DEPARTMENT OF HEALTH CARE SERVICES
Stakeholder Advisory Committee (SAC)
Behavioral Health Stakeholder Advisory Committee (BH-SAC)

February 17, 2021
9:30 a.m. – 12:10 p.m.

SAC AND BH-SAC JOINT MEETING SUMMARY

SAC Members Attending*:* Bill Barcellona, America's Physician Groups; Doreen Bradshaw, Health Alliance of Northern California; Michelle Cabrera, County Behavioral Health Directors Association; John Cleary, MD, Children's Specialty Coalition; Anne Donnelly, San Francisco AIDS Foundation; Kristen Golden Testa, The Children's Partnership/100% Campaign; Michelle Gibbons, County Health Executives Association of California; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; Virginia Hedrick, California Consortium of Urban Indian Health; Anna Leach-Proffer, Disability Rights California; Sherreta Lane, District Hospital Leadership Forum; Mark LeBeau, California Rural Indian Health Board; Kim Lewis, National Health Law Program; Farrah McDaid Ting, California State Association of Counties; Jarrod McNaughton, Inland Empire Health Plan; Sarita Mohanty, MD, SCAN Foundation; Erica Murray, California Association of Public Hospitals and Health Systems; Linda Nguy, Western Center on Law and Poverty; Andie Patterson, California Primary Care Association; Chris Perrone, California HealthCare Foundation; Brianna Pittman-Spencer, California Dental Association; Janice Rocco, California Medical Association; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Cathy Senderling, County Welfare Directors Association; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Doug Shoemaker, Mercy Housing; Stephanie Sonnenshine, Central California Alliance for Health; Kaycee Velarde, Kaiser Permanente; Bill Walker, MD, Contra Costa Health Services; Ryan Witz, California Hospital Association; Anthony Wright, Health Access California.

SAC Members Not Attending: Libby Sanchez, SEIU; Jonathan Sherin, MD, Los Angeles Department of Mental Health.

Behavioral Health Stakeholder Advisory Committee (BH-SAC) Members Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Jei Africa, Marin County Health Services Agency; Ken Berrick, Seneca Family of Agencies; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; Carmela Coyle, California Hospital Association; Jessica Cruz, NAMI; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sarah-Michael Gaston, Youth Forward; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Andy Imparato, Disability Rights California; Veronica Kelley, San Bernardino County; Kim Lewis, National Health Law Program; Linnea Koopmans, Local Health Plans of California; Robert McCarron, California Psychiatric Association; Farrah McDaid Ting, California State Association of Counties; Maggie Merritt, Steinberg Institute; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Jonathan Porteus, WellSpace Health; Hector Ramirez, Consumer Los Angeles County; Kiran Savage-

Sangwan, California Pan-Ethnic Health Network; Cathy Senderling, County Welfare Directors Association of California; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Chris Stoner-Mertz, California Alliance of Child and Family Services; Mandy Taylor, California LGBTQ Healthand Human Services Network, a Health Access Foundation program; Catherine Teare, California Health Care Foundation; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Stephanie Welch, California Health and Human Services; Jevon Wilkes, California Coalition for Youth.

BH-SAC Members Not Attending: Alex Dodd, Aegis Treatment Centers; Laura Grossman, Beacon Health Solutions; Britta Guerrero, Sacramento Native American Health Center; Deborah Pitts, University of Southern California Chan Division of Occupational Science and OccupationalTherapy; Libby Sanchez, SEIU; Jonathan Sherin, MD, Los Angeles County Department of Mental Health; Gary Tsai, MD, Los Angeles County.

DHCS Staff Attending: Michelle Baass, Jacey Cooper, Kelly Pfeifer, MD, Palav Babaria, MD, Jeffrey Callison, and Morgan Clair.

Public Attending: There were 362 members of the public attending.

Welcome, Director's Opening Comments, Introduction of New Members and New Meeting Format, Roll Call, and Today's Agenda
Michelle Baass, DHCS Director
Baass welcomed members to the first joint meeting of SAC and BH-SAC members and reviewed the new meeting format. Following today's meeting, we will send a survey to get feedback on the new meeting format and member preferences for virtual, in person, or hybrid meetings in the future. Baass introduced new SAC members, Brianna Pittman-Spencer from the California Dental Association, Sarita Mohanty from The SCAN Foundation, and Kaycee Velarde from Kaiser Permanente, as well as new BH-SAC member, Laura Grossman from Beacon Health Options. Baass thanked the California Health Care Foundation for its ongoing support of these meetings.

