DEPARTMENT OF HEALTH CARE SERVICES

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

Hybrid Meeting
February 16, 2023
9:30 a.m. to 3:30 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; Anne Donnelly, San Francisco AIDS Foundation; 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; Anna Leach-Proffer, Disability Rights California; Kim Lewis, National Health Law Program; Beth Malinowski, SEIU; Jarrod McNaughton, Inland Empire Health Plan; Sarita Mohanty, MD, SCAN Foundation; Erica Murray, California Association of Public Hospitals and Health Systems; Linda Nguy, Western Center on Law and Poverty; Jolie Onodera, California State Association of Counties; Chris Perrone, California HealthCare Foundation; Brianna Pittman- Spencer, California Dental Association; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Laura Sheckler, California Primary Care Association; Janice Rocco, California Medical Association; Cathy Senderling, County Welfare Directors Association; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; 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: John Cleary, MD, Children's Specialty Coalition; Mark LeBeau, California Rural Indian Health Board; Sherreta Lane, District Hospital Leadership Forum; 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; Kirsten Barlow, California Hospital Association; Ken Berrick, Seneca Family of Agencies; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; Jessica Cruz, NAMI; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Laura Grossman, Beacon Health Solutions; Robert Harris, Service Employees Service Union; Virginia Hedrick, California Consortium of

Urban Indian Health; Veronica Kelley, Orange County; Karen Larsen, Steinberg Institute; Kim Lewis, National Health Law 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; Catherine Teare, California Health Care Foundation; Gary Tsai, MD, Los Angeles County; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services.

BH-SAC Members Not Attending: Alex Dodd, Aegis Treatment Centers; Sarah-Michael Gaston, Youth Forward; Andy Imparato, Disability Rights California; Linnea Koopmans, Local Health Plans of California; Robert McCarron, California Psychiatric Association; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Jonathan Porteus, WellSpace Health; An-Chi Tsou, SEIU; Mandy Taylor, California LGBTQ Health and Human Services Network, a Health Access Foundation program; Jevon Wilkes, California Coalition for Youth.

DHCS Staff Attending: Michelle Baass, Jacey Cooper, Yingjia Huang, Aaron Toyama, Autumn Boylan, Pamela Riley, MD, René Mollow, Anastasia Dodson, Susan Philip, Michelle Retke, Tyler Sadwith, Sydney Armendariz, Jeffrey Callison, Morgan Clair, and Clarissa Sampaga.

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

Welcome, Director's Opening Comments, Introduction of New Members, Roll Call, and Today's Agenda

Michelle Baass, DHCS Director

Baass welcomed the committee and shared the plan for the day. Baass introduced new SAC members: Amanda Flaum from Kaiser Permanente and Trina Gonzalez from the California Hospital Association. She also noted that this would be the last meeting for Stephanie Sonnenshine, who shared that she appreciated the committee and its commitment to Medi-Cal.

Director's Update

Michelle Baass and Jacey Cooper, DHCS

Presentation Slides

Baass and Cooper presented an overview of the Governor's Budget. The budget

continues the expansion of Medi-Cal for undocumented individuals 26-49 years old and significant CalAIM commitments and investments. The budget also includes a renewal of the managed care organization (MCO) tax. DHCS is working with the Centers for Medicare & Medicaid Services (CMS) on how to support the Medi-Cal program with the MCO tax.

Cooper reported on a proposal related to the Designated State Health Program (DSHP) and primary care and obstetric rate increases based on the recently approved 1115 waiver. DHCS adjusted primary care fee-for-service (FFS) rates as managed care was paying higher than 80percent. OB/GYN rates increased for both managed care and FFS. The 10percent increase will apply to codes that were under 80 percent of Medicare. The budget includes funding for the California Behavioral Health Community-Based Continuum (CalBH-CBC) waiver to be discussed at the BH-SAC meeting today. It includes $6.1 billion in funds over five years for implementation. Transitional rent will be added as a benefit under CalAIM managed care and as a specialty mental health services benefit under the CalBH-CBC, recognizing the importance of more community supports to assist members.

Cooper presented on the Reproductive Health Services waiver for a $200 million investment to ensure Californians continue to have full access to all reproductive health services. DHCS will submit an 1115 waiver capacity-building initiative with 50/50 match and request DSHP for this service to reach 85 percent federal match. DHCS will make grants to reproductive providers to add evening and weekend hours or other strategies to add capacity given the Supreme Court decision striking down *Roe v. Wade*. The program will be posted for a 30-day public comment period in March and will then be submitted to CMS.

