DEPARTMENT OF HEALTH CARE SERVICES

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

July 21, 2022
9:30 a.m. – 1:30 p.m.

SAC AND BH-SAC JOINT MEETING SUMMARY

SAC Members Attending*:* Bill Barcellona, America's Physician Groups; Doreen Bradshaw, Health Alliance of Northern California; Michelle Cabrera, County Behavioral Health Directors Association; LeOndra Clark Harvey, California Council of Community Behavioral Health Agencies; John Cleary, MD, Children's Specialty Coalition; Kristen Golden Testa, The Children's Partnership/100% Campaign; Virginia Hedrick, California Consortium of Urban Indian Health; Anna Leach-Proffer, Disability Rights California; Kim Lewis, National Health Law Program; Beth Malinowski, SEIU; 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; Chris Perrone, California HealthCare Foundation; Laura Scheckler, California Primary Care Association; Brianna Pittman- Spencer, California Dental Association; Janice Rocco, California Medical Association; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; 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: Anne Donnelly, San Francisco AIDS Foundation; Michelle Gibbons, County Health Executives Association of California; Sherreta Lane, District Hospital Leadership Forum; Mark LeBeau, California Rural Indian Health Board; Farrah McDaid Ting, California State Association of Counties; Cathy Senderling, County Welfare Directors Association; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Stephanie Sonnenshine, Central California Alliance for Health; Doug Shoemaker, Mercy Housing.

Behavioral Health Stakeholder Advisory Committee (BH-SAC) Members Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Ken Berrick, Seneca Family of Agencies; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; LeOndra Clark Harvey, California Council of Community Behavioral Health Agencies; Jessica Cruz, NAMI; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Laura Grossman, Beacon Health Solutions; Andy Imparato, Disability Rights California; Veronica Kelley, San Bernardino County; Karen Larsen, Steinberg Institute; Kim Lewis, National Health Law Program; Linnea Koopmans, Local Health

Plans of California; Farrah McDaid Ting, California State Association of Counties; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; Hector Ramirez, Consumer Los Angeles County; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Chris Stoner-Mertz, California Alliance of Child and Family Services; Catherine Teare, California Health Care Foundation; Gary Tsai, MD, Los Angeles County; An-Chi Tsou, SEIU; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Jevon Wilkes, California Coalition for Youth.

BH-SAC Members Not Attending: Jei Africa, Marin County Health Services Agency; Carmela Coyle, California Hospital Association; Alex Dodd, Aegis Treatment Centers; Sarah-Michael Gaston, Youth Forward; Robert McCarron, California Psychiatric Association; Farrah McDaid Ting, California State Association of Counties; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Jonathan Porteus, WellSpace Health; Cathy Senderling, County Welfare Directors Association of California; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Mandy Taylor, California LGBTQ Health and Human Services Network, a Health Access Foundation program;

DHCS Staff Attending: Michelle Baass, Rene Mollow, Karen Mark, Autumn Boylan, Lindy Harrington, Tyler Sadwith, Jeffrey Callison, and Morgan Clair.

Guest: Corrin Buchanan, Deputy Director for Policy and Strategic Planning for California Health and Human Services Agency.

Public Attending: There were 142 members of the public attending.

Welcome, Director's Opening Comments, Introduction of New Members, Roll Call, and Today's Agenda
Michelle Baass, DHCS Director

Baass welcomed members to the joint meeting of SAC and BH-SAC and first hybrid meeting with both in-person and webinar participation. Baass introduced a new SAC member, Laura Schekler, from the California Primary Care Association. Baass thanked the California Health Care Foundation for its ongoing support of these meetings.