Director's Update
Michelle Baass and Jacey Cooper, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/021722-SAC-BH-SAC-core-presentation.pdf

Baass provided an overview of the Governor's proposed 2022-23 budget. Cooper reviewed slides with detailed information on DHCS programs in the proposed state budget, including the expansion of full-scope Medi-Cal coverage, effective January 2024, to low-income Californians ages 26-49 regardless of immigration status, funding for the California Advancing and Innovating Medi-Cal (CalAIM) initiatives, provider payments for equity and practice transformation to respond to care gaps and align to the DHCS Quality Strategy, elimination of AB 97 provider payments, reduction of Medi-Cal premiums and co-payments, a comprehensive telehealth proposal, and continuing efforts to reform skilled nursing facility payments. The $138 billion proposed total budget for DHCS also includes behavioral health investments for Bridge Housing and Mobile Crisis Services to address the immediate housing

and treatment needs for people experiencing homelessness with serious behavioral health conditions. COVID-19 remains a focus in the budget with impacts on caseload projections, vaccine administration, and redetermination costs. Related to the ending of the public health emergency (PHE), DHCS is working alongside other state Medicaid Directors on strategies to maintain coverage for 14.5 million Medi-Cal beneficiaries.

Baass continued with updates on Medi-Cal Rx, which launched in January 2022. All Medi-Cal pharmacy services transitioned from managed care to a fee-for-service (FFS) statewide delivery system to standardize benefits, with annual savings of $827 million, improve access and efficiency, and strengthen the state's ability to negotiate supplemental drug rebates with drug manufacturers. Baass reported on the significant initial implementation challenges. DHCS is actively working with Magellan to address call center wait times, delays in prior authorization processing, and challenges with data and reporting.

On February 9, DHCS released the Medi-Cal managed care plan Request for Proposal that will lead to new contracts being implemented across all plans and model types. There is conditional approval for 17 counties to change their managed care model and a direct contract for 32 counties proposed with Kaiser Permanente. Taken together, this will enable DHCS to hold plan partners and subcontractors more accountable and achieve more holistic care that addresses social drivers of health, cultural and linguistic differences, and behavioral health.

Questions and Comments

Cleary: I want to highlight the pediatric population and specifically California Children's Services (CCS). I'm glad to hear the approval process is becoming more streamlined for Medi-Cal Rx. That's not the word I got two days ago from key leaders in Orange County. The CCS population has a range of medications that are uncommon. The approval rate is very high after review. I request that we have an assumption of approval that could be rescinded later, rather than the conditions we are experiencing now. I know these are relatively small issues compared to the total, yet the complexity and rarity of drugs for CCS is a unique challenge and requires unique leadership from DHCS.

Imparato: Can you explain the budget changes for Medi-Cal working people with disabilities and how you will promote that to the disability community?

Cooper: DHCS will reduce premiums to zero for all Medi-Cal beneficiaries subject to a premium. I can send you the entire list of details. This was in place during the PHE, and we are proposing that it continue.

Golden Testa: Can you explain the proposed equity payments and the mechanism of these payments? Do the payments go through Community Supports? In addition, we appreciate the vaccine data for Medi-Cal versus California and the breakdown by race. Can you provide a breakdown for children's COVID-19 vaccinations by race?

Cooper: Yes, we are happy to provide the breakdown for children and race. The practice transformation grants are focused on primary care pediatrician offices, OB-GYNs, and behavioral health providers to focus on closing those care gaps. We can talk offline so I

understand your question better. There are funds available through CalAIM incentives and Providing Access and Transforming Health (PATH), but these payments are intended for provider offices to update electronic medical records to identify care gaps in their system or implement population health management (PHM) strategies.

Wright: We appreciate the expansion of Medi-Cal for undocumented individuals and eliminating premiums and copayments. Are there technical or budget reasons for this not starting until 2024? Is it possible to start sooner than 2024? On Medi-Cal Rx, we agree with the focus on getting medications to people right now. Can you say more about the mechanism for holding Magellan accountable through the contract? On procurement, can you offer specifics on the Kaiser Permanente direct contract? Will all previous Kaiser Permanente patients who enroll in Medi-Cal be able to stay in Kaiser Permanente, or is it a subset?