Behavioral health proposals include:

- A proposal to strengthen oversight of the substance use disorder (SUD) licensing and certification program to ensure staffing, oversight, and transparency of the program.
- Additional funding from Opioid Settlement Funds for opioid response.
- Additional funding for county costs within the Community Assistance, Recovery, and Empowerment (CARE) Courts program.

There were no reductions to DHCS in the budget. Delays include the Behavioral Health Bridge Housing (BHBH) program, Behavioral Health Continuum Infrastructure Program, and Buyback of the Two-Week Checkwrite Hold.

Questions and Comments

Gibbons: I have concerns about Trailer Bill Language (TBL) related to children and youth with California Children's Services (CCS) and want to understand how they are accessing services and how that is being monitored. A coalition of child and youth

advocates sent a letter to DHCS to request a timeline for reviewing the evaluation.

Cooper: The team will reach out for a meeting with County Health Executives Association of California (CHEAC), its members, and managed care plans (MCPs), and will release the evaluation shortly thereafter. The purpose of the expansion is that the whole-child model should be consistent across counties. DHCS wants to align single plans with County Organized Health Systems (COHS). We are happy to engage about the concerns. The proposed phasing was based on earlier feedback from CCS partners and other stakeholders.

Wright: Is there anything in the budget or that is needed in the budget on plan readiness for expansion and the changes in January 2024? Anything with either MCPs or patient communication, especially for those who might have to change plans?

Cooper: We are in the midst of the readiness process with many deliverables expected from MCPs and many changes in how communication will roll out to providers and members. Teams are meeting with all the plans, including conducting site visits, to ensure readiness for the transition. In the summer or fall, DHCS will make go/no-go decisions. Additional resources were added previously and are in place.

Wright: What if there's a no-go decision and a given plan is not ready for expansion?

Cooper: We are planning contingencies now. This would vary by county, region, plan, etc., to minimize disruption and confusion for members. We will post a policy document this spring that will outline the information and it will be updated throughout 2023.

Nguy: Will information about the network overlap be available to members transitioning to new plans?

Cooper: We haven't historically posted the readiness submissions that include provider networks. We'll get back to you.

Philip: We don't share readiness materials, but are doing careful transition planning to communicate which plans are exiting, new, etc. We are producing a MPC transition policy guide and will share that. This has all the different policies relevant to the 2024 transition, and DHCS will make it public this spring.

Nguy: I also want to publicly appreciate DHCS' commitment to fully implement Health for All. I want to note there have been budget commitments to implementing supports for members with share of cost Medi-Cal and continuous Medi-Cal eligibility.

Kelley: Is it a full or partial delay of BHBH?

Cooper: It is a partial delay.

Sonnenshine: On the MCO tax, I urge DHCS to work with health plans to ensure these are reinvested in the Medi-Cal delivery system, supporting provider network capacity. For the primary care rate increases, I understand the emphasis is on FFS. Will DHCS

consider improving capacity of primary care providers in managed care? We hear that our primary care partners are struggling and want to ensure they are robust enough to accept new members.

Cooper: We agree. If a MCP is paying below 80 percent and we adjust those codes, the increase would have to flow through to providers. Most plans are not in that situation. We are conducting our own analysis in addition to these remedies.

Lewis: Is the reproductive health services 1115 waiver a new waiver or an amendment to the existing waiver? Is there TBL intended to be released? Is there a concept paper or any other details you can share? Does it include services for people coming from out of state?

Cooper: It will be a separate 1115 waiver. It will cost $200 million with only a small portion from the General Fund. We will request budget neutrality and DSHP. DHCS will do a full proposal for public comment, submit it to CMS, negotiate a waiver with CMS, and then issue guidance. From a cash flow perspective, it will be outside the current fiscal year. We are including it this year for transparency, and the Legislature will need to approve the funds. The intent of the funding is not to pay for direct services, including out-of-state abortions. The approach is to ensure that we can maintain the capacity of our reproductive health network and system across the state and ensure they can meet the demand of both Medi-Cal and other individuals. We will release the proposal for public comment in early March and hold 1 to 2 public hearings.

Eisen: On the increase in license fees, will the mandatory certification program include all outpatient SUD treatment programs? Is it necessary to increase fees, given there will be more programs included? Will there be a fuller stakeholder input conversation about how the state is planning to use the federal Opioid Settlement Funds (OSF) beyond naloxone distribution?

Cooper: The certification will be for outpatient programs. DHCS conducted an assessment in the budget change proposal and that is public. Since 2017, there were multiple new proposals for DHCS to work on licensing without funding, and we need to ensure we have the oversight capacity and accountability for these responsibilities.

