MANAGED CARE ADVISORY GROUP

Meeting Notes: June 13, 2024

Introductions

Amara Bahramiaref, Branch Chief, Managed Care Policy Branch, Managed Care Quality and Monitoring Division (MCQMD), called the Managed Care Advisory Group (MCAG) meeting into session and welcomed all in attendance virtually on the webinar and in person.

Doulas

Erica Holmes, Division Chief, Benefits Division and Sa Nguyen, Health Program Specialist, Managed Care Quality and Monitoring Division gave an update on Doulas.

- Relative to maternal health, the Department wants to ensure that every birthing individual is informed and can take control of their health journey. Medi-Cal members have access to many options when it comes to choosing maternal care providers who are sensitive to cultural, and language needs as well as individual preferences in terms of time, place, and manner of the birthing experience.
- Doulas are one of the many options available to Medi-Cal members, and Doulas serve as a trusted and integral part of the care delivery team for birthing individuals.
- The Department added Doula Services on January 1, 2023. Doula Services are available in both the Fee-For-Service (FFS) and managed care delivery systems.
- Doulas Services include health education, advocacy, and physical, emotional, and nonmedical support provided before, during, and after childbirth or end of a pregnancy, including throughout the postpartum period.
- Two (2) qualification pathways to become a Doula in Medi-Cal:
    - Training Pathway:
        - Complete a minimum of 16 hours of training in one of a handful of specific areas, including: lactation support; childbirth education; foundations of anatomy of pregnancy and childbirth; nonmedical comfort measures, prenatal support, and labor support techniques; and developing a community resource list.

        - » Attest to providing support as a Doula at a minimum of three (3) births.
    - Experience Pathway:
        - » At least five (5) years of active Doula experience in a paid of volunteer capacity within the previous seven (7) years.
        - » Attesting to skills in prenatal, labor, postpartum care as demonstrated by three (3) written client testimonial letters or professional letters of recommendation from a physician, licensed behavior health provider, nurse practitioner, nurse midwife, licensed midwife, community-based organization (CBO), or another enrolled doula.
        - » Letters must be written within the last seven (7) years and at least one (1) of the three (3) letters must come from a licensed provider, CBO, or another enrolled Doula.
- » As of May 2024, DHCS has approved 426 group and individual's applications, 304 of which were from individual Doulas.
- » The Medi-Cal FFS Doula reimbursement rate was part of the Targeted Rate Increase initiative that went live on January 1, 2024. To this end, Doula rates have increased as follows.
    - Current max per pregnancy with standing recommendation: $3,152.65.
    - Previous max per pregnancy with standing recommendation: $1,514.34.
    - With a second recommendation, doulas can also receive an additional $1,458.99 on top of max amount provided with the standing recommendation.
- » Federal regulations require that preventive services, inclusive of doula services, be recommended by a physician or other licensed practitioner.
- » To help increase access and reduce barriers, as well as meet the federal requirement, DHCS issued a "Standing Recommendation", which authorizes a core set of services for birthing individuals, as follows:
    - One (1) initial visit
    - Eight (8) additional visits in any combination of prenatal/postpartum visits
    - Support during labor and delivery, abortion, or miscarriage.
    - Up to two (2) extended postpartum visits.

