DEPARTMENT OF HEALTH CARE SERVICES

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

Hybrid Meeting
July 20, 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; Amanda Flaum, Kaiser Permanente; Michelle Gibbons, County Health Executives Association of California; Trina Gonzalez, California Hospital Association; Sherreta Lane, District Hospital Leadership Forum; Anna Leach-Proffer, Disability Rights California; Kim Lewis, National Health Law Program; Beth Malinowski, SEIU; Linda Nguy, Western Center on Law and Poverty; 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; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Laura Sheckler, California Primary Care Association; 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: Michelle Cabrera, County Behavioral Health Directors Association; Dannie Cesena, California LGBT Health And Human Services Network; Sarah- Michael Gaston, Youth Forward; LeOndra Clark Harvey, California Council of Community Behavioral Health Agencies; Virginia Hedrick, California Consortium of Urban Indian Health; Mark LeBeau, California Rural Indian Health Board; Carlos Lerner, Children's Specialty Care Coalition; Jarrod McNaughton, Inland Empire Health Plan; Jolie Onodera, California State Association of Counties; Cathy Senderling, County Welfare Directors Association;.

BH-SAC Members Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Kirsten Barlow, California Hospital Association; Steve Fields, Progress Foundation; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Robert Harris, Service Employees Service Union; Samuel Jain, Disability Rights California; Meshanette Johnson-Sims, Carelon Behavioral Health; Veronica Kelley, Orange County; Linnea Koopmans, Local Health Plans of California; Kim Lewis, National Health Law Program; Aimee Moulin, UC Davis Health; 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; 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; Angela Vasquez, The Children's Partnership; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services.

BH-SAC Members Not Attending: Jei Africa, San Mateo County Behavioral Health and Recovery Services; Ken Berrick, Seneca Family of Agencies; Michelle Doty Cabrera, County

Behavioral Health Directors Association of California; Dannie Cesena, California LGBT Health And Human Services Network; Jessica Cruz, NAMI; Vitka Eisen, HealthRIGHT 360; Sarah-Michael Gaston, Youth Forward; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; Virginia Hedrick, California Consortium of Urban Indian Health; Karen Larsen, Steinberg Institute; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Jolie Onodera, California State Association of Counties; Jonathan Porteus, WellSpace Health; Cathy Senderling, County Welfare Directors Association of California; Jevon Wilkes, California Coalition for Youth.

DHCS Staff Attending: Michelle Baass, Jacey Cooper, Palav Babaria, MD, Michelle Retke, Bambi Cisneros, Tyler Sadwith, Lindy Harrington, Autumn Boylan, Yingjia Huang, Morgan Clair.

Public Attending: There were 285 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 SAC and BH SAC members to the joint hybrid meeting.

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

Baass offered an update on key components of the approved state budget, including a review of specific DHCS initiatives. Baass reported that the Managed Care Tax (MCO tax) was approved and is effective April 2023 – December 2026. The MCO tax will provide approximately $19 billion in funding to build provider capacity and increase access and quality for Medi-Cal members. She stated that provider rate increases will begin January 2024 for primary care, maternity care, and non-specialty mental health services to 87.5% of Medicare. There are additional rate increases planned for January 2025.

Baass explained that the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) demonstration includes a new workforce element of $480 million per year for five years that was added in the May budget revision to strengthen pipeline development of behavioral health professionals through both short-term investments and longer term pipeline development. She reported that the budget also included support for the Children and Youth Behavioral Health Initiative as well as local implementation support for behavioral health reform under CalAIM and the CARE Act.

Questions and Comments

Savage-Sangwan: The code used by community health workers (CHWs) for health management education and training is included in rate increases. Are you applying the increased rate only for other providers billing this code or would it apply to CHWs billing this code also. CHWs are at 80% of Medicare, so we do think it's important to include CHWs.

Cooper: DHCS is releasing codes tomorrow and that will include all of the details. I will take this back to follow up and confirm.

Golden-Testa: Is there flexibility within the 2025 rate increases for CHWs or is it tied to the services

for the providers listed?

*Baass***:** We will follow up on this to understand the impact related to the service codes, but it is generally the traditional billers of those services.