Sadwith: We share more information on OSF in the Governor's Budget.

Ramirez: Can DHCS provide language with the initiatives to ensure counties and providers have the technical expertise and support to ensure services are truly accessible, especially for those with disabilities and linguistic needs and use trauma-informed and culturally accessible practices? Based on a letter I received, I am concerned about transitions, disruption, continuity, access, communication, and equity. What ensures that members continue to have timely access to services that are disability accommodating, trauma informed, and culturally responsive?

Sadwith: As DHCS implements federal requirements related to continuity of care for members transitioning between delivery systems, including between counties or MCPs, there are federal protections in place related to continuity of care. We have issued

guidance for county mental health plans (MHPs) that outline their obligations to communicate with Medi-Cal members the continuity of care options. County MHPs are required to take steps for up to 12 months to coordinate with members' mental health providers and enter into agreements to continue delivering services to that member even if that provider is not part of the MHP network. However, providers are not obligated to enter these agreements with the new MHP, so this is not a guarantee of continued access. I can share the policy guidance that is publicly available. There are federal and state standards in place, and DHCS is strengthening standards for timely access through network adequacy, time and distance standards, as well as strengthening oversight, access, and availability of mental health care for members.

Cooper: Tomorrow we will announce the Medi-Cal Member Advisory Committee and implementation consultant, Everyday Impact Consulting, for member training and engagement. The first meeting is planned for later this spring, with funding from the California Health Care Foundation and Lucille Packard Foundation.

Golden Testa: The system changes for multi-year continuous coverage of children and youth takes about a year. Was this budgeted for this year?

Baass: The California Statewide Automated Welfare System (CalSAWS) change orders are part of the normal maintenance and operations. When the full statewide CalSAWS system goes live, it is accounted for in the budget.

Golden Testa: How does the trigger language work for this policy? Does that mean that readiness for implementation can't start until there is a decision about future General Funds?

Baass: We plan to convene the group to start thinking about this later in 2023 so we can go live on January 1, 2025. We will engage pending the appropriation and will start readiness activities.

Unwinding of the COVID-19 Public Health Emergency (PHE)

Yingjia Huang and Aaron Toyama, DHCS

Presentation Slides

Huang presented updates on the continuous coverage unwinding. She reported that the federal government has delinked the COVID-19 PHE from the continuous coverage requirement that kept enrollees in continuous coverage since March 2020. The continuous coverage protection ends on March 31, 2023. The official ending of the PHE is May 11, 2023. California will implement the unwinding plan on April 1 with a June 2023 renewal/redetermination date. Auto-renewal, followed by a packet mailed with online renewal options will begin on April 1. The first Medi-Cal disenrollments will occur on July 1, 2023.

DHCS engaged more than 1,700 Coverage Ambassadors and launched a toolkit that includes social media graphics, customizable flyers, call scripts, printouts, and other materials. DHCS also launched www.KeepMediCalCoverage.org to help direct members and partners to county portals and other pathways.

Toyama presented an overview of how the unwinding will affect areas beyond Medi-Cal redeterminations referenced in Part One of the Medi-Cal COVID-19 PHE and Continuous Coverage Operational Unwinding Plan.

Questions and Comments

Veniegas: HHS released data in August 2022 indicating that administrative churning would result in about significant numbers of Native Hawaiians and Pacific Islanders losing their continuing coverage. What is planned to focus on these communities? Are there opportunities for COVID relief outreach groups and other trusted messengers to share messages?

Huang: That is top of mind, and we will share this with Ambassadors. Some members may qualify for other coverage (e.g., employer, Covered California, Medicare). We are working closely with Covered California and GMMB to create targeted, cohesive messaging and materials for those most likely to be moving between programs. Senate Bill (SB) 260 automatically moves people to a Silver Plan in the Exchange if they are over income for Medi-Cal, and we are coordinating with Covered California so the consumer journey is seamless.

Rocco: Is there a plan to get materials to providers so they can help with messaging? A fact sheet with continuity of care information would be helpful for those changing plans.

Huang: A targeted toolkit for providers is in the works. Covered California and DHCS are creating a continuous coverage fact sheet that we will disseminate broadly.

Africa: Our county is moving from CalWIN to CalSAWS in the next few months, adding to the complexity of ensuring continuous coverage. We have staff that have never done redeterminations and it takes about six months of training to come up to speed. Is there anything other than written materials we can use to support this process?