Cooper: Related to the expansion start up in 2024, DHCS is making substantial eligibility changes for 700,000 lives, and we are being thoughtful about how we can accomplish the postpartum expansion and the asset changes as well. The expansion impacts networks and rates as well as DHCS systems. We are working closely with partners to phase things in and ensure everything works well. This is also happening during the unwinding of the PHE. On Magellan, we meet daily. We have made it clear there will be withholds on a number of pieces within the contract where we can hold them accountable. On Kaiser Permanente, this is an expansion to 32 counties with 12 months of continuity for all counties. It will have existing linkages for family members.

Baass: Kaiser Permanente will be bound by all of the contract provisions that are part of procurement as well as elements specific to Kaiser Permanente on continuity for dual eligibles (Medi-Cal/Medicare) and foster youth.

Ramirez: I am especially excited about the undocumented expansion and hope the timeline can be moved up for implementation of services. I also want to highlight the need for services to those of us experiencing long COVID-19 symptoms. It is difficult to access services and medications. Even when we are vaccinated and boosted, many high-risk Californians become infected and deal with the aftermath of having COVID-19, such as cardiovascular disease, mental health complications, and psychiatric medication interactions. Many of us with COVID-19 are frontline workers, people of color, and in the disability community. I commend the theme of accountability in your remarks and want this to be communicated related to compliance with civil rights and access to disability services. Los Angeles is the largest public mental health system in the country, and we don't have rights. There are people who have not been able to access services due a disability, and many filing complaints experienced retaliation. Particularly with the Governor's focus on conservatorship services, there is a need for an investment to enforce our rights.

Baass: the core tenets of the new contract include accountability and transparency, such as more public reporting, so that DHCS and individuals can hold plans accountable regarding their choice of plans and being clear on how and where services are delivered.

Cooper: We currently cover all COVID-19 services, and I would like to hear from you offline to follow up and know where you experienced gaps.

McNaughton: I look forward to hearing what you are learning about best practices for retaining members as we unwind the PHE. I know DHCS is working through challenges on the pharmacy carve-out and I commend staff for helping us to move forward with special cases to ensure access to continuous glucose monitoring for dozens of members who were backlogged in getting those through Magellan. We are moving forward to pay for those so that members are not harmed. I encourage my colleagues to partner with DHCS on specific issues that arise. We are doing a network endocrinologist survey to ensure we are meeting needs and can share that with DHCS. Finally, will DHCS have a requirement for Kaiser Permanente to take new undocumented beneficiaries joining the program?

Baass: Kaiser Permanente's enrollment parameters are through continuity for duals and foster youth. If an undocumented person met those conditions, then it would apply.

Wilkes: On the Behavioral Health Bridge Housing, can unsheltered youth ages 12-24 who are experiencing homelessness and needing behavioral health treatment be served under these funds? Can nonprofits serving unsheltered youth experiencing homelessness access these funds as well?

Baass: These dollars are for counties and tribes. In terms of who can be served, this is funding for beds or infrastructure, so the criteria are definitely open for anybody with a behavioral health need.

Lewis: With the PHE ending, we are focused on the many cases that will need redetermination. An area that gets less attention, and I think is going to create a lot of confusion for people, is about what they can still get or not get and what flexibilities will continue after the PHE. We are worried that people will not know that they can no longer get a service and then get billed. So, medical debt could become a huge issue for services previously covered under the PHE. Is there a way to make sure people understand what is continuing and through what vehicle, such as State Plan Amendments or waivers? That way, we would know what's in the queue outside of the obvious pieces in the budget.

Baass: This is a really good idea. Some things are clear that are moving forward in the budget. For all the flexibilities we used, we have spreadsheets listing them because they are so complex. I will take this back as an action item to think through how we can be clearer.

Nguy: I echo the appreciation for the major budget investments. We would like to see elimination of premiums in statute. Related to the budget and recognizing the significant impact of the procurement will there be any expected effort to extend the Managed Care Organization (MCO) tax, given its positive impact on the budget?

Baass: The procurement is new, and the redetermination will also impact enrollment, so we did not propose to extend the MCO.

LeBeau: I appreciate the presentation, in particular topics related to the behavioral health initiatives, such as infrastructure and the mobile crisis initiative. On the rollout, I reviewed allocations for mobile crisis unit acquisition and appreciate DHCS incorporating tribal governments along with county partners. Because tribal governments don't receive recurring

funding from the state as counties do, it is difficult to do planning work for infrastructure. The pandemic made it even more difficult to develop proposals for submission. With the mobile crisis unit application, the awardees are heavily counties and only one tribal government in the entire state made it through the process. That draws attention to barriers faced by tribal governments. I want to offer recommendations to engage tribal clinics to respond and partner with the tribal governments. I think I heard that the round two deadline has been extended. If I misheard, I would encourage an extension to allow for tribal entities to further engage in planning work to submit for round two.