- DHCS also created a Doula Services Recommendation Form, which is available on DHCS website and can used to receive an additional recommendation for members to receive up to nine (9) additional postpartum visits. This second recommendation could also be noted in the member's medical record.
- Managed Care Doula Services Implementation, Monitoring, and Oversight:
    - Performance monitoring such as surveys and reporting templates helps DHCS in creating appropriate policies for improving health outcomes and ensure access to high quality health care for all Medi-Cal Managed Care Plan (MCP) Members.
- Managed Care Doula Services Guidance:
    - Issued policy guidance via APL 23-024.
    - Issued Standing Recommendation for Doula Services for pregnant/post-partum Medi-Cal Members.
    - Maintains a dedicated Doula Services as Medi-Cal Benefit webpage.
- Managed Care Doula Process Flow Example (*see slide 13*):
    - Doulas interested in serving the Medi-Cal population will need to: Meet minimum qualifications; Obtain a National Provider Identifier (NPI) number; Enroll as a Medi-Cal provider (e.g., via DHCS Medi-Cal Provider Application, and Validation for Enrollment (PAVE)); AND enter into contracts with MCPs. Doulas may contract with MCPs depending on the geographic area they are in. Doulas must enter into contracts with MCPs to receive reimbursement for Doula Services provided to MCP members.
    - For the onboarding process, MCPs must provide doulas with all necessary, initial and ongoing training and resources regarding relevant MCP services and processes, including any available services through the MCP for prenatal, perinatal, and postpartum Members.
    - Doulas must obtain a recommendation. In addition to DHCS' standing recommendation, the initial recommendation can be provided as a written recommendation in the member's record or standard form. Doulas who use DHCS' standing recommendation for their members should note the standing recommendation in their records.
    - Doulas must confirm MCP Member eligibility and enrollment. Doulas must verify the Member's MCP enrollment for the month of service. Doulas must contact the Member's MCP to verify eligibility.

- Once Doula Services are provided, Doulas must document the dates, time, and duration of services provided to Members. Documentation must be accessible to the MCP and DHCS upon request.
- Doulas cannot double bill, as applicable, for Doula Services that are duplicative to services that are reimbursed through other benefits.
- MCPs must pay all Clean Claims submitted by Providers in accordance with DHCS' Medi-Cal Managed Care Boilerplate Contracts. A Clean Claim is, "one that can be processed without obtaining additional information from the provider of the service or from a third party". MCPs are expected to pay Clean Claims within 30 days of receipt, unless the Provider and MCP have agreed in writing to an alternate payment schedule.

» Managed Care Doula Services Contracting Update:

- As of May 2024, 21 MCPs have executed contracts with Doulas.
- The following information includes duplicated counts for Doulas contracted with multiple MCPs. Many of the Doulas are contracted with multiple MCPs and/or support multiple counties.
  - 332 executed contracts with 158 unique National Provider IDs.
  - 197 pending contracts
  - 42 counties have Doulas with executed contracts.
- For MCPs without Doula Contracts, MCPs are expected to have contracts in place soon.

» Managed Care Doula Services Marketing and Communications:

- MCPs have informed Members, Health Care Providers, and Hospitals/Birthing Centers about Doula Services in several ways:
  - Host webinars, forums, focused meetings.
  - Partner with local health jurisdictions and collaboratives.
  - Conduct provider training with educational materials.
  - Send newsletters, bulletins, or mailer.

» Managed Care Doula Services Promising Practices:

- The following strategies have been shared by MCPs to help prevent barriers to Members receiving Doula Services:
  - Be flexible with contracting with individual/group Doulas.

        - Hospital/Labor and Delivery staff education.
        - Internal MCP staff education.
        - Region wide marketing campaigns and communicating with local community organization.
        - Designating an MCP liaison.
        - Develop resource document that can be shared with Doulas so they can reference requirements placed by the MCP.
        - Publish resources on MCP webpage.

Transition Care Services (TCS)

Bonnie Kwok, Medical Consultant I, Population Health Management gave a presentation on TCS:

- TCS: Occurs when Member transfers between settings or levels of care.
    - Goals:
        - Members transition to the least restrictive level of care that meets their needs/is aligned with member preferences in a timely manner without interruptions in care.
        - Members receive the needed support/coordination to have a safe and secure transition.
        - Members have the needed support and connections to services that make them successful in their new environment.
- Phased TCS Requirements Effective:
    - Phase 1: January 1, 2023
        - Required MCPs to ensure high-risk Members receive all transitional care services including having care manager/single point of contact (POC) to assist in transition.
    - Phase 2: January 1, 2024
        - MCPs required to ensure transition care services are complete for all Members, with different minimum requirements for High/Lower Risk Members.
        - All Members transitioning into or out of a Skilled Nursing Facility (SNF) are considered High-Risk Members in 2024.
    - Adjusted the prospective rate in response to the challenges.
- Updated TCS Requirements for All Members Effective January 1, 2024:
    - Know when Member is admitted/discharged/transferred.

