Tribal and Indian Health Program Representatives Meeting

Department of Health Care Services

May 23, 2022

DHCS

Overview

- Welcome and Introductions
- Agenda Review
- Items for Next Meeting

Public Health Emergency (PHE) Unwinding

- **The COVID-19 PHE will end soon and millions of Medi-Cal beneficiaries may lose their coverage.**
- To minimize the number of Medi-Cal beneficiaries that lose coverage DHCS developed the Medi-Cal COVID-19 Public Health Emergency (PHE) Operational Unwinding Plan.
- The two primary purposes of this document are to describe DHCS' approach to:
  1) unwinding or making permanent temporarily flexibilities implemented across the Medi-Cal program during the PHE; and
  2) resuming normal Medi-Cal eligibility operations following the end of the PHE.

Public Health Emergency (PHE) Unwinding

- **Top Goal of DHCS:** Minimize beneficiary burden and promote continuity of coverage for our beneficiaries.
- **How you can help:**
  - Become a **DHCS Coverage Ambassador**
  - Download the Outreach Toolkit on the DHCS Coverage Ambassador webpage
  - Join the DHCS Coverage Ambassador mailing list to receive updated toolkits as they become available

DHCS PHE Unwind Communications Strategy

- **Phase One: Encourage Beneficiaries to Update Contact Information**
  - **Launch immediately**
  - Multi-channel communication campaign to encourage beneficiaries to update contact information with county offices.
    - » Flyers in provider/clinic offices, social media, call scripts, website banners
- **Phase Two: Watch for Renewal Packets in the mail. Remember to update your contact information!**
  - **Launch 60 days prior to COVID-19 PHE termination.**
  - Remind beneficiaries to watch for renewal packets in the mail and update contact information with county office if they have not done so yet.

DHCS Coverage Ambassadors Webinar

- DHCS is conducting a webinar regarding the new DHCS Coverage Ambassadors
  - **Date: Tuesday, May 24, 2022 10:00 am – 11:00 am Pacific Time, or**
  - **Date: Wednesday, May 25, 2022 1:00 pm – 2:00pm Pacific Time**
- Registration information is available on the DHCS Coverage Ambassador webpage
- After registering for your preferred session, you will receive a confirmation email containing information about joining the webinar.

DHCS Director's Update

Michelle Baass
DHCS Director

Medi-Cal Eligibility and American Indian Youth in Foster Care

Dee Paull
DHCS Medi-Cal Eligibility Division

Eligibility for Foster Care and Extended Foster Care Youth

- State and Federal Law establishes automatic full scope Medi-Cal Eligibility for individuals enrolled in Foster Care and Extended Foster Care
- No income or assets test are required for individuals in these groups.
- Youths in these programs are eligible for fee for service providers unless they reside in a County Organized Health Systems (COHS) county
- Counties can reach DHCS to inquire about Foster Care Medi-Cal eligibility guidance through the DHCS Foster Care Email Box which is: DHCSFosterCareProgram@dhcs.ca.gov

Tribal Youth in Foster Care

- Tribal youth in foster care are eligible for full scope Medi-Cal under State Plan Amendment (SPA) 13-041.
- All County Welfare Director's Letter (ACWDL) 17-03
- All County Welfare Director's Letter (ACWDL) 18-16

Action Plan

- DHCS is drafting an ACWDL to educate counties on the movement of youths from foster care into tribal guardianship.

- How do the impacted Tribes envision working with DHCS to address federal Title IV-B requirements?

Questions or Clarification?

I am available to help provide clarification on Foster Care Medi-Cal Eligibility questions.

Dee Paull

Associate Governmental Program Analyst

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CalAIM Enhanced Care Management & Community Supports

Information for Providers

Michel Huizar
DHCS Branch Chief

Today's Agenda

- **Overview of CalAIM, ECM & Community Supports**
- **Roles of MCPs & Providers of ECM & Community Supports**
- **Next Steps**
- **Q & A**

DHCS is interested in hearing your questions and feedback, especially addressing any barriers to becoming an ECM or Community Supports provider.

Overview of CalAIM ECM & Community Supports

California Advancing and Innovating Medi-Cal (CalAIM)

DHCS launched CalAIM – a multi-year initiative – to improve the quality of life and health outcomes for Californians by implementing broad delivery system, program and payment reform across the Medi-Cal program.

Over half of Medi-Cal spending is attributable to the **5% of enrollees with the highest-cost needs**

Medi-Cal enrollees typically have **several complex health conditions**

Enrollees with complex needs must often engage in **several delivery systems to access care**

American Indians / Alaska Natives report severe health risks and disparities – including substance use disorder, asthma, diabetes, and suicidality – **compared to other ethnic groups**

CalAIM seeks to:

1. Identify and manage member risk and need through whole person care approaches and addressing Social Drivers of Health;
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity; and
3. Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

What are ECM & Community Supports?

CalAIM includes a number of initiatives that will support the American Indian / Alaska Native (AI/AN) populations enrolled in Medi-Cal managed care, including ECM and Community Supports:

Enhanced Care Management

A **Medi-Cal managed care benefit** that addresses clinical and non-clinical needs of high-need, high-cost individuals through the coordination of services and comprehensive care management.

Community Supports

Services that **Medi-Cal managed care plans (MCPs) are strongly encouraged but not required to provide** as substitutes for utilization of other services or settings such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.

Building on What We Know. ECM and Community Supports built on the design and learnings from California's **Whole Person Care Pilots (WPC)** and **Health Homes Program (HHP)** and replaced both models to scale interventions to a statewide care management approach as of **January 1, 2022.**

Enhanced Care Management (ECM)

- New statewide mandatory managed care benefit available to eligible high-need individuals enrolled in managed care.
  - **NOTE: ECM is only available for enrollees in Medi-Cal managed care.** AI/AN populations residing in non-County Organized Health System (COHS) have the ability to opt-out of Medi-Cal managed care enrollment for Fee-For-Service (per CalAIM Section 1915(b) waiver).
- Implementation began in HHP and WPC counties on January 1, 2022 for certain populations. **Implementation will be statewide from July 1, 2022.**
- Part of broader CalAIM Population Health Management system design through which MCPs will offer care management interventions at different levels of intensity based on member need, with ECM as the highest intensity level.

ECM within Levels of Care Management in Medi-Cal Managed Care

level of need/risk

Enhanced Care Management

- Intended for highest risk members who need long-term coordination for multiple chronic conditions, social determinants of health issues, and utilization of multiple service types and delivery systems.

Complex Case Management

- Intended for high-risk members who need coordination of services for complex conditions or episodic need.

Basic Population Health Management

- Intended for members who require support with planning and coordination that is not at the highest level of complexity, intensity, or duration.

ECM Populations of Focus ("POFs")

ECM go-live is occurring occur in stages, by Population of Focus. AI/AN populations will qualify for ECM if they are eligible for one of the following ECM POFs:

Populations of Focus	Go-Live Timing
1. Individuals and Families Experiencing Homelessness 2. Adult High Utilizers 3. Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD)	**January 2022** (WPC/HH counties); **July 2022** (all other counties)
4. Incarcerated and Transitioning to the Community 5. At Risk for Institutionalization and Eligible for Long Term Care (LTC) 6. Nursing Facility Residents Transitioning to the Community	**January 2023** (statewide)
7. Children / Youth Populations of Focus	**July 2023** (statewide)

For more information on POFs, see the ECM Policy Guide.

ECM Core Services

- Outreach and Engagement
- Comprehensive Assessment and Care Management Plan
- Coordination of and Referral to Community and Social Support Services
- Enhanced Coordination of Care
- Member and Family Supports
- Health Promotion
- Comprehensive Transitional Care

Community Supports

- Focused on addressing combined medical and social drivers of health needs and avoiding higher levels of care and associated costs.
- Medically appropriate, cost-effective alternative services or settings that are provided "in lieu of" / substitute for more costly services or settings such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.
- Strongly encouraged but not required for Medi-Cal MCPs to implement (not benefits).
  - NOTE: Community Supports are only available to enrollees in Medi-Cal managed care. AI/AN populations residing in non-County Organized Health System (COHS) have the ability to opt-out of Medi-Cal managed care enrollment for Fee-For-Service (per CalAIM Section 1915(b) waiver).
- **Optional** for Medi-Cal Managed Care Plans to offer and for Members to receive.
- Must be **medically appropriate and cost-effective.**
- Began implementation statewide on January 1, 2022.

Community Supports Services

DHCS has pre-approved 14 medically appropriate and cost-effective Community Supports that MCPs may offer. MCPs may also submit proposals to offer additional Community Supports that are not on this menu, subject to DHCS approval.

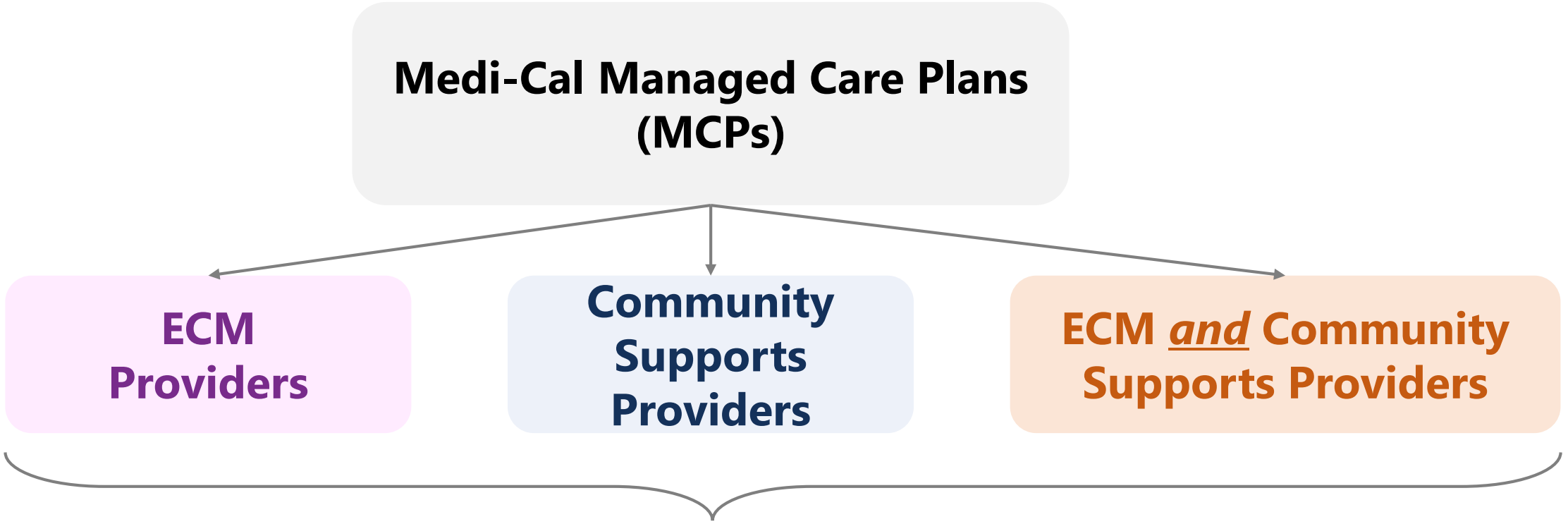
Pre-Approved DHCS Community Supports include:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically-Tailored Meals or Medically-Supportive Foods
- Sobering Centers
- Asthma Remediation

Roles of MCPs & Providers of ECM & Community Supports

Roles & Responsibilities

MCPs contract with community-based providers to offer ECM and Community Supports:



Including Tribal & AI/AN Partners

MCPs…

- Establish provider networks to deliver ECM and elected Community Supports.
  - Medi-Cal MCPs **must** attempt to enter into a Subcontractor Agreement with each American Indian Health Services facility (per 22 CCR Sections 55110 & 55180) to provide ECM.
  - However, American Indian Health Services are not required to contract with MCPs in order to provide and be reimbursed for services.
- Authorize ECM and Community Supports and assign members to ECM and Community Supports providers.
- Oversee and monitor ECM/Community Supports service delivery.
- Provide training for ECM/Community Supports providers.
- Submit to DHCS a Model of Care for ECM/Community Supports, inclusive of a required section in which MCPs **must** describe their coordination with Tribal partners to ensure sufficient and timely ECM Provider access for American Indians

ECM Providers…

- Are **Community-based entities**, with experience and expertise providing culturally appropriate, intensive, in-person care management services to individuals they will serve in ECM (example: people experiencing homelessness).
- Take responsibility for coordinating care across multiple medical, behavioral, and social service systems, assigning a **Lead Care Manager** to each individual in ECM. Lead Care Managers meet with individuals in person and form a trusting relationship.
- **Contract with Medi-Cal health plans** as ECM Providers and negotiate rates.
  - **NOTE:** American Indian Health Service Programs do **not** need to contract with MCPs to receive reimbursement. IHPs will be reimbursed through the standard invoicing guidance.
- Must be able to either submit 837 claims to MCPs or use a DHCS invoicing template to bill MCPs if unable to submit claims, and must have a documentation system for care management.
- Receive **standardized information** from Medi-Cal health plans about the individuals they are serving, to help them understand all needs (example: past utilization of emergency services).

ECM Providers can be **American Indian Health Service Programs.**

Medi-Cal MCPs ***must*** contract with the existing WPC Lead Entities and/or HHP Community-Based Care Management Entities. To the extent those were Indian Health Service Programs in prior years, then they will be ECM Providers too.

