Medi-Cal Managed Care Advisory Group Meeting

March 14, 2024
Webex Event Number (Access Code): 2660 048 5239
Event Password: MCAG*

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DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Thank you for joining!

Please place all calls on **mute**, not hold, to avoid hold music

To ask a question throughout the presentations, please send to **everyone** through chat

Once each presenter is done, we ask that you utilize the 'raise your hand' function to ask questions

At the end of each presentation the host will read off any questions posed in chat

Director's Update

Michelle Baass

Director,

Department of Health Care Services (DHCS)

Introductions and Agenda Overview

Amara Bahramiaref

Branch Chief,

Managed Care Policy Branch

DHCS

Agenda

- 2024 Managed Care Plan (MCP) Post-Transitional Updates
- Enhanced Care Management (ECM)
- Screening and Transition Tools (STT)
- 10-minute Break
- Memorandum of Understanding (MOU) Updates
- Managed Care Plan (MCP) Liaisons
- Providing Access and Transforming Heath (PATH) – Technical Assistance (TA) Marketplace
  - Vision of The Cross (VOTC) A Guide to Our Technical Assistance (TA) Marketplace Journey
- Open Discussion

2024 MCP Post-Transitional Updates

Bambi Cisneros

Assistant Deputy Director,

Health Care Delivery Systems

DHCS

Preparation for the 2024 MCP Transition

Operational Readiness Assessment

- DHCS required MCPs to submit approximately 250 Operational Readiness deliverables corresponding to the MCP contract
- For example, Operational Readiness deliverables focused on:
  - Quality Improvement
  - Utilization Management
  - Network Adequacy
  - Delegation Oversight
  - Continuity Of Care
  - Population Health Management
  - Enhanced Care Management
  - Community Supports
- DHCS conducted deep dive assessments for five MCPs identified as high-priority due to the size and complexity of their expansion to additional counties or the number of members they will serve, as well as being new to providing Medi-Cal managed care services

Member Engagement

- **Pre-Transition:** DHCS utilized various strategies for engaging members, raising awareness about the 2024 transition and their rights, and providing contact information
  - Letters
  - Call campaigns
  - Text campaigns
  - Member-focused web resources
  - DHCS' Friday newsletter
- **Post-Transition**: DHCS is analyzing member call data, grievances, appeals, and stakeholder survey feedback to identify and address member challenges
- ***Ongoing:*** DHCS is collaborating with MCP partners and advocates to ensure effective communication and resolution of identified transition issues

MCP Transition Monitoring Approach

Due to the scale and complexity of the 2024 MCP Transition, DHCS is utilizing a multi-pronged approach to enable oversight and ensure compliance with MCP Transition policies.

	Activities	Cadence
MCP Survey Responses	Previous and Receiving MCPs are required to submit Continuity of Care (CoC) performance data via survey across four (4) domains: » CoC for all transitioning members and Special Populations members (note: Special Populations members are especially vulnerable members as defined in the MCP Transition Policy Guide) » CoC for Enhanced Care Management (ECM) and Community Supports » Member Issues	***Biweekly*** *November through February;* ***Monthly*** *through March; and* ***quarterly*** *through December 2024*
Stakeholder Survey	DHCS is soliciting and tracking stakeholder feedback through a survey; MCPs are also expected to track stakeholder input and ensure appropriate feedback loops exist with MCP leadership	***Monthly*** *November 2023 through March 2024*
Other Activities	DHCS is also monitoring plan-to-plan data sharing to confirm CoC protections are honored. » **Plan to Plan Data Sharing** (Biweekly): DHCS is reviewing copies of data files shared between Previous and Receiving MCPs for timeliness and completeness.	***Monthly and Biweekly*** *November 2023 through March 2024*

Preparation for ICF/DD & Subacute Transition

Operational Readiness Assessment

- DHCS and DDS convened an ICF/DD Homes Carve-in Workgroup starting in February 2022 to inform policy guidance for the transition.
- DHCS convened a Subacute Care Stakeholder Workgroup between December 2022 - April 2023.
- DHCS required MCPs to collectively submit approximately 231 Operational Readiness deliverables corresponding to the MCP contract

Member and ICF/DD Home Provider Engagement

- **Pre-Transition:** DHCS utilized various strategies for engaging members to raise awareness about the transition and their rights, including 30 and 60-day notices, Notice of Additional Information, and a member call campaign. DHCS convened nine (9) ICF/DD webinars and office hours, and five (5) subacute care webinars open to the public.
- **Post-Transition**: DHCS is conducting post-transitional monitoring of MCPs and continuing to hold office hours through April to identify and address operational challenges.
- **Ongoing:** DHCS is collaborating with MCP partners and advocates to ensure effective communication and resolution of identified transition issues.

ICF/DD & Subacute Transition Context

Scale and Complexity

- **Scale**: Approximately 4,700 members were identified to transition from Fee-for-Service to an MCP on January 1, 2024; about 4,000 ICF/DD and 700 Subacute
  - Approximately 95% of these members transitioned on January 1, 2024
- **Complexity**: These transitions took place by county to make the LTC benefit statewide:
  - ICF/DD, ICF/DD-Habilitative, ICF/DD-Nursing Homes – 31 non-County Organized Health System (COHS) counties
  - Subacute Care Facilities – 31 non-COHS counties (adult); 36 counties (pediatric)

Monitoring Approach

DHCS is monitoring the ICF/DD Homes and Subacute Care Facilities carve-in to ensure MCPs are taking appropriate actions to carry out their contract obligations pertaining to timely claims payments, member grievances, and access for potential oversight actions.

Dates	Frequency
Post-Transition Monitoring (2024)	
January 1 – February 29	Bi-Weekly
March 1 – June 30	Monthly
Regular Quarterly Monitoring (2024)	
July 1 – December 31	Quarterly

Oversight/Technical Assistance Activities

- In addition to analyzing Post-Transition monitoring data, DHCS is conducting the following oversight activities to identify and resolve provider concerns:
  - Extended Office Hours to April 2024 for MCPs, ICF/DD Home providers, and other stakeholders/advocates to discuss operational issues and share promising practices
  - Established weekly meetings with key ICF/DD Home providers and provider associations to troubleshoot and escalate concerns
  - Performing targeted MCP outreach to conduct further deep dives into the MCP's processes and identify where any corrective action is necessary
- Evolving MCP and ICF/DD Home Provider needs will help drive priority technical assistance areas.
  - DHCS will continue to develop additional resources to provide continued post-transition support.

Questions?