Baass: February 28 is the deadline for round two. Of the 36 planning grantees, nine are tribes. I know the team has made a lot of effort to engage. I will check on thoughts about further extending the deadline and follow up with you.

Rocco: Thank you for the updates and the work DHCS is doing to address the significant challenges with the rollout of Medi-Cal Rx. On the expansion of eligibility for Medi-Cal, what is DHCS doing to address network adequacy if the patient population expands significantly?

Baass: It is an expansion of 714,000 individuals and that is one of the reasons the implementation is set for 2024. We want to make sure that the network is ready because this is a significant expansion.

Koopmans: We are only in week seven of implementation of Enhanced Care Management (ECM) and Community Supports, but I want to note that the transition from Whole Person Care and Health Homes Program has gone smoothly. I have questions and concerns about the proposal for the Kaiser Permanente contract. Can you share the timing for trailer bill language to be available? What can we expect it to include? Can you also speak to what the specific enrollment rules will be for foster youth and duals? Can you speak to the nexus of the Foster Care Model of Care workgroup and foster youth being included in the Kaiser Permanente proposal?

Baass: The foster care aspect of Kaiser Permanente enrollment and the Foster Care Model of Care are separate issues. The Foster Care Model of Care workgroup will probably commence in early summer. Foster care in the Kaiser Permanente proposal is related to Kaiser Permanente as an option in 32 counties for managed care plan (MCP) choice. There is no requirement that youth be enrolled in managed care; it is still an optional choice. Given that many foster youth change counties based on placement decisions, we wanted to provide a path for continuity and seamless coverage for a child or youth in foster care. That is the thinking behind the trailer bill language. In the next week or two, the trailer bill will be posted and available on the Department of Finance website. It will outline enrollment related to Kaiser Permanente. Individuals who are enrolled today in Kaiser Permanente and lose their employer-sponsored coverage can transition to Kaiser Permanente under Medi-Cal. And, enrollment would include Kaiser Permanente Medi-Cal members who can opt to stay in Kaiser Permanente. It would also include continuity provisions and the feasibility study for duals for the non-Coordinated Care Initiative (CCI) counties that are unaligned. We will work with local plans and community partners for the roll out.

Quality/Equity Roadmap Measures and Metrics
Palav Babaria, MD, DHCS

Slides: https://www.dhcs.ca.gov/services/Documents/021722-SAC-BH-SAC-core-presentation.pdf

Babaria provided an update presentation on the Comprehensive Quality Strategy (CQS) that was recently posted publicly. There are five bold goals at the state level to improve quality "50 percent by 2025" in each goal.

Babaria reviewed the specific measures to be tracked for each state-level goal. For example, one goal is to close the racial and ethnic disparities for well-child visits and immunizations by 50 percent to be tracked through infant, child, and adolescent well-child visits and childhood and adolescent vaccinations measures. She also outlined the equity measures that will be stratified by race and ethnicity through plan and provider reporting. Many of the equity measures align with race/ethnicity stratification measures from the National Committee for Quality Assurance (NCQA), Covered California, and CalPERS to reduce the reporting and administrative burden for plans and providers. She also reviewed new measures in the Managed Care Accountability Set (MCAS) for health plans that support the CQS. Babaria outlined measures for other managed care entities, mental health plans, dental managed care, Drug Medi-Cal Organized Delivery Systems (DMC-ODS), and dental FFS.

Questions and Comments

Gibbons: On maternity care goals, why we are not looking at disparities in birth outcomes to capture the equity challenges? For example, African American women have access to routine care and still have worse birth outcomes. My second question is about finding ways to capture preventative measures. Is this because of aligning to NCQA? Finally, I see chlamydia on the list, but syphilis is a bigger concern in California and leads to congenital syphilis with significantly detrimental impact.

Babaria: Absolutely there are opportunities to vary from NCQA. It is useful to adopt measures that are already developed because it can take years to develop and roll out new measures. There are gaps, and we are tracking where to support new measure development. We are looking at maternal mortality and morbidity birth outcomes at the state-level. For the plan-reported level, which is how many of the measures are designed to be implemented, the small numbers make it less useful. We are working with CDPH to drive the health care system specific measures to support and align with statewide public health outcomes.