Director's Update
Michelle Baass, DHCS Director
Slides: https://www.dhcs.ca.gov/services/Documents/072122-SAC-BH-SAC-presentation.pdf

Baass introduced Corrin Buchanan, Deputy Director for Policy and Strategic Planning for California Health and Human Services Agency (CalHHS), to provide an update on the Community Assistance, Recovery and Empowerment (CARE) Court. CARE Court is a framework to deliver mental health and substance use disorder services to the most severely impacted Californians. CARE Court is focused on approximately 7,000 to

12,000 Californians with schizophrenia spectrum or other psychotic disorders who meet specific health and safety criteria. Family members, behavioral health (BH) providers, first responders, or counties can make referrals. Accountability is built in to require the county to provide the services needed and allows the court to order prioritization of housing resources. CalHHS has engaged with a broad array of stakeholders to gather input for the legislation introduced in response to the Administration's proposal. The legislation proposes implementation through two cohorts of counties in 2023 and 2024. The model has strong supporters and those who raise concerns. CalHHS is interested in all questions and comments. Additional information is available at the following CARE court links: carecourt@chhs.ca.gov and https://www.chhs.ca.gov/care-court/.

Questions and Comments

Ramirez: Can you provide a list of stakeholders and identify any disability rights groups? I am not aware of this outreach. Hispanics are the majority population of California, particularly in Los Angeles where I live. The CARE Court information has been primarily in English and not tailored to Latino communities, although they will be impacted by the proposal. Is there a plan to roll out information and outreach to our community?

Buchanan: Stakeholder engagement included listening sessions across the state with service providers, individuals with lived experience, and many other groups that are listed on the CalHHS website. We have also engaged through affinity groups and other meetings from March until now. CalHHS has an ongoing role to gather feedback through early implementation. We are always interested in feedback to make the engagement meaningful and accessible.

Cabrera: An interesting feature of CARE Court is that it sets up a payer-agnostic entry point into county BH services for people meeting the criteria. How does DHCS anticipate counties prioritizing CARE Court individuals especially in the context of the Medi-Cal entitlement? One rationale for this is that counties have received significant investment in recent budgets. In the most recent round of BH infrastructure funding, only nine of the recipients were county BH. There are future rounds coming, but I would like to understand how DHCS will align future rounds of investments with how those resources might benefit CARE Court and county youth efforts.

Baass: In terms of prioritization and Medicaid policy, it is an entitlement for whoever qualifies. CARE Court recognizes that private insurers will also pay for it, and this is additional funding available to counties to provide services. The BH infrastructure funding was intended for launch-ready projects. As we plan for future rounds of funding, we want to work with counties and regions to identify what is needed.

Wilkes: Transition age youth, ages 18-25, should be excluded from CARE Court and diverted to the systems created for them. We should think about how we support youth with high acuity and BH challenges as we build up a workforce to support them.

Nguy: We share some of the concerns on CARE Court, particularly the recent addition

of legal aid as a source of legal representation. We surveyed our members, and they oppose that. I would appreciate hearing the Administration's plans.

Buchanan: Conversations on this are ongoing. We see an opportunity offered by legal aid to think expansively about advocacy on behalf of the client and the aligned skill set with legal aid to take on that broader role. We are happy to continue the conversation.

McNaughton: In a recent board meeting at Inland Empire Health Plan, there were questions about the connections between local stakeholders to make sure that the infrastructure like housing is ready to roll out. Are there plans to bring stakeholder groups together more formally to support a holistic work plan?

Buchanan: Yes, that work needs to get started soon to help judicial and city partners, county behavioral health, and other social safety net programs at the local level prepare. This includes technical assistance and channels of communication and planning. We look forward to engaging with stakeholders to do that effectively.

Tsou: I am interested in the timing for the next set of amendments. We are concerned about the lack of standards regarding contracting services for the CARE Court and want the workforce to have living wages and benefits, regardless of whether they are in-house or contracted. We also have concerns about having a clear record of the hearings and want court reporters in each of the hearings.

Buchanan: I don't have a firm deadline on amendments to share. The Legislature will reconvene soon, and will finalize amendments in the next couple of weeks.

Stoner-Mertz: We know individuals are suffering and appreciate the attention brought to this. As we recommended in coalition letters, we suggest taking a pilot approach to this due to some real potential risks. As mentioned, there are limited resources in terms of prioritization. I also agree with the statements made about transition age youth.