Enhanced Care Management

Laura Miller MD

Medical Consultant II, Quality and Population Health Management

DHCS

Brief Updates

- Population of Focus (POF) Launches
- Quarterly Implementation Report Data Update
- Referral/Authorization Process Update
- Persons Experiencing Homelessness Spotlight
- ECM Policy Updates

POF Launches – 1/1/2024

- Birth Equity POF:
  - ECM Birth Equity POF FAQs will soon be available on ECM webpage.
  - Transitional Care Services (TCS) – available to all pregnant and postpartum individuals.
  - Priority focus area for TCS for 2024 includes transitions for pregnant/postpartum individuals.
    - ECM Birth Equity POF highlighted at TCS Summit on 3/6/24.

- Justice-Involved (JI) POF:
  - Plans in process to refine models of care.
  - 1:1 TA meetings scheduled in February and March.
  - Site visit in Los Angeles with ECM provider – promising practices and barriers to implementation.
  - Pre-release JI services planned for October 2024.
  - Updated JI Policy Guide planned for delivery early Q2.

Released: Spotlight on ECM for Individuals and Families Experiencing Homelessness

DHCS is excited to release the **ECM for Individuals and Families Experiencing Homelessness POF Spotlight.**

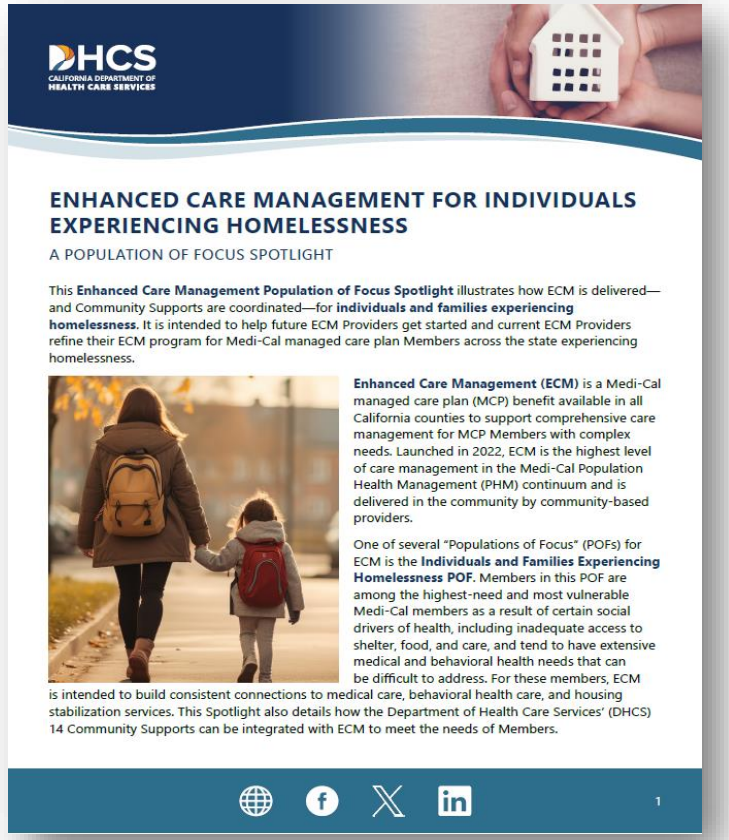
- ✓ Lifts key DHCS policies and resources on serving individuals and families experiencing homelessness in ECM; including, approaches to outreaching and engaging individuals experiencing homelessness.
- ✓ Contains Member vignettes that illustrated how to implement ECM for these POF:

LGBTQ youth with substance use disorder needs experiencing homelessness

Older adult with bipolar disorder experiencing homelessness

- ✓ Explains how Community Supports can be integrated to best serve Members and families experiencing homelessness.

This is the second in a **series of Spotlights** DHCS plans to release to provide more detail on how Providers can deliver ECM models tailored to the needs of different POF.



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ENHANCED CARE MANAGEMENT FOR INDIVIDUALS EXPERIENCING HOMELESSNESS

A POPULATION OF FOCUS SPOTLIGHT

This **Enhanced Care Management Population of Focus Spotlight** illustrates how ECM is delivered—and Community Supports are coordinated—for **individuals and families experiencing homelessness.** It is intended to help future ECM Providers get started and current ECM Providers refine their ECM program for Medi-Cal managed care plan Members across the state experiencing homelessness.

Enhanced Care Management (ECM) is a Medi-Cal managed care plan (MCP) benefit available in all California counties to support comprehensive care management for MCP Members with complex needs. Launched in 2022, ECM is the highest level of care management in the Medi-Cal Population Health Management (PHM) continuum and is delivered in the community by community-based providers.

One of several "Populations of Focus" (POFs) for ECM is the **Individuals and Families Experiencing Homelessness POF.** Members in this POF are among the highest-need and most vulnerable Medi-Cal members as a result of certain social drivers of health, including inadequate access to shelter, food, and care, and tend to have extensive medical and behavioral health needs that can be difficult to address. For these members, ECM is intended to build consistent connections to medical care, behavioral health care, and housing stabilization services. This Spotlight also details how the Department of Health Care Services' (DHCS) 14 Community Supports can be integrated with ECM to meet the needs of Members.

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To learn more, please visit the ECM and Community Supports webpage.

Q2 2023 Quarterly Implementation Report

- On January 29th, DHCS released an updated **ECM and Community Supports Quarterly Implementation Report** with data through Q2 2023.
- This report summarizes implementation trends and data for the first 18 months of both programs, January 2022 – June 2023.

Headline Numbers Through Q2 2023		
140,886	**75,834**	**167,960**
Unique Members Received ECM	Unique Members Utilized Community Supports	Community Supports Services Delivered

- To explore the full report, see ECM and Community Supports Quarterly Implementation Report (arcgis.com).

Updates on Referral and Authorization Processes

As of February 2024:

DHCS Actions Previously Taken

ECM

- Standardized authorization and re-authorization timelines.

ECM & Community Supports

- Encouraged presumptive authorization.
- Reinforced expectation that majority of referrals should be sourced from the community.

Sources: ECM and Community Supports Policy Guides

2024 Update on ECM referral and authorization standards

- DHCS has started design work to standardize ECM referrals and authorizations.
- DHCS is conducting stakeholder interviews with MCPs on their existing processes and soliciting feedback on universal ECM referral standards.
- Goal: Bring draft guidance to Collaborative Planning Implementation (CPI) Facilitators for feedback during next meeting.

ECM Policy Guide: February 2024 Updates

DHCS released an updated ECM in February 2024 on the ECM and in lieu of services (ILOS) webpage. Please refer to the ECM Policy Guide for full guidance on each of these topics.

