Medi-Cal Managed Care Advisory Group Meeting

March 13, 2025

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Thank you for joining!

- When joining the meeting **all attendees** will be **muted.**
- Once each presenter is done, we ask that you utilize the **‘raise your hand’ function** to ask questions and request to be unmuted.
- To ask a question throughout the presentations, please send to **everyone** through chat.
- At the end of each presentation the host will read off any questions posed in chat.

Introductions and Agenda Overview

Agenda

- Community Reinvestment All Plan Letter (APL) Overview
- Population Health Management (PHM) Service: Medi-Cal Connect Updates
- Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Overview
- Justice-Involved (JI) Initiative Overview
- Providing Access and Transforming Health (PATH) Capacity and Infrastructure Transition, Expansion and Development (CITED) Round 4 Overview
- Community Supports Service Definition Refinements Overview
- Birthing Care Pathway Overview and Next Steps
- Community Advisory Committee (CAC) Overview
- Open Discussion

Community Reinvestment All Plan Letter (APL) Overview

DHCS

Released: Community Reinvestment APL

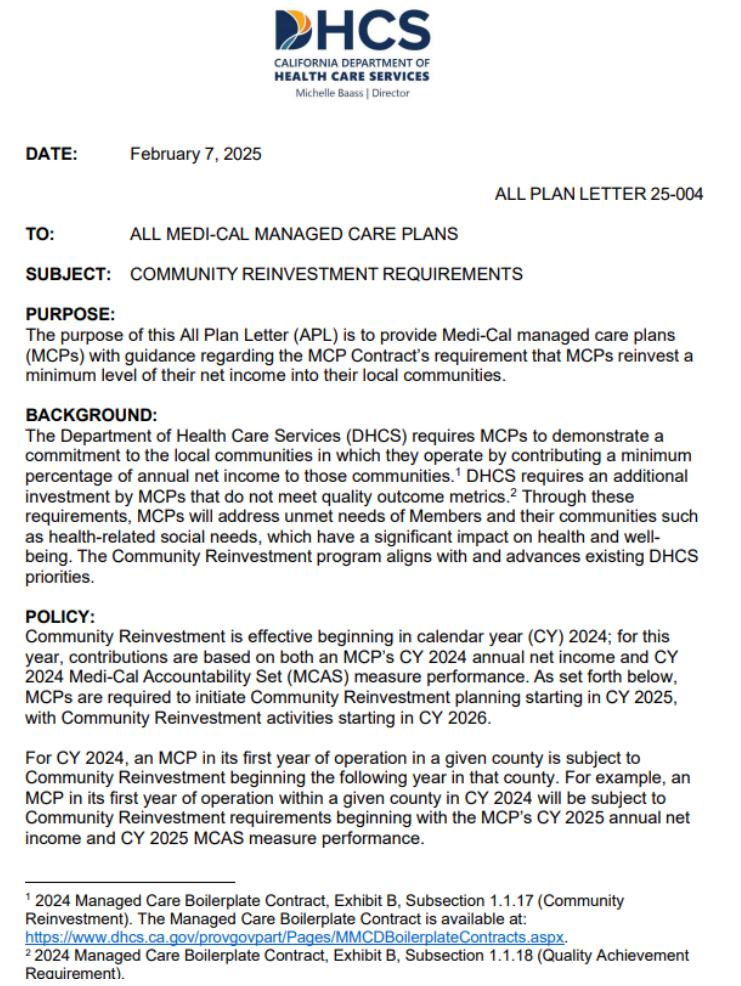
DHCS released the **Community Reinvestment All Plan Letter (APL)** on February 28th, 2025. Now live on the MCP APL Webpage!

Key Components Include:

- Guiding Principles
- Applicability to MCPs & subcontractors
- Requirements for MCPs & subcontractors
- Timeline

We appreciate your request for further discussion on the Community Reinvestment program. At the next MCAG meeting, June 12, 2025, we will provide details on:

- **MCP Approaches**: Insights into how MCPs are meeting Community Reinvestment requirements
- **Financial Impact**: Estimates on the financial impact of the Community Reinvestment initiative based on DHCS projections



DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: February 7, 2025

ALL PLAN LETTER 25-004

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: COMMUNITY REINVESTMENT REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the MCP Contract's requirement that MCPs reinvest a minimum level of their net income into their local communities.