Types of ECM Provider

» In addition to American Indian Health Services programs, Medi-Cal MCPs may choose to contract with a wide range of provider types:

- Federally Qualified Health Centers/Community Health Centers
- Hospitals or hospital-based physician groups or clinics (including public hospitals and district and/or municipal public hospitals)
- Primary care providers or specialists or physician groups
- County behavioral health plans
- Behavioral health entities
- Community based organizations (CBOs)
- Community mental health centers;
- Local health departments
- Rural health centers;
- SUD treatment providers;
- Community Based Adult Services (CBAS) providers;
- In Home Supportive Services (IHSS) providers;
- Skilled nursing facilities;
- Organizations serving individuals experiencing homelessness and/or justice-involved individuals;
- CCS providers;
- Other qualified providers or entities that are not listed above, as approved by DHCS.

Community Supports Providers…

- Are organizations that already deliver critical **social services**, including housing navigation, recuperative care, medically-tailored meals, or community transitions.
- **Contract with Medi-Cal health plans** as Community Supports Providers and negotiate rates. DHCS has published pricing guidance for the Community Supports to assist.
  - These organizations traditionally have not contracted with Medi-Cal MCPs. Community Supports is bringing change to what MCPs' networks look like.
  - **NOTE:** American Indian Health Service Programs do **not** need to contract with MCPs to receive reimbursement. IHPs will be reimbursed through the standard invoicing guidance.
- **Receive referrals** from ECM and other providers, health plans, or requests from individuals and families.
- Either submit 837 claims to MCPs or use a DHCS invoicing template to bill MCPs if unable to submit claims.

Who are Community Supports Providers?

» **Examples:**
- Social services agencies;
- Counties;
- Life skills training and education providers;
- Home health or respite agencies;
- Home delivered meals providers;
- Affordable housing and supportive housing providers;
- Sobering centers.

» These organizations are often known as **"Community Based Organizations"** (CBOs).

Community Supports providers can include **American Indian Health Services programs and clinics** and **established social service organizations serving tribal populations**.

Other Requirements for ECM & Community Supports Providers

Medicaid Enrollment/Vetting

- Providers are required to be Medicaid-enrolled where a State-level enrollment pathway exists, as is required by Federal law.
- If no State-level Medicaid enrollment pathway exists, providers must be credentialed by the MCP and/or undergo other MCP vetting.

Experience and Expertise

- ECM Providers must have experience serving Medi-Cal Members, including the POFs and have experience and expertise with the services outlined in the MCP contract.
- Community Supports Providers must have sufficient experience and expertise in the provision of the services being offered and have a history of serving Medi-Cal Members in a community-based manner.

»Coordination Process

- ECM Providers must have agreements in place to engage with local providers to coordinate member care and use a care management documentation system capable of integrating information necessary to manage and maintain a sharable care plan.

»Cultural Competency

- ECM and Community Supports Providers must have the capacity to provide culturally appropriate and timely in-person care management activities and be able to communicate to the member in culturally and linguistically appropriate and accessible ways.

Next Steps

Reach Out to Your local Medi-Cal Managed Care Plan(s)

NOTE: Medi-Cal MCPs ***must*** attempt to enter into a Subcontractor Agreement with each American Indian Health Services facility (per 22 CCR Sections 55110 & 55180) to provide ECM.

Please access the Medi-Cal Managed Care Health Plan Directory to identify the MCPs in your county and/or contact **CalAIMECMILOS@dhcs.ca.gov** with any questions about how to work with MCPs to get involved in ECM or Community Supports.

BREAK

12:00 PM – 1:00 PM

DHCS

Behavioral Health Update

Tyler Sadwith
DHCS Assistant Deputy Director

Drug Medi-Cal Organized Delivery System (DMC-ODS) Update

- DHCS published Behavioral Health Information Notice 20-065 in 2020
  - Clarifies DMC-ODS counties' obligations to reimburse IHCPs for DMC-ODS services
  - Clarifies AI/AN Medi-Cal beneficiaries' rights to receive DMC-ODS services at any IHCP
- DHCS will issue draft updated guidance for Tribal partner and stakeholder review to clarify when the IHS All-Inclusive Rate can be reimbursed for DMC-ODS services
  - Limited to provider types listed in Supplement 6 to Attachment 4.19-B
  - Consistent with guidance provided in April 2021 to Indian Health distribution list
  - Consistent with DHCS Behavioral Health Information Notice 20-022 regarding counties' obligations to reimburse IHCPs for Specialty Mental Health Services

Justice Package

2022

- Justice-Involved Advisory Group
- PATH supports to help justice-involved initiatives' capacity building and prepare for implementation
- Access to recovery services for individuals, including for justice-involved populations

2023

- Mandatory Medi-Cal application process upon release from county jails and juvenile facilities
- Services for eligible justice-involved populations for 90 days pre-release
- Coordinated re-entry, including:
  - Behavioral health warm handoff to plans and counties
  - ECM population of focus for coordinated re-entry
  - Community Supports (e.g., housing support, medically supportive foods) for justice-involved upon re-entry

Upon System Readiness

- Enhancements for facilitating data sharing, including for justice-involved populations
- Automated suspension process

Traditional Healers and Natural Helpers

- In 2021, DHCS submitted a request to cover Traditional Healer and Natural Helper services.
  - Section 1115 expenditure authority for Traditional Healer and Natural Helper services
  - Provided by Indian health care providers
  - To DMC-ODS beneficiaries
  - From January 1, 2022, through December 31, 2026

Traditional Healers and Natural Helpers (Continued)

- CMS has neither approved nor disapproved the request
- DHCS remains committed to securing CMS approval
- Tribal MAT Project *Tribal and Urban Indian Community Defined Best Practices* funding and technical assistance opportunity to support planning and implementation efforts

CalAIM Behavioral Health Initiatives Timeline

Policy	Go-Live Date
Specialty Mental Health Services - Criteria for Services	January 2022
Behavioral Health No Wrong Door	July 2022
Contingency Management	Fall 2022
Behavioral Health Standard Screening and Transition Tools	January 2023
Behavioral Health Payment Reform	July 2023
Behavioral Health CPT Code Transition	July 2023
California Behavioral Health Community-Based Care Waiver	October 2022 (Earliest to CMS) July 2023 (Starts)
Administrative Integration of SMH and SUD	January 2022 (Starts) January 2027 (Fully Integrated)
DMC-ODS Traditional Healers and Natural Helpers	TBD

Behavioral Health Payment Reform

Key Elements

Go live: July 1, 2023

1. Transition counties from cost-based reimbursement to FFS.
2. Transition from Certified Public Expenditures to Intergovernmental Transfers (IGT) for the county provided non-federal share.
3. Transition from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, known as CPT coding, when possible.

Payment Reform Guidance

- **Updated Billing Manuals (effective July 1, 2023) and other coding transition guidance.**
  - Available Now
    - SMH Billing Manual
    - 837 Companion Guides
  - Coming Soon
    - DMC Billing Manual
    - DMC-ODS Billing Manual
    - HCPCS to CPT Coding Crosswalk
- **Additional guidance is forthcoming.**
  - County rate schedule
  - CPE to IGT transition Information Notice
- For questions, email: BHPaymentReform@dhcs.ca.gov.

What is the aim of the No Wrong Door (NWD) for Mental Health Services Policy?

To ensure beneficiaries receive timely mental health services without delay, regardless of where they initially seek care.

To ensure beneficiaries can maintain treatment relationships with trusted providers without interruption.

How did DHCS develop the NWD policy?

Workgroups

2019-2020 CalAIM stakeholder workgroups and Tribal partner discussions demonstrated the need to ensure beneficiaries have streamlined access to services and treatment.

CalAIM Proposal

CalAIM proposal released for Tribal public notice and Tribal hearing in April 2021.

CalAIM Section 1115 Amendment submitted in June 2021.

AB 133 chaptered in July 2021.

NWD Public Comment

Draft policy released in January 2022.

Tribal partners received draft guidance via Indian Health Executive Director list

DHCS reviewed and integrated feedback.

Final Policy

Released in March 2022 via BHIN 22-011 and APL 22-005.

No Wrong Door Policy

Clinically appropriate and covered Non-Specialty Mental Health Services (NSMHS) and SMHS services are covered and reimbursable Medi-Cal services even when:

1. Services are provided prior to determination of a diagnosis, during the assessment period, or prior to determination of whether NSMHS or SMHS access criteria are met
2. The beneficiary has a co-occurring mental health condition and SUD
3. Services are not included in an individual treatment plan* **OR**

   **Applies to NSMHS per APL; SMHS guidance forthcoming via BH Documentation Reform*
4. NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

Peer Support Services and Certification

- The Peer Support Services benefit will be covered as a county option with July 1, 2022, as the earliest effective date.
- DHCS issued Peer Support Specialist Certification requirements through Information Notice 21-041.
- Many counties designated the California Mental Health Services Authority (CalMHSA) as the entity that will implement their Medi-Cal Peer Support Specialist Certification Program in FY 2022-2023.
- Indian Health Care Providers can deliver Peer Support Services under the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services programs depending on county coverage

Standardized Screening and Transition Tools for Adults and Youth

- Adult and youth screening and transition of care tools go live on January 1, 2023.
- Adult tools were beta tested in fall 2021 and are currently undergoing pilot testing.
  - Adult tools will be released for Tribal partner review and stakeholder comment following pilot testing.
- Youth tools were beta tested in March 2022 and are currently out for stakeholder comment. Youth tools will be pilot tested in summer 2022.
  - Youth tools will be released for Tribal partner review and stakeholder comment following pilot testing.
- Informational and technical assistance webinars will begin later this year.

1115 BH Community-Based Continuum Demonstration

- DHCS will apply for a new Medicaid Section 1115 demonstration to expand access to and strengthen the continuum of community-based mental health services for Medi-Cal beneficiaries living with serious emotional disturbance or mental illness.
- California's 1115 demonstration will amplify California's ongoing behavioral health initiatives, and be informed by findings from DHCS' 2022 *Assessing the Continuum of Care for Behavioral Health Services in California*.
- **DHCS plans to release a concept paper to solicit Tribal partner input and stakeholder feedback on the proposed demonstration approach. DHCS will follow Tribal consultation and public comment period consistent with SPA 12-002 and the Tribal Consultation Policy SPA Synopsis.**

Behavioral Health Updates

- DHCS sends a weekly Behavioral Health eBlast to interested stakeholders with announcements, draft and final policy guidance, updates, and funding and technical assistance opportunities.
- DHCS Office of Tribal Affairs sends the weekly Behavioral Health eBlast to the Indian Health Executive Director distribution list.
- If you would like to receive the weekly Behavioral Health eBlast directly, please contact Michele Taylor at Michele.Taylor@dhcs.ca.gov

Behavioral Health Mobile Crisis Services

Crisis Care Mobile Units (CCMU) Project: Support and expand behavioral health mobile crisis and non-crisis services.

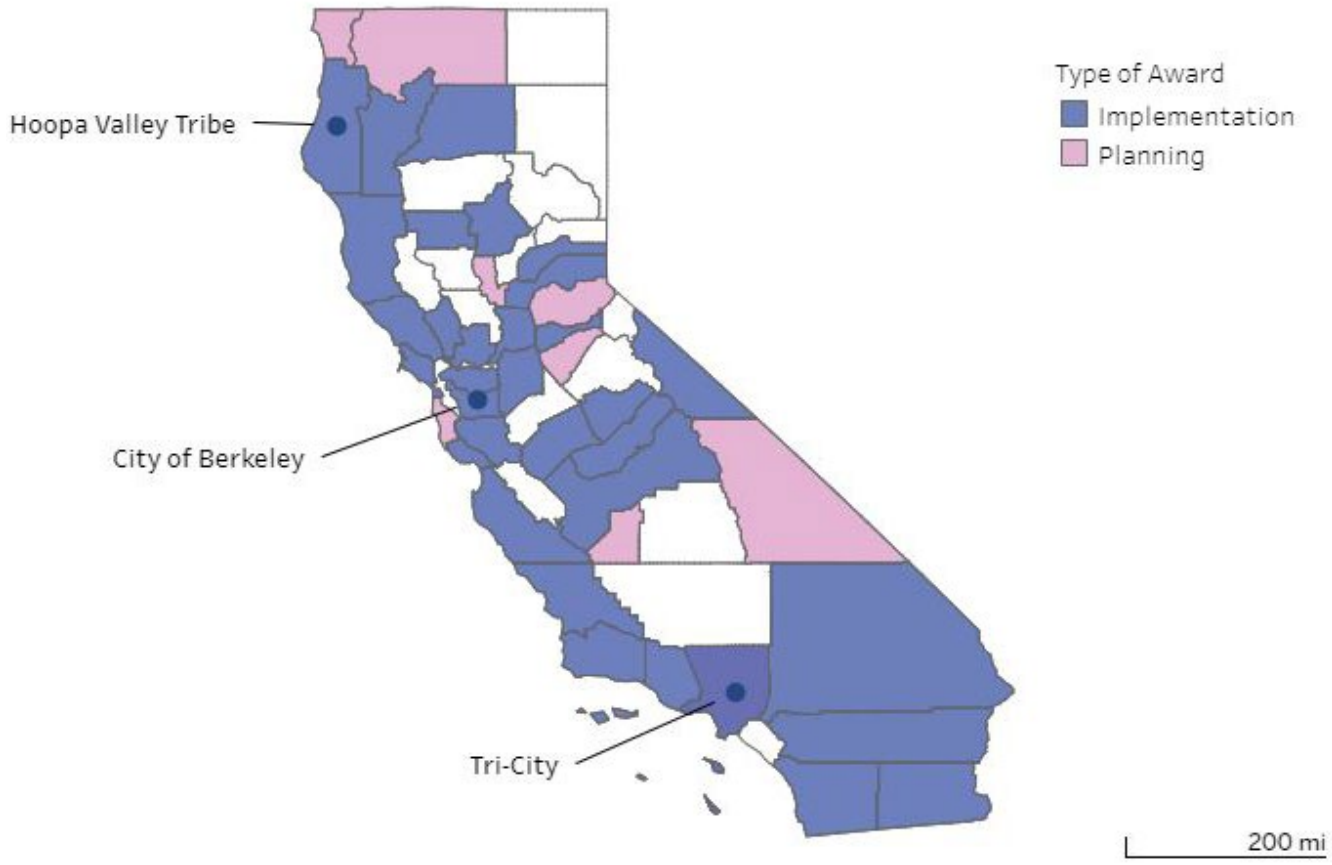
- Grants to implement or expand CCMU programs.
- Provides funding for infrastructure and some direct services to create or enhance mobile behavioral health crisis services.
- Prioritizes services for individuals 25 years old and younger.
- Funded through Behavioral Health Response and Rescue Project (BHRRP) and the Behavioral Health Continuum Infrastructure Program (BHCIP)
  - BHRRP: $55 million
  - BHCIP: $150 million

CCMU Project Impact

- **$160 million** awarded through two funding rounds*
- **51** county, city, or tribal entity behavioral health authorities received funding.
  - **10** planning grants
  - **41** implementation grants
- **130** new CCMU teams.
- **107** enhanced CCMU teams.