Section	Policy Guide Update
County-Based Targeted Case Management (TCM) & ECM	» Starting July 1, 2024, Members who meet ECM") POF criteria should be enrolled in ECM and **may not enroll in ECM and County-based TCM Programs at the same time** (except as described below). » One-Year Exceptions: (1) County-based TCM for communicable diseases or (2) County-based TCM for home visiting programs for the purpose of promoting the well-being of children and families.
Dual-Eligible Members	» Updates guidance on provision of ECM for MCP Members who are enrolled in a Non-Exclusively Aligned Enrollment (EAE) Dual-Special Needs Plans (D-SNP) who have an active authorization to receive ECM at the end of 2023.
Use of Data to Monitor ECM: Healthcare Common Procedure Coding System (HCPCS)	» MCPs must require their contracted ECM Providers to submit claims for the provision of ECM services using the national standard established in the ECM and Community Supports HCPCS Coding Guidance.

Questions?

Email any questions to the CalAIMECMILOS@dhcs.ca.gov email box.

Screening and Transition of Care Tools

Alexandria Simpson

Staff Services Manager II, Medical Behavioral Health Policy

DHCS

Background and Purpose

- Previously, multiple mental health STT were in use for Medi-Cal members across the state, which led to **inconsistencies around when and how members were referred** to county networks and MCP networks.
- To **streamline this process and improve patient care**, DHCS developed standardized Screening and Transition of Care Tools for Medi-Cal Mental Health Services.

Statewide implementation of the initiative began on January 1, 2023.

Development Process

The development process for the Screening and Transition of Care Tools involved robust testing and stakeholder input, including:

- **Working groups** to inform tool development and process
- **Beta testing** to refine tools before piloting on a larger scale
- **Pilot testing** to ensure statewide applicability
- **Field testing** to identify critical issues following updates
- **Public comment** periods to solicit additional feedback

The Screening and Transition of Care Tools

The Screening and Transition of Care Tools have distinct purposes:

Adult and Youth Screening Tools: Determine the appropriate Medi-Cal delivery system for members who are ***not currently receiving mental health services*** when they contact their MCP or MHP seeking mental health services.

- Not required if a provider (e.g., a primary care physician) refers a member to an MCP or MHP based on an understanding of their needs.

Transition of Care Tool: Supports timely and coordinated care for members who are ***currently receiving mental health services*** from either the MCP or MHP when services are transitioned to or added from the other system.

Screening and Transition of Care Tools: Successes

- Increased clinical efficiency and reliability.
- Supports information exchange across delivery systems.
- Transition of Care Tools provides insight into service delivery and supports care coordination and non-duplication of services.

"Having standard forms cuts down on confusion and ensures the type of information exchanged is consistent." - MCP

Screening and Transition of Care Tools: Challenges

- Concerns that Screening Tool scores do not always match members to the appropriate delivery system.
- Difficult to track referrals and develop closed-loop workflows.
- Transition of Care Tool too long or requires double documentation.

Next Steps

- DHCS is taking steps to monitor implementation:
  - **Targeted engagement with stakeholders** to discuss how the tools are being operationalized.
  - **Working one-on-one with MCPs and MHPs**.
  - Identifying areas for **technical assistance** and/or quality improvement.

Questions?

- If you have additional questions, please email DHCS at: BHCalAIM@dhcs.ca.gov and/or MCQMD@dhcs.ca.gov
  - Subject line: “Screening and Transition of Care Tools”

Memorandum of Understanding (MOU) Updates

Amara Bahramiaref

Branch Chief, Managed Care Policy Branch

DHCS

Goals of the MOUs

The 2024 Medi-Cal Managed Care Contract (Contract) requires all MCPs to enter into MOUs with counties and third-party entities (Other Parties (OPs)) to contractually ensure the provision of whole-system, person-centered care.

DHCS Goals for Requiring MOUs

- **Establish minimum requirements** around key Contract provisions for MOUs (e.g., training, data-sharing.)
- Clarify **roles and responsibilities for coordination of the delivery of care and services** of all Members, including across MCP carved out services.
- Establish **formal processes for how MCPs and OPs will collaborate and coordinate on population health programs**, including referring and linking Members to Community Supports.
- Establish **data sharing pathways** between MCPs and OPs to support care coordination and enable robust monitoring.
- Provide mechanisms to ensure **overall oversight and accountability** for MCPs to execute MOUs with OP.
- **Provide transparency** into roles/responsibilities and relationships between MCPs and Ops.

MOU templates incorporate **existing service and program requirements into a single document** to support MCP/OPs decision-making and relationship building. Templates are more robust where DHCS has promulgated detailed policies/guidance.

MOU Requirements & Structure

The MOU Templates are part of a broader set of documents and additional items focused on the release and execution of the MOUs. These items include:

All Plan Letter (APL) and Behavioral Health Information Notices (BHIN) on MOU Requirements:

APL 23-029 and BHINs 23-056 and 23-057 explain the intent and purpose of the provisions set forth in the MOUs.

- Sets expectations of MCPs, such as an annual review of the MOU.
- Details requirements related to MOU execution and submission to DHCS.
- Lays out a monitoring plan for how DHCS will oversee MCP and Other Party's compliance with the MOU requirements.

Base MOU Template

Contains provisions that must be included in all MOUs

- Clarifies roles and responsibilities of MCP and Other Party.
- Establishes "rules of engagement" to cooperate and address disputes.
- Includes DHCS recommended optional provisions that parties may consider for execution.

MOU Requirements & Structure (cont.)

Bespoke MOU Templates

Specific to MCP and Other Party's relationship and programs applicable under the MOU:

- Contains the general and program-specific required provisions, including incorporating Other Party requirements based on existing guidance.
- Contains DHCS recommended optional provisions that parties may consider for that particular MOU.
- Links to specific polices incorporated in the MOU.

The following Bespoke MOUs are effective 1/1/2024:

- In-Home Supportive Services
- Mental Health Plans
- Drug Medi-Cal Organized Delivery System
- Regional Centers
- Local Health Departments
- County Social Services Programs and Child Welfare
- Women, Infant, & Children

The following Bespoke MOUs are effective 7/1/2024:

- Drug Medi-Cal Organized State Plan
- County-Based TCM

Overview of MOU Resources

DHCS is releasing resources to assist MCPs and OPs with implementing the MOUs

- **DHCS MOU Webpage**
  - Houses the DHCS issued APL 23-029, Base MOU Template and Bespoke MOU Templates.
  - MOU Frequently Asked Questions (FAQs) (forthcoming)
    - Provide additional guidance on the APL, Base MOU, and Bespoke MOU Templates.
    - Clarifies aspects of MOUs in response to stakeholder feedback.
    - Examples of questions answered include: "What are the optional provisions?"; "How can the parties share data?"; and "How will the MOUs be enforced?"
  - Other updates will also be posted on the webpage as they become available.