BACKGROUND:
The Department of Health Care Services (DHCS) requires MCPs to demonstrate a commitment to the local communities in which they operate by contributing a minimum percentage of annual net income to those communities.[1] DHCS requires an additional investment by MCPs that do not meet quality outcome metrics.[2] Through these requirements, MCPs will address unmet needs of Members and their communities such as health-related social needs, which have a significant impact on health and well-being. The Community Reinvestment program aligns with and advances existing DHCS priorities.

POLICY:
Community Reinvestment is effective beginning in calendar year (CY) 2024; for this year, contributions are based on both an MCP's CY 2024 annual net income and CY 2024 Medi-Cal Accountability Set (MCAS) measure performance. As set forth below, MCPs are required to initiate Community Reinvestment planning starting in CY 2025, with Community Reinvestment activities starting in CY 2026.

For CY 2024, an MCP in its first year of operation in a given county is subject to Community Reinvestment beginning the following year in that county. For example, an MCP in its first year of operation within a given county in CY 2024 will be subject to Community Reinvestment requirements beginning with the MCP's CY 2025 annual net income and CY 2025 MCAS measure performance.

[1] 2024 Managed Care Boilerplate Contract, Exhibit B, Subsection 1.1.17 (Community Reinvestment). The Managed Care Boilerplate Contract is available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[2] 2024 Managed Care Boilerplate Contract, Exhibit B, Subsection 1.1.18 (Quality Achievement Requirement).

To learn more, please visit the Managed Care All Plan Letter webpage

Questions?

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Population Health Management (PHM) Service: Medi-Cal Connect Updates

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Agenda

- Vision | Goals | Objectives of Medi-Cal Connect
  - Release 3 Timeline Update
  - Release 3 Rollout Approach
  - User Success Story
- Release 3 Capabilities Update
  - Anticipated Data Sources
  - DHCS Dashboard Update
  - Risk Stratification, Segmentation and Tiering (RSST)
  - Stakeholder Portal Mock-Ups

Vision for Medi-Cal Connect

- To provide a data-driven business solution that supports whole-person care by integrating information from trusted partners to support population health functions and allow for multi-party data access and sharing.

Goals of Medi-Cal Connect (1/2)

The PHM Service has four primary goals supported by ten core objectives:

Member Experience:

- Streamline access
- Navigate benefits
- Reduce service gaps
- Enable self-service updates

Whole Person Care:

- View member risks and unmet needs
- Utilize risk stratification

Goals of Medi-Cal Connect (2/2)

The PHM Service has four primary goals supported by ten core objectives:

Population Level Insights:

- Facilitate data aggregation and integration.
- Act on population-level health trends and disparities.

Informed Policymaking:

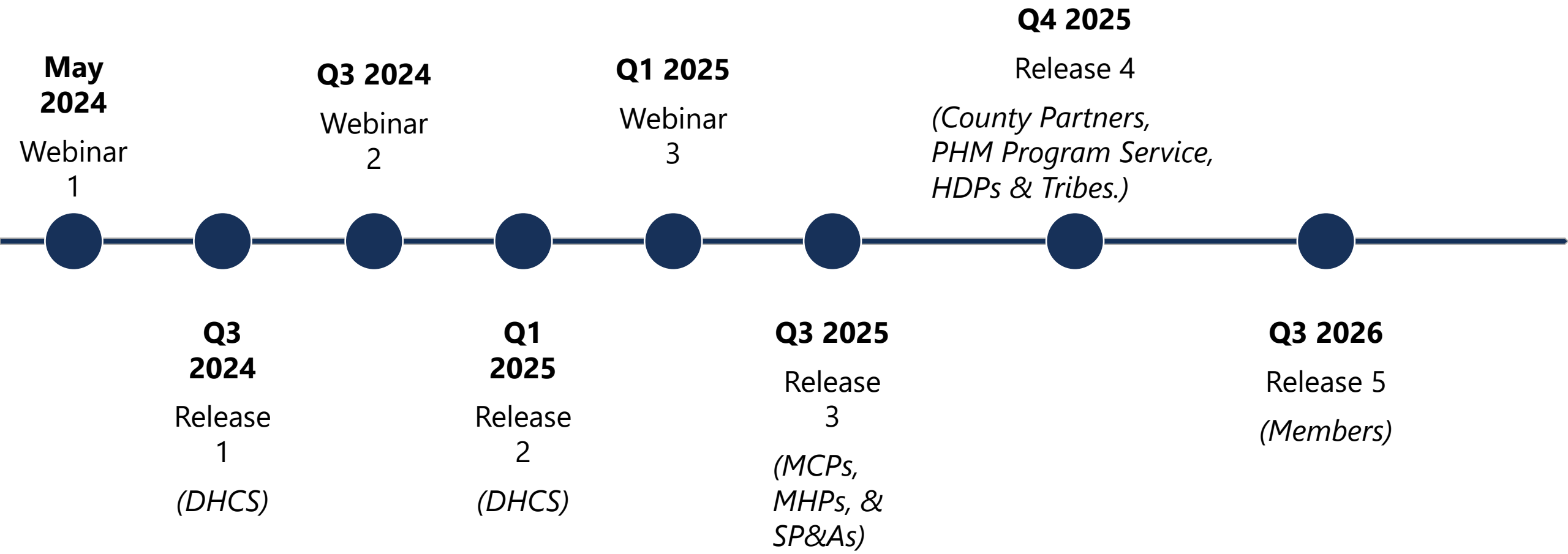
- Strengthen Medi-Cal oversight and monitoring.
- Leverage analytics and insights.