Director Baass provided an update on the DHCS budget and noted that the full list and updated implementation timeline will be posted on the DHCS website. The budget builds on previous investments to expand coverage and includes funding for navigation and enrollment; includes value-based payments to reform skilled nursing facility (SNF) financing; $1 billion for retention payments paid directly to hospital and SNF workers; and additional budget items related to equity and practice transformation focusing on DHCS clinical quality objectives related to preventive care, maternal care and behavioral health (BH) integration as well as California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Justice-Involved initiative, BH bridge funding, mobile crisis funding, the doula benefit, and the Children and Youth Behavioral Health Initiative (CYBHI). A new rate methodology will begin in calendar year 2024 and includes a new quality and workforce incentive program and DHCS authority to impose sanctions.

Questions and Comments

Golden-Testa: Are you including multiyear continuous coverage for young children in the budget with a start date in 2025? We are happy to offer support for this.

Baass: Yes, it is included in the budget policy summary.

Mollow: We are doing internal work now, but not ready for implementation work yet.

Wright: First, there are individuals who will age out of coverage prior to implementation of expanded coverage to undocumented adults. Is there a way to alert them via a notice that coverage will be available soon? Is work being done on health plan readiness such as network adequacy? Second, we are excited about the immediate reduction of premiums to zero. Is this done annually? Third, I want to confirm whether, since the public health emergency (PHE) is continuing, will all related initiatives remain in place?

Baass: On the coverage expansion, we are thinking through options for how to notice on that. The PHE is ongoing, and this extension means no one will become ineligible. DHCS teams are working on plan readiness, rates, and other items that need to happen for 700,000 more individuals to be enrolled in January 2024. The reduction of premiums did go-live July 2022 and it stays in effect unless there is a future budget change.

Lewis: On the expansion of coverage to additional uninsured adults, will you use same process as the previous one for the older and younger adult expansions? Also, given that the coverage for the COVID uninsured group may include some of the expansion population, will you be able to track and send notices to individuals who may become eligible in 2024 and who may lose coverage at the end of the PHE?

Mollow: Yes, we will use the same process as in past efforts on notifications and stakeholder engagement. On the second part of the question, the group you mention should only be in the uninsured group if they are not eligible for Medi-Cal. Yes, we do have requirements from the Centers for Medicare & Medicaid Services (CMS) to assess the COVID group at the end of the PHE to determine if they might be eligible. They receive coverage only for COVID-19 conditions and any related treatment.

Eisen: Director Baass spoke to increasing wages for SNF and hospital workers. There have also been investments to strengthen the BH workforce, however none of those policy measures have been directed to improve worker pay. What are the barriers?

Baass: The funding is for retention payments for SNF, hospital, and psychiatric hospital workers in certain classifications to recognize they were on the frontline for COVID. There is no specific budget proposal related to general wage issues within DHCS.

Eisen: The BH workforce were essential workers who worked throughout the COVID crisis as well. As you know, there were many overdose deaths in that same period and so I wish we could consider the BH workforce for retention payments as well.

Director Baass continued with a discussion of the Consumer Advisory Committee. The goal, with support from CHCF, is to hear directly from Medi-Cal consumers as DHCS works through policies. The Center for Health Care Strategies is developing considerations for the design of the advisory committee in terms of support and training, technology, language access, and a design framework for engagement.

Imparato: I hope DHCS will consider access and support needs for those with intellectual disabilities. They are not always included in stakeholder input groups.

Golden-Testa: I am happy to share some of the input received for a recent report. Participants should be compensated and supported with childcare and transportation. In addition, community organizations should be contracted to support consumers' participation and co-design of the process.

Dr. Mark provided an update on the $350 million COVID-19 Vaccination Incentive Program. The three components were a vaccine response plan proposed by managed care plans (MCPs), direct member incentive gift cards of up to $50 after vaccination, and vaccine outcome achievement payments. She reported on program outcomes including data on each measure targeted for vaccination improvement. Slides: https://www.dhcs.ca.gov/services/Documents/072122-SAC-BH-SAC-presentation.pdf.

Questions and Comments

Clark-Harvey: What was effective for different populations, and what were best practices? This advisory group could be helpful as you design strategy.

Mark: I really look forward to that conversation once we dive deeper into what we have.