Huang: Counties are providing information through the Readiness Toolkit, and DHCS will provide technical assistance. We know the system migration is a vulnerability that introduces risk layered on top of the unwinding. Counties have mitigated these risks wherever possible.

Lewis: What is the current successful renewal rate for those who go through various pathways?

Huang: In prior months, 25 percent were auto renewed, but with all the flexibilities it has increased gradually to 30 percent. This is lower than pre-COVID given stale data.

Lewis: Will County readiness plans be available publicly?

Huang: Plans are still coming in. We are planning targeted conversations and report-outs with stakeholders. There are common concerns, and we will prepare a summarized report of themes.

Lewis: I suggest you set up a statewide phone number for counties when people can't get through and to help highlight difficulties/hot spots. On tracking the undeliverable mail, is this for the February member letter or a separate effort? What will happen with that information?

Huang: The February mailer is sent to all 9 million Medi-Cal households, similar to the earlier mailer, letting members know that there is an end date to continuous coverage, plus FAQs and bar codes to easily assess return rates. This will help us know if additional flexibilities have effectuated any uptick in terms of finding people. The yellow envelopes will house the actual redetermination packets once renewals begin and will be pre-populated.

Lewis: There has been variation in what materials are available in which languages. It might be helpful to have centralized information on when/where to access materials in every language.

Golden Testa: It would be helpful to have contingency plans for county readiness and also to have materials and the website available in more languages. What will the state do with undeliverable mail returned via the February mailer?

Huang: A feed on undeliverable mail will go back to counties. They have a business process to verify updated information by phone or text and update the files. DHCS will keep track of this, too.

Golden Testa: Will there be materials to share with schools about how they can help with reinstatement?

Huang: We meet with the California Department of Education regularly, especially on data matching. We will develop specific targeted messaging for sister agencies and share that when ready. Current messaging is general and broad.

Golden Testa: Will you explore working with Community Health Workers (CHWs) or other individuals to target specific communities of color?

Huang: Media principles, strategies, and phases being developed. We are focused on awareness now and will take this idea back to the Continuous Coverage Unwinding Workgroup.

Golden Testa: I suggest GMMB join our next meeting to share their outreach plans.

Hedrick: Is there a plan for any communications to American Indian/Alaska Native community, particularly those accessing services through the Indian Health Care delivery network?

Huang: Yes, we have directed GMMB to develop a Tribal-specific toolkit that will be shared for comment through the Office of Tribal Affairs.

Gibbons: Local health department state-supported test sites closed recently, and resources will further decline. We need to disseminate messaging to members and the general public about how to access resources and provide information on how to access testing resources going forward.

Cooper: We are partnering with the California Department of Public Health (CDPH), including issuing guidance to MCPs. DHCS issued an All Plan Letter and Medi-Cal has a very broad benefit for COVID testing. We want to ensure health plans and members understand where they can access tests and treatment.

Malinowski: Our local unions want to be strong partners and have indicated they have not been part of the county readiness planning. Please consider engaging labor partners in this process.

Nguy: We are interested in the call center staffing issues given the difficulties in reaching counties even before the unwinding. What will the call center metrics entail? Will GMMB be forming outreach partnerships with the community, and if so, when?

Huang: We are assessing call center metrics. For workforce vacancies, counties are transparent about this and looking at creative ways to manage the workload. DHCS is supporting them to create special task forces related to the workload; for example, how to direct the flow of redeterminations when they come in. We will work alongside the County Welfare Directors Association over the next 14 months and understand the need for monitoring and strong county partnerships. GMMB will present at the Unwinding Workgroup tomorrow and discuss partnerships. They have a rigorous plan for ongoing interviews as they continuously monitor and refine the campaign strategy.

Wright: Does DHCS know, or have you modeled, how many people are in each of the categories of transition away from Medi-Cal? Does the communications plan include outreach to special groups, such as the COVID-19 Uninsured Group?

Huang: We don't have concrete numbers or projections. We estimate 2 to 3 million individuals will be disenrolled, and some will move to Covered California, employer-sponsored insurance, or Medicare via special open enrollment. Others may get back on Medi-Cal after a preliminary 90-day disenrollment and renewal process. SB 260 should help with some of the movement and lag between Medi-Cal and Covered California. There are 440,000 individuals in the COVID-19 Uninsured Group this month, and they will receive a 60-day notice about their coverage ending, hearing rights, options for coverage, and a copy of the single streamlined application. This group is not included in the streamlined SB 260 process because they are in FFS Medi-Cal, not case-managed at the county, having entered through a presumptive eligibility construct. They will have to complete a full application for continued coverage.