- **TA**
  - DHCS will be providing TA as needed.
  - DHCS MOU email address: MCPMOUS@dhcs.ca.gov

Base MOU Template Requirements

Every MOU template contains the following provisions as required under the Contract:

- **Definitions.** Sets forth the defined terms used in the MOU, such as the "MCP-LHD Liaison." This section also states that capitalized terms not otherwise defined in the MOU have the meaning ascribed by MCP's Contract.
- **Services Covered by This MOU.** Describes the services that MCP and the other party must coordinate for Members.
- **Party Obligations.** Describes each party's provision of services and oversight responsibilities (e.g., each party must designate a point of contact to act as the liaison for coordinating with the other party).
- **Training and Education.** Requires MCP to provide education to Members and Network Providers about Covered Services and other party's services available. MCP must also train employees who carry out responsibilities under the MOU and, as applicable, Network Providers, Subcontractors and Downstream Subcontractors on the MOU requirements and services provided by the other party.
- **Referrals.** Requires the parties to refer to each other as appropriate and describes each party's referral pathways.
- **Care Coordination.** Describes the policies and procedures for coordinating care between the parties, addressing barriers to care coordination, and ensuring ongoing monitoring and improvement of care coordination.
- **Quarterly Meetings.** Requires the parties to meet at least quarterly to address care coordination, Quality Improvement (QI) activities, QI outcomes, and systemic and case-specific concerns, and to communicate with others within their organizations about such activities.

Base MOU Template Requirements (cont.)

Every MOU template contains the following provisions as required under the Contract:

- **QI.** Requires the parties to develop QI activities specifically for oversight of the MOU requirements, including any applicable performance measures and QI initiatives, such as those to prevent duplication of services, as well as reports that track referrals, Member engagement, and service utilization.
- **Data Sharing and Confidentiality.** Requires the MCP to have policies and procedure for sharing the minimum data and information necessary to ensure the MOU requirements are met and describes the data and information the other party may share with MCP to improve care coordination and referral processes. Requires the parties to implement policies and procedures for how the minimum necessary information and data (determined by the parties) will be shared in accordance with applicable law.
- **Dispute Resolution.** Describes the policies and procedures for resolving disputes between the parties and the process for bringing the disputes to DHCS (and California Department of Social Services (CDSS) as appropriate) when the parties are unable to resolve disputes.
- **Equal Treatment.** Provides that nothing in the MOU is intended to benefit or prioritize Members over persons who are not Members also receiving services from the other party.
- **General.** Sets forth additional general contract requirements, such as the requirements that the MCP must publicly post the executed MOU, the MCP must annually review the MOU, and the MOU cannot be delegated.

2024 MOU Execution Timeline

- 1/1/2024 Requirement to Have Executed MOUs Go Live:
  - MCPs submit executed MOUs on a rolling basis.
  - MCPs are required to submit quarterly report demonstrating good faith effort and executed MOUs.

Quarter/Year	Quarterly Submission Reporting	Submission due to DHCS
Q4:2023	October 1- December 31	Last business day of December
Q1: 2024	January 1- March 31	Last business day of April
Q2: 2024	April 1- June 30	Last business day of July
Q3: 2024	July 1- September 30	Last business day of October
Q4: 2024	October 1- December 31	Last business day of January

Overview of MOU Resources

DHCS is releasing resources to assist MCPs and Other Parties with implementing the MOUs

- **DHCS MOU Webpage**
  - Houses the DHCS issued APL 23-029, Base MOU Template and Bespoke MOU Templates
  - MOU FAQs:
    - Provide additional guidance on the APL, Base MOU, and Bespoke MOU Templates
    - Clarifies aspects of MOUs in response to stakeholder feedback
    - Examples of questions answered include: "What are the optional provisions?"; "How can the parties share data?"; and "How will the MOUs be enforced?"
  - Other updates will also be posted on the webpage as they become available

- **Technical Assistance**
  - DHCS will be providing technical assistance as needed
  - DHCS MOU email address: MCPMOUS@dhcs.ca.gov

MOU's Effective January 1, 2025

- Home and Community-Based Services (HCBS) Waiver Agencies and Programs;
- Legislative and Governmental Affairs (LGA)/California Department of Corrections and Rehabilitation (CDCR), county jails, and youth correctional facilities;
- Continuums of Care;
- First 5 Programs;
- Area Agencies on Aging;
- California Caregiver Resource Centers;
- Local Education Agencies;
- Indian Health Services/Tribal Entities.

MCP MOU Execution Next Steps

To comply with the 2024 Medi-Cal Managed Care Contract requirement to enter into MOUs with counties and Other Parties (OPs), MCPs should take the following actions:

- MCPs
  - MCPs should be reaching out and forming relationships with counties/OPs.
  - MCPs and counties/OPs should commence discussions regarding executing the MOUs.
  - DHCS is aware that executing the MOUs will take time and that counties/OPs have certain processes that need to be followed, thus MCPs must demonstrate a good faith effort to meet the MOU requirements of APL 23-029 and the MCP Contract.
- DHCS
  - DHCS to finalize 2024 MOU Templates (e.g. TCM, Drug Medi-Cal State Plan Counties).
  - DHCS is developing the 2025 MOU Templates.

Questions?

Managed Care Plan (MCP) Liaisons

Dana Durham

Division Chief, Managed Care Quality & Monitoring

DHCS

Managed Care Plan (MCP) Liaisons

- **Long Term Services and Supports (LTSS) Liaison:** Serves as the day-to-day liaison to assist facilities in addressing claims and payment inquiries and assist with care transitions among the LTSS Provider community to best support Members' needs.
- **In-Home Supportive Services (IHSS) Liaison:** Serves as the day-to-day IHSS liaison to coordinate with county IHSS agency. May be assigned to the LTSS liaison.
- **Dental Liaison:** Available to Medi-Cal dental Providers to assist with referring the Member to other Covered Services.
- **MCP Child Welfare Liaison (formerly called Foster Care Liaison):** Serves as point of escalation to identify and resolve systematic and operational obstacles for accessing services and close coordination with Member's other services.
- **California Children's Services (CCS) Liaison:** Serves as the primary point of contact responsible for CCS members' care coordination.
- **Tribal Liaison:** Works with each Indian Health Care Provider (IHCP) in its Service Area and coordinates referrals and payment for services provided to Indian Members who are qualified to receive services from an IHCP.
- **Regional Center (RC) Liaison:** Coordinates with each RC to assist Members with developmental disability in understanding and accessing services, and acts as a central point of contact for questions, access and care concerns, and problem resolution, as required by W&I section 14182(c)(10).
- **Transportation Liaison:** MCP direct line for Providers and Members to receive real-time assistance directly from MCP for unresolved transportation issues.