Lewis: On the MCO spending for Medi-Cal services, does this cover both fee for service (FFS) and managed care? For the non-specialty mental health services, is the increase for all types of services across the board or is it specific services? Is it only for the managed care plans (MCPs)?

Cooper: Again, we will release the code list tomorrow including all codes for non-specialty mental health, but it should be across the board. The process is that we increase the FFS schedule, which automatically flows into the MCPs. We do a plan-by-plan assessment depending on what they pay, with considerations related to Prop 56 funds.

Malinowski: We appreciate the investments in provider capacity, workforce, and public hospitals. Related to behavioral health payment reform, will there be opportunities throughout the year to engage in dialogue on the rates and whether it is working for the provider community?

Cooper: Yes, we are committed to making adjustments to the fee schedule to get it right. Right now, we are making sure everything is rolled out, and in the coming months, we will have additional staff internally to help.

Wright: In the adjustments made to the MCO tax in the May Revision, are all allocations set or will there be changes in Governor's proposed budget in January 2024 for the next year? Is there an end date for the rate increases?

Baass: The framework is set. There will be refinements within categories that are developed going forward associated with how to accomplish the equity enhancement and geographic differences. These are base rate increases and there is no end date. This is all based on the MCO tax passing and it will fund six years beginning January 2024. As we approach year 3-4, there will need to be discussions about how to continue to support this.

Bradshaw: We appreciate support for primary care and rural areas. My understanding is that there is an additional primary care, community health center bucket within the increases. Can you share your thinking on the opportunities for rural health centers to benefit from that?

Baass: We don't have details to share although rural rate increases are being considered for 2025.

Koopmans: On BH-Connect, what is the timing and funding level for the cross-sector incentive pool?

Cooper: There is a funding amount set and this requires CMS approval. In the next month, the actual waiver will be written, and public input solicited through the formal 30-day comment period prior to submission. There will be two public hearings. After submission to CMS, there will be negotiations with CMS to refine the details.

Wunsch: There will be a public hearing on August 11th on the BH-Connect Waiver.

Lane: Is there initial thinking about how rural will be defined for the hospital seismic relief?

Baass: The Department of Health Care Access and Information is responsible for seismic relief

and the distressed hospital loan fund, and they will be developing definitions. It would be best to reach out directly to them for information.

Rocco: Will the rates be released tomorrow as well as the codes?

Cooper: No, it will be only the codes released tomorrow. Once we have CMS approval, we will release rates. When the State Plan Amendment is posted, it will include the full fee schedule.

Additional Updates

Boylan provided an update on the Justice Involved Initiative Waiver. DHCS released the draft policy and operational requirements for implementing the Medi-Cal Justice Involved Reentry Initiative and is reviewing comments to provide final guidance by late Summer 2023. She commented that CMS released a Medicaid Directors' letter on this topic and guidance continues to evolve, therefore, there may be revisions in California's approach to align to CMS.

Boylan also provided an update on the Providing Access and Transforming Health (PATH) Capacity Building Justice Involved Initiative to support correctional facilities, county behavioral health departments, and other implementing partners to start-up pre-lease services approved in the waiver. She reviewed the timing and approval process for the application for capacity building funding. Boylan noted that services to individuals in correctional facilities will begin between April 2024 – March 2026. DHCS also released a TA survey to support planning and implementation of the pre-release services.

Questions and Comments

Senella: There are issues to resolve although recent discussions have clarified many questions, such as pre-release services reimbursement being paid as FFS. There are remaining questions, such as the role of MCPs, how to accomplish an effective handoff at the time of release, how a MCP will be chosen, and how to ensure that ECM providers understand the needs of the population?

Gibbons: It would be useful to have information on the surveys sent to health departments directly, rather than relying on this information to filter through from correctional facilities, since many health departments handle correctional health care. Another implementation issue is that we may not know a person's release date in advance. We appreciate DHCS adjusting for this and look forward to continued dialogue.

Sheckler: It would be helpful to share any information on the role of MCPs. CPCA appreciates the specific information in the guidance about FQHCs being able to claim FFS reimbursement for pre-release services outside their PPS rate. FQHCs are interested in pre-release care management and post-release ECM services. There are still operational issues about how that will work, including billing FFS for CHW services and ensuring this isn't subject to reconciliation.