Wright: How does this communications plan crosswalk with the contract/plan changes in January 2024?

Cooper: We're doing scenario planning on this. We will continue the redetermination process as federally required throughout this time period, and there will be separate notices tied to health plan transitions in January. We are trying NOT to disrupt individuals coming in and out around plan changes in the limited number of counties, but we will release scenarios and use cases based on specific counties and situations. There will be opportunities for feedback with stakeholders shortly, and we will publish this information in the policy guidance.

Wright: We appreciate you not aging out the young adults in Health for All, and I wonder if pushing back some counties until these changes happen would avoid more patient disruptions?

Cooper: We should note that the data will be ambiguous; some people will not respond or renew their Medi-Cal because they have other coverage. We will be trying to cross check data across multiple sources to assess the outcomes as well as possible.

Senderling: Counties have been planning for the unwinding for almost three years, but the sheer volume pending is unprecedented. Counties are in a constant series of training, hiring, and trying to target the workforce. We really appreciate the strong partnership with DHCS, including meetings, refresher trainings, etc. Please reach out to me for troubleshooting general issues or specific issues in any county. We are very committed to maintaining people on coverage!

Donnelly: Thanks to DHCS for partnering with CDPH and the State Office of AIDS to see if people living with HIV who may be disenrolled could be connected automatically with the benefits through Covered California and through the AIDS Services Program and the Health Insurance Portability Payment Program.

Ramirez: Will there be any special outreach to those who contracted COVID-19 and long COVID or exacerbated cardiometabolic and other medical conditions during the pandemic? As we transition, this is an opportunity to target specialized health services to this high-risk group.

Cooper: Unfortunately, we don't always know when someone tests positive for COVID. The main thing we can do during the unwinding is to remind everyone how important it is to remain covered and not have a gap in coverage or access. This message should reach everyone.

Ramirez: I recommend messaging that people who have been exposed or contract COVID check their enrollment since coverage is even more important in this case.

CMS Approval of CalAIM Justice-Involved Initiative

Jacey Cooper, Autumn Boylan, and Aaron Toyama, DHCS

Presentation Slides:

Cooper shared that she was pleased to announce that CMS approved the state's 1115

demonstration around justice-involved individuals and in-reach services. Cooper noted that 80 to 90 percent of people incarcerated at any given time are on Medi-Cal or eligible. Cooper highlighted this as a critical health equity issue since individuals of color are disproportionately incarcerated in California by a wide margin. To change the trajectory, more is needed in terms of services and supports. Cooper shared that 17 counties piloted versions of the program during Whole Person Care (WPC). An independent evaluation showed promising outcomes. UBoylan shared that the effort will be led by Sydney Armendariz and the Office of Strategic Partnerships. She shared the eligibility criteria for justice-involved pre-release services, including one or more of the following conditions: mental illness, substance use disorder, chronic conditions, pregnant/postpartum, HIV/AIDS, or traumatic brain injury. Services will be available for a 90-day window prior to release to ensure they are enrolled in Medi-Cal and connect to a trusted care manager. The waiver approval included $410 million for a Providing Access and Transforming Health (PATH) capacity-building program to help support correctional facilities, county behavioral health departments, and other key partners to be ready for implementation in April 2024.

Toyama also spoke about the Reentry Initiative Reinvestment Plan.

Questions and Comments

Gibbons: If a county was already providing services, like coordinating health care services and care plans, can they not include them in the demonstration and get paid for them?

Cooper: We defined a list of services that will draw down federal funds that are currently not doing so. Since California has already invested significantly in the justice-involved population, specifically around Enhanced Care Management (ECM) and Community Supports, those services will be part of our reinvestment plan for this and how we invest our state General Funds. We've been funding Medication Assisted Treatment (MAT) in a variety of ways within jail settings, which are good investments for building the infrastructure/systems. This will require that MAT be provided within every correctional setting, and we will need to go back and forth with CMS to clarify new investments. It doesn't change what will draw down federal funds based on the list of services CMS approved in the waiver.

Gibbons: On the monitoring side, I understand county systems are expected to monitor in-reach, but what happens once individuals transition out into the community? Is each part of the system getting monitored on its own metrics?

Cooper: Yes, the independent evaluation will test all the components, including re-entry. The waiver was approved on the premise that this project would be budget neutral by reducing inpatient stays and emergency room utilization.

Gibbons: County health departments need to be a core partner since we often are the service provider in carceral settings.

Cooper: We will make sure we are clear on our list of partners.