Wright: I would appreciate understanding any differences between plans or types of plans related to improving vaccination rates. It is distressing there is still a gap for the Medi-Cal population. Are the differences due to barriers for low-income populations, or something about the Medi-Cal delivery network and systems? For the metrics where no plan achieved the benchmark, was the money distributed? How do the achievement payments work when you have very few or no plans meeting the standards?

Mark: You articulated the specific challenges well. We are looking at the plan-by-plan analysis and will share. We don't have the underlying data required to compare Medi-Cal and a similar population not on Medi-Cal. The high-performance pool was structured so that, if plans did not meet the metric and not all the money was paid out in the main part of the program, the money went to the high-performance pool. There were also limits in the high-performance pool, so not all money allocated was paid out.

Sangwan-Savage: We compared these data to state data and Medi-Cal has fallen farther behind as a whole. On the comparison, I think we do have data to compare

because we can compare Medi-Cal vaccination rates to the vaccine equity metric and assess how it compares to the least healthy equity quartile. Even in that, we have a gap. This is concerning about the role we expect MCPs to play in making sure that people get vaccinated. Additionally, this data is only for the first dose; this is not Medi-Cal members who are fully vaccinated. I also have questions about whether plans that did not perform were paid. I think we should look at strategies other than MCPs for a public health approach to this. We should be working on boosters, and I have concerns about the ability of MCPs to accomplish that. How is DHCS thinking about the role of MCPs to keep our most vulnerable Californians safe?

Mark: You raise great points. There is a lot of work left to be done and to get as many vaccinated as possible, it will take all of us working together, MCPs, community groups and all of you. We are diving into this data to see how to make progress.

Koopmans: Do we know where California is relative to other states in vaccinations for the Medicaid population? I don't think the gap is unique to California. Also, when you look at strategies that were successful, an important consideration is what the vaccination rates are in that overall geography to understand how the gap for Medi-Cal populations might compare.

Mark: Yes, gaps between Medicaid populations and the population overall exist throughout the country. If anything, California has smaller gaps than many other states. However, our goal is to close the gap so everyone gets vaccinated. Anecdotally, some MCPs are closing gaps in locations with low county vaccination rates. Vaccination rates vary tremendously throughout the state and there is more vaccine hesitancy in some places.

McNaughton: We ask every one of the 5,000 – 7,000 calls per day to our call center if they are vaccinated or want an appointment. A surprising number are not interested in vaccination. We have some follow up questions and this helped us develop strategies to partner with the faith community and others. I am happy to share the data.

Mark: Yes, it would be helpful to receive that information.

Ramirez: Given the populations you are focusing on and significantly low rates, it highlighted to me that changing strategies might have been necessary during the pandemic. We know misinformation is one of the leading causes of people being unwilling to get vaccinated. We need ways to combat that and help individuals with support or incentives to follow up with boosters. The worst outcomes are in Hispanic, Native American, and Black communities. Perhaps an adaptation of the strategies is needed to help our community move forward. Also, the conclusion of the presentation seemed misleading. I want us to be honest and it should be okay to point out that it was a failure, perhaps because we weren't expecting the impact of misinformation on the strategies. It seems important to highlight the need to have different approaches in the conclusion, and what the biggest barriers have been in deployment. It wasn't as much about access as we thought earlier on; it was attitudinal barriers.

Velarde: Can you explain where the data is from?

Mark: The data for measures 1-3 were reported by MCPs, and measures 4-10 were from combining CAIR2 (California Immunization Registry) 2 data with Medi-Cal eligibility data.

Velarde: We found internally at Kaiser a large discrepancy between our internal data and CAIR 2. It may be that gaps were actually due to discrepancies in the data.

Grealish: It would be useful to stratify this data by justice-involved populations to see how it compares to Medi-Cal. We have the Medi-Cal utilization project, which is a data sharing agreement between the California Department of Corrections and Rehabilitation and DHCS. The comparison may identify a need to target efforts.

Kelley: We have the Community Vaccine Advisory Committee (CVAC) with a focus on communities of color. Perhaps it would be helpful to reconvene the CVAC to look at the data and offer their views or possible solutions.