Providing Access and Transforming Heath (PATH) – Technical Assistance (TA) Marketplace

Dana Durham

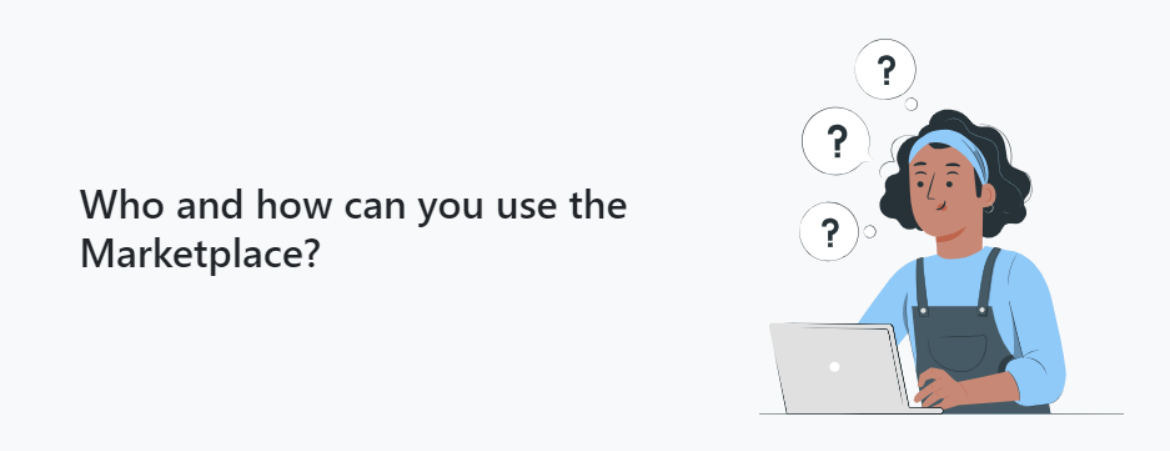
Division Chief, Managed Care Quality & Monitoring

DHCS

TA Marketplace Website Updates

To attract applicants that have not engaged in the TA Marketplace, we have made significant changes to the webpage layout and added several new features to the TA Marketplace.

- December 2023
  - Revamp of TA Marketplace homepage & secondary pages.
  - Addition of TA Vendor profile cards.
- January 2024
  - TA Marketplace Advanced Filters.



TA Marketplace Homepage

DHCS | PATH

Explore the Marketplace | Sign In

Home / Technical Assistance

Technical Assistance Marketplace

The PATH Technical Assistance (TA) Marketplace serves as a virtual marketplace for TA services, a one-stop-shop website where entities can access TA resources from curated and approved Vendors. The TA Marketplace initiative provides funding for providers, community-based organizations, counties, and others to obtain TA resources to establish the infrastructure needed to implement Enhanced Care Management (ECM) and Community Supports.

Explore the Marketplace

Experienced Vendors

Discover our experienced Vendors who have the experience and subject matter expertise to provide high-quality service on the TA Marketplace. Find trusted partners who can help you prepare to provide ECM and/or Community Supports in California.

View Vendors

Project Types

The TA Marketplace offers three project types that range from packaged projects ready for implementation to custom-designed technical support. View the different project types to find the best project type for your organization's TA needs.

Learn More

Project Domains

TA Marketplace projects are grouped into seven domains to help you find a project and TA Vendor that meets your TA needs.

View the different project domains that best fit your organization's TA Needs.

View Domains

Who and how can you use the Marketplace?

Step 1

Anyone Can Browse the TA Marketplace

Anyone can browse services on the TA Marketplace without creating an account! Browse the Marketplace and learn how to access free TA services to help implement ECM and Community Supports.

Browse Marketplace

Step 2

Find Out If I'm Eligible to Shop the TA Marketplace

While anyone can browse the TA Marketplace, you must qualify and apply to be a TA Recipient to shop and receive free TA services from the Marketplace.

Learn More

Step 3

Apply to Shop the TA Marketplace

Ready to shop? Start your application to become a TA Recipient and shop the Marketplace.

Apply Now

Step 4

Select a TA Project

After exploring the TA Marketplace, approved TA Recipients should identify the TA Project and Vendor that meets their TA needs. You can compare vendors and projects based on Vendor's unique points and client testimonials.

Step 5 (Recommended)

Connect with a Vendor

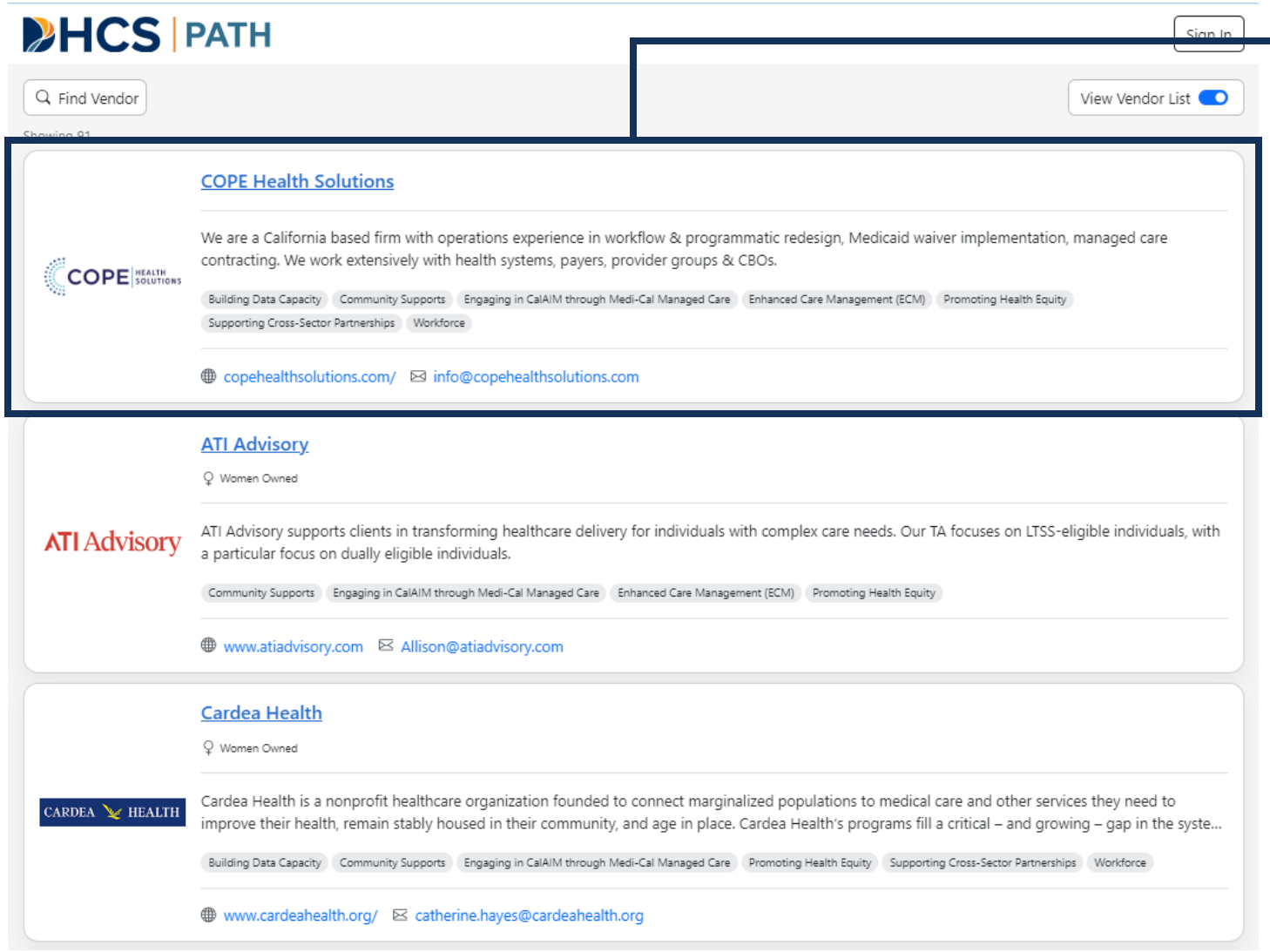
Approved TA Recipients can reach out to TA Vendors directly to discuss their ability to provide the types of TA services that their organization might need. This is highly recommended for TA Recipients that select Hands-On projects. Contact information for the TA Vendor is available on every TA Vendor Profile Page.