Taylor: I have an ongoing concern with the collection of sexual orientation and gender identity (SOGI) data to make sure it is collected and reported in every instance where we collect race and ethnicity. Collection at the point of eligibility and enrollment is a good starting place, but we have been at that starting place for three years since AB 959 passed. Transgender members of color experience significant and disproportionately poor health outcomes and barriers to access to affirming health care. Eligibility may be completed by a parent who does not know the gender identity of their child or by someone not yet confident they want this data at the state, but trusts their provider with the information.

Babaria: Thank you for keeping us on track on this topic. We are long overdue to include all of the other demographic information where disparities exist. We are updating the Medi-Cal paper application to include SOGI, and that will allow us to stratify the information. Also, as

CalHHS rolls out the data exchange framework and health care entities implement the interoperability requirements, this is included and will allow more uniform data collection. I agree that the comfort to disclose SOGI and other information can change over time. DHCS Quality and Population Health Management (QPHM) is leading efforts to improve beneficiary information and will include ways for individuals to update data over time.

Veniegas: Building on previous comments, it is important to plan forward on risk stratification and transparency to understand the reasons for access gaps, especially if data are incomplete. We need to understand the risk stratification algorithms to understand where gaps unintentionally contribute to inequities.

Babaria: I will return to this group to provide an update on PHM. DHCS will launch a public advisory group, and I welcome all of you to join us. We will also stand up a scientific advisory committee to help us think through how to make the algorithm achieve our goals of quality equity.

Wilkes: How are doulas being tracked in the process of maternity care? Also, are we tracking trauma data?

Babaria: DHCS is rolling out a doula benefit in Medi-Cal. We are working with plans and providers to understand best practices and share lessons learned. We will be looking at the data because doulas have a critical role to address disparities. ACEs Aware has conducted many trainings and screenings, and DHCS is analyzing the data as a first step to understand trends and inform next steps.

Pittman-Spencer: Will Medi-Cal MCPs be reporting on fluoride varnish? There are many places and providers who can provide fluoride varnish, and it will be important to capture all of the services and not incentivize duplication. I am glad to see the two dental prevention accountability measures in both delivery systems. How will the FFS system meet those goals? Lastly, because of COVID-19 and provider shutdowns, care levels were lower in 2020, and that is being used as the baseline year. How might the lower utilization that year affect increases over time?

Baass: I will follow up with responses to your questions.

CalAIM and 1115 Waiver Update
Jacey Cooper, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/021722-SAC-BH-SAC-core-presentation.pdf

Cooper provided an in-depth update on CalAIM, waivers, and related CMS approvals. DHCS has developed new communication platforms, including an updated website, fact sheets, and social media to get the word out and explain the complexity of CalAIM. Cooper provided information about the goals and specific levers to meet the needs of the whole person, such as Community Supports and non-traditional providers. The full vision of CalAIM will take many years to accomplish. Cooper highlighted data on Medi-Cal populations to underscore the need and potential to achieve equity through CalAIM. Cooper provided a detailed list of the approved CalAIM initiatives and described the multiple authorities that fit together to

accomplish CalAIM. CalAIM extends across all delivery systems of Medi-Cal managed care, dental managed care, specialty mental health services (SMHS), and DMC-ODS. Cooper reviewed many of the delivery system changes, such as standardization of enrollment, benefits and payments, streamlining SMHS and DMC-ODS policies and access, and implementing robust accountability and oversight measures. Oversight and accountability measures include a new member advisory board and annual consumer satisfaction surveys across all delivery systems beginning in 2023.

ECM and all 14 Community Supports were approved by CMS. Medi-Cal MCPs are encouraged to offer Community Supports, which are voluntary for MCPs to offer and for members to use. To support the extensive change, DHCS received approval for $1.4 billion for PATH to maintain, build, and scale ECM and Community Supports, and ensure a smooth transition. Cooper offered specifics about how PATH funds will be deployed and the funding for each element of the initiative. PATH funds will be used to transition Whole Person Care pilot services to Community Supports, provide technical assistance, support collaborative planning, and develop capacity and infrastructure, such as IT.