Boylan: We are happy to work offline with CPCA on this.

Lewis: The guidance document was helpful to understand implementation. There are still issues, such as the ones raised today, that are important to follow up on, especially the release timing. Most stays are 90 days or less. We are advocating for a front-door start time and service delivery system. In particular, the expectation to pre-enroll in a MCP at the point of discharge doesn't seem realistic, given the MCP would need to be ready to operationalize serving that member in one day. Perhaps there is another way, instead of a FFS warm handoff, to get ECM in-reach with an

existing provider that would continue to serve that member in the community, rather than expecting ECM providers to do FFS, which is not the existing design for ECM.

Boylan: Thank you for the comments.

Owen: We are working locally with our partners on initial implementation and have been learning a great deal about the multiple needs, including being unhoused, needing behavioral health treatment, support for a pregnancy, and more. My question is whether data will be largely a local county conversation or whether DHCS will provide data statewide as we develop an ECM network to meet the unique needs of this population? We can share data locally; however, it may be that the data is accessible via DHCS and that would be valuable. What is the timeline for each community to begin and what are the considerations about start-up? Also, I want to make the point that MCPs have an obligation to share ECM care plans with justice involved partners for members already in ECM who become incarcerated and members transitioning from incarceration back to the MCP.

Boylan: I will take the data question back for follow up. The implementation timing is a local issue depending on the readiness of correctional facilities and completion of the readiness review process. Correctional facilities have from April 2024 through March of 2026, to go live.

Koopmans: Could the survey being released ask about data sharing and how to establish real-time data sharing about release timing? This is top of mind for the plans.

Boylan: The survey already went out to correctional facilities; however the implementation plan has not been released and will cover all of the minimum requirements, including data sharing.

Additional Updates

Huang shared initial data on the Public Health Emergency (PHE) Unwinding. She shared information about the data dashboard, which includes a statewide view and county specifics in addition to CMS submissions. She offered information on the timeline for renewals and the 90-day cure period following determination. Huang provided pre-pandemic data on renewals and discontinuances as context for understanding the current landscape. More than one million Medi-Cal members per month over the next year are scheduled for redetermination, with approximately 26-29% expected to be auto-renewed through the ex parte process. The remaining group will receive a yellow envelope to submit information for re-determination. She noted that outreach includes sharing redetermination information with MCPs and expanding the more than 2,900 navigators statewide to assist members with redetermination. She reported that California submitted five additional waivers for flexibility on renewals, such as suspending requirements to apply for other benefits, cooperate with local child support agencies, and flexibilities for hard-to-reach members.

Questions and Comments

Lewis: It concerning that 225,000 individuals lost coverage in the first month. Are you collecting information from the counties on follow up to understand the number of packets returned? Is there an expectation on follow up?

Huang: The number who lost coverage is lower than projected. On the follow-up, DHCS is not collecting that information formally. Counties do track the follow up as an established business process and there is policy for counties to follow up. The biggest reason members are discontinued is that they don't return the packet, although it is not because the packet was returned due to an

incorrect address.

Cooper: The early redetermination process had a 12% returned mail rate and it is now down to 8%.

Veniegas: Given the large number of people who are unhoused, what flexibility exists for members with a DPSS address? Is there a non-response rate for this if they don't pick up their mail?

Huang: It is current policy to accept general delivery addresses and they are not discontinued. We do not think this is an issue. In addition, if an individual has a $0 income attestation on their application, the county can presume they are homeless and advance the redetermination.

Wright: Given we don't know the actual number of individuals still eligible versus those who have higher incomes or employer-based coverage, do we have comparison data from other states on renewals? Are we tracking the people who obtain coverage with Covered CA?

Huang: We can share links of aggregated data from CMS for all states. California has a lower disenrollment rate than other states. Each state has different policies in place – some states have not started, and others have front-loaded individuals who are ineligible. California is not frontloading redeterminations but has spread them out over 12 months given the volume. We are working closely with Covered CA to track and we rely on them to report publicly on individuals with coverage through the marketplace. We will work with them to produce a cohesive narrative.

