FOLLOW UP ITEMS: SAC-BH SAC JOINT MEETING and BH SAC MEETING
October 19, 2023
Member Comments for Potential Follow Up

SAC		
Agenda Item/Topic	**DHCS Response**	**DHCS Follow-Up**
Directors Update		
Pittman-Spencer: On the MMAC, how is dental included? Some of the changes in how we talk about the dental program, for example to Medi-Cal Dental instead of Denti-Cal, came from understanding that Medi-Cal beneficiaries didn't know they had a dental benefit.	*Baass*: We surveyed MMAC members for priority topics. I appreciate the input and will take that back.	**Consider including Dental Medi-Cal for discussion at MMAC**
Lewis: The MMAC is an important entity for input, and we need to utilize it effectively to steer DHCS with a different perspective than advocates offer. The managed care plan implementation in January impacts many people, and I have some concern about how advocates can triage and troubleshoot cases. What is the best way for advocates to identify and communicate problems?	*Cooper*: We will take that back and offer a process for this. *Cooper*: We have a shared mailbox to send concerns regarding the transition, including after go-live. This allows for the internal escalation process.	**Confirming that the question was answered at a later time during the SAC-BH SAC meeting as noted here. No f/u needed.**
Golden-Testa: I see the QR code on the notice. Is there also a link or website to send families for information if they don't have a notice?	*Baass*: Yes, we can send the link in follow up. There is a link on the home page for the MCP transition and then a member page with questions geared to the transition on that landing page.	**Send information to Golden-Testa** Link to the member notices and Notice of Additional

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		Information pertaining to the MCP transition: Members | Managed Care Plan Transition | DHCS
Veniegas: With regard to the MCP transition, I read that radiology was not going to be included in one of the services. If a beneficiary needs radiology through the transition, does that cost fall to counties?	*Cooper*: Can you send us the question? Radiology should continue to flow and oftentimes doesn't require a prior authorization unless it's high cost. Even so, prior authorizations should be flowing.	**Confirm whether the question was sent in writing and answered.**
Koopmans: Does the 1.2M members transitioning in Los Angeles include fully delegated Kaiser members that are transitioning to Kaiser under a prime contract?	*Cooper*: I do not think they are included because that number is 900,000 for Kaiser.	**Consider an additional note to clarify to Koopmans**
Status of Medi-Cal Redeterminations and January 2024 Expansions		
McNaughton: I appreciate the thoroughness of the dashboard and want to share thoughts from our partnership with the county teams in Riverside and San Bernardino. We discovered that about 40,000 members with renewal dates over the past four months were disenrolled by the state but are not on the counties' monthly disenrollment files. We hired 60 enrollment partners and are working to identify how we can support reconciliation	*Huang*: Can you let us know which redetermination list? June would be the best month for using the reconciliation because there were discrepancies in July and August. The counties likely pulled it from the county system and the lists you get from DHCS are pulled from the state system. I am happy to follow up on this.	**Confirm the redetermination list used locally and reach out to see if there is remaining confusion** **HCBE Update: Met with IEHP**

SAC		
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systems to maintain coverage. How often do you review reconciliation?		**and IEHP sent DHCS the lists to review. Confirmed "data mismatches" were not mismatches and explained to IEHP on why the data was reflected this way. Item closed.**
O*wen*: On the undocumented expansion, is there data that DHCS can provide to MCPs for members transitioning where there isn't the health plan choice. This was raised at our community health worker collaborative. We are aiming for a seamless transition, with primary care selections made and members knowing about initial health assessments. Planning and support for this population is different than the younger population because the language barriers are greater.	*Huang*: I will take that back to the managed care team.	**Discuss the issue with DHCS internal team** **HCBE Update: Discussed with MCOD. MCOD will reach out to CenCal. This was already provided to CenCal by MCOD in regular DHCS-MCP**