In the DMC-ODS initiative, California is the first state in the country to be approved for contingency management (CM) services. CM provides motivational incentives and will be piloted and rigorously evaluated in DMC-ODS counties. Peer support specialists were approved as a new benefit to expand culturally appropriate services and promote recovery engagement and self-advocacy across the state launching in July. For dual eligible beneficiaries, DHCS will transition to a statewide Medicare Advantage or Dual Eligible Special Needs Plans (D-SNP) to align enrollment. Beneficiaries will be assigned to a corresponding Medi-Cal MCP based on their choice of a D-SNP. CMS also approved continuation and expanded funding for the existing Global Payment Program (GPP). DHCS is developing equity monitoring metric protocols to include in GPP. There will be continuing and new evaluations of many CalAIM initiatives. Cooper offered a list of additional elements of CalAIM that are approved, such as coverage for out-of-state former foster youth, technical changes in Community-Based Adult Services (CBAS), and chiropractic services for Indian Health Service and tribal providers. Cooper outlined approvals still pending with CMS, including a phased implementation of the elimination of the asset test for Medi-Cal eligibility, multiple re-entry services for individuals involved in the justice system, and approval of natural healers in DMC-ODS. Finally, DHCS will begin work toward a Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) IMD waiver application, starting with expansion of the full behavioral health continuum of care to leverage budget investments in behavioral health. Stakeholder engagement will begin in spring 2022 for a waiver submission in fall 2022.

Questions and Comments

Mohanty: Could you comment on how DHCS is aligning all of the CalAIM initiatives with the Master Plan for Aging?

Cooper: There are many components of CalAIM that reinforce the Master Plan for Aging. To mention a few, better integration of care for dual enrollees, community supports and home modifications to remain safely at home, caregiver respite services, and wraparound services for those in assisted living. A huge win with Community Supports is that it covers both

institutional levels of care and allows us to engage early so individuals can live safely in their home. I would be happy to provide a mapping of CalAIM initiatives for older adults.

Harvey: We appreciate the collaboration on tribal natural healers and are hopeful for approval. I also want to emphasize the component of the PATH program that is direct support to providers. Can we do even more? I want to encourage that and share my gratitude.

Lewis: This is an initiative of daunting scope and ambition. You spoke to the evaluation component. How are you thinking about monitoring the overall effort, and how might communication be provided to stakeholders and the public? For example, having data dashboards on what is happening in the roll out, what services happen, and how it is impacting people. The roadmap is complicated as to who gets what, where and how, so a way to visualize it for people to understand is really important. Also, is there a way to communicate without jargon about how efforts are successful along the way?

Cooper: We do plan a lot of reporting, especially on the new components. AB 133 requires extensive reporting, and providers will submit encounter data. There is always a lag, but as it reaches a level of completeness, we are committed to providing dashboards on various CalAIM components, utilization of services with race, ethnicity, and other factors, and are focused on oversight and accountability with this level of change and new services. We know we will need to update policy based on implementation lessons learned.

Sonnenshine: Previously, there were discussions about feasibility assessments that DHCS would undertake for the D-SNP expansion. Can you share anything on that assessment? My other question is about funding through PATH for collaborative planning and implementation and technical assistance to providers. I see that applications will be in quarter three. I am looking for details so that, as plans are thinking through how to partner in the community, we know what DHCS will focus on and what partners will have access to, so we support but do not duplicate efforts.

Cooper: DHCS is working on the feasibility study for non-CCI counties to implement D-SNP. I will need to follow up to get information to you and all the plans. On PATH funding, we will make sure we are communicating how this will roll out. We are doing statewide presentations to make sure plans are informed. The challenge is that we are still negotiating some protocols with CMS and want to ensure we don't get ahead of final approvals. We are working to bring on a third-party administrator to assist. I will follow up.

Wilkes: Thank you to DHCS for working toward a healthier California. I hope we can reach a point where counties opt out versus opt in to show how they are engaging in this opportunity. I want to lift up the peer support element; we know schools need it and we know youth need it. Will nonprofit organizations be able to participate in the juvenile justice elements?

Cooper: We are very focused on the juvenile justice population and want to engage with community-based organizations. I can follow up on that with you.

Shoemaker: I am wondering if there is a disconnect between the case management services traditionally offered in permanent supportive housing and the clinical case management

proposed under ECM. I am concerned about continuity of providers in permanent supportive housing. Have you heard about discussions related to the differences in the scopes of work? Are there concerns surfacing about disruptions or challenges about making the provision of ECM within supportive housing as efficient and comprehensive as possible for housing providers signed up for that effort?