Golden Testa: Can you review the breakdown of the data on the 225,000 who lost coverage?

Huang: Of the one million, 2.4% were disenrolled because they are ineligible for a variety of reasons. About .2% of the one million are over income and are being assessed for coverage through Covered CA.

Cooper: Of the 21%, 88% were disenrolled for procedural reasons, such as they didn't respond.

Baass: We are working with CHCF and navigators to get qualitative information on procedural reasons for disenrollment.

Huang: All states are struggling with this. DHCS is working with CHCF on a short survey of random sampling of people disenrolled for procedural reasons. Covered CA is also surveying to understand why some individuals who transitioned out of Medi-Cal did not enroll in a plan.

Golden Testa: The Children's Partnership is planning focus groups later in the year on this topic. What data is shared with MCPs and navigators about the 88% who are disenrolled? Also, we are hearing reports that people are submitting information and the county doesn't have it.

Huang: MCPs already receive a list monthly with a coded reason for each person disenrolled. We are augmenting that with data on people coming up for renewal. Navigators have two lists: one of people coming up for renewal and the second is a list of disenrollment with the reason, so they can tailor outreach. We are aware of the issue that people mention they submitted information that the county does not have. We are offering training and technical assistance to both counties and CBOs related to eligibility systems.

Nguy: I want to encourage DHCS to request flexibility from CMS to renew eligibility for non-MAGI individuals with stable income without checking data sources. I also want to highlight that the 90-day cure period does cause disruptions and is a Medi-Cal termination, even though they can re-

enroll. We need to minimize the coverage cutoff and ensure members get continuous coverage to avoid this. I appreciate there is additional training to CBOs and county workers because we have heard that people have challenges trying to use BenefitsCal.

Huang: We are looking at messaging related to the 90-day cure period to clarify this. Also, we are looking at flexibility for Title 2 as you mentioned. BenefitsCal is new and the transition to a new portal at the same time is complicating this process. We are working with CBO partners, counties, and systems to make sure everything is working smoothly.

Flaum: Related to navigators, do we know how they are coordinating follow up in counties based on the two lists? Locally, we want to ensure the list is getting worked.

Huang: We defer to their internal partnerships to coordinate.

Owen: DHCS has been clear that health plans should support state and county efforts and utilize communication materials in local outreach. We are working on the monthly lists to outreach to members and meet with county partners. We know who has not reenrolled but not why, so we work with community health workers and primary care providers to reach out.

Behavioral Health Modernization
Michelle Baass and Tyler Sadwith, DHCS

Baass offered updates following the release in March of the proposal to modernize the state's behavioral health system. She reported that the $4.68 billion general obligation bond would fund voluntary community-based residential treatment, permanent supportive housing, and housing for homeless individuals or veterans with a behavioral health condition. Baass noted the proposal also modernizes the Mental Health Services Act (MHSA) to include individuals with substance use disorder (becoming the Behavioral Health Services Act or BHSA) and includes other access and accountability elements. Baass commented that DHCS has conducted stakeholder webinars and received input and support for the bond and that stakeholder input about workforce resulted in modifications. She indicated there were many comments on the importance of MHSA as a source of population-based prevention efforts. Baass reviewed funding for each element of the initiative.

Questions and Comments

Kelley: Is there an effort to assess the current MHSA to assess the upstream programs that will not fit into the new mandated buckets for MHSA and will result in people falling out of our system? It's a concern for counties that we have been building a system for 20 years and now have to shift into the buckets outlined. We appreciate including substance use disorder in the BHSA, however, adding a population without adding resources makes it difficult.

Baass: We are working to get direct specific feedback on what counties, CBOs, and providers think may not be prioritized and we welcome your input on that. We are prioritizing the most vulnerable, the most at risk for severe mental health and behavioral health and also recognize the opportunity to assess what is needed locally. We are proposing to change the three-year planning process to become a county based, integrated behavioral health plan of needs that includes MCPs and social service agencies and offers ideas to blend and braid programs and funding to leverage dollars not previously part of the plan.