SAC		
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		communications. Item can be closed.
Sheckler: I appreciate the unwinding dashboard. It's easy to navigate and very useful. We hope that the expansion of assisters in health centers will help with the high procedural disenrollment rates. One concern to flag from members and partners is that health centers and CBOs are still waiting for the implementation of the integrated release of information (ROI) to track the status of Medi-Cal applications in real time. Without this, navigators are left with time consuming workarounds using the call center. Is there an update on when we can expect to see the ROI functionality go live? Are there county-level estimates on how many eligibles per county there are for the adult expansion?	*Huang*: On the ability for CBOs to log in to BenefitsCal, we are working on CalSAWS migration, effective October 30th and that means there are multiple changes converging during the unwinding. In tandem is the development of ROI. There are privacy and security pieces to work out that are complex, given the level of security needed for members' privacy. I don't have an estimated date of implementation. I know it's a valuable asset and we are committed to making sure we have the best product as well as to protect the information of members. In spring of 2024, we will have a better timeline. On the county breakdown for the adult expansion, we do have an estimate and will follow up.	**Continue to update SAC-BH SAC on the timeline**
Enhanced Case Management (ECM)/Community Supports, Data Sharing and Authorization to Share Confidential Medi-Cal Information (ASCMI) Pilot		
Nguy: I appreciate DHCS' work to standardize eligibility and look forward to guidance being implemented. Is there still opportunity for stakeholder feedback on the guidance?	*Philip:* We provided an update of the CS policy guide in July. And as we move forward on additional service definitions or refinements, we will have a stakeholder process to work with providers and other stakeholders. There are also work groups focused on implementation guidance and	**Share information on CS policy guide and next steps with Nguy**

SAC		
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	TA that are also a venue for input. I can share that information with you.	
Barlow: Are the MOUs public information posted online?	*Sadwith*: MCPs, County Mental Health Plans and county DMC-ODS do post executed MOUs on their website, based on recently issued guidance requirements for MOUs.	**Provide information on completed MOU online location** MOU templates posted: MCPMOUS (ca.gov)
BH SAC		
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Behavioral Health Payment Reform Update		
Senella: On stand-alone services, can you clarify that this is everything except inpatient services? Previously those standalone services did apply to inpatient with the exception of care coordination. Could you clarify if it's care coordination that is part of the per diem and the other things remain stand-alone or is it accurate that all four are part of the per diem for inpatient services?	*Fitzgerald*: The current guidance distributed to counties is that those four services for residential treatments are allowed to be billed separate and above and that if a beneficiary resides in an inpatient setting, those cannot be billed. But let me take that back and confirm.	**Confirm stand-alone services included and carved out of per diem for inpatient**
Clark-Harvey: The travel time issue is difficult. We appreciate DHCS hears the concern and there's a diversity of county readiness, willingness, and experience for this implementation. In the meantime, providers are bleeding and there are services being	*Cooper*: Could you send us information about particular counties we need to focus on?	**Confirm information is sent by Clark-Harvey**

BH SAC		
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shut down as a result of inadequate rates. Counties are our partners, and we know that they are working hard. However, this is a crisis situation. This isn't an issue of providers having bad business models. The cost reimbursement model was in place for decades and the transition to something else was very quick. *Clark-Harvey*: Yes. I sent information about counties that are working well with providers and good models and practices that we hope will be uplifted. We have shared those publicly as well.		
Eisen: Some counties didn't turn on the codes for those to be billed outside of the per diem rate. Some counties did. It's helpful to know there is an opportunity for reconsideration. I don't want to go back to a cost reconciliation process; however, the change has been incredibly dynamic and there's inconsistency from county to county about what is or isn't a billable service. It took years of planning for the state and the country to go from ICD 9 to ICD 10, and we went to CPT coding in a matter of months. In one county alone, in an outpatient program, we lost close to $300,000 in outpatient services in one month. I can't imagine how smaller providers are handling that. I'm not convinced that the rate negotiated between counties and providers, or the state and the counties take into consideration what it means to staff programs	*Cooper*: With specialty mental health, if it is in the fee schedule, then it is the responsibility of the county to provide that service. In Medicaid you can't choose when to provide a benefit if it's statewide and a mandate. We may need to look at our BHIN to make sure that is clear. There shouldn't be a case where a county didn't turn the code on. We need to keep talking this through and clarify so there is no variation from county to county. We will take the comments back for sure.	**Review the series of comments on rates for follow up conversation**

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and become productive. If we can't pay our staff at the same rate as a county worker and we have to drive productivity, the nonprofit provider system will eventually collapse on itself. I want to make sure that we're tracking not just losses of programs, but changes in service patterns which may be driven by trying to maximize billing. If field-based services drop because it's hard to get reimbursed; if group counseling drops because it's not efficient, we have to be able to analyze why it happened. *Lewis*: We don't generally weigh in on rate issues, however we are alarmed by how the rollout has proceeded and the lack of urgency by counties and the state. For youth, these are mandated requirements regardless of the amount of money available. Allowing this to move toward wait lists and losing providers could mean a move toward a lawsuit, so we need to work together to intervene before the crisis worsens. We need to be more alarmed about this. This is not what kids and families need and want. They expect these services to be in schools, in the home and other places in the community where they need them when they're medically necessary. So I will weigh in on this rate issue because it is a fundamental failure of the entitlement if these services go away.		