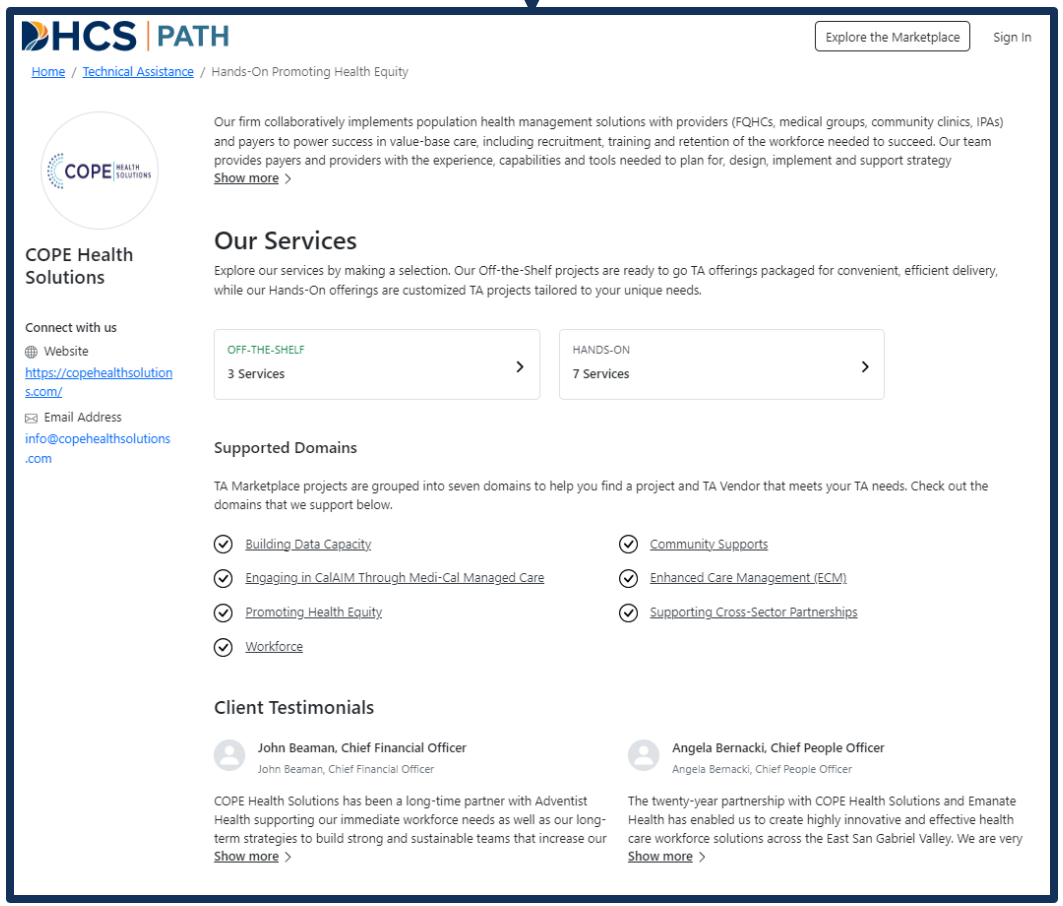
Step 6

Apply for a TA Project

Once TA Recipients have identified a TA Project and Vendor that meets their TA needs, Recipients must complete the Project Eligibility Application (PEA). The purpose of the PEA is to vet the ideas for TA Projects put forward by TA Recipients and Vendors for appropriateness within the CalAIM PATH framework.