Medi-Cal Connect

Release 3 Timeline Update and Success Story

DHCS

Medi-Cal Connect Status Update



*Health Delivery Partners (HDPs), Managed Care Plans (MCPs), Mental Health Plans (MHPs), State Partners and Agencies (SP&As)

Medi-Cal Connect Success Story

Post-Release 1: Leveraging Dashboards and Taking Action

The Problem

- Dr. Patrick, who works at DHCS, is looking to **review quality measures by county**.
- He uses **Medi-Cal Connect to view dashboards** and learn about screenings and immunization rates.

The Findings

- His team noticed **Imperial County was performing better** than neighboring counties in screening and childhood immunizations.
- He reached out to Imperial County to identify county-led efforts.

The Impact

- His team **uses Medi-Cal Connect to identify counties with disparities** in childhood vaccination rates among Black/African American members, and shares with local Medi-Cal Plans what he learned from Imperial County.
- These plans could **adopt and implement similar strategies** to improve their screening and immunization rates.

Medi-Cal Connect

Release 3 Roll Out Approach

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Rollout Approach

Concept and Key Activities

Identification (Q1 2024)

- Identify and select Advisors (MCPs and Medi-Cal Behavioral Health (BH) Divisions)
  - Maximum = nine
- Kick-Off with Advisors

Active Engagement (Q2-3 2025)

- Establish re-occurring working sessions with Advisors to build validity and trust in key capabilities.
- Focus will be capabilities “show & tell”, progress testing and user adoption.
- Topics may include:
  - How do capabilities align with DHCS policy requirements
  - How is Medi-Cal Connect accessed (portal vs API)
  - How can Medi-Cal Connect used by Medi-Cal Plans internally

Testing and Launch (Q3-4 2025)

- Establish Champion Plans.
- By July 18, 2025: Release to all Medi-Cal Plans.
- Post-Launch: Establish voluntary Service Expert Users Group focused on sharing feedback and best practices to inform future technical roadmap.

Medi-Cal Connect Release 3 Capabilities:

Anticipated Data Sources

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Anticipated Data Sources

The following data sources *will* be available in Medi-Cal Connect as of Release 3:

All Medi-Cal Claims Data
(All-Payer Claims Database-Common Data Layout File):

Description: comprehensive claims data provides a detailed view of services rendered, billing codes, diagnosis, and other claims-related information.

Key Data Points:

- Medical, dental and pharmacy claims
- Provider identifiers (National Provider Identifier, first name, last name)
- Service dates
- Diagnosis and procedure codes

* RSST

Supplemental Eligibility File:

Description: Enriches the core eligibility data by adding detailed demographic and contact information, improving the accuracy and depth of member data.

Key Data Points:

- Member demographics
- DHCS Contact information
- Some data for specific programs or services (duals)

Medi-Cal Connect Generated Data:

Description: Medi-Cal Connect will be a new data source upon launch by generating several member insights or member characteristics to support care coordination.

Key Data Points:

- Member Flags (i.e. likely eligible for Enhanced Care Management (ECM) Community Supports)
- RSST* risk tiers
- Evidence of underutilization

Medi-Cal Connect Release 3 Capabilities:

DHCS Dashboard Update

DHCS

Reminder: Key PHM Dashboards (1/2)

The following dashboards will be available to Medi-Cal Plan Users by Release 3 and are currently available to DHCS users as of Release 2*. Development is in progress and mock-ups will be shared with Advisors as part of engagement.

Condition Prevalence Dashboard

- Intended to provide insight into the **prevalence of clinical conditions** and related utilization of services.
- Users will explore and evaluate utilization metrics for subpopulations relative to selected comparison groups.