Cooper: It is important to separate the two aspects of this. In ECM, one population for care management is someone who is experiencing or at risk of homelessness. This is intended to be a street-based ECM program to coordinate services, including, but not limited to, housing, behavioral health, and related services. Separate from that, there is a suite of Community Supports that includes housing navigation, deposits, and liaison services. Someone can receive ECM and Community Supports, and they can be bundled to a single provider or to separate providers. So, before someone is housed, there is engagement, deposits, and liaison sustaining services. Once someone is in housing, temporary or permanent supportive housing, those liaison services often have a case management component. It is not required to have ECM to receive those other housing services. DHCS has eligibility criteria and service expectations within liaison and transition services for case management. I can follow up with you to talk through the various parts.

Veniegas: I want to note that it's important to go into the CM evaluation design with race, ethnicity, and drug interaction information. In Los Angeles County, the likelihood of admission once a person presents in the emergency department has an association with race and ethnicity, and this may differ between the types of stimulants. This is important to plan with the counties implementing CM. There is evidence showing success with a combination of treatment efforts, including CM, relapse prevention, and culturally specific cognitive behavioral therapy. Some counties have the ability to do these multiple approaches and have improved outcomes with the pilot. I look forward to hearing about the evaluation design.

Cooper: We will post the evaluation design and look forward to working with you. We do plan to bring an equity lens to the evaluation.

Stoner-Mertz: I especially appreciate the PATH program and support for community-based organizations (CBO). On the payment reform process, providers are wondering what this will mean for them related to rates and agreements. Have you developed a plan and timeline on how this will impact them, how you are ensuring transparency and network adequacy?

Cooper: Yes, we have detailed documents and timelines. We can consider a detailed presentation to BH-SAC to walk through payment reform. We understand the significance of the change from cost based payment to a fee schedule across SMHS and SUD services for reimbursement for counties and providers.

Donnelly: The National Harm Reduction Coalition released a report showing a dramatic increase in stimulant use in California. I would like to continue the discussion with DHCS about how even more resources might be appropriate in that area. I am happy to see HIV as one of the qualifying conditions in the justice initiative and wonder if you have considered adding hepatitis C as an eligibility criteria?

Cooper: Yes, hepatitis C is included. The website has the complete list, but the slide was a

condensed list.

Imparato: On peer support certification, the statute glossed over the difference between someone with lived experience as a person who received services from the system and somebody who has lived experience as a parent or a family member. As you implement the statute, can you clarify that family members are peers for family members and the people with lived experience are peers for people with lived experience? Also, some states have a role for a peer in the policy making process, a peer specialist who works within state government and offers that perspective

Cooper: Thank you, I will take that back to the team.

Cabrera: To build on previous comments, I want to call out that the pillars of equity focused programs in county behavioral health plans are currently optional benefits. The fact that counties opt in does not bring new resources, and this hampers the ability to promote equity. Both sets of optional benefits could be game changers, and it is unfortunate they are still optional benefits.

Fields: One reality is that the innovation and capacity to implement community-based, 24-hour alternatives to medical settings exists primarily in the nonprofit sector. California has a disparate range of alternatives, and in some places there are none. This is largely due to a lack of technical assistance coming to counties. We can't assume counties know what the possibilities could be rather than getting caught up with what already exists in their county. It is important for DHCS to reach out about alternatives to broaden the continuum of care. This is about treatment needed in the community, as well as housing. In the waiver looking at IMD expansion, I hope there is attention to hold applicants to buying beds in their community as an alternative to institutional treatment. It will be important that anyone wanting to expand IMDs show what they have in community, instead of defaulting to IMD.

Cooper: We agree and look forward to discussion. The IMD waiver is to build out the full continuum of services for individuals with SMI, including clinically-enriched housing services.

Baass: Round two planning grants in the behavioral health continuum infrastructure program remain open to support counties and tribes to understand what the community continuum should include.

Savage-Sangwan: I appreciate the investments for CBOs. We are depending heavily on CBOs that have not participated in Medi-Cal before, and we may need a broader discussion of the barriers CBOs face in addition to technical assistance. What are the ways to make provider enrollment and contracting work for the providers coming into Medi-Cal? On the annual behavioral health consumer satisfaction survey, are we doing anything to update the methodology to improve the data?

Cooper: Thank you, we are still working on how to implement the consumer survey, and it may happen in phases or change over time. Currently, the surveys do differ across delivery systems, and we are looking at how to standardize over time.

Barcelona: On medical loss ratio implementation, we understand there will be a stakeholder

process beginning soon, but we don't have a date. Do you have information on that?