- Ensure each Member is evaluated for all care settings appropriate to their needs.
- Oversee completion of discharging facility's discharge planning process.
- Ensure all discharged Members have a primary care provider who can follow up care.
- Ensure chronic issues are addressed post-discharge.
- Ensure referrals and confirm follow up to Community Supports, Enhanced Care Management (ECM), and waiver agencies for In-Home Supportive Service (IHSS) and Home and Community-Based Services (HCBS) programs.
- Ensure timely prior authorizations.

» TCS Requirements for All Members (cont.) – (*see slides 26-27*):

- MCP must ensure the Member has a single point of contact for the duration of the transition for High-Risk Members. Care Manager responsibility includes (but not limited to):
  - » Ensures appropriate clinical information is shared with the Member and follow-up providers.
  - » Ensures medication reconciliation is complete post discharge.
  - » Ensures the completion of all recommended follow-up care, including primary care visit.
  - » Ensure Members are assessed for ECM, Complex Care Management (CCM), Community Supports eligibility, etc. and referred within 30 days post discharge and confirmed access was made.
  - » For Low-Risk Members: Ensure each Member has access to a dedicated TCS team for at least 30 days after discharge.
  - » Ensure Member completes follow-up primary care/ambulatory visit within 30 days post discharge, including medication reconciliation.
  - » Ensure Members are assessed for ECM, CCM, Community Supports eligibility, etc., were referred, and outreached to confirm access and or for enrollment.

» DHCS Support for TCS Implementation:

- Engagement with and Technical Assistance (TA) for MCPs, hospitals, SNFs and Primary Care Providers.
- MCP survey in Summer 2023.
- Population Health Management (PHM) Advisory Group.
- TCS All-Comer Webinar (January 2024).
- TCS Summit (March 2024).
- Sharing best practices to address barriers for TCS implementation.

- Priority Areas for TCS Implementation:
    - DHCS will provide additional TA and/or release further guidance to MCPs to ensure Members are fully supported during Transitions of Care.

Transitional Rent

Glenn Tsang, Policy Advisor for Homelessness and Housing gave a presentation on:

- Goals of CalAIM Transitional Rent Services Amendment Request:
    - Transitional Rent coverage provides up to six (6) months rental assistance in the Managed Care delivery system.
    - Transitional Rent proposal will be in addition to existing Community Supports.
- Proposed Eligibility Criteria for Transitional Rent:
    - DHCS proposing to provide up to six (6) months of Transitional Rent
    - Meets one (1) or more of the following criteria.
        - Transitions from medical settings (i.e., institutional care, facilities, etc.).
        - Transitions from other public systems or settings (i.e., state prison, county jail, child welfare system, etc.).
        - Transitions from shelter, transitional housing, or re-housing
        - Other very high-needs populations (i.e., individuals experiencing unsheltered homelessness, individuals in Full-Service Partnership programs).
- Timeline of TR Design:
    - Hoping to release later in July 2024. Once released, will have more focused conversations with groups, advocates, stakeholders on how to operationalize Transitional Rent.
    - The concept paper will be vehicle used for public comment periods and feedback.
    - Targeting October 2024 to have policy guides as the 15th Community Support. Will plan to roll out by January 1, 2025.

Tribal Liaisons in Medi-Cal Managed Care

Robert Moore, MD, MPH, MBA, Chief Medical Officer, Partnership HealthPlan of California (PHC) gave a presentation on Tribal Liaisons in Medi-Cal Managed Care

- Initial findings suggest official Medi-Cal demographic data under-counts those self-identified American Indian (AI)/Alaska Natives (AN).