*Remaining funding currently allocated to future CCMU activities.

CCMU Awardees



Overview: Medi-Cal Mobile Crisis Services Opportunity

Mobile crisis teams offer community-based intervention to individuals in need wherever they are, including at home, work, or anywhere else in the community where the person is experiencing a behavioral health crisis.

Under the American Rescue Plan Act (ARPA), **states are eligible for an 85% enhanced Federal Medical Assistance Percentage (FMAP)** for qualifying mobile crisis services for 12 quarters between April 2022 and April 2027.

DHCS intends to **submit a State Plan Amendment (SPA)** that establishes a new Medi-Cal mobile crisis benefit, effective as soon as January 2023.

DHCS envisions that its mobile crisis service will align with the state's other efforts to **support individuals experiencing a behavioral health crisis.**

DHCS is **designing a mobile crisis services benefit** to ensure all Medi-Cal members have access to coordinated crisis care 24 hours a day, 7 days a week, 365 days per year.

Mobile Crisis Services Benefit

DHCS will submit a SPA that establishes a **new Medi-Cal mobile crisis services benefit**

Under ARPA, states are eligible for an **85% enhanced FMAP** for qualifying mobile crisis services for three years

Mobile crisis services will align with other efforts to **support individuals experiencing a behavioral health crisis**

DHCS anticipates the mobile crisis services benefit will be **effective as soon as January 2023**

DHCS will **work with Tribal partners** to design the mobile crisis services benefit beginning in spring 2022

CMS guidance regarding the mobile crisis services benefit is available **here**

Overview: Qualifying Mobile Crisis Services

In December 2021, CMS released a State Health Official letter providing guidance on the scope of and enhanced payments for qualifying community-based mobile crisis intervention services.

Minimum ARPA Requirements

- ✓ Services are available 24/7 and timely by a multi-disciplinary mobile crisis team.
- ✓ Teams include at least one behavioral health professional and other professionals/paraprofessionals with expertise in behavioral health.
- ✓ Teams are trained in trauma-informed care, de-escalation strategies, and harm reduction.
- ✓ Teams provide screening, assessment, stabilization, de-escalation, and coordination with health care services and other supports.
- ✓ Maintain relationships with community partners (e.g., medical, behavioral, and crisis providers).

CMS Recommendations

- ✓ Incorporate peers in the mobile crisis team.
- ✓ Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion.
- ✓ Implement GPS technology in partnership with the region's crisis call center hub to support efficient connection to resources and tracking.
- ✓ Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff.

Overview: Landscape of Mobile Crisis Services in California

While many counties in California operate mobile crisis teams, these teams do not cover all beneficiaries, all regions, or all behavioral health services across the state. DHCS is conducting information-gathering interviews with county representatives to identify challenges and opportunities in offering mobile crisis services.

- In the county survey conducted as part of the 2022 *Assessing the Continuum of Care for Behavioral Health Services in California,* mobile crisis was cited as the most urgent need in the crisis continuum. Fifty-one counties (86% of survey respondents) reported seeking to expand or improve mobile crisis services.
- Key takeaways from county interviews include:
  - ✓ Mobile crisis services expand and contract based on available funding sources. **Additional funding is needed** to cover transportation and downtime for mobile crisis teams and to ensure timely response.
  - ✓ **Workforce is a significant challenge** in staffing teams that are available 24/7, 365 days per year.
  - ✓ Most counties interviewed **rely on law enforcement** to mitigate safety concerns and transport individuals to higher levels of care when needed.
  - ✓ Counties report a **variety of mechanisms to dispatch teams**, including coordination with 911 and using standalone mobile crisis lines.

Tribal Interviews: Key Takeaways

All tribal representatives interviewed reported a disjointedness between Tribal and county-led behavioral health services.

- **Minimal Crisis Services.** Tribal behavioral health needs exceed IHP BH capacity. Some county mobile providers serve Tribal members off Tribal lands closer to urban centers. In some areas, county engagement is limited to 5150 holds.
- **Remoteness.** Service barriers for reaching AI/AN individuals on or near Tribal lands include long distances, bad roads, poor cell service, and poor internet connection both on Tribal lands and unincorporated county areas.
- **Reliance on County Sheriff.** Some county Sheriffs co-respond and provide long distance transportation to county ED. Ambulances fearful of responding on Tribal land without Sheriff. Concern about Tribal patients' fear of Sheriff.
- **Disconnected Services.** Sheriff drops patient off for long wait in ED. No alternative destination. No warm hand off from county facility to IHP for follow up. No interface between county and Tribal data systems.
- **Cultural Humility.** Concern about racism and stigma, and county providers not understanding the cultural context of a crisis scene with Tribal community and family dynamics. Reluctance to county assessment via telehealth.
- **Historical Distrust**. Some AI/AN individuals in need of services distrust county providers. Some Tribes reluctant to engage in MOU process with counties due to administrative challenges and a perceived lack of knowledge and respect among some counties for Tribal political status, history, culture, federal/legal rights, and internal processes.

County Interviews: Key Takeaways

All counties interviewed reported interest in expanding mobile crisis services; however, they report shared challenges and concerns around standing up mobile crisis teams that are available 24/7.

- **Funding.** Counties report using a combination of Medi-Cal, Mental Health Services Act, and grant funding to pay for mobile crisis services. Programs expand and retract based on available funding sources. Funding is one of the top challenges reported by counties in standing up mobile crisis teams.
- **Workforce.** Counties report challenges with hiring mobile crisis teams and retaining staff. Staffing challenges result in slower response times and the inability to offer services 24/7. No counties interviewed currently offer 24/7 mobile crisis services. Workforce is one of the top challenges reported by counties in standing up mobile crisis teams.
- **Timeliness.** The majority of counties report a 60-minute goal response time after receiving a call for a mobile crisis teams. However, counties are not consistently tracking or enforcing timeliness standards, and many expect that teams are not meeting the 60-minute goal. County representatives expressed concern that introducing an enhanced rate for faster response times could result in negative unintended consequences, including prioritizing geographically close calls or avoiding more complex situations.

County Interviews: Key Takeaways (Continued)

All counties interviewed reported interest in expanding mobile crisis services; however, they report shared challenges and concerns around standing up mobile crisis teams that are available 24/7.

- **Law enforcement.** All counties interviewed reported relationships between mobile crisis teams and law enforcement. Some counties distinguish between mobile crisis teams that consist exclusively of behavioral health professionals/paraprofessionals and co-response teams. Counties report that safety of mobile crisis team members is a priority that can result in law enforcement involvement. Some counties report law enforcement are the primary responders for crises that occur in the middle of the night.
- **Children and youth.** Almost all counties report having at least one youth-specific team that responds to crises in schools or other settings. In some cases, youth teams are exclusively grant funded. Other counties do not staff youth-specific teams, but cross-train mobile crisis team members on youth-specific issues.
- **Peers.** Counties report increased use of peer support specialists onto mobile crisis teams. However, there are concerns around the re-traumatization of peers in crisis settings. One county reports using peers during follow-up after a mobile crisis visit, with a clinician or pair of physicians acting as the first response.

County Interviews: Key Takeaways (Continued)

All counties interviewed reported interest in expanding mobile crisis services; however, they report shared challenges and concerns around standing up mobile crisis teams that are available 24/7.

- **Dispatch.** Counties have different approaches to dispatching mobile crisis teams. Some counties operate standalone mobile crisis lines, while others coordinate with 911 to identify behavioral health crisis calls. Counties asked how 988 will integrate with and supplement existing mobile crisis services.
- **SUD services.** Counties are not consistently delivering SUD services as part of mobile crisis response. One county reported training teams in naloxone administration, but experiencing hesitancy among team members to carry naloxone. Counties shared that emergency medical services (EMS) teams more frequently respond to SUD-related emergencies.
- **Transportation.** Three counties interviewed have some teams that transport beneficiaries to higher levels of care in member vans. For most counties and teams, law enforcement or EMS transport individuals when needed.
- **Technology.** Some counties reported interest in increased use of technology to support mobile crisis service delivery and follow-up, including access to shared electronic health records to inform primary care providers when a beneficiary has received crisis care.

High-Level Timeline: Stakeholder Engagement Approach

Stakeholder engagement will occur throughout the SPA drafting and submission process, leveraging existing forums and standing meetings.

Month	Activity
April	Landscape research
	Information-gathering interviews
	Meeting with behavioral health stakeholders
May	CalAIM BH Workgroup
	BH-SAC Meeting
	Tribal and Indian Health Program Large Group Webinar
June	CalAIM Children and Youth Advisory Group Meeting
	Meetings with associations and consumer advocacy groups
July	All-Stakeholder Webinar
	BH-SAC Meeting
August	Public Comment
	Tribal Notice
	Tribal and Indian Health Program Small Group Webinar

Children and Youth Behavioral Health Initiative

Autumn Boylan, DHCS Deputy Director
Tisha Montiero, DHCS Section Chief

Overview of the Children and Youth Behavioral Health Initiative

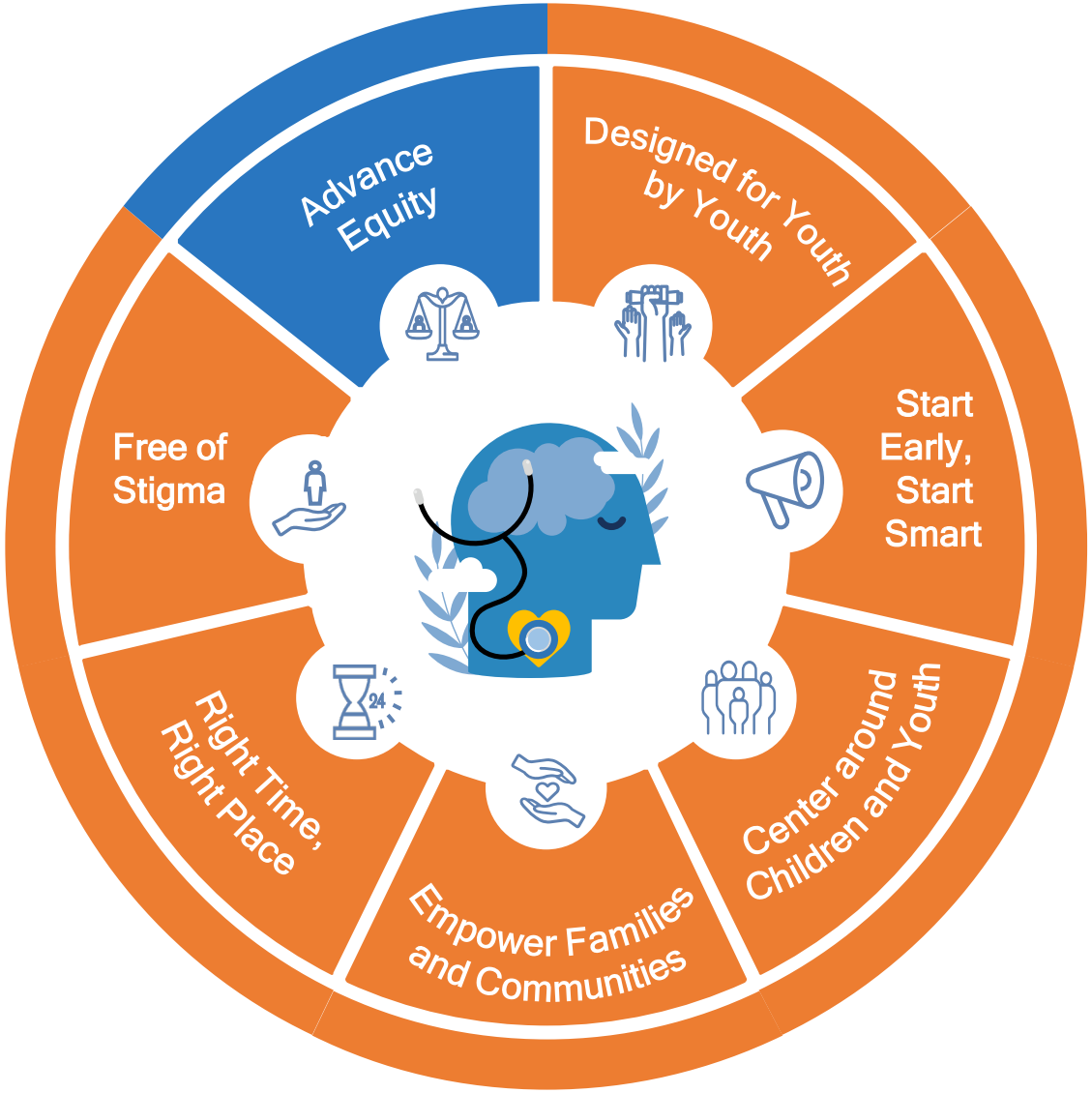
The goal of the **Children and Youth Behavioral Health Initiative is to address the behavioral health challenges** facing children and youth **by reimagining the systems that support behavioral health and wellness for children, youth, and their families**