New Community Health Worker (CHW) Provider Classification
René Mollow, DHCS
Mollow offered updates on the CHW benefit and reviewed slides on the covered services, benefits and fee schedule.
Slides: https://www.dhcs.ca.gov/services/Documents/072122-SAC-BH-SAC-presentation.pdf

Questions and Comments

Cabrera: We do not have a CHW benefit for specialty mental health services (SMHS) or substance use disorders (SUDs), however, there are CHWs in these delivery systems and they are critical to reducing disparities. This is funded largely through the Mental Health Services Act (MHSA) and is not leveraging Medi-Cal reimbursement. CHWs work side-by-side with peer support specialists. Because the CHW benefit includes elements of BH, we want to partner with you about communication to MCPs and others to clarify the distinctions for CHWs, peer support specialists, and counselors in the school initiative. Otherwise, there is potential for confusion or duplication.

Golden-Testa: We are excited about the new benefit and also concerned about a new element included in the All Plan Letter (APL) but not discussed in the work group on medically necessary eligibility criteria. Other states with a similar benefit have not used these criteria. We hope DHCS will consider removing this.

Mollow: Providing that information was to give context for the delivery of those services because for medical purposes, there have to be medical necessity criteria established. We will look at the comments you provided to the draft APL and respond.

Scheckler: We are particularly happy to see health navigation included as a covered service for CHWs. However, because FQHCs can't bill fee-for-service (FFS) or managed care for CHW services, the primary way that health centers will be able to access payment is by adding the services to the Prospective Payment Systems. We will look to DHCS for guidance on how FQHCs should document CHW costs and visits in order to include them in the rates and substantiate the services and costs. We appreciate the work on this and look forward to guidance.

Lewis: Some of our concerns were identified in the collective letter on the APL. I am not sure if stakeholder meetings are continuing this subject, and I request some additional conversation on the breadth of what can be covered, as well as CHW provider requirements and qualifications of community-based organizations (CBOs) that are not Medi-Cal providers or may not have the clinical staff to become Medi-Cal providers. We don't want them to be left behind until 2023 in terms of contracting and MCPs.

Mollow: I will take that back to discuss ongoing engagement looking at the pathway for CBOs as a Medi-Cal provider type. For others enrolled in Medi-Cal, they can bill us for CHWs. I think it will be important to look at MCP criteria to leverage that. We will look at a process to continue discussions of the covered benefit.

Kelley: I want to reiterate that counties have utilized MHSA dollars for almost 20 years to implement promotores. We are using health promoters from and in the community. There is a difference between more standard business practice and working with trusted people in community. San Bernardino County has lessons learned from using CHWs with native populations, Latinx, the Black community, lesbian, gay, bisexual, transgender, queer, intersex, Asian Pacific Islander, with everyone. It was a little different in each case and DHCS can leverage the knowledge gained working with stigmatizing health conditions and BH, including SUD for this new system.

Wright: What are the intersections of this benefit with the queer and trans cultural practice of peer-led groups and services? How might they fit into the new classification?

Mollow: There are two pathways for CHWs in Medi-Cal - by training or certificate. If that is historical training, then at some point they will have to come through with the certificate process. CHWs will support populations through their lived experience. If there is any perception of exclusion, I want to hear that to make sure people are not perceiving a population is excluded because a particular term or words are missing. That is not our intent. Our goal was to develop this as broadly as we could to secure the necessary federal approvals. Now, we need to think through the more detailed information available in provider manuals and policy guidance. If information published in the provider manual or the draft APL includes errors, let us know. The value is looking at individuals who have lived experiences to support beneficiaries.

Update on Medi-Cal Expansion to Eligible Adults Ages 50+, Regardless of Immigration Status
René Mollow, DHCS

Mollow reported on the successful implementation of the Older Adult Expansion, effective May 1, 2022, to Californians 50 years of age and older, regardless of immigration status. Slides: https://www.dhcs.ca.gov/services/Documents/072122-SAC-BH-SAC-presentation.pdf

Questions and Comments

Wright: Is there any update on the number of people that have come into the program through other means beyond the restricted scope transition?

Mollow: That data is not available yet. We are tracking and will offer an update.

Mohanty: I want to clarify whether there is outreach to other individuals not already enrolled in restricted scope Medi-Cal who may be eligible but not enrolled?