- Current Landscape:
  - 38 tribal health corporations, 127 sites statewide in California.
  - California has 109 federally recognized tribes.
- PHC Landscape:
  - 52 federally recognized tribes, nine (9) non-federally recognized tribes, 18 rural Tribal Health Centers, three (3) Behavioral Health (BH)-only Tribal Health Providers, 15,569 individuals AI/AN self-identified.
- Health Inequities in AI/AN Population:
  - AI/AN populations have more health inequities than any other ethnic group.
- Underlying Causes of Inequities in CA Indians:
  - Discrimination – overt discrimination and implicit bias.
  - System issues – trans-generational trauma, systemic racism, structure/funding/staffing of health care providers.
  - Cultural factors – relationship between health and spirituality.
- Why Health Plan Tribal Liaisons?
  - Minimum functions: channels communication for AI/ANs who are Health Plan Members to have issues addressed.
    - Channel of communication with Tribal Health Centers and urban Indian organizations.
    - Be the Health Plan expert on regulations and issues affecting the AI/AN population.
  - Ideally:
    - Tribal Liaison is a Native American person who has lived experience with transgenerational trauma and Native American cultural values and practices.
- PHC's Tribal Liaison – Yolanda Latham, BA, MBA
- Tribal Engagement Activities:
  - Annual in-person meeting of tribal health center leaders.
  - Health Plan Tribal Health working group with a strategic/tactical plan.
  - Tribal Perinatal Initiative.
  - Listening sessions, roundtables, consultation sessions.
- In-person visits to tribal health centers and Urban Indian Organizations Path to better outcomes:

- Must have a cultural understanding/respect for autonomy.
- Healing transgenerational trauma through embracing culture/autonomy.
- Start with needs/priorities of tribes and tribal health centers.
- Learn the power of storytelling and restorative justice in teaching/influencing behavior.

Managed Care Accountability Sets (MCAS)

Priya Motz, DO, MPH, Quality and Population Health Management (QPHM), Branch Chief, Quality and Health Equity Transformation, gave a presentation on MCAS:

- MCAS High and Minimum Performance Levels:
  - Performance measures selected by DHCS for annual reporting by MCPs.
  - MCAS reflects the quality, accessibility, and timeliness of care MCPs provide to their Members.
- Domains: Children's Health vs Reproductive Health & Cancer Prevention
  - Orange: potentially moving the indicated measures to be accountable
- Domains: Chronic Disease Management vs BH
- MCAS Measure Alignment:
  - Looking to increase Children's Preventative Care
- Quality Improvement (QI) and Health Equity (HE) Activities for All MCPs:
  - State is broken into six (6) geographic areas based on Medi-Cal enrollment, trying to control variables and improve communication with MCPs.
- Regions:
  - Central Coast, Southeastern, San Francisco/Sacramento, North/Mountain, San Joaquin Valley, Southern Coast.
- QI and HE Framework (*see slide 58*):
  - Lean QI and HE Process:
    - Organizational systems support for QI.
    - Plan-county focused interventions based on Member demographics, network provider needs.
    - Infrastructure processes that bridge local programs to Members/providers.
  - Comprehensive QI and HE process – address clusters/patterns of QI weak areas and strengthen infrastructure.

        - » Organize and systematically implement sustainable interventions that move the needle.
    - Root Cause analyses Transformational Corrective Action Plan (CAP).
        - » Sustainability of interventions that address root cause of poor-quality outcomes.
        - » Small tests of change on vulnerable areas based on performance.
        - » Align QI and HE efforts across the MCP organization.
- » QI and HE Framework Triggers for Measurement Year 2022:
    - Look at regional performance, try to find other challenges that may have been missed.