Teare: It is a welcome move to look across funding systems for behavioral health services. Can you say more about what leveraging Medi-Cal would look like operationally? Is there an

analysis of the Medi-Cal expansions that may have taken over for some of the MHSA services?

Baass: Since the MHSA began, the ACA passed, expanded Medi-Cal coverage to undocumented individuals and other new benefits and services have been added. There is a need to rethink the use of the MHSA because of opportunities to draw down more federal dollars.

Savage-Sangwan: We appreciate not only the inclusion of community defined evidence practices, but also including them across the continuum of care. There is work ahead to identify and integrate community defined evidence practices and we urge planning on that. We appreciate including substance use disorders to advance racial justice. We need to be aligning across systems and also aligning funding and accountability mechanisms. There is concern about making specific reforms to MHSA ahead of that cross-system planning. Have we considered working with CMS to include California Drug and Alcohol Programs in our Medi-Cal State Plan? Also, can you confirm this is set for the March ballot as opposed to November, given that more time might be helpful?

Baass: Yes, the MHSA ballot initiative is set for March 2024. Because of the dire need for behavioral health services today, we wanted to move ahead as soon as possible. Related to CMS, we are thinking through how to build the evidence and rationale for that discussion.

Cooper: We have had high-level discussions with CMS on this. I participate in the CMS health equity work group and agree that there are aspects of the models and practices in Medi-Cal as well as other components to lift up for the future. We look forward to partnership with you on this.

Ramirez: There is a significant need for stakeholder voice in oversight and accountability. The MHSA has not realized the same level of transformation in all counties. For each county to have a unique implementation of priority needs for groups like Native American, LGBTQ and people with disabilities, it could further marginalize the needs for specific populations. The MHSA did not provide, or mandate services be provided to people with disabilities across the state. In LA County, many needs for Spanish language materials and other issues are yet to materialize. I encourage the dedicated analysis of the impact of the proposed change, especially for communities already disenfranchised. There are significant reforms happening and the consequence could be to further marginalize equity populations and disrupt services, particularly where we don't have a community planning process that is consumer based. My recommendation is to broaden and ensure priority for primary stakeholders from equity populations for whom the benefits of the MHSA have yet to be realized.

Fields: I want to raise issues not yet discussed on the bond measure. We have a system of residential treatment alternatives and a continuum of care, from crisis residential to supported housing, based on integrated programs in the community. As we look to the bond measure, it is important to include residential 24-hour treatment and not continue to implement a model of crisis intervention and housing. For individuals with substance use and severe mental illness, treatment is best practice as opposed to just being in housing with supported staff. I want to ensure that we value practice-based evidence, not just evidence-based practice, and include community integrated programs that reflect local needs to avoid over institutionalization.

Lewis: I appreciate the addition of SUD to the MHSA to become the BHSA and it is important to add those resources as well. Transparency and accountability are essential – not just to identify the need and spending for BHSA, but also where the funding is going in the system overall. We need to track realignment county funding and the full system of services. Decisions are being made about how funding is used that should be discussed and prioritized in a transparent way.

How are we going to shift to priorities as we leverage federal funds with realignment and BHSA funds? There is no requirement in realignment to fund specific services and there is a lot of flexibility – maybe too much flexibility in the decisions about how funding is used and what is working, what is evidence driven.

Stoner Mertz: We focus on the potential impact on services to children and youth. We are concerned there is no clear guidance about continuing funding for critical services provided through the MHSA. We have surveyed members about services that could or couldn't be continued under Medi-Cal and are concerned there are gaps. We need to ensure a set aside for children and youth programming.

Vasquez: We are hopeful that the set asides currently in place for children and youth will remain. When the MHSA was passed in 2004, prevention and early intervention was included, however the children and youth set asides came about through a campaign, beginning in LA County 15 years ago and later institutionalized in state policy, to use 51% of funding for children and youth. We urge DHCS to consider how to ensure that kids are kept whole through these reforms.

Harris: We appreciate including substance use in the BHSA given the high number of alcohol and opioid related deaths. We can learn what to do for youth prevention and early intervention from the innovative programs funded by Prop 64. Also, I want to underscore the many stakeholder comments related to training for SUD service delivery. More definition surrounding workforce is needed within the legislation, because without people to provide services, it is an empty promise.