Lewis: It's exciting to see the readiness assessments being done to understand our baseline. Some of this is outside of the waiver and already are required under federal law (e.g., coordinating Medi-Cal enrollment for juveniles). I want to see the reinvestment plan going to CMS, if possible.

Cooper: We will publicly post the reinvestment plan once it goes to CMS. Screening and enrolling for Medi-Cal went live on January 1, 2023, and we didn't need a federal waiver to do that, but AB 133 moved this from voluntary to mandatory for all counties. We have a full assessment that DHCS, CWDA, and counties have been completing so we have a full picture of how screening and enrollment are currently working across facilities, and we are working with counties to ensure implementation by June 30, 2023. There will be a separate process to screen adults for eligibility for in-reach services; all children and youth are automatically eligible.

Lewis: Many people come into the system for less than 90 days. Hopefully if they're on Medi-Cal managed care they won't lose it. There may be questions about how the capitation works for those individuals that hopefully can be resolved to support continuity. Having CHWs assist with applications would seem to make sense.

Cooper: We are working on guidance for how we will treat the suspension for short-term stays, maintaining coverage in managed care on the back end, and will make this very clear in our implementation plan to CMS. Basically, anyone who is incarcerated for less than 28 days will have a different aid code during their stay so we can be reimbursed for their in-reach services. We are working through the scenarios and the complex operationalization. We will also look at applications to understand trends around screening and dispensation. One promising practice is bringing CHWs and community-based organizations (CBOs) into correctional settings to help with screening and enrollment, also helping with connections to external agencies on release.

Teare: Will some of the PATH Justice-Involved Capacity-Building Program go to collective efforts within a community to do joint planning?

Boylan: We are considering the best model for the grant right now, and want to make sure there's sufficient support for correctional facilities and county partners to build critical infrastructure to operationalize the initiative. We will keep this in mind.

Cooper: Agencies that are eligible for ECM or CS will also be eligible for the other PATH funding, so this will be nuanced.

Sonnenshine: Do you have a sense of how many people will be eligible for ECM as they transition out of incarceration?

Cooper: We have estimates, but I don't have them handy.

Sonnenshine: Does the state have a sense of the workforce currently available for this work, either in the facilities or related partner organizations? Health plans will be hiring networks of ECM providers to support members as they transition out, so these data points would help us think about workforce development over the next several months.

Cooper: We don't have a good pulse on all the people doing the work across the state. It will likely be added to the next round of CalAIM Incentive Payment Program for health plans to start network assessment.

Sonnenshine: Will there be capacity targets as a component of the evaluation?

Cooper: This will vary, but some evaluation questions will be: Are members who are eligible for ECM services receiving those services? Are we connecting them to housing transition services or recuperative care in counties where this is available? We will also look at touches with primary, specialty, and behavioral health care post-release. In WPC pilots, people had higher rates of connections to SUD treatment. There are some amazing clinics that focus on the justice-involved population, and we will connect with those networks. It may not be feasible from day one and we hope to build this with IPP assessments and PATH funding.

Sonnenshine: Recognizing that individuals with traumatic brain injury (TBI) are one of the qualifying populations, is there thought about expansion of the assisted living waiver or other opportunities to expand capacity for residential placements for individuals experiencing TBI? From a health plan perspective, navigating TBI into stable housing when it doesn't exist is a big challenge.

Cooper: This has been a longstanding challenge. DHCS has expanded the assisted living waiver for slots and availability, but it's still not statewide. There are also investments on the California Department of Social Services side with the Community of Care Expansion grants, increasing assisted living facilities for people with behavioral health needs and TBI. We have more work to do with this population.

Fields: People coming out of incarceration settings don't differ fundamentally in their treatment needs when they have a severe mental illness/substance use diagnosis. It's important to look at the capacity in various counties for providing 24-hour treatment settings in the community for those coming out of carceral settings. We haven't seen expansion of these settings, and it's a competing triage with hospital discharges. We want to build a framework of integration or we will make the mistake of moving people from institution to supportive housing with no treatment in between, and then people will end up in hospitals and emergency rooms. We must expand county systems' alternatives to institutional treatment. There is a chance here to set a new model for transition planning to community-based treatment programs that are adequately designed and supported to prevent return to acute states or emergency rooms. Programs designed exclusively for populations exiting incarceration will have more stigma, and instead we can integrate these clients into general mainstream settings that will also improve outcomes.

Boylan: These are great points and helpful as we think about messaging and transitions.

Baass: The BH Infrastructure Program, which is intended to build out some of this capacity as well, was designed to be integrated in the way you suggest.