Mollow: Yes, we had a group of individuals already enrolled in restricted scope coverage and only eligible for emergency or pregnancy-related services. That is the 247,000 individuals who were transitioned. The team developed an outreach and transition plan for this group that started about a year ago. The plan posted on the website speaks to outreach efforts to educate individuals enrolled in restricted scope coverage about this upcoming change. They received three letters from DHCS about the transition, timing and MCPs. In Los Angeles or Sacramento County, they were also informed about dental managed care. That is the outreach for the existing population. We also worked with health and enrollment navigators and gave information to all populations about this upcoming change. We are leveraging work with the health enrollment navigators about this coverage option as they interact in the community.

Lewis: Did you say how many were default enrolled into managed care? Also, did you default based on any existing provider relationships in the network of a particular plan?

Mollow: I can get the number. They were all in FFS and may not have had a regular source of care. We did not use a provider algorithm in the default.

Update on Children and Youth Behavioral Health Initiative (CYBHI)
Autumn Boylan, DHCS
Boylan reviewed the goals of the CYBHI and the urgent need for the $4.7 billion investment. She reviewed the extensive stakeholder process including more than 500 stakeholders, with a priority of engaging youth and families in the redesign of the delivery system. Slides: https://www.dhcs.ca.gov/services/Documents/072122-SAC-BH-SAC-presentation.pdf

Questions and Comments

Veniegas: I want to offer highlights of data from 77 public school districts and six charter school districts in Los Angeles. In many districts, there were punitive policies even related to first-time incidents of MH or SUD. The concern from CBOs is that institutions

with a culture of punitive policies on BH incidents may not be suited to deliver evidence-based or community-defined practices. There may be a way through the grant process or technical assistance for school districts to consider adopting more affirmative healing-centered policies that will advance the practices you are looking for with the systems change. I can connect you with the organizations and school-based health center entities that gathered this data and shared it with the California Community Foundation.

Cabrera: County BH programs have decades of experience in school-based mental health services. There are historical reasons for the existing relationships and some counties contract with schools for services that are part of IDEA (Individuals with Disabilities Education Act). Counties also offer services under Early and Periodic Screening, Diagnostic, and Treatment and to some students with commercial insurance. We are unique in having provider networks that include schools and are part of network adequacy for DHCS. We have questions about how the fee schedule will interact with existing networks so that we don't disincentivize schools to continue in our network. There is a lot of complexity in the development of the fee schedule. Also, related to the virtual services platform, there is a lack of access, and provider shortages are not unique to Medi-Cal. Health plans have little incentive to connect parents to specialty providers to meet needs. I'm flagging this to avoid the frustration that can happen if there are no services or the wrong services available once parents and youth connect to the virtual platform. It is important to have a clear understanding of what we can and intend to connect people to as well as ensuring integrity in what insurance will offer.

Grealish: I didn't see justice-involved youth populations identified and wonder if they were engaged to ensure their needs are addressed. If this hasn't happened, I am happy to help connect you. For example, the Office of Youth and Community Restoration, and Probation. We hear that schools are seeing a sharp increase in BH issues and needs. I note the importance of ensuring those voices are represented in these efforts.

Boylan: We are entering a second phase and would appreciate the assistance engaging the right people. I will circle back with you because it is our intention to make sure we are thinking about the needs of justice-involved youth in terms of school-based services, the virtual platform, and the practices we are selecting.

Kelley: I am wondering how we will address technology deserts, where there is no bandwidth or satellite coverage, and access for clients who can't afford personal data plans even if they are available? Also, how might we leverage local platforms that have launched with MHSA? In Orange County, we launched platforms alongside the Department of Education and local hospitals, informed by youth.

Boylan: We are having discussions with the Think Tank about the digital divide and how to ensure the platform is available in all areas of the state. We will have a telephone call center that provides services and supports for young people to bridge some of that digital divide. On existing platforms, we are engaging with CalMHSA and do want to learn from counties and leverage existing local programs and platforms. The Think Tank includes individuals from the Orange County effort who are advising us.

Berrick: I underscore the lack of services available for youth as well as the lack of clarity about services available through MCPs. How will you work with MCPs to ensure access as evidence-based practices are employed? How will integration across sectors ensure a continuum of care for youth when their needs exceed standard outpatient services?