Cooper: The team is working to get the stakeholder process going, so I will get back to you.

Public Comment

Erica Hernandez, LA Children's Hospital Project Coordinator: I work in substance use prevention and want to quickly highlight a project. One of our youth advocates and former high school health leaders checked in on how the local substance use services helpline tended to youth callers. Based on those calls, we were able to provide important feedback to our county on how to make the line operators more youth friendly and remind them of minor consent. If there is interest, she can present her findings here. We started the project to provide important information to youth on what it may be like to call treatment providers. In the process, we were reminded of how important it is for youth serving institutions and providers to provide youth friendly services from beginning to end.

Christina Glassco, Mental Health Systems: We are a community-based provider of behavioral health services across California. I am thrilled to see the promise of improved access for members through the flexibility on medical necessity through CalAIM. For example, the removal of diagnosis requirements and services being formalized on the treatment plan. I am disappointed to see that some county funders are simply moving the requirements from a disallowed audit issue to a compliance finding. So, while we may no longer be recouped or disallowed for the services, we would still have a ding in an audit for compliance. I believe this unnecessarily restricts providers and does not meet the intent of the CalAIM medical necessity revisions. I hope that DHCS will consider how to support counties to remove additional bureaucratic barriers that cause implementation issues for contracted providers.

Susan Lapadula: Congratulations to the DHCS team for their efforts. I'd like to comment on the long-term care carve-in through CalAIM. I am hoping to learn more about the skilled nursing facility new reimbursement based on quality.

Carol Brown: I am thankful CalAIM is moving ahead because many of our foster youth are placed where they are not receiving the mental health services they are supposed to receive. I want to piggyback on Kim Lewis's questions about data oversight and accountability. Currently the mental health data that we have is a year old. Will there be efforts to get more current data as we move forward in CalAIM?

Janet Vadakkumcherry, Associate Vice President of Managed Care for Health Center Partners of Southern California: We represent 17 member organizations, including 12 Federally Qualified Health Centers, four Indian Health Centers and Planned Parenthood of the Pacific Southwest, with more than 180 practice sites in five counties, serving more than 900,000 patients and almost 4 million patient visits annually. Regarding Medi-Cal Rx, it would be great if the data and statistics reported today, whether supplied by Magellan or DHCS, could be made public in follow up to this meeting on the DHCS website. I am glad to see provider training requirements in the RFP being moved to a biannual basis instead of annual. This will relieve administrative burden on providers. I am hoping to understand more about the efforts and whether there are additional strategies to reduce the burden related to new

provider trainings.

Mona Patel, Vice President of Ambulatory Care Delivery at Children's Hospital Los Angeles: I am a practicing pediatrician and excited to see the progress on customer service with Medi-Cal Rx. I want to comment on children with medical complexity and CCS populations. What we are seeing is that community pharmacies are really struggling to process prior authorizations. I would like to request reinforced education for the community pharmacies. My staff at Children's Hospital are spending quite a bit of time educating pharmacists as our families try to secure medications. I also want to comment on the very complex medications that our patients have in the pediatric population to see if there can be any change or additions to modifying the Contract Drug List for this specific population. What we are doing is preserving access by stocking the medications in our own specialty pharmacy in the hospital. If anything can be done specifically to look at the pediatric doses that would be great.

Michael Humphrey, County of Sonoma IHSS: I am a former member of SAC and want to comment on the Home and Community-Based Services program. I became approved in December 2021 and should have been approved in November. My application needs to be back-dated because I was in the hospital and that has complicated approval. I hope there is time for a follow-up conversation to resolve this because it affects many people. Andy Imparato should also participate in the discussion because there could be a class action lawsuit involved. I hope someone will give me a call.

Julie Silas HomeBase, the Center for Common Concerns: We are a nonprofit organization that provides technical assistance to communities working to prevent and end homelessness. I want to support Doug Shoemaker's concern and request greater clarity around the overlap between ECM and Community Supports, particularly for homeless service providers. I also want to support incorporating coordinated discharge planning for justice involved individuals to avoid reentry into homelessness.

Plans for 2022 Meetings, Next Steps, and Adjourn
Michelle Baass, DHCS

Thank you for the discussion today. We will send a survey to gather your input about the format for future meetings. We look forward to your comments.

The 2022 dates are scheduled as listed below:

- May 12, 2022
- July 21, 2022
- October 20, 2022.