Grealish: We at California Council on Justice Behavioral Health want to continue to be thought partners and support this work. On provider capacity, we also think about hidden networks of community-based, trusted, credible messengers that live outside the mainstream Medi-Cal system, and how can we get them into the system to be ECM providers? We look forward to the reinvestment planning. When will MCP selection take place, especially for those in prison, to avoid multiple transitions? Can an ECM provider help with this? Is the process of managed care suspension for those incarcerated for a short timeframe worked out?

Toyama: In-reach is built on a FFS environment with billing and enrollment similar to Medi-Cal FFS. Transitioning effectively to the community is important. We are planning for an auto assignment to a health plan and then choice. The goal is to find ways to reduce time between release and enrollment, so people are enrolled upon release.

Cooper: The majority of incarcerated people are already enrolled in Medi-Cal and assigned to a health plan. We will have more information and guidance about suspensions soon.

Donnelly: Under the waiver, will people in jails, not just prison, have access to hepatitis C treatment?

Cooper: I think so, but we'll get back to you.

Berrick: We must think really carefully about system integration as we move these initiatives forward. The Department of Juvenile Justice transition that's occurring is an opportunity to bridge and support transitions for these young adults. We should work together to make these transitions more effective.

Cooper: On that note, Eliza Hart form the Office of Youth and Community Restoration is here, and we're working closely together on these topics.

Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)/Medi-Cal for Kids & Teens Education Campaign

Pamela Riley, MD, and René Mollow, MSN,RN, DHCS

Presentation Slides:

Riley presented the Medi-Cal for Kids & Teens Outreach & Education Toolkit. The goals of the toolkit are to promote awareness of children's preventive services; improve member understanding of how Medi-Cal for children and youth work; the recourse they have; and increase coordination with plans, providers, key state and local agencies, CBOs, and advocates. There is also a focus on standardized training for health care and other providers that plans will disseminate to their networks.

Mollow presented details about the toolkit and commented that the brochures highlight key points emphasized in consumer testing: (1) services are free; and (2) transportation is available. All materials are available on the Medi-Cal for Kids & Teens webpage. In

January 2024, MCPs are required to conduct the Medi-Cal for Kids & Teens Provider Training for network providers to ensure they can support families to fully utilize covered benefits available to them.

Questions and Comments

Golden Testa: I would be interested in hearing more about what teens had to say in the focus groups. Do you have any intention to develop video materials as part of this outreach?

Mollow: Not yet, but we can discuss. Plans could also create something of their own.

Golden Testa: I would also recommend connecting this to Phase 3 of the unwinding campaign, which includes information on the Medi-Cal expansions. These seem complementary.

Mollow: We will take that back. We already disseminated this broadly to navigators, WIC, and MCPs. We can consider other focused messaging.

Golden Testa: On the provider training, since Child Health and Disability Prevention Program certification is sun-setting, it could be helpful to link these two health plan efforts.

Cooper: We are incorporating some of these ideas already. I will take this idea back.

Savage Sangwan: On language access, was testing done in English only or are you planning to consumer field test the translated materials?

Mollow: We tested the materials in English and Spanish, which is how we learned about words that did not translate well into Spanish and adjusted those.

Lewis: Thanks for the outreach and education on this complex benefit. I hope this toolkit gets to parents, caregivers, and others. What about a standalone brochure on behavioral health benefits since the carveout and dual systems are so complex, especially for youth in foster care and other systems? Distributing this to child welfare workers, probation officers, and others would allow them to be messengers also.

Grealish: I agree, and also would include the Department of Juvenile Justice and SB 823 Realignment, as well as DDS and the Regional Centers where there has also been confusion.

Mollow: We did send to those agencies and directly to the Regional Center Association.

Veniegas: In Los Angeles County, we have a Youth Services Policy Group that has been focused on EPSDT, substance use services access, and continuous coverage for children and youth. I would be happy to make connections there and also connections and support for Asian/Pacific Islander youth. Please join us for the Immigrant Health Access Task Force.

Stoner-Mertz: We can also offer our alliance and our member agencies as a place to vet materials. I agree that we should create some videos and wonder how we can integrate this work with the Children and Youth Behavioral Health Initiative. How are you thinking about integrating these two efforts? What about transition aged youth not living with caregivers and targeting messages to that group?

Mollow: We are trying to broadly reach individuals and families based on their age. Mail for teens will go to both the teen and to the family. We will take both of you up on your offers for collaboration and training, and will also roll this out to various other stakeholder workgroups and conduct a webinar during which people can share their reactions and insight.