Boylan: It is complex, given that this will operate across all-payers. We are working with health plan associations, counties and others to develop consistent practices, understand what scaling means geographically and by topic. On integrating with community schools, we are meeting with the California Department of Education regularly and want to be thoughtful about how these fit into the landscape of existing programs. CalHHS has conducted a landscape analysis of school- based services we are using to think about the design and interaction of programs.

Ramirez: I want to ensure you embed strategies that do not perpetuate the stigmatizing models that made things so horrible for people of my age. I hope that people with long-term lived experience provide information so the Think Tank is not the echo chamber that provided stigma in the past. I have a concern about relying on CalMHSA due to its failures for youth of color. I hope there is considerable thought about that.

Stoner-Mertz: When will school capacity grants roll out? I have similar concerns as those expressed by Michelle and Ken. As CalAIM rolls out, we need to consider the challenges we see with No Wrong Door (NWD) access.

Boylan: Grants begin at the end of 2022 and there will be multiple granting rounds to support readiness for the fee schedule implementation.

CalAIM Update
Tyler Sadwith and Lindy Harrington, DHCS
Slides: https://www.dhcs.ca.gov/services/Documents/072122-SAC-BH-SAC-presentation.pdf

Sadwith reported on the NWD policy issued March 2022, intended to improve timely BH services regardless of where a person enters the system. He reviewed the development process, timeline, and final version of the NWD policy. A key element includes payment for services provided prior to a diagnosis even if it is determined that the beneficiary is better served in another system. He reviewed the plan to monitor performance.

Sadwith continued with an update on the Justice-Involved (JI) initiative. He reviewed data and disparities related to this population and provided a visual of how CalAIM services such as Community Supports are linked to specific JI services. Together, the services and supports provide individuals services pre-release, enrollment in Medi-Cal coverage, and connections to BH, social services, and other providers that can support their reentry from prisons, jails, and youth correctional facilities. Sadwith outlined the specific criteria for the target population and services available. He noted that youth are not subject to criteria and are automatically eligible for pre-post release services.

Sadwith also provided information on the $1.44 billion funding through Providing Access and Transforming Health (PATH) to support capacity building for effective pre-release care for JI populations and enable coordination between justice agencies and county behavioral health agencies. Finally, he reviewed the status of CMS approval.

Questions and Comments

Eisen: NWD applies to SMHS, but not to SUD and this remains a separate wrong door. There are challenges creating a statewide policy for SUD due to differences across counties. The population is transient and may receive services in one area but be enrolled in Medi-Cal elsewhere. Is there consideration to addressing this? These are barriers for people seeking services and I hope we can adopt a NWD policy for SUD. On the graphic for the JI package, can you clarify the payer for the in-reach period when Medi-Cal is not active? Finally, I am not certain that American Society of Addiction Medicine (ASAM) has changed the criteria to make a person eligible for residential or outpatient treatment if they have not endorsed they recently used substances. Someone coming out of incarceration is unlikely to endorse recent drug use.

Sadwith: This is very helpful feedback to solve for implementation challenges. It seems the issue is a need to work on county-transfer policies or implementation, so it is more patient-centric and we can look at that. In January 2023, pre-release Medi-Cal application will begin, and the coverage will be in suspended status because we do not have CMS approval to pay for services during incarceration. There is no change to the funding or payer pre-release until CMS approves to cover those 90-day pre-release services. Finally, thank you for flagging the placement issues. We will look into the pre-release disclosure issues you raise and follow up.

Tsai. I appreciate the ambition of this administration and my comment is from a change-management perspective. There are dozens of initiatives that each require work, and some like BH payment reform are transformational. I have concerns about all that we are taking on because it affects our shared success and could set us up for failure if we can't execute the way we might without more time. There have been instances where we had one week to review a 160-page Drug Medi-Cal billing manual document and that isn't feasible. Payment reform, for example, requires that we work with electronic health record vendors, and this takes time. I understand we all want to run towards these positive advances in our system and I hope we can be strategic with timing.