Quality Measures Dashboard

- **Intended to analyze quality performance** for a given calendar year and initiative.
- The dashboard may be configured to allow "drill downs" into **member level data.**

Health Equity Dashboard

- Intended to analyze and **monitor existing knowledge about disparities** for a given calendar year and Health Equity Key Area to support the evolving DHCS strategy for health equity.

*Excluding RSST

Reminder: Key PHM Dashboards (2/2)

The following dashboards will be available to Medi-Cal Plan Users by Release 3 and are currently available to DHCS users as of Release 2*. Development is in progress and mock-ups will be shared with Advisors as part of engagement.

RSST Dashboard

- Intended to **track distribution of the risk tiers** within the Medi-Cal program, including statewide averages, regional averages, population and MCP specific averages, and tiering thresholds for each subdomain.

Care Management Demographics

- Intended to provide demographic data on members receiving ECM and Community Support services.

*Excluding RSST

Medi-Cal Connect Release 3 Capabilities:

RSST

DHCS

RSST

- **RSST is a state-wide, transparent, standardized risk tiering mechanism that enables MCPs to proactively identify members who may benefit from services or interventions.** Information about a Medi-Cal member will be used by the RSST algorithm to determine a member's risk tier. The risk tiers correspond to the likelihood of a negative health event or outcome occurring to an individual in the next year.

RSST Continued

Medi-Cal Member Data:

- Member data will be inputted into the algorithm (e.g., claims data, demographics, utilization).

RSST Algorithm:

- The machine learning algorithm will predict the risk that the member will experience an adverse outcome.

Risk Tiers:

- The algorithm will be translated to risk tiers, which will help guide and inform care management.
- Risk tiers include Low, Medium, and High.
- High-Risk: MCPs will be required to conduct assessment for high-risk members per PHM Policy.

Advantages of a state-wide RSST Algorithm (1/2)

MCPs are currently required to design and maintain their own methods for stratifying their members. Each member must be stratified at least annually. When Medi-Cal Connect is live, **MCPs will be required to use RSST as a baseline**, which can be supplemented with local data, to connect Members to services.

- **Consolidates data from various sources** to create a more comprehensive patient profile and risk tier.
- Provides a **standard process for defining high-risk individuals**, helping address care gaps.
- Provides a uniform method to **ensure members are tiered consistently**, regardless of plan assignment.

Advantages of a state-wide RSST Algorithm (2/2)

MCPs are currently required to design and maintain their own methods for stratifying their members. Each member must be stratified at least annually. When Medi-Cal Connect is live, **MCPs will be required to use RSST as a baseline**, which can be supplemented with local data, to connect Members to services.

- **Incorporates social risk** to provide a more complete understanding of patient needs.
- **Supports systematic identification**, ensuring all members in need are assessed, not just high-cost members.
- Provides the foundation for DHCS to better understand and **improve care for high-risk members**.

Questions?

DHCS

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Overview

DHCS

Federal Approvals to Transform BH Care in Medi-Cal

In mid-December, DHCS received approval from the Centers for Medicare & Medicaid Services (CMS) for the transformative BH-CONNECT initiative. BH-CONNECT grows out of our understanding of the lived experience of Californians with BH needs and data-driven analysis of available services.

- BH-CONNECT seeks to transform California's behavioral health delivery system by **expanding access to highly effective community-based services, strengthening the BH workforce,** and **ensuring Medi-Cal members receive high quality care**.
  - CMS approved key elements of BH-CONNECT through a new Section 1115 demonstration and a series of new State Plan Amendments (SPAs).
- As part of the BH-CONNECT Section 1115 approval, CMS also approved **Transitional Rent services** to ensure members going through vulnerable periods are stabilized, reducing their risk of returning to institutional care or experiencing homelessness.
- California also received approval to ensure **eligibility for reentry services** conforms with new federal rules and to align the provision of several Community Supports with CMS' updated health-related social needs services framework through updates to the California Advancing and Innovating Medi-Cal (CalAIM) Demonstration.

Why BH-CONNECT?

- BH-CONNECT is at the center of multi-pronged BH initiative.
- Prior to BH-CONNECT's approval, California has **invested nearly $15 billion in state funds** and launched **landmark policy reforms** improve access and strengthen the continuum of care:
  - The **CalAIM**
  - The **Children and Youth Behavioral Health Initiative** (CYBHI)
  - The **Behavioral Health Transformation**
  - The **Behavioral Health Continuum Infrastructure Program**
  - The **Behavioral Health Bridge Housing**
  - **Mobile Crisis Services**
  - **988 Suicide and Crisis Lifeline**
- BH-CONNECT offers financing for initiatives through a combination of a **Medicaid 1115 Demonstration**, new **SPA**s, and **updates to state guidance**.