Birthing Care Pathway Project
Palav Babaria, MD and Pamela Riley, MD, DHCS
Slides available

Cooper offered introductory remarks about the importance to DHCS of improving quality maternity care by taking a different approach and directly engaging Medi-Cal members in their care to address the significant disparities. She noted that Medi-Cal pays for over 50% of births in California and commented that this initiative aims for a comprehensive assessment of policy and financing of maternal care.

Babaria presented the Birthing Care Pathway Project, a care model from conception through 12-months postpartum to reduce morbidity and mortality and address the worsening racial and ethnic disparities in outcomes, particularly for Black, American Indian/Alaska Native (AI/AN), and Pacific Islander individuals. Babaria reported that DHCS will launch a Clinical Care Work Group and a Social Drivers of Health Work Group. Work groups will include team-based care professions, doulas, midwives, OB GYN providers, pediatricians, family practice providers, and local agencies. She described additional elements of the Project, including a series of stakeholder interviews to define what the model should include and an internal DHCS policy and payment work group. She spoke to a series of member engagement activities to ensure the final design reflects the priorities of member experience and reflections. She commented that a public report of the policy recommendations will be issued Summer 2024 and she acknowledged the support of the California Health Care Foundation and the David and Lucille Packard Foundation for the project.

Questions and Comments

Gibbons: I am excited to have this kick off, especially the inclusion of how members feel about their care. On the work groups, it would be beneficial to add public health department staff to the clinical work group, such as home visitors, the Black Infant Health Program, the Comprehensive

Perinatal Services Program (CPSP) provider training voice, and public health nurses. I would caution that we do not shift away from the pathways where people get care, like home visiting, to rebuild and manage in Medi-Cal, but instead find ways for Medi-Cal and federal funding to go upstream and invest in public health to continue to oversee services.

Babaria: We definitely have representation of CPSP, Black Infant Health, and home visiting as well as local and state public health in the work groups and agree these are critical partnerships.

Flaum: Are the participants for the work groups chosen? I saw doulas listed and want to flag the work DHCS is doing on rates for equity and interviews with delivery system providers. I hope that that will be an input into this work.

Babaria: We have identified membership and will be announcing the participants soon. The work you mention absolutely will be an input. There isn't a specific proposal we have already developed so we are still in a broad listening phase. There will be more engagement, including other venues and initiatives to offer input on the areas of focus.

Golden Testa: I want to make sure we include community health workers in both work groups. I agree with the focus on the areas and populations facing disparities and I also want to make sure that support services are available to all.

Perrone: How do you see the member voice work group intersecting with other work groups? Is there a co-design? Are members informing the process?

Babaria: We hope to leverage the health equity roadmap process when it kicks off to offer learning that is relevant for the birthing care work. We also wanted to create a specific group for this project with a thought of oversampling for the maternity population. The health equity roadmap work is across numerous demographics. There may be aspects of policy where co-design is not helpful, such as payment fee schedules, and other elements where member voice and a co-design process will be used.

Cooper: We are in an initial phase of mapping and gathering member feedback. There will be a second phase of compiling the pieces that will be more of a co-design directly with members. This isn’t only about policy; it is also about the actual member experience and how to incorporate that in decisions along the way. What might it mean to develop the expectation and training for excellence to make sure that care delivers the best patient experience?

Savage-Sangwan: I appreciate seeing more focus on member voice in DHCS’ work because that is key to equity. Do you envision collaboration with other departments as part of developing this? The issue of whether people face discrimination in hospitals has a lot to do with how we develop the workforce and how we enforce non-discrimination.

Babaria: Yes, public health is a clear partner and as we dive into the provider and facility realm, there are additional state partners to include. We can follow a process similar to the children and youth strategy where cross-departmental initiatives at the state level were involved.

Lewis: There are lessons learned in the doula implementation such as challenges to getting a new partner involved in, and accepted by, the system, such as stories of hospitals refusing admission of both patient and doula for the birth. We need to ensure that trusted individuals, like community health workers, have a positive experience and that patients get referred to the doula services they want and need. This will bring positive impact in terms of trust and maybe health outcomes.