Vendor Profile Cards





Explore the Marketplace

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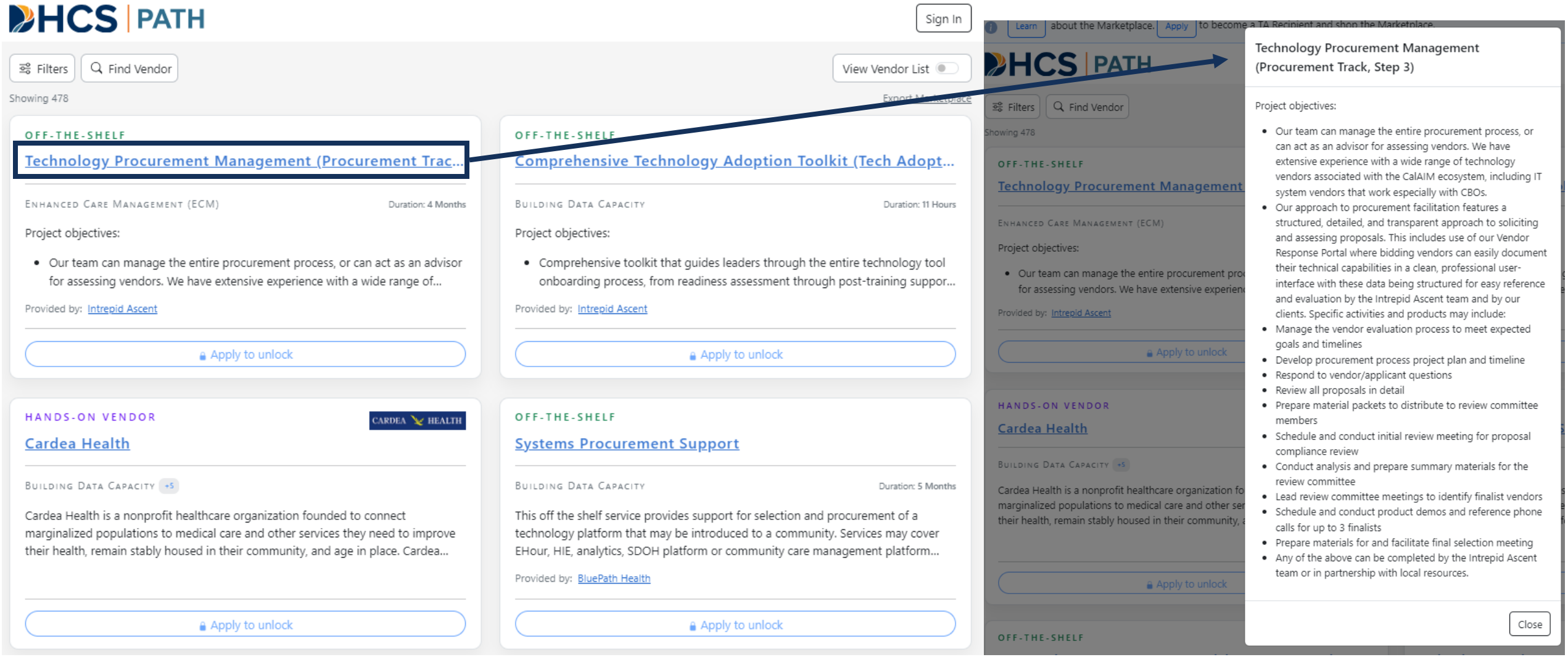
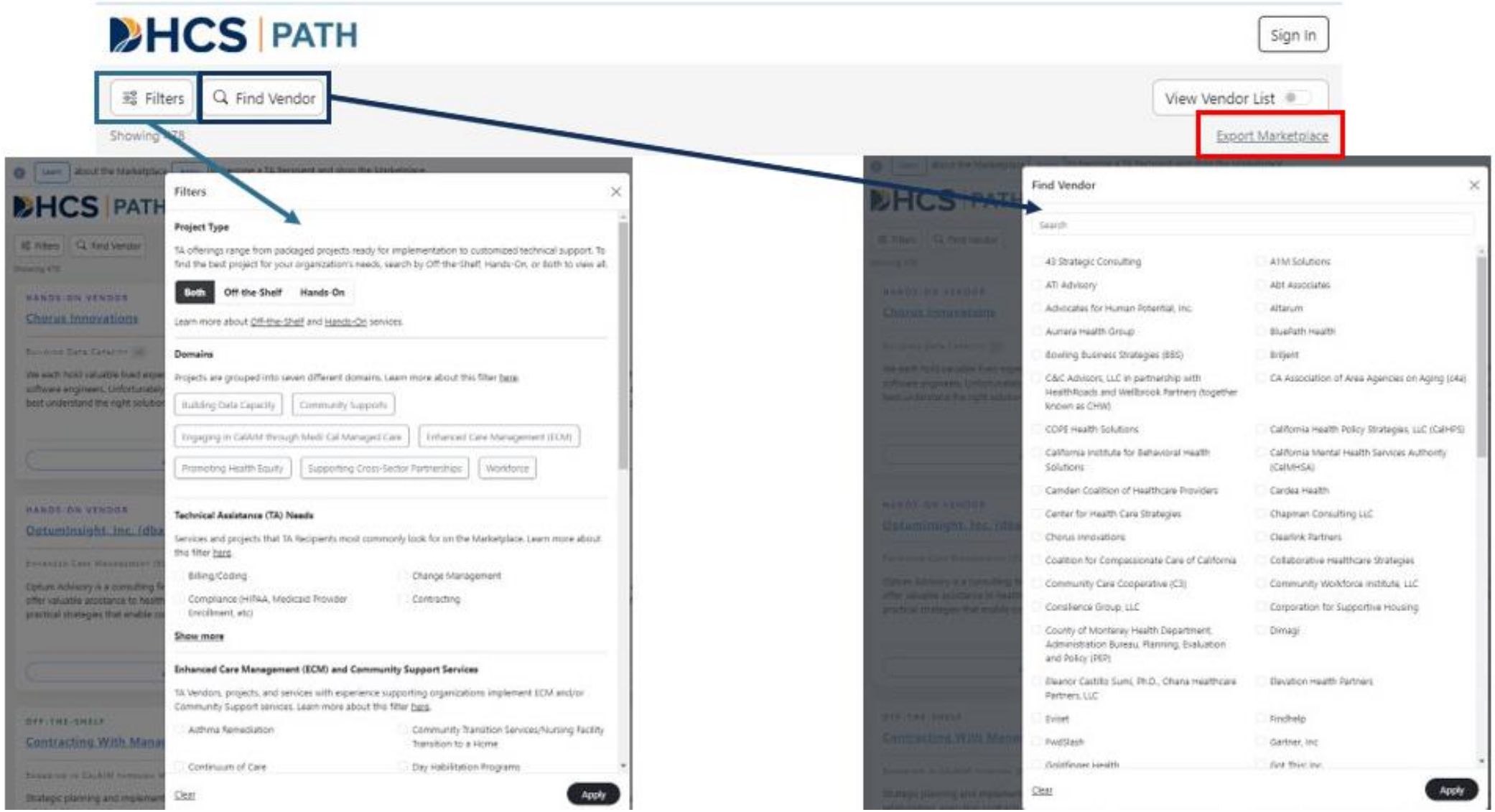
Home / Technical Assistance

Explore the Marketplace Sign In



TA Marketplace Filters



Questions?

- Visit the TA Marketplace website today! https://www.ca-path.com/ta-marketplace/marketplace
- Contact us! ta-marketplace@ca-path.com

Or scan here to visit the TA Marketplace!

Vision of The Cross (VOTC)
A Guide to Our Technical Assistance (TA) Marketplace Journey

Andrea Edwards, VOTC Program Administrator

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DHCS

VOTC & Their Mission

"To empower individuals through our uniquely designed education and counseling programs to bring healing and restoration to their lives."

- Using proven therapeutic drug and alcohol education and counseling methods.
- Designed for a peaceful, faith-based, family environment.
- We offer intensive residential recovery program for adult (and dual-diagnosed) men, women and women with children.
- Provide outpatient programs for men and women and transitional housing for men and women.
- Focus on comprehensive treatment services to heal the 'whole' person and encourage positive change.
- Clients learn skills to solve emotional and behavioral problems, address relationship issues, and improve quality of life.

Our Recovery Campus

- Unique 3.4-acre recovery campus.
- Three (3) adjacent suburban-style cul-de-sacs.
- 32-bed women's substance use residential treatment program.
- 30-bed men's residential treatment program and sober recovery residences/transitional housing (Opened May 2019).
- Outpatient & Intensive Outpatient programs.
- Transitional Housing for Women and Men (occasionally women and men with their child or children).
- Four (4) off-campus sober recovery residences/transitional housing locations.
- Total housing capacity: 180 residents.

Why the TA Marketplace?