Update on Integration of Dual Eligibles into Managed Care

Anastasia Dodson, Susan Philip, and Michelle Retke, DHCS

Presentation Slides

Dodson presented background information on dual coverage through Medicare and Medi-Cal. As of January 1, 2023, most people who were dually eligible, including those in skilled nursing facilities, were in Medi-Cal managed care. Of those in FFS who were being transitioned to Medi-Cal managed care, some selected a MCP by late December 2022; most were default enrolled into a MCP on February 1, 2023. Of the 325,000 members that needed to be enrolled, many were in Central Valley and Bay Area counties where this represents a significant transition for Medicare providers. Dodson asked everyone to share that Medicare providers do not need to enroll in a Medi-Cal MCP to continue receiving Medicare reimbursement as usual. Enrolling in a Medi-Cal plan does not impact Medicare, provider access, or a member's choice of original Medicare or Medicare Advantage.

Medi-Cal managed care has important benefits for dual eligibles, and there are more expectations of MCPs to cover long-term services and supports, including skilled nursing facilities, Community-Based Adult Services, as well as CalAIM Community Supports and ECM for eligible populations. Dodson shared the crossover billing process and commented that dual eligible members should never receive a bill for Medicare services. This is "balance billing" and is illegal under state and federal law.

Questions and Comments

Mohanty: What are you finding on processes that are working best for education and outreach?

Dodson: We must use multiple strategies that include one-on-one questions and sometimes multiple touches with trusted messengers are needed.

Ramirez: I am a Medi-Medi member and got the letter you described. I felt anxiety about the transition because my clinic was not sure I could remain their client, and I wasn't sure how to get my medication, which is very critical to my health and stability. I'm very

concerned about the lack of information some providers have about this transition and the potential impact.

Sonnenshine: As a COHS, this does not represent a change for us, but we have providers in multiple counties or statewide and they are confused by the messaging. Some are asking if we are now a Dual Eligible Special Needs Plan, so I would encourage DHCS to continue pushing the message out and consider sharing even with counties where no changes are happening so organizations like ours can help understand the confusion.

Perrone: Do you know what the gap is between the Medicare and Medi-Cal networks (e.g., how many Medicare physicians do not participate in Medi-Cal)?

Cooper: The federal government tasked us to do an access study to compare the Medi-Cal, Medicare, and commercial networks for access and shortages. We will have this in a few years.

Perrone: RAND has Medicare and some Medicaid data and may be able to help with analysis.

Public Comment

Janet Vadakkumcherry, Health Center Partners of Southern California: Thank you for the meeting, presentations, and your hard and thoughtful work in support of Medi-Cal members. Regarding Medi-Cal for Kids & Teens, I would like to suggest that in counties with multiple MCPs, the MCPs should be required to combine efforts and do a single training versus asking providers to be offline for patient care and attend multiple trainings with the same content. Our providers are already overrun with multiple trainings that take hours of their time, both at the managed care and independent physician association levels, which is administratively burdensome, just so the managed care entity can check a compliance box. The quality of the trainings vary. A logical approach would be to identify trainings that could be in common and get DHCS support in developing a process to streamline them so providers can get the information they need and spend more time taking care of patients. Plans in our county have indicated that it will take regulatory changes at the state level to effectuate these changes. I hope DHCS can support this. Thank you for your time and consideration.

Diane Van Maren, Developmental Services Network: It's our understanding that the dual mandatory enrollment does not apply to individuals living in small intermediate care facilities, developmentally disabled, habilitative, and nursing homes at this time. Is that correct?

Philip: That is correct. The proposal and current trailer bill has the carve-in becoming effective on January 1, 2024.

Dodson: For anyone enrolled in managed care erroneously, our Managed Care Operations Division is making corrections one by one so we appreciate people alerting us to anything that needs to be corrected, which we will do as quickly as possible.

Jeff Farber, Helpline Youth Counseling: Thank you for the opportunity to speak. It's amazing to see the state making so much movement in so many areas. Under the EPSDT communications, I suggest there be a dedicated effort to involve school districts across the state. As an organization that provides specialty mental health and substance use treatment and prevention services, we do a lot of work with school districts, and that is where most people get their information. I think the toolkit should be shared with schools along with probation and the other groups mentioned.

Next Steps and Adjourn

Michelle Baass, DHCS

Baass noted that hybrid meetings will continue. The next meeting is May 24, 2023, from 9:30 a.m. to 1:30 p.m. There will be further discussion and communication about whether the meeting will be a combined SAC/BH-SAC or two separate meetings.