Health Plan Transitions and Status of Readiness
Bambi Cisneros and Michelle Retke, DHCS

Cisneros provided an update on MCP readiness for the plan transition in 2024. Cisneros reviewed three groups of plans, indicating it is organized primarily around the required filing submissions to DHCS, not by plan model. For example, Community Health Plan of Imperial Valley (Group 3) is the new Local Initiative in a single plan county, not a commercial MCP. She noted that there are over 200 deliverables required for each plan to submit and DHCS considers 74 of the deliverables to be key policy decisions for plan readiness and the go/no-go decision September 1st, 2023. She explained DHCS' approach for high priority MCPs, including plans entering new markets or accepting significant number of new members. Cisneros reviewed specific information included in the DHCS review process, such as how plans are staffed and trained to address member inquiries about continuity of care policies. She outlined the principles DHCS is using for members transitioning to new MCPs. Cisneros presented the topics included in the policy guidance for MCPs released in June 2023 as well as additional topics to be released in Fall 2023, such as data transfer and oversight. She offered specifics on policy guidance for members transitioning to new MCPs in January 2024, who are eligible for Continuity of Care (CoC) protections, which has well established policy and guidance. Special populations with complex and chronic conditions have enhanced protections to avoid any disruption due to the transition. This includes CoC for providers and CoC for services and will be extended from the existing 90 days to six months.

Questions and Comments

Pittman- Spencer: There was an issue early this year with the long-term care population being transitioned into dental managed care. There was communication to patients and to MCPs, but not to the fee for service dentists. There may be lessons learned for the current transition.

Koopmans: Continuity of Care hinges on having the correct data and this is an important topic. As we approach January, is there a timeline for final STCs and approval from CMS?

Cisneros: We are getting close to approval. We are confident the information discussed is what will be reflected in final STCs.

Lewis: We are glad there is a full guide for continuity of care policy because we have seen challenges with patients being billed during other transitions and hope the policies outlined will avoid this. We recommend there be a consumer option to work with DHCS when there are systemic problems to solve them out quickly and avoid beneficiaries being sent to collection.

Savage-Sangwan: Is there a consideration about populations with challenges transitioning MCPs other than special health care needs, such as members with limited English proficiency?

Public Comment

Richard Gallup, Santa Cruz, California: I'm a person with lived experience and volunteer with Access California, a program of Cal Voices. As a state advocate, I am concerned about peer workers and peer workforce that have not been discussed. State agencies need to include us as part of the transitional change currently happening. Secondly, it is questionable whether the bond measure is legal the way it is being done. The community planning process has to be, and needs to be, part of the Mental Health Services Act modernization. The purpose of the MHSA is to address needs and gaps of services throughout the communities, which vary from county to

county. Also, Kaiser needs to provide adequate, timely mental health services. That is one of the barriers and a complaint grievance may need to be filed with the Department of Managed Health Care. Special populations need peer workers to help them understand how to navigate managed care. They're not used to the managed care model versus the Medi-Cal system where the doctor handles everything for them. Thank you.

Tara Gamboa Eastman, Steinberg Institute: Thank you all for the rich discussion on all of the topics today. I want to focus my comment on the modernization proposal. We're thankful to the administration and stakeholders for coming together to work on this transformational effort. We're incredibly supportive. We do have one recommended amendment to strengthen the outcomes and accountability portion. While we acknowledge that there's broad data collection efforts noted in the bill, and also some data quality metrics to ensure that we're collecting similar data across the counties, we would like DHCS to be required to create specific metrics so that we can accurately compare the stories across the counties. Thank you so much for the hard work and look forward to our continued partnership.