Enhanced Care Management (ECM)

Seema Shah, MD, Medical Consultant II, QPHM, gave a presentation on ECM Children and Youth Populations of Focus (POF)

- » What is ECM?
    - Statewide Medi-Cal MCP benefit to support comprehensive care management for Members with complex needs.
- » ECM POF (*see slide 63*):
    - Nine (9) POFs that apply to either or both for Adults, Children and Youth:
        1. Individuals Experiencing Homelessness.
        2. Individuals At Risk for Avoidable Hospital or Emergency. Departments (ED) Utilization. (*Formerly called 'High Utilizers'*).
        3. Individuals with Serious Mental Health and/or Substance Use Disorder Needs.
        4. Individual Transitioning from Incarceration. (**New in January 2024*)
        5. Adults Living the Community and At Risk for Long-Term Care (LTC) Institutionalization.
        6. Adult Nursing Facility Residents Transitioning to the Community.
        7. Children and Youth enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS condition.
        8. Children and Youth Involved in Child Welfare.
        9. Birth Equity POF. (**New in January 2024*)
- » What are the ECM Core services?

- Members in ECM receive seven (7) core services based on their needs, tailored to their POF and their individual needs.
    1. Outreach and Engagement.
    2. Comprehensive Assessment and Care Management Plan.
    3. Enhanced Coordination of Care.
    4. Coordination of and Referral to Community and Social Support Services.
    5. Member and Family Supports.
    6. Health Promotion.
    7. Comprehensive Transitional Care.

Justice Involved (JI) ECM POF

David Tian, MD, MPP, FASAM, Acting Branch Chief, Clinical Population Health Care Management, gave a presentation on the JI ECM POF.

- ECM JI Launch Timeline:
    - Prior to launch of EMC benefit for JI individuals, required model of care submissions from Medi-Cal MCPs showed significant gaps.
    - Provide intensive TA to MCPs in a Pre-CAP process to address gaps in priority areas as soon as possible.
- Pre-CAP results and next steps:
    - Minimum requirement to have one (1) experienced provide of ECM JI services improved from 39.4 percent to 99.1 percent of the 114 Plan-County combinations.
    - Pre-CAP response letters were distributed to MCPs in early mid-June 2024.
    - DHCS will follow up with MCPs in upcoming months regarding additional requirements in priority areas.
    - DHCS is continuing to monitor MCP's progress in priority areas with expectation for continuous improvement and progress in network capacity, corrections system engagement, and network overlap.

Collaborative Planning and Implementation (CPI) Initiative – Providing Access and Transforming Health (PATH)

Michel Huizar, Branch Chief, and Itta Johnson, PCG CPI Workstream Lead, gave a presentation on CPI – PATH.

- CPI Overview:
    - CPI Initiative: provides funding for county and regional collaborative planning efforts to support implementation of ECM and Community

Supports. There are 26 collaboratives led by nine (9) facilitator organizations in 2024.

- CPI Initiative Timeline:
  - Registration into CPI initiative began in in January 2023
    - Registration is open and ongoing.
  - 2nd Best Practice launched in December 2023
    - DHCS will host Two Best Practice webinars each year.
- Participation and Engagement:
  - Provided update on current Registration Data.
  - Tracking current types of organizations and eligible participants (*see slide 82*).
- Participant Experience with Medi-Cal and CalAIM (*see slide 83*)
- Role of MCPs in CPI:
  - MCPs actively participate in PATH CPI efforts in the counties they serve to address challenges and gaps related to ECM and Community Supports implementation.
- CPI focus on DHCS Action Plan Priorities:
  - To support Expansion of Provider Networks, CPIs participants are collaborating on ways to design and deliver enhanced provider directories.
    - MCPs have been great at submitting rosters of incoming providers to support this effort.
  - Facilitators enlist in community-wide marketing campaigns to increase awareness of services (strengthening market awareness).
  - CPI facilities are planning a test of change for MCP data sharing with Community Information Exchanges and Health Information Exchanges (CIE/HIE) (improving data exchange).

Open Discussion

- Are there any updates on Community Reinvestment?
  - Cannot comment but are working on it actively and the goal is to roll it out soon. It will be on the CalAIM website. It is not ready yet and we will have people in person to present on it.