The initiative will take a **whole system approach** by creating **cross-system partnerships –** involving stakeholders and Tribal partners from the various systems that support children and youth behavioral health **–** to ensure that **the reimagined system is children and youth centered and equity focused**

Source: California Health and Human Services Agency

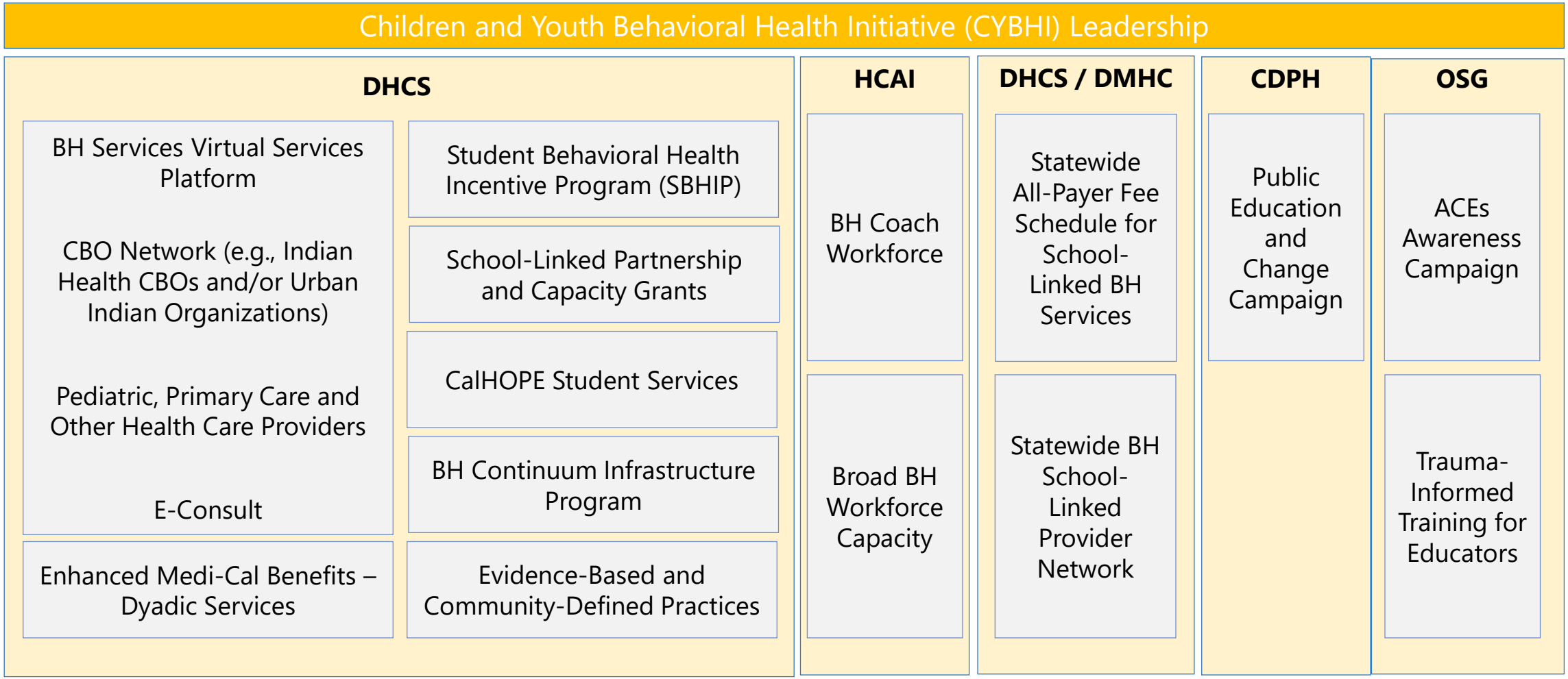
Reimagine behavioral health and emotional wellbeing

for ALL children, youth, and families in California by delivering equitable, appropriate, timely, and accessible mental health and substance use services and supports from prevention to treatment to recovery in an innovative, up-stream focused, ecosystem



Source: California Health and Human Services Agency

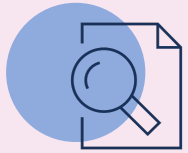
Overview of CYBHI Workstreams



Pediatric, Primary Care and Other Health Care Providers includes Tribal and Urban Indian Health Programs

Workstream: BH Virtual Services and E-Consult Platform

xx Date is subject to change



Workstream Overview

Build and drive adoption of the Behavioral Health Virtual Services Platform for all children, youth and families in California

Support delivery of equitable, appropriate, and timely behavioral health services from prevention to treatment to recovery

Provide an E-Consult platform for pediatric and primary care providers to E-Consult with BH providers

Potential Recipients

- Children and youth
- Parents and caregivers
- Educators
- Pediatricians and primary care physicians (E-Consult)

Key Milestones

- Solicitation of services: **Q4, 2022**
- User engagement sessions: **Timeline TBD**
- Platform launch: **January 1, 2024**

Source: CYBHI Program Brief; CYBHI Think Tank Application

Vision statement and guiding principles for BH Virtual Services and E-Consult Platform

Vision

Build and drive adoption of a Behavioral Health Virtual Services and E-Consult Platform for all children, youth and families in California that supports delivery of equitable, appropriate, and timely behavioral health services from prevention to treatment to recovery

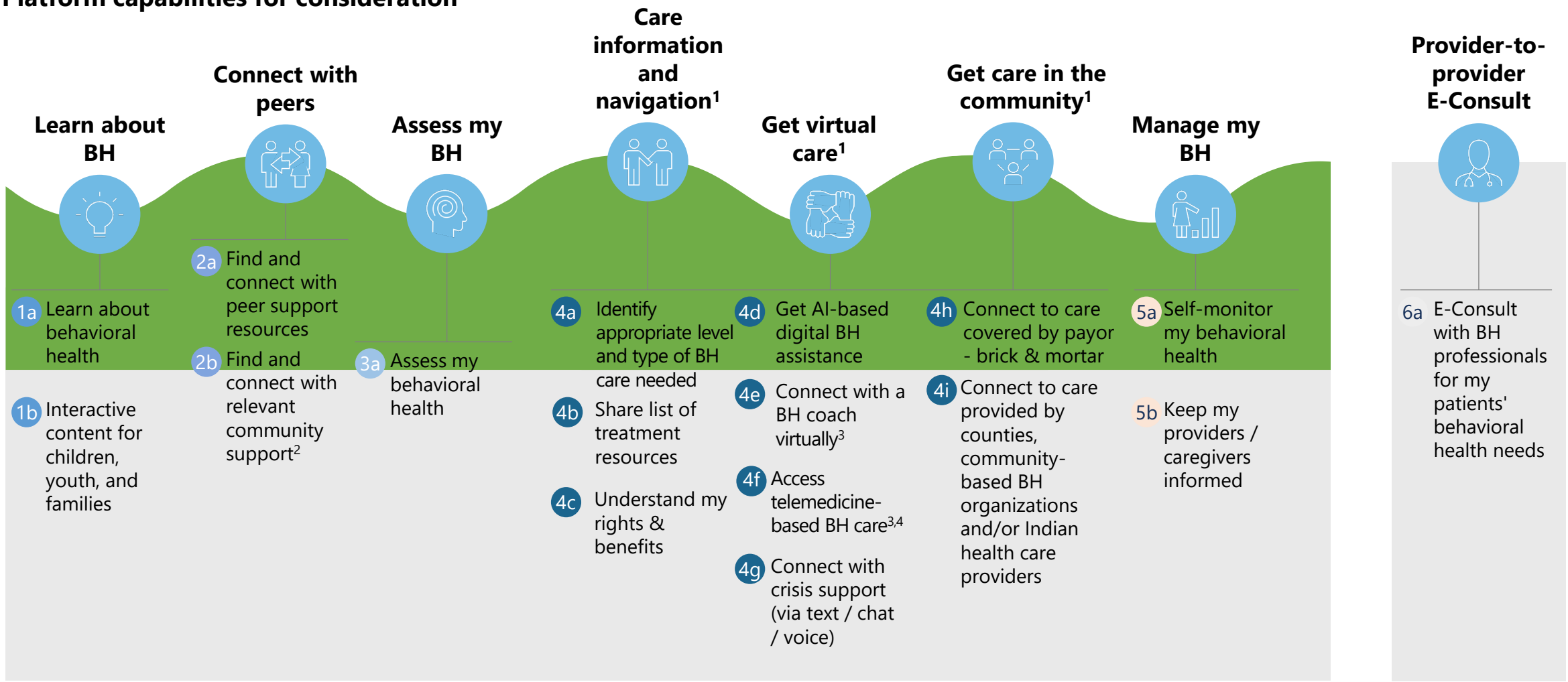
Guiding principles

- Maximize impact on behavioral health for all children and youth in California (regardless of type of coverage) through improved access, quality, affordability and experience
- Drive broad and inclusive adoption of BH Virtual Services and E-Consult Platform across California for children & youth and other relevant users (e.g., pediatricians)
- Streamline access to the platform and integrate across the BH care delivery system
- Destigmatize seeking help for behavioral health needs
- Enable delivery of the most effective and least resource-intensive treatment pathway (e.g., for young people that may not need individual counseling)
- Focus on health equity by facilitating deeper connection between children, youth and families and community-based care
- Prioritize privacy; ensure platform is compliant with all necessary privacy, security and interoperability regulations
- Enable clinicians to better support their patients through E-Consults

Source: Based on DHCS and OSP leadership discussion from Jan-Mar 2022

BH Virtual Services and E-Consult Platform capabilities for consideration

Platform capabilities for consideration



1. Part of 'Find and get BH care' capability
2. Community organizations based on my identity / affiliation
3. May include scheduling care
4. Connect with therapist, psychologist, or psychiatrist virtually

Source: Capabilities based on DHCS and OSP leadership discussion from Jan-Apr 2022 and discussions with behavioral health experts

Capabilities to consider for BH Virtual Services and E-Consult Platform (1/3)

Capability group	Capabilities	Description
Learn about BH	1a **Learn about behavioral health**	**Educational content** (e.g., testimonials, videos, podcasts, informational documents) **on behavioral health and related topics** (e.g., sexual orientation, mental health, gender identity, suicide, anxiety, depression, bullying, relationships, emotions, eating disorders, substance use, food, housing, or job insecurity) **for children, youth,** families, caregivers, educators, or providers
Assess my BH	1b **Interactive content for children, youth, and families**	**Educational content on behavioral health topics** (e.g., signs of a panic attack) **communicated through interactive content** (e.g., video games, AI-based quizzes and chats)
Connect with peers	2a **Assess my behavioral health**	**Screener to assess behavioral health status via self assessment** (e.g., user survey tailored by age group); potential to augment assessment via data outside of self-assessment (e.g., claims data, location of children / youth in low HPI quartile regions)
Care information and navigation	3a **Find and connect with peer resources**	Tool to **search and connect with relevant peer resources**
	3b **Find and connect with relevant community support**	Tool to **search and connect with in-person or virtual community organizations based on my identity / affiliation** (e.g., interest / affinity groups, afterschool programs)
	4a **Identify appropriate level and type of BH care** needed	Tool to **identify potential levels** (e.g., low acuity) **and appropriate type of care needed based on patient needs** (e.g., peer group, BH coach, psychiatrist)
	4b **Share list of treatment resources**	

Capabilities to consider for BH Virtual Services and E-Consult Platform (2/3)

Capability group	Capabilities	Description
4.1 Care information and navigation	4c **Understand my rights & benefits**	Tool to **understand patient rights and health insurance coverage** (or lack thereof) for relevant services and direct to appropriate contacts for further questions about coverage
	4d **Get AI-based digital BH assistance**	AI-based tool to **provide automated cognitive behavioral therapy (iCBT)** and point to appropriate resources
	4e **Connect with a BH coach / peer virtually**	Tool to **connect live with behavioral health coach / peer** and manage billing for services
	4f **Access telemedicine-based BH care**	Tool to **connect children, youth and their families** (e.g., website referral) **with psychologist / therapist** for virtual clinical services and manage billing for services
	4g **Connect with crisis support** (via text / chat / voice)	Tool to **refer out to a service or website providing crisis support** services (e.g., hotline, drop-in centers)