Sadwith: We hear you and understand there is an unprecedented array of reforms and changes. The county BH delivery system is tasked with executing a massive change management process. As you know, 90 percent of success is implementation. Thank you for flagging this and we will look for opportunities to ensure greater stakeholder engagement and review.

Veniegas: In the meetings of the JI work group, I have not seen any reference to services or coordination for individuals who are incompetent to stand trial. I am interested in any updates on that. The Hospital Health Care Delivery Commission has a

correctional health services standing committee that may be a resource. CCF has supported a subset of potential contractors under Community Supports focused on housing navigation. They are sharing early implementation insights, including not having anyone to ask about what scope of services is allowable in specific situations, how to get referrals, operational definitions needed to adapt patient management systems, and more. So, I underscore Gary's comments about how hard implementation can be.

Sadwith: Just to confirm my understanding, for the provider network working on housing-related services, it sounds like they are seeking guidance and collaboration from MCPs implementing Community Supports?

Veniegas: Yes, while there's capacity building from Whole Person Care (WPC) into CalAIM, there is also a business development bridge as some of the ECM and CS are coming online. Some of those organizations may not have been part of WPC. We have at least 300 organizations who are serving people experiencing homelessness and could potentially be part of this business development pipeline under CalAIM.

Stoner-Mertz: Although we are a month into NWD, we hear from members they are not seeing any significant changes. I agree with previous comments about paying more attention to the detailed implementation issues as they come up. For example, the work with CBOs requires granularity to ensure that ultimately those services are getting to the youth and families that need it. I think documentation is very much connected, particularly in a moment when our workforce crisis is so real. We need to dig into the details to ensure that we reduce the paperwork barriers that exist in our systems.

Lewis: It is important to be able to get services from both systems at the same time, which I think is clear in the guidance, but there are remaining questions. It should be that, wherever you show up, you do the screening, assessment and determine the service array needed. In our view, it should not ever be an answer that you called the wrong number. Bringing in ECM or other mechanisms of care management is critical. If people are thwarted at the front door or turned away, they may not go to another door.

Grealish: Even though the JI package is pending CMS approval, many in the JI population will meet the criteria for ECM as implemented now for serious mental illness, SUD, and homeless or at risk of homelessness. I wanted to flag that because there could be confusion and we want to maximize access for JI in the community.

Harrington offered a review of the work plan for the CalAIM Medical Loss Ratio (MLR) requirements. In 2022, elements such as compliance review and oversight of third-party vendor cost reporting will move forward. Harrington outlined the timeline for various provisions going forward. For example, in 2023, all MCPs including dental will be required to impose equivalent MLR reporting requirements on delegated entities and by 2028, DHCS and CMS will audit MLR data. Harrington also reviewed the specific MCPs and subcontractor entities subject to CalAIM MLR requirements. The DHCS workplan was submitted to CMS in June 2022 and it will be posted on the website.

Questions and Comments

Barcelona: We remain concerned that the narrow scope of the third-party vendor statement excludes all of the acquisition and operation of care coordination and population health management from the medical loss side of the ledger. This seems to contradict the aims overall and I wonder if you have feedback from CMS on that?

Harrington: There is no new information. We continue to have conversations with stakeholders and CMS to refine what's included and not.

Perrone: I am curious about the landscape analysis. Is it being conducted externally? Will it be available publicly? Can you share a scope of work (SOW)?

Harrington: We are doing this with internal resources so there is no SOW to share.

Public Comment

Steve McNally, Orange County: I am on the County Behavioral Health Advisory Board, but my comments are my own. I learned a lot today and I appreciate that. I like to leave meetings empowered to do something, and I'm not sure what you want me as a citizen to do. There are many more of me, as users of the system, than there are providers. I would ask that you continue to focus on implementation. We all can agree that things are broken, but we are never quite sure what person or what agency to go to for a solution. Thank you for all your efforts.

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

The remaining 2022 date for a stakeholder meeting is October 20, 2022. We will continue to use a hybrid meeting format barring any change in pandemic guidance. The 2023 meeting dates will be announced at the October meeting. Thank you to everybody who made this hybrid meeting a success, including the Office of Communications team and Bobbie for her excellent facilitation.