- We discovered the TA Marketplace by error, thinking it was a condition of applying for PATH CITED Round 2 funding!
- Begin by discerning the specific requirements and desires of your organization concerning your ECM and/or Community Supports programs.
- Who doesn't love to shop for free?

What Vendors & Projects We Chose

- Vendor #1: Innovation Horizons & Health Policy Matters
  - Project #1 is for our ECM Program – "Evaluation of Care Coordination & Care Management Outcome".
  - Project #2 is for our Community Supports Program– "Enhance Care Coordination & Social Determinants of Health".
- Vendor #2: Pacific Clinics
  - Project is for our Community Supports Housing Navigators to become "Certified Housing Specialists".
- Vendor #3: University of Southern California Keck School of Medicine
  - Project is for our ECM personnel, our Medical Director (Dr. Neil Louwrens), and leadership to partake in an online "Street Medicine" training seminar.

Challenges Along The Way

- Account setup difficulty faced.
- Error in QR code provided on account setup instructions.
- Prompt resolution by TA Marketplace team.
- Account successfully created and smooth sailing since.
- Marketplace upgrade noted but still easy to navigate.

TA Marketplace Successes

- Establishing wonderful new relationships with vendors.
- Receiving an incredible ECM comprehensive assessment.
- Incorporating best practices for ECM program.
- Gaining a depth of knowledge.
- Saving time and energy by not creating internally.
- Expert advice and quality products from vendors.

Questions or Feedback?

Our journey with the TA Marketplace has been transformative, bringing positive changes to our programs and reinforcing our commitment to empowering individuals on their path to healing and restoration.

Thank you.

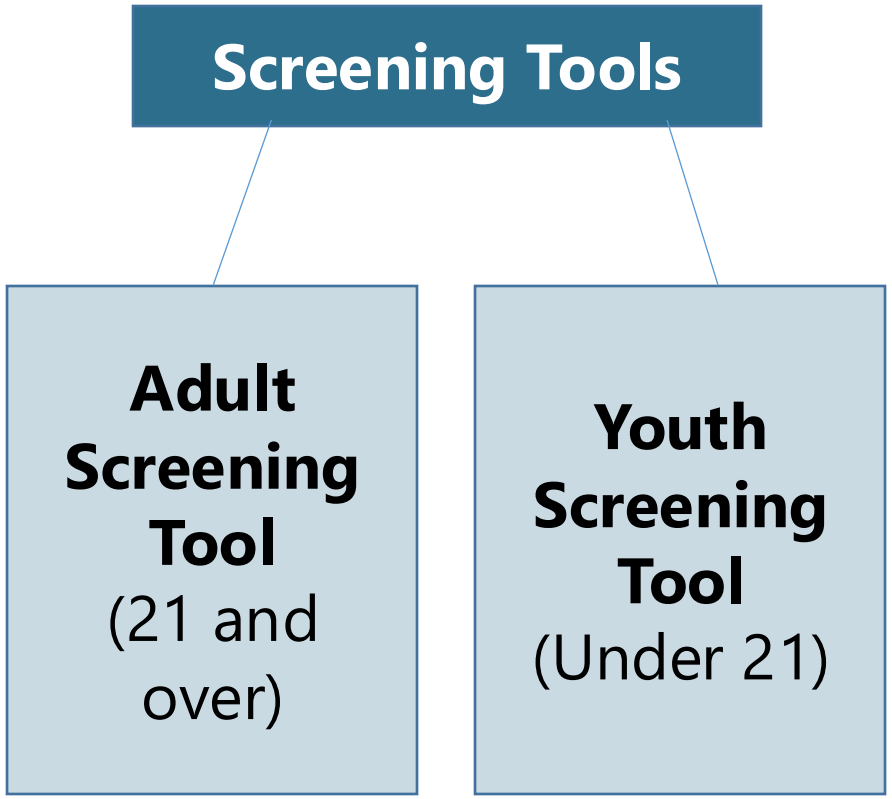
Open Discussion

If you have questions or comments, or would like to request future agenda items, please email: advisorygroup@dhcs.ca.gov.

Appendix
Screening and Transition Tools (STT)

The Screening Tools

- The **Adult and Youth Screening Tools** for Medi-Cal Mental Health Services determine the appropriate delivery system <u>for members who are *not* currently receiving mental health services</u> when they contact the Medi-Cal MCP or county Mental Health Plan (MHP) seeking mental health services.
- Distinct Screening Tools have been developed for Adults ages 21 and over and Youth under age 21.



The Screening Tools (cont.)

Instructions

Screening Questions

Scoring

Adult Screening Tool (14 questions)

- Safety
- Clinical Experiences
- Life Circumstances
- Risk

Youth Screening Tool (23 questions)

- Safety
- System Involvement
- Life Circumstances
- Risk

The Transition of Care Tool

- The **Transition of Care Tool** for Medi-Cal Mental Health (MH) Services supports timely and coordinated care for members currently receiving mental health services. This tool is used when completing a transition of services to the other delivery system (i.e., MCP to MHP or MHP to MCP) or adding a service from the other delivery system.
- A single Transition of Care Tool has been developed for all members, including Adults and Youth.

Transition of Care Tool (Adults and Youth)

Transition of Care Tool (cont.)

- Instructions
- Referring plan & care team information
- Member demographics & contact information
- Member health information
- Services requested & destination plan information

Frequently Asked Question

Q: Are the Screening Tools required when individuals are referred by a provider to an MCP for Non-Specialty Mental Health Services (NSMHS) or a Mental Health Plan (MHP) for Specialty Mental Health Services (SMHS)?

- **A:** The Screening Tools are required for use when an individual who is not currently receiving mental health services contacts the MCP/MHP **directly** to seek services.

[answer continued on next slide]

Frequently Asked Question (Cont'd)

Q: Are the Screening Tools required when individuals are referred by a provider to an MCP for NSMHS or an MHP for SMHS?

- **A: If a provider** (e.g., a primary care physician or school nurse) specifically **refers an individual** to an MCP for NSMHS or to an MHP for specialty mental health services **based on an understanding of the individual's needs, the MCP/MHP is not required to use the Screening Tools**. MCPs/MHPs should follow existing protocols for provider referrals in these scenarios.
  - For example, counties may have established referral pathways whereby schools or other service providers that have already conducted some level of screening send individuals who likely require specialty mental health services to the MHP.

[answer continued on next slide]

Frequently Asked Question (Cont'd)

Q: Are the Screening Tools required when individuals are referred by a provider to an MCP for NSMHS or an MHP for SMHS?

- **A:** Alternatively, **if a third party** (including but not limited to a health care provider) **simply connects the individual to the MCP/MHP as a resource** (e.g., gives them the MCP/MHP phone number for more information about what services may be available to them) **without having conducted a screening or brief assessment** to determine the appropriate delivery system for referral, the **Screening Tools must be used**.