Capabilities to consider for BH Virtual Services and E-Consult Platform (3/3)

Capability group		Capabilities	Description
4.2 Get virtual care	4h	**Connect to care covered by payor**	Tool to **identify potential providers tailored to the specific patient need** (e.g., BH condition, location preferences, virtual / in-person needs) **based on coverage** (e.g., providers that are accepting new patients and work with user plans, commercial plans, county behavioral health services, managed care organizations)
	4i	**Connect to care provided by county and community-based BH organizations**	Tool to **identify** and **provide warm hand-offs to Indian health programs, county behavioral health services, community mental health centers or school-based health centers** based on the specific patient need (e.g., BH condition, geography)
	5a	**Self-monitor my behavioral health**	Tool to **enable children / youth to monitor their behavioral health** on a regular basis (e.g., manual entry, ingestion / integration with external data such as sleep monitors)
	5b	**Keep my providers / caregivers informed** of my behavioral health	Tool to **provide caregivers** (e.g., parents) **and providers information** of behavioral health status and actions taken
6 Provider-to-provider E-Consult	6a	**E-Consult with BH professionals** for my patients' behavioral health needs	**Tool for pediatric and family practice providers to consult with BH professionals virtually** to manage behavioral health conditions of their patients (i.e., children and youth) and provide ongoing practice-focused training and education

Statewide Fee Schedule and Provider Network for School-Linked Services

PRELIMINARY AS OF 4/20/2022

Objective

By January 1, 2024, DHCS, in collaboration with DMHC, will develop and maintain:

- A school-linked statewide fee schedule for outpatient mental health and substance use disorder services provided to a student, 25 years of age or younger, at or near a school-site
- A school-linked statewide provider network of at or near school-site behavioral health counselors

Background on Medi-Cal Delivery System

Medi-Cal managed care plans, county BH plans, AND commercial health plans are required to reimburse providers for a predefined set of medically necessary outpatient mental health and substance use disorder services provided to a student, 25 years of age or younger, at or near a school-site

Source: California Department of Health Care Services

School-Linked Partnership and Capacity Grants

PRELIMINARY AS OF AS OF 4/13/2022

Workstream Objective

Provides direct grants to support new services to individuals 25 years of age and younger from schools, providers in school, school affiliated CBOs, or school-based health centers

Will support statewide school-linked fee schedule and behavioral health network of providers

Workstream Details

- 2021 Budget Act includes $550,000,000 over two years
  - $400,000,000 allocated to pre-school through 12th grade
  - $150,000,000 allocated to institutions of higher education

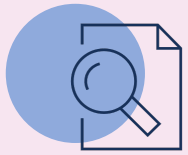
Potential Recipients

- **Tribal entities**
- Local education agencies
- Institutions of higher education
- Childcare & preschools
- Health plans
- CBOs
- BH providers
- County BH

Source: California Department of Health Care Services

Scale up of evidence-based interventions (EBIs) and community-defined practices (CDPs)

xx Date is subject to change



Workstream Overview

With input from stakeholders and Tribal partners, DHCS will select a limited number of evidence-based practices (EBPs) to scale throughout the state based on robust evidence for effectiveness, impact on racial equity, and sustainability

Grantees will be required to share standardized data in a statewide behavioral health dashboard

2021 Budget Act includes $429,000,000 in FY 2022-2023

DHCS will enter into an Interagency Agreement with Mental Health Services Oversight & Accountability Commission (MHSOAC); 10% of total funds earmarked for MHSOAC

Potential Recipients

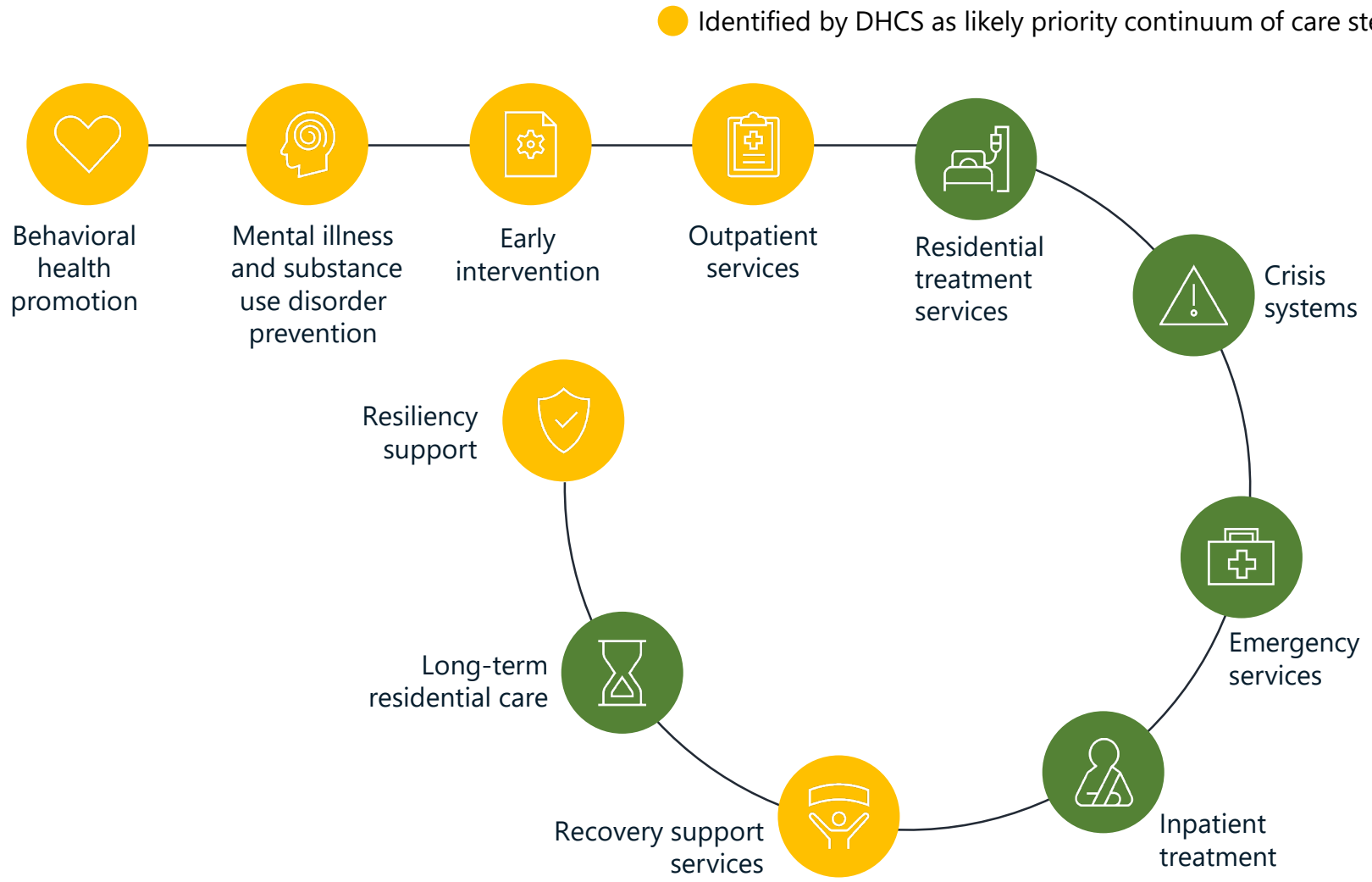
- Tribal Entities
- Managed Care Plans
- Commercial Health Plans
- Community Based Organizations
- Behavioral Health Providers
- County Behavioral Health

Key Milestones

- Preliminary scope of granting program defined **~August 1, 2022**
- Grants open on **~December 1, 2022**

Source: CYBHI Public Webinar, 3/15/22

The Behavioral Health Continuum of Care



Source: California Health and Human Services Agency

Potential prioritization is focused on upstream promotion, recovery, and resilience to

- Address behavioral health *before* children and youth have high needs
- Complement other efforts already under way
- Enable efforts that are feasible for DHCS to sustain and scale

Workstream goals

The goal for the EBI & CDP workstream is to select an **appropriate set of practices to scale with the allocated funding by the end of the year**

The aim is to be **solution-oriented** and **aligned with our guiding principles** as we select practices that are **within our span of control** and **can influence as a workstream – practices that:**

- Have meaningful impact on outcomes for children and youth
- Have demonstrated impact within the communities we want to reach, or can be adapted to do so
- Are scalable
- Are appropriate to scale
- Can be implemented with fidelity (e.g., support for codification, tech support)
- Are sustainable

Source: California Health and Human Services Agency

Governor's May Revision

Budget Proposals - $89 million

Wellbeing and Mindfulness Programs. Support programs, provided in K-12 school or community-based settings, that teach wellness and mindfulness practices to teachers and students and support schools and community-based programs to incorporate wellness and mindfulness programs on a regular basis into the school day, before and after school activities, summer school, and community-based settings. Support students and schools to form on-campus clubs for mental health and mindfulness, including NAMI on Campus, Bring Change to Mind High School, and Mindfulness Clubs.

Parent Support and Training Programs. Expand community-based parent support and training programs that build knowledge and capacity of parents to address their children's behavioral health needs, including evidence-based programs such as Triple P, Know the Signs, and Mental Health First Aid Training.

Discussion

Questions?

DHCS CYBHI Contact Information

DHCS Contact Information for Questions/Feedback: CYBHI@dhcs.ca.gov

DHCS Children & Youth Behavioral Health Initiative Webpage

DHCS School Behavioral Health Incentive Program (SBHIP) Webpage

DHCS Behavioral Health Continuum Infrastructure Program (BHCIP) Webpage

CalHOPE Student Support Webpage

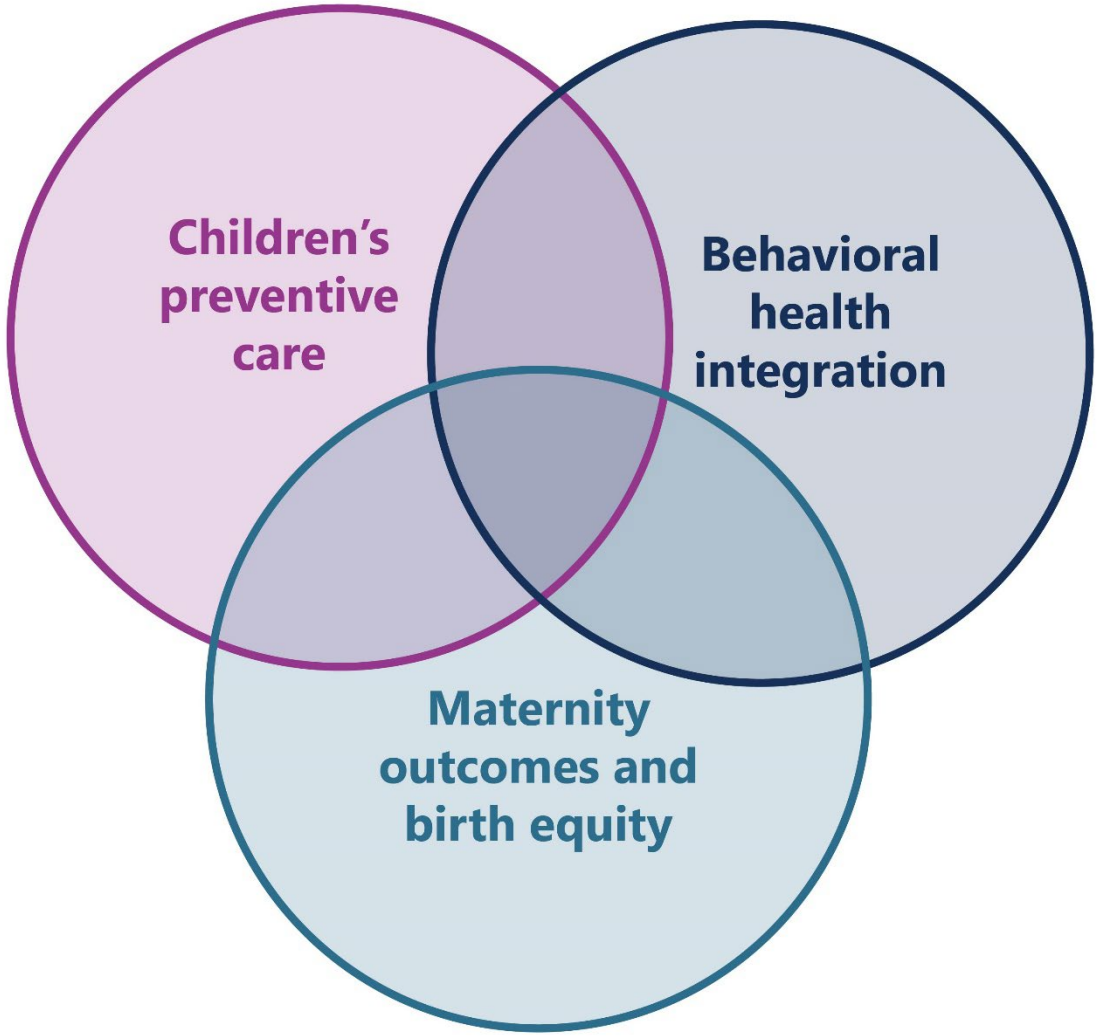
Quality and Population Health Management Program Update

Palav Babaria, MD, MHS
DHCS Deputy Director
Chief Quality Officer

Defining the vision:

https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx

The long view of health and wellness in California



Thinking big:

BOLD GOALS:
50x2025

STATE LEVEL

Close racial/ethnic disparities in well-child visits and immunizations by 50%

Close maternity care disparity for Black and Native American persons by 50%

Improve maternal and adolescent depression screening by 50%

Improve follow up for mental health and substance use disorder by 50%

Ensure all health plans exceed the 50th percentile for all children's preventive care measures

Specific Measures

Infant, child and adolescent well-child visits Childhood and adolescent vaccinations
Prenatal and postpartum visits C-section rates
Prenatal and postpartum depression screening Adolescent depression screening and follow up
Follow up after ED visit for SUD within 30 days Depression screening and follow up for adults Initiation and engagement of alcohol and SUD treatment
Infant, child and adolescent well-child visits Childhood and adolescent vaccinations Blood lead & developmental screening Chlamydia screening for adolescents

BOLD GOALS: 50x2025

STATE LEVEL

Close racial/ethnic disparities in well-child visits and immunizations by 50%

Close maternity care disparity for Black and Native American persons by 50%

Improve maternal and adolescent depression screening by 50%

Improve follow up for mental health and substance use disorder by 50%

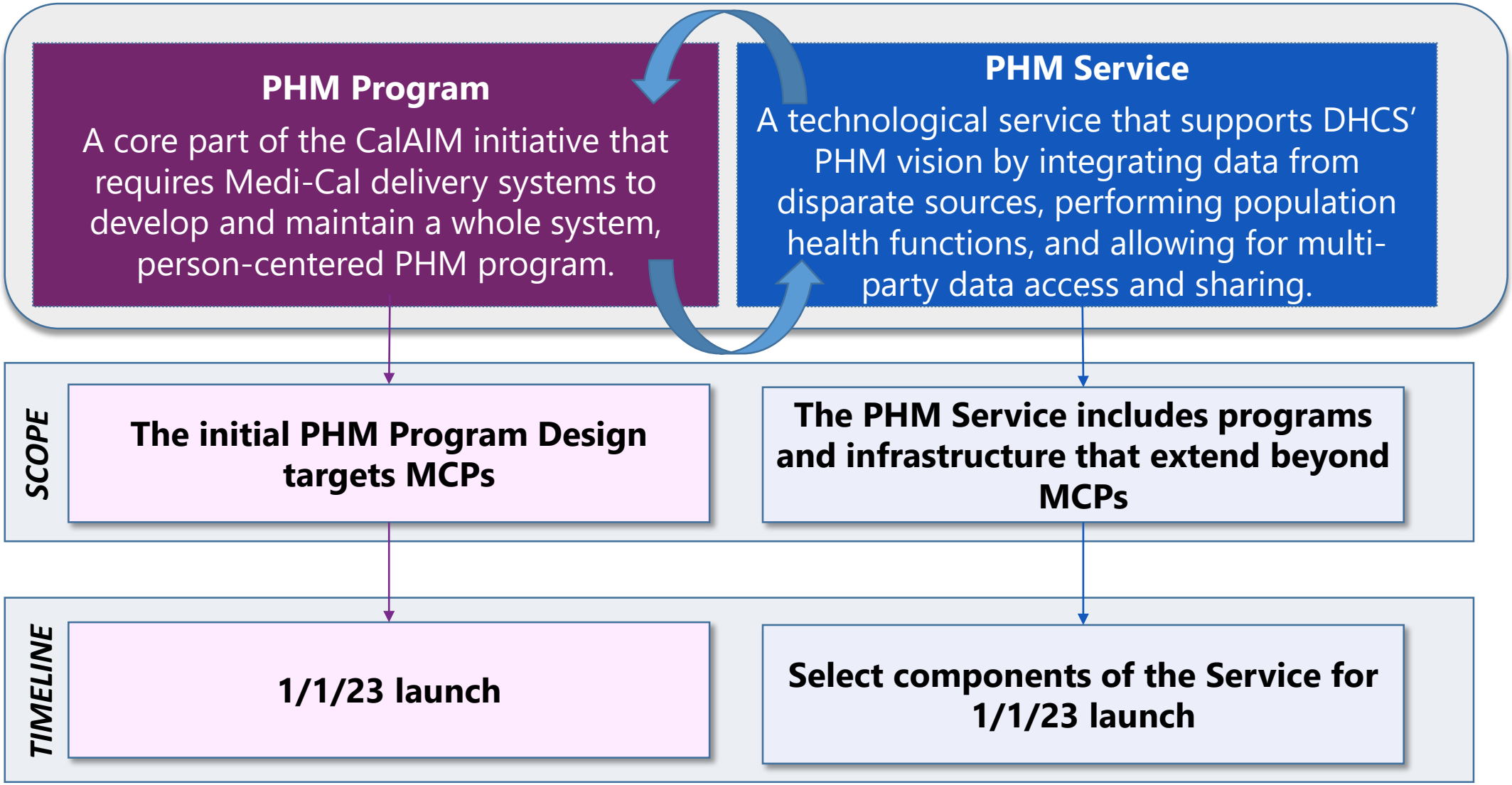
Ensure all health plans exceed the 50th percentile for all children's preventive care measures

Creating a multi-pronged foundation for Health Equity

Health Equity Domains

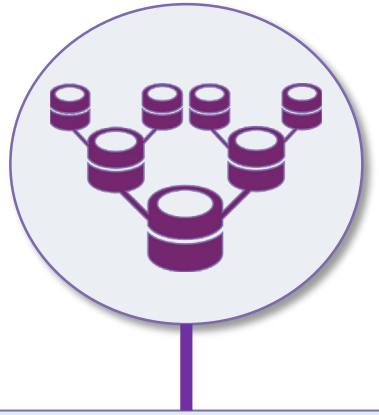
- Managed Care/FFS (including CCS)
- Dental
- Behavioral Health
- School Based Services
- HCBS/1915c Delivery System
- CalAIM & Quality Strategy
- Alignment With Public Health

CalAIM Population Health Management Program: A powerful tool to achieve the vision



PHM Service: Overview of Capabilities

The PHM Service will aggregate, link, and provide access to a variety of data types and support key population health functions.



1. Integrate Data from DHCS and Other Sources

Integrate physical and behavioral health data, social services, dental, developmental, home and community-based services, IHSS, 1915c waiver, and other program and administration data from providers, MCPs, counties, CBOs, DHCS, and other government departments and agencies.

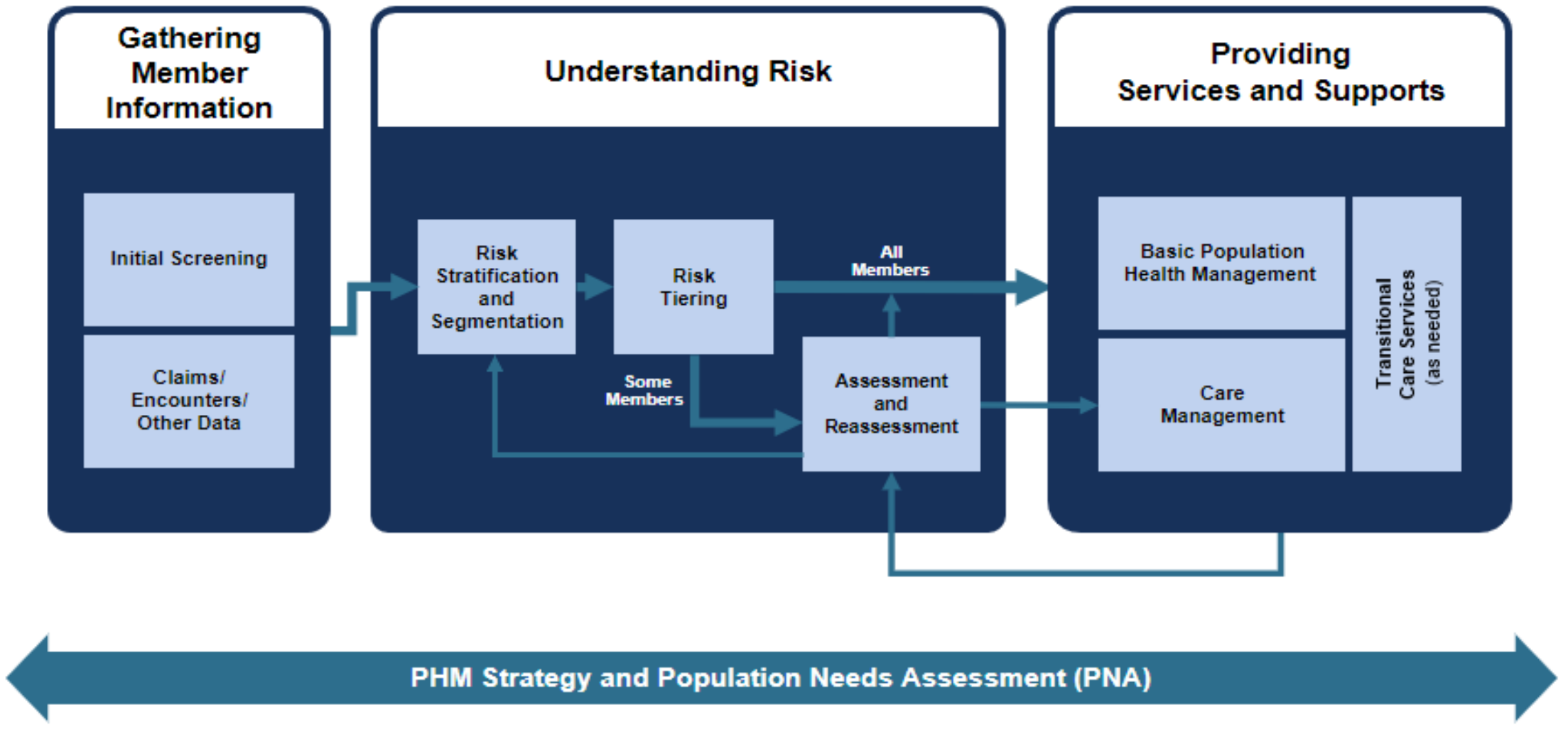
2. Enable Key PHM Functions and Services

Facilitate and support key population health functions such as individual screening and assessment; risk stratification, segmentation and tiering; and gap reporting.

3. Provide Access to PHM Data

Provide users access to integrated data to support population health management use cases and streamline care delivery. Intended users include DHCS as well as MCPs, counties, providers, Members, human services programs, and other partners.

PHM Framework Overview



Member Vignette: PHM in Action

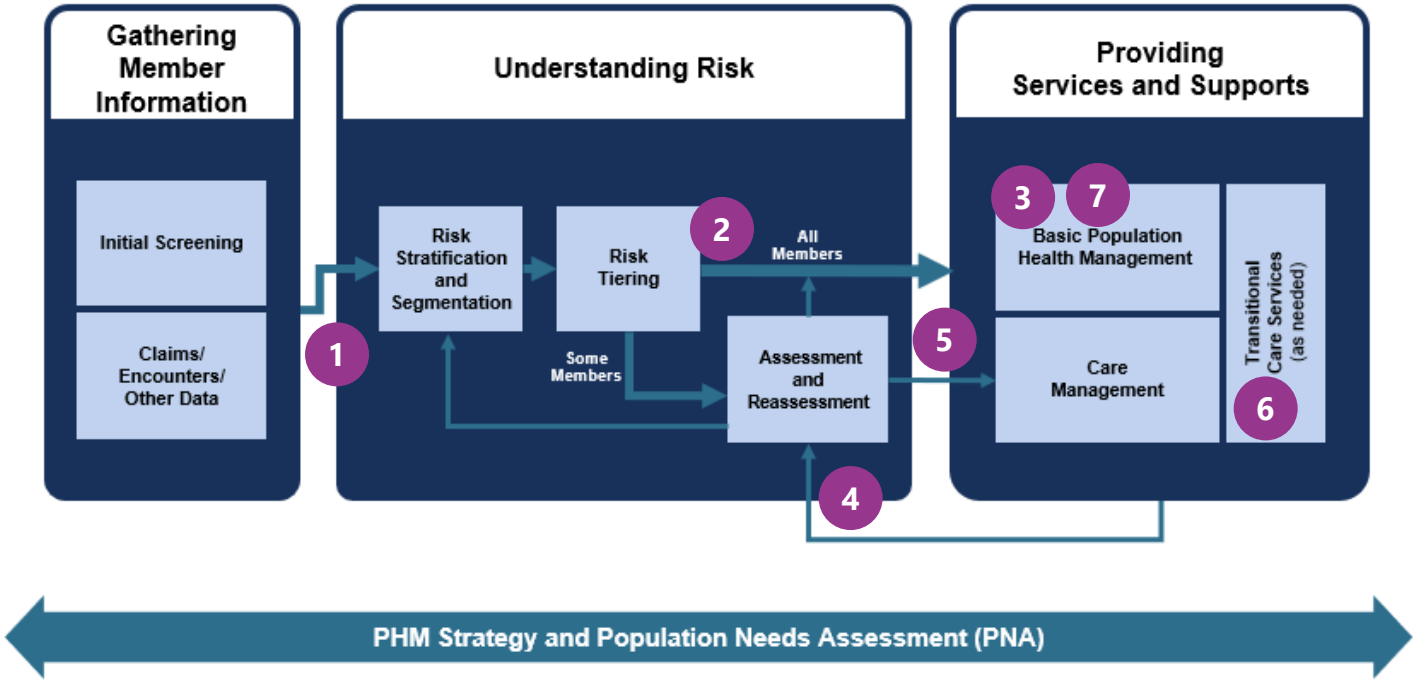
1 2 Linda has her first prenatal appointment; Her provider does a history and physical, diagnosing her with gestational diabetes. Her health plan receives the information.