Steve McNally, Mental Health Advisory Board Member, Orange County: I am on a local Behavioral Health Advisory Board, along with 900 people and 59 elected members across state. My concern is the lack of honesty and trust that I see at the meetings. It seems to me this is being rushed through without clarity about what's going on in the community. I think we need to own where we are, how we got here, and where we go in the future. Over the last five years, $100 million dollars each year could have been spent on community planning to understand capacity, awareness, access, and all the things we still don't know. I think the Oversight and Accountability Commission was tasked with creating those standards and having accountability. Many of the things that you're talking about being new aren't new, they just weren't done. I find it difficult that people are speaking to how great this is, but they can't explain exactly how much substance use disorder funding there will be or how many people will be affected. It is as if you're trading serious mental illness for mild to moderate and going after federal money. I don't think you've made the case that this current system is working so well that you can expand it without new funding and that you can add all these other players to the table. It's frustrating as a parent. The aspirations are terrific, but the operational aspects of it are not there. Did you ever talk to people who actually use the system to find out if we are fixing a problem that really exists? I think we're rushing something through the system that's not articulated and not presented to the community ahead of time. Thank you for your kindness in letting me talk.

Steve Leoni, Mental Health Consumer and Advocate: I second Steve McNally's comments. I was at the side of Rusty Selix and Richard Van Horn and other people who designed and worked to get the MHSA ballot measure passed. I believe I have some standing to talk about what it meant originally. I'm very concerned that we are in such a hurry to do this. The MHSA was not just extra funding, it was meant to be a different kind of funding, used differently from Medi-Cal. They spent 10 years making sure it would work before doing the ballot measure. The early results on what is now called Full Service Partnerships indicate they work very well. The state has failed over the last two decades to implement it correctly; there has been a lot of drift, there has been a lot of agendas, and as a result, they're not performing as well as they used to from what little data we have. Now you are saying we are going to require them to use Medi-Cal money to expand funding and bring in federal dollars although it is in the law that you can't use MHSA funding for anything that another funding source can pay for. The only way that it will make makes sense is if you swap out some aspects of Full Service Partnership or MHSA funding for Medi-Cal. Medi-Cal is about doing things that help mental illness. The MHSA funding is focused on recovery and building up a person's ability to deal with mental illness. That is a profoundly different thing. You can't simply swap out one for the other. I'm worried that, in our rush to expand the amount of dollars, we may

be swapping out techniques that work well, for techniques that will work less well, in the name of bringing in more money. I don't think that is going to serve people well.

Aaron Bailey, VP of Corporate Development and General Counsel: I am General Counsel for outpatient treatment centers and mental health providers in Orange County, most notably the Edge Treatment Center in Santa Ana. My intention today was to repeat my encouragement that DHCS actively engage with its stakeholders in the treatment community, in advance of the inevitable shift to mandatory licensure of outpatient centers, and for the purposes of developing new and comprehensive regulations that ensure safe and effective treatment for a vulnerable population in critical need of care and to effectuate DHCS policy goals in a transparent manner that we can actually follow. That is moot because mandatory certification was enacted via the budget trailer bill. I congratulate DHCS on the long overdue change, but I was surprised to find it pushed through quickly without substantive community engagement or draft regulations. It was concerning to hear that stakeholder feedback will happen at the notice and comment stage near the end of the regulatory process. It's still an important and constructive step in the development of both the industry and DHCS as a regulatory agency. Mandatory certification means unethical and unscrupulous treatment centers can no longer avoid consequences by merely electing not to be certified or surrendering their certification when caught. And as a regulatory agency, DHCS will grow as the full array of state and federal administrative due process requirements now apply to the enforcement and policy efforts in this field. I'm sure there will be growing pains on both sides, and it's my sincere hope that DHCS and the treatment community partner together substantively, not merely as a formality, to build a stronger and more professional clinical and regulatory environment worthy of the public trust and of our great state. Thanks for your time.

Chynell Clark, comment submitted via chat: It is essential that funds intended to benefit the community should go to established organizations already doing the hard work and direct services supporting underserved communities, promoting peer-to-peer programs, and eliminating barriers to care, as is often the case in clinical settings.

Next Meeting, Next Steps and Adjourn
Michelle Baass, DHCS

Baass noted that hybrid meetings will continue. The next meeting is October 19, 2023. The joint SAC/BH-SAC meeting will be from 9:30 a.m. to 1:30 p.m. The BH-SAC meeting will be from 2:00 – 3:30 p.m. There will be further communication about agenda topics.