECM or to encourage ECM providers with a population focus of high utilizers to be co-located in the emergency department. We will follow up to think about sharing best practices across MCPs and how they are focusing on utilization. The core of ECM for high utilizers, proven time and time again with study after study, is that you can have a significant impact if you intervene in a timely way. Thank you for your comments.

Leach-Proffer: Is it possible for DHCS to publish the list of CS available by MCP and county?

Cooper: We will send the link in follow-up to this meeting.

Lewis: On ECM, are the numbers unduplicated? Is there a projection for plans on who should be

in ECM by adults and kids?

Cooper: On the first question, ECM is unduplicated. CS is not unduplicated because a member can receive more than one CS during a time period. On the second question, we will have plan-specific ECM enrollment data later this year by plan and county. We are building the dashboard.

Babaria: We will get as granular as possible within the size of the data set. In addition, the Incentive Payment Program in years 3-5 will show the penetration rate of eligible ECM and enrolled members. PHM key performance indicators is another source of data. We will collect and summarize findings later this year.

Koopmans: Reporting utilization by population of focus is challenging because many members will qualify for multiple categories and services.

Cooper: There will be guidance for how to report the primary population of focus and data quality will improve over time. It is important to see that the provider types for those populations are growing and that individuals in those populations of focus are getting services, understanding they could be in multiple categories. All populations of focus are required, not optional.

Nguy: We appreciate the granular data on ECM and CS by demographics. On CS data, can DHCS provide an unduplicated count of anyone getting housing-related CS?

Cooper: Yes, we can follow up to provide that.

Kelley: I agree that county behavioral health can be a good ECM provider. I want to flag the challenge of having to go into three different databases as an ECM provider. There is a need for standardization between CS and requirements for housing navigation with Behavioral Health Bridge Housing, as well as the MHSA modernization with FSPs housing support.

Cooper: I would like to follow up about the bridge housing requirements and the overlap so that I can bring the right team members to the discussion. Thank you for being an ECM provider.

Veniegas: I know that historically this body has been intentional about including youth-centered voices. Given the important populations of focus for people who are experiencing homelessness and individuals who have been justice-involved, there might be an opportunity moving forward to think about consumer advocates and providers who could be included with the advisory committees that represent these populations of focus. I am happy to help recruit, particularly from our Los Angeles County network.

Cooper: Thank you. We have a children's group. We can check to make sure we have enough representation. I appreciate the recommendation and offer of support.

McNaughton: When the audit team goes through the care management system for ECM, we want to make sure that if the data requirement is released, the audit team is up to speed on data system requirements.

Cooper: We don't require that provider's input into your system. Some plans do that, others are not. We require that your team knows the assigned ECM provider and it is documented and shareable with DHCS, or the case manager if it's not ECM. We require the case manager or complex case manager, or ECM provider to be documented in your system and available.

Mollow: A follow-up comment to the discussion earlier on the videos. There were issues with the upload on videos and we are working to get it on the website. They can be found on the DHCS YouTube link, and the team is working on getting that link updated on our website. To follow up on the text messaging, DHCS messages are general. MCPs and counties will do targeted messages.

Public Comment

Yvette Willock, Los Angeles County Justice Care and Opportunities Department: I want to thank DHCS leadership for the listening tours and for using the information to make adjustments. I worked previously in an LA County department contracted with four MCPs as an ECM provider. There were challenges meeting the requirements and standards that the four different plans had for a given task. We have wonderful working relationships with the health plans and are seeking to streamline things, but grateful that DHCS leadership received that information across the state and will be providing updated guidance to streamline things and to standardize for ECM providers who serve the justice-involved population. Standardization and streamlining will be significant to support the continued expansion of ECM providers versus having it get smaller because providers are unable to meet the various requirements. I am grateful for your receiving that feedback from various providers across the state and making the adjustments. I look forward to reading the updated guidelines.

Next Meeting, Next Steps and Adjourn
Michelle Baass, DHCS

Baass noted that hybrid meetings will continue. The next meeting is July 20, 2023, from 9:30 a.m. to 1 p.m. for the joint SAC and BH-SAC and 2 – 3:30 p.m. for the BH-SAC meeting. There will be further communication about agenda topics.