3 A care coordinator from Linda's health plan reaches out and connects Linda to WIC services and a doula

4 5 At 28 weeks, Linda is diagnosed with high blood pressure and depression, referred to high risk pregnancy specialist and is enrolled in CCM.

6 At 37 weeks pregnant, Linda is diagnosed with preeclampsia and admitted for labor induction. Supported by her doula, she delivers her healthy son, Jacob. Her CCM care manager helps with the transitions from hospital

7 Linda's health conditions have resolved. Linda and Jacob receive dyadic services during Jacob's well child visits. Linda no longer needs support from CCM. Her plan continues to monitor and support her family through BPHM.



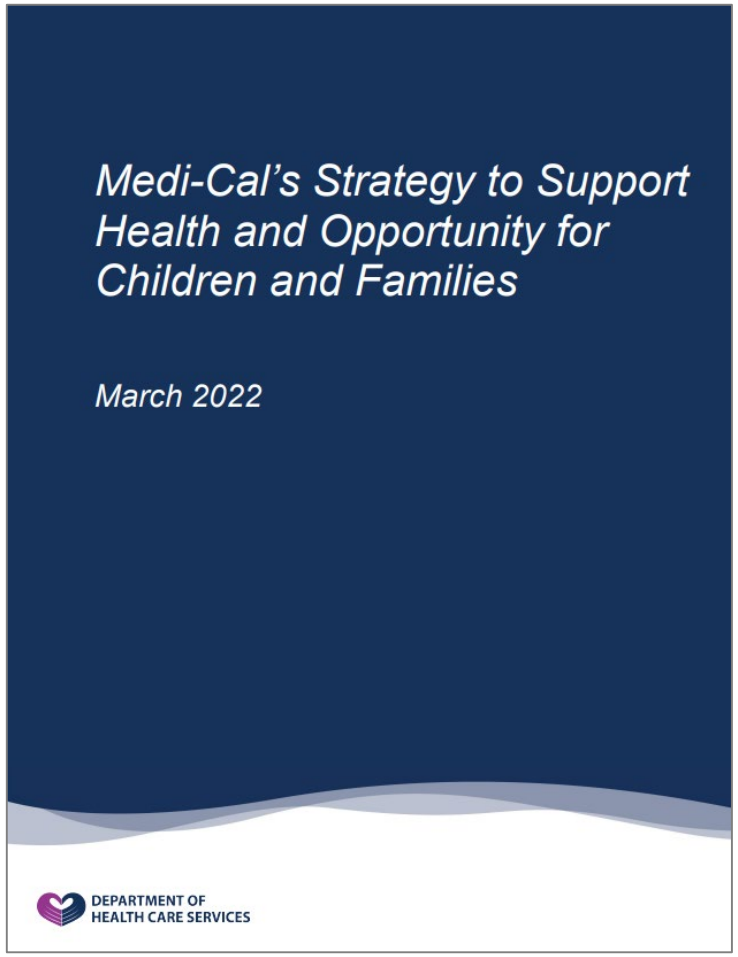
Aligning incentives for Quality & Equity: The Value Based Payment Roadmap

- Incentive programs
- Rate adjustments for quality & equity
- Alternative payment models (FQHC, managed care re-procurement)
- Reporting on primary care spending
- Health Equity & Practice Transformation Payments ($700 million in May revise)

Equity & Practice Transformation Payments

- $700 million proposed in Governor's 22-23 budget
- To support outpatient provider-level transformation focused on the DHCS Bold Goals 50x2025 initiative and COVID-19 related gaps in care
- To support provider infrastructure, technology, team based care, workflow and training needs and preparation for alternative payment models
- Opportunity to incentivize/scale best practices & support provider-level PHM infrastructure
- Tribal health programs providing primary care and contracted with Medi-Cal managed care plans are encouraged to apply

How does this all tie together?



Forward-looking policy agenda for children and families enrolled in Medi-Cal that **unifies the common threads of existing and newly proposed** child and family health initiatives

Eight Action Areas with detailed **key initiatives** that are designed to:

- Solidify coverage for children
- Promote whole-child and family-based care
- Strengthen leadership and accountability structures
- Implement evidence-based, data-driven initiatives

Two infographics, including an **easy to read** one pager with Action Areas and a **detailed table** **with a status update and expected implementation timing** for each key initiative

Access Medi-Cal's Strategy to Support Health and Opportunity for Children and Families

Action Areas

Each action area includes key initiatives – some already underway and others newly proposed – with detailed approaches on how to solidify coverage for children, promote whole-child and family-based care, strengthen accountability structures, and implement data-driven initiatives to support implementation.

- New leadership structure and engagement approach
- Stronger coverage base for California's children
- Stronger pediatric preventive and primary care
- Streamline access to pediatric vaccinations
- New health plan accountability for quality outcomes
- Family-centered approach
- Child and adolescent behavioral health investments
- Next steps on the foster care model of care

Managed Care Transition Update

Preparing for the 2024 Transitions Related to the Managed Care Plan Procurement and County Model Changes

Michelle Retke
DHCS Division Chief

Guardrails for Today's Discussion

- The scope of this discussion is specific to the 2024 MCP transition and considerations for member populations, counties, plans and provider groups to help inform DHCS' planning and stakeholder engagement efforts.

Managed Care Transformation

DHCS is Transforming Medi-Cal Managed Care Through Multiple Efforts Slated to Take Effect in January 2024

New Mix of High-Quality Managed Care Plans Available to Members

Procurement of Commercial Managed Care Plans

- Competitive proposal process for commercial plans
- Statewide, in counties with a model that includes commercial plans

Model Change in Select Counties

- Conditional approval for 17 counties to change their managed care model
- Subject to federal approval
- Includes a new Single Plan Model and expansion of COHS model

Proposed Direct Contract with Kaiser

- Proposed for 32 counties
- Subject to state and federal approval
- Leverages Kaiser's clinical expertise and integrated model to support underserved areas in partnership with

Restructured and More Robust Contract Implemented Across All Plans in All Model Types in All Counties

Improved Health Equity, Quality, Access, Accountability and Transparency

Updated MCP Contract Will Apply to Model Change MCPs

Key MCP Contract Content Updates (1 of 2)
1. Additional and enhanced requirements to **better align with DHCS priorities**, state and federal regulations, published All Plan Letters (APLs), California State Auditor (CSA) report recommendations and Medical Audit findings.
2. New requirements for public posting of reporting, activities, survey results, financial information, and Memoranda of Understanding with third parties to support **transparency**.
3. Strengthened quality requirements to align with DHCS Comprehensive Quality Strategy to achieve **high quality care**.
4. Increased expectations for providing **access to** care across a comprehensive array of person-centered health care and social services to align with **CalAIM**.
5. Improved requirements for systematic **coordination of services and comprehensive care management** to ensure the needs of the entire population are met.
6. Updated requirements for MCPs to partner with DHCS to **increase health equity** and **reduce health disparities**.
7. New requirements to support strategies that address unmet health-related social needs through Community Supports, Population Health Management, Care Management and **Social Drivers of Health (SDOH)**.

Updated MCP Contract Will Apply to Model Change MCPs

Key MCP Contract Content Updates (2 of 2)
8. Stronger provisions for network providers to better understand and meet community needs through **local presence and engagement**.
9. New requirements to support enhanced **children's services**.
10. Additional requirements to expand access to evidence-based **behavioral health services**.
11. Updated requirements to ensure MCPs have robust **accountability, compliance, monitoring and oversight programs**.
12. New requirements for **emergency preparedness** to ensure delivery of care and **essential services** during and after an emergency.
13. Additional requirements that build on current **value-based payment** efforts linking provider payments to value.
14. Expanded reporting requirements and strengthened performance requirements with penalties for non-compliance to support **accountability and oversight.**

Tentative Timeline for County Model Change Transition

Working County Model Change Transition Timeline	
Summer 2022	DHCS releases operational readiness deliverables and timeline
August 2022	DHCS announces contract awards for commercial MCP procurement
No Later than Fall 2022	DHCS initiates operational readiness process for MCPs
Late 2022	DHCS submits amendments to the 1915(b) waiver and to the 1115 demonstration for CMS review and approval of county model changes
October 2023	DHCS target date to release 2024 MCP rates
October - November 2023	DHCS initiates member noticing
November 2023	DHCS initiates data exchange to support member transitions & continuity of care
January 1, 2024	New MCP contracts go into effect
All dates subject to change	

Engagement with Tribal Partners

Takeaways from DHCS Discussion with Tribal Partners (CRIHB & CCUIH)

- Members changing managed care plans (MCP) in 2024 need advance notice. To avoid disruptions, members need to know if their plan is leaving, remaining plan option(s) and any actions they need to take.
  - DHCS will send advance notice to members regarding the January 1, 2024 transition starting in October/November 2023
  - CRIHB and CCUIH will support member outreach and communication

- Sacramento and San Diego are complex Geographic Managed Care counties:
  - CRIHB and CCUIH would like to get input from members in those regions especially knowing that the MCP options will reduce from 5 plans in Sacramento and 7 in San Diego to 3 plans in each county.

Takeaways from DHCS Discussion with Tribal Partners (CRIHB & CCUIH)

- Previous Medi-Cal managed care transitions were disruptive for clinics & providers:
  - MCPs contracting with Indian Health Care Providers (IHCP) were not always aware of protections and rules specific to IHCPs (e.g., hiring out-of-state practitioners without requiring CA licensure);
  - Tribal organizations were not always included in contract discussions to ensure these protections were in place; and
  - Lags in provider credentialling led to delayed payments for Tribal Health programs.

DHCS Collaboration with Tribal Partners to Assure a Smooth Transition

- DHCS will promote MCP's awareness of the legal protections for IHCPs to ensure a smoother transition in 2024
  - Particularly, MCPs adherence to the *Medicaid Managed Care Addendum for Indian Health Care Providers*
- DHCS will aim to facilitate Tribal Partners' and IHCP's close work with MCPs
- DHCS will seek to collaborate with all Tribal Partners to effectively communicate to tribal members about any changes in their plans and actions to take, including support with:
  - Messaging in notices
  - Outreach and communication via Tribal Partners and IHCPs

On-Going Engagement with Tribal Partners

- DHCS will bring MCP Transition issues for discussion to future Tribal and Indian Health Program Representatives Meetings:
  - August 12, 2022
  - November 2022
  - Meetings in 2023

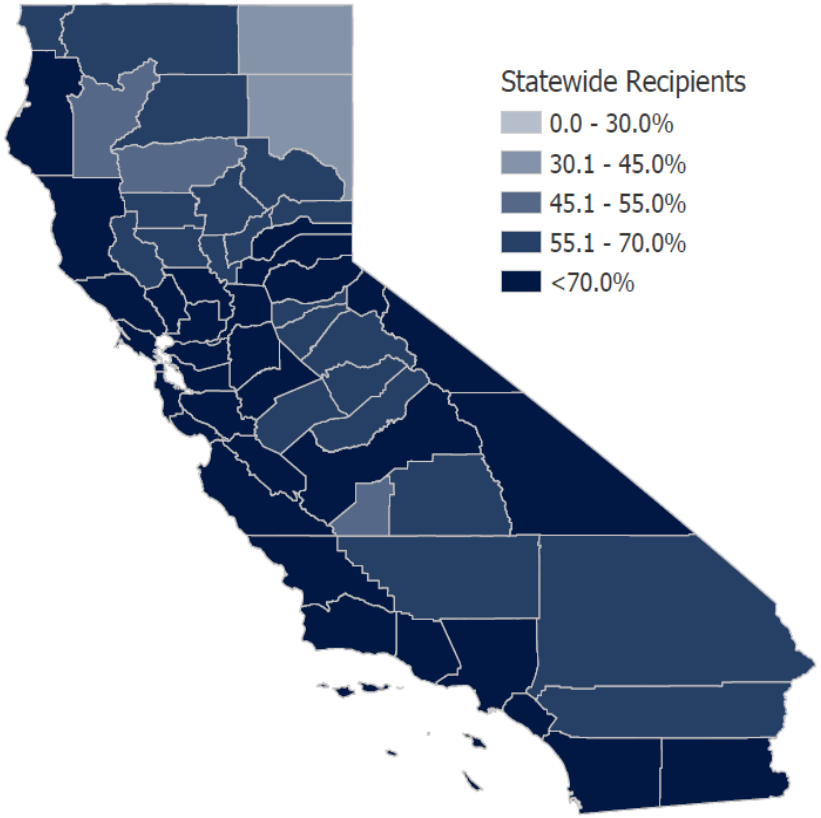
- DHCS will also reach out to Tribal Partners for additional consultation and feedback on specific MCP Transition issues

Update on COVID-19 Vaccination Rates

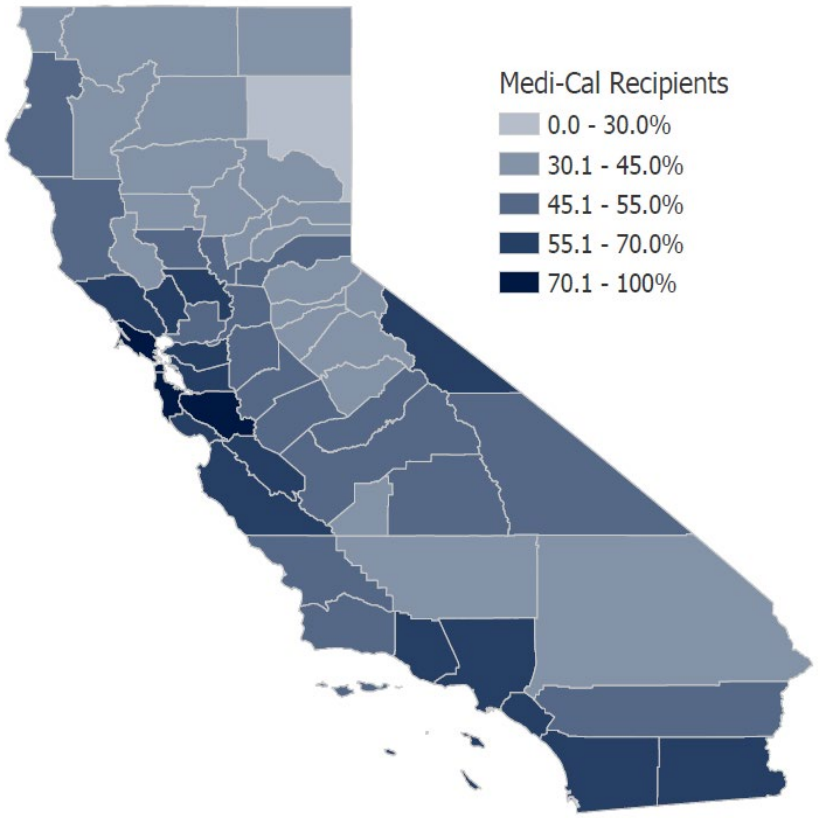
Dr. Priya Motz
Office of the Medical Director

Received at least one dose as of April 11, 2022
Percentage of 5+ years old, by county

All Californians

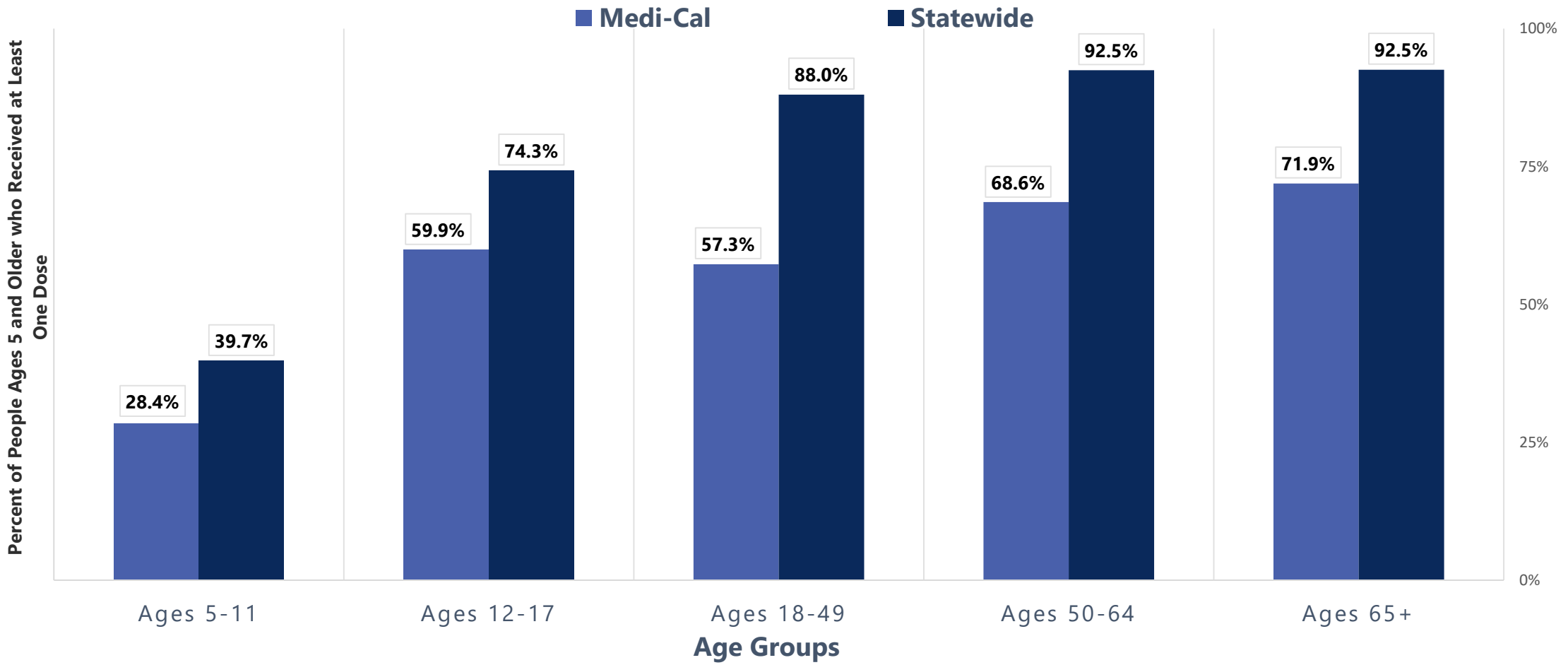


Medi-Cal Beneficiaries



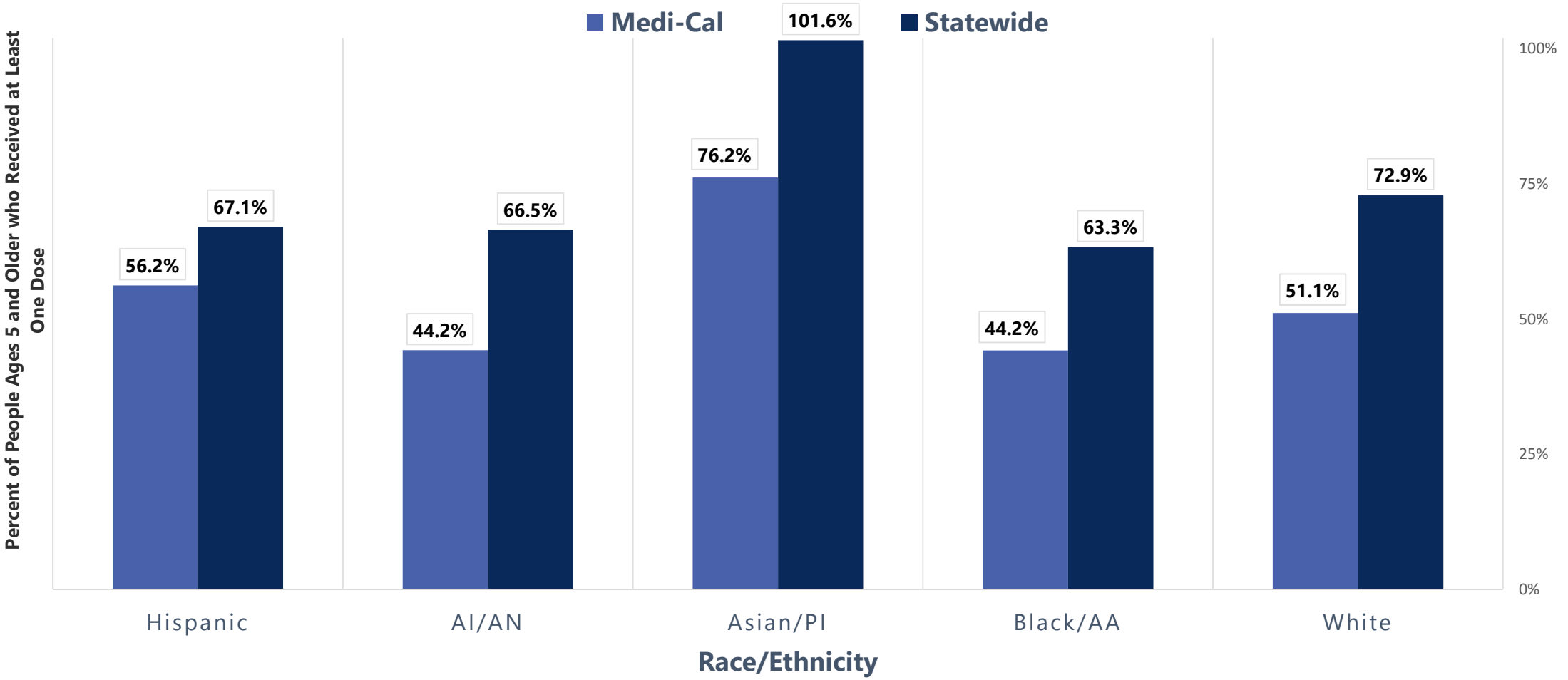
Note: Medi-Cal beneficiaries are a subset of all Californians

Received at least one dose as of April 11, 2022 Comparing Medi-Cal Beneficiaries to all Californians



Note: Statewide rates are calculated using the California Department of Finance P-3 projections for the denominator. Estimates may slightly vary from the true value.

Received at least one dose as of April 11, 2022 Comparing Medi-Cal Beneficiaries to all Californians



Note: Statewide rates are calculated using the California Department of Finance P-3 projections for the denominator. Estimates may slightly vary from the true value.

COVID Vaccine Incentive Program

- Vaccine Response Plan ($50M): Submitted by MCPs to DHCS September 1, 2021
- Direct member incentives ($100M): Gift cards up to $50 for members after vaccination
- Vaccine outcome achievement ($200M): MCP payments tied to 3 intermediate outcome and 7 vaccine uptake measures
- Baseline vaccination rate as of August 29, 2021
- Outcomes evaluated as of…
  - October 31, 2021
  - January 2, 2022
  - March 6, 2022

Vaccine Uptake Outcome Measures

- Two measures related to race/ethnicity
- Percent of Medi-Cal beneficiaries ages 12 years and older from the race/ethnicity group with the lowest, and second-lowest, baseline vaccination rate who received at least one dose of a COVID-19 vaccine
- Almost all plans (23/25) working on improving vaccination rates among Native Americans
- To receive full payment, plans must close the gap between the vaccination rate among their Native American members and their overall plan vaccination rate

Statewide Progress on Measures 1-3

Vaccine Incentive Program Measure	Rate Aug 29	Rate Nov 1	Target Nov 1	Rate Jan 2	Target Jan 2	Rate Mar 6	Target Mar 6	Met goal?
Measure 1: Percent of homebound Medi-Cal beneficiaries who received at least one dose	64.7%	69.2%	71.2%	72.2%	77.6%	75.1%	84.1%	No
Measure 2: Percent of Medi-Cal beneficiaries ages 50-64 years of age with one or more chronic diseases who received at least one dose	66.0%	70.3%	72.6%	73.2%	79.3%	75.3%	85.9%	No
Measure 3: Percent of primary care providers in the MCP's network providing COVID-19 vaccine in office	**49.3%**	**56.8%**	**54.2%**	**61.4%**	**59.2%**	62.7%	64.1%	No

Preliminary data

Statewide Progress on Measures 4-10

Vaccine Incentive Program Measure	Medi-Cal ≥ 1 dose Aug 29	CA ≥ 1 dose Nov 1	33.3% gap closure target	Medi-Cal ≥ 1 dose Nov 1	CA ≥ 1 dose by Jan 2	66.6% gap closure target	Medi-Cal ≥ 1 dose Jan 2	CA ≥ 1 dose Mar 6	Medi-Cal ≥ 1 dose Mar 6	Gap on Mar 6
4: 12+ years	51.1%	78.7%	60.3%	56.1%	83.2%	72.5%	59.0%	86.2%	61.1%	25.1%
5: 12-25 years	**43.9%**	**65.5%**	**51.1%**	**50.6%**	70.7%	61.7%	54.3%	75.0%	57.1%	17.9%
6: 26-49 years	46.9%	81.4%	58.4%	52.1%	86.1%	73.1%	54.9%	89.6%	57.0%	32.6%
7: 50-64 years	60.4%	84.2%	68.3%	63.9%	88.3%	79.0%	66.1%	90.7%	67.6%	23.1%
8: 65+ years	69.0%	83.0%	73.7%	71.4%	86.7%	80.8%	73.4%	88.2%	74.6%	13.6%
9: Black/African American	**35.6%**	**N/A***	**42.5%***	**41.6%**	N/A*	51.2%*	45.3%	N/A*	47.9%	16.1%
10: American Indian/Alaska Native	**36.7%**	**N/A***	**43.2%***	**42.4%**	N/A*	51.6%*	45.3%	N/A*	47.4%	20.4%

*Target is overall plan rate; 33.3% gap closure target based on Nov 1 Medi-Cal rate of 56.3%; 66.6% gap closure target based on Jan 2 Medi-Cal rate of 59.0%

Preliminary data

High Performance Pool (HPP)

Measure	Achievement Criteria	Number (%) of plans achieved
% of Medi-Cal members age 12+ who received ≥ 1 dose by March 6	85% or higher OR relative improvement of 75% or greater	0 (0%)
% of Medi-Cal members age 5-11 who received ≥ 1 dose by March 6	No more than 10% below county rate	8 (33%)
% of Medi-Cal members age 12+ fully vaccinated and boosted by March 6	No more than 10% below county rate	2 (8%)

Preliminary data

COVID Vaccine Response Plan

- Collaboration with various tribal experts and facilities to improve rates
- Incentivizing vaccinations
- Informative letters and sessions for members providing education around COVID
- Media campaign
- Member outreach campaigns

Items for Next Meeting/Final Comments

Thank You for Participating In Today's Webinar