Goals of BH-CONNECT

BH-CONNECT aims to:

- Expand the continuum of community-based services and evidence-based practices (EBPs)
- Strengthen family-based services and supports
- Improve access, health outcomes, and invest in delivery system reforms
- Strengthen the BH workforce
- Access federal funds for short-term stays in facility-based care
- Support successful transitions to community-based care and reintegration
- Promote improved health outcomes
- Ensure stability for members going through vulnerable periods

Key BH-CONNECT Federal Approvals

Section 1115 Demonstration Approvals:

- Workforce Initiative
- Activity Funds
- Access, Reform and Outcomes Incentive Program
- Community Transition In-Reach Services
- Short-term Inpatient Psychiatric Care, including in Institutions for Mental Disease (IMDs)
- Transitional Rent

SPA Approvals:

- Assertive Community Treatment (ACT)
- Forensic ACT (FACT)
- Coordinated Specialty Care for First Episode Psychosis
- Clubhouse Services
- Individual Placement and Support Model of Supported Employment
- Enhanced Community Health Worker (CHW) Services

** Transitional Rent coverage will be available in the Medi-Cal Managed Care delivery system.*

Other Components of BH-CONNECT

Leveraging Existing Authorities & State-Level Guidance:

- Centers of Excellence to support fidelity implementation of EBPs
- Clarification of coverage of evidence-based child and family therapies, including Multisystemic Therapy, Functional Family Therapy, Parent-Child Interaction Therapy, and High-Fidelity Wraparound
- Initial joint child welfare/specialty mental health visit
- County Child Welfare Liaison role within Medi-Cal MCPs
- Implementation of CMS milestones related to quality of care for patients of inpatient and residential facilities

Other Components of BH-CONNECT

Leveraging Existing Authorities & State-Level Guidance

- Centers of Excellence to support fidelity implementation of EBPs
- Clarification of coverage of evidence-based child and family therapies, including Multisystemic Therapy, Functional Family Therapy, Parent-Child Interaction Therapy, and High-Fidelity Wraparound
- Child and Adolescent Needs and Strengths Alignment
- Initial joint child welfare/specialty mental health visit
- County Child Welfare Liaison role within Managed Care Plans
- Implementation of CMS milestones related to quality of care for patients of inpatient and residential facilities

Enhancing the Continuum of Care (CoC) (1/3)

BH-CONNECT builds upon other investments to strengthen the continuum of BH care in California.

- Prevention & Wellness Services
- Outpatient Services
- Intensive Outpatient Treatment
- Peer & Recovery Services
- Community Services & Supports
- Crisis Services
- Inpatient & Residential Treatment

Cross-Cutting Initiatives:

- Infrastructure Investments
  - (BH Transformation)
- Workforce Initiatives
  - (BH-CONNECT, BH Transformation)
- Statewide Incentive Programs
  - BH Quality Improvement Program; BH-CONNECT; Access, Reform, and Outcomes Incentive Program

Enhancing the CoC (2/3)

On this slide and the next, BH-CONNECT initiatives are in **bold**

- **Prevention and Wellness Services:**
  - **Activity Funds;** Children and Youth BH Initiative; Student BH Incentive Program; Dyadic Services; Wellness Coaches
- **Outpatient Services:**
  - Updated Access Criteria; Documentation Redesign; No Wrong Door; Payment Reform; Standardized Screening and Transition tools; Administrative Integration; Justice-Involved Initiative; Contingency Management; DHCS Opioid Response
- **Intensive Outpatient Treatment Services:**
  - **Clarification of Evidence-Based Therapies for Children and Families ACT; FACT; Coordinated Specialty Care for First-Episode Psychosis**; Community Assistance, Recovery and Empowerment Act

Enhancing the CoC (3/3)

- Inpatient Residential Treatment Services:
  - **Enhanced Quality of Care in Psychiatric Hospitals and Residential Settings; Predischarge Care Coordination Services; Strategies to Decrease Lengths of Stay in Emergency Departments**
- Crisis Services:
  - Psychiatric Residential Treatment Facilities; Mobile Crisis Services; CA Bridge Program; CalHOPE; 988 Lifeline
- Community Services & Supports:
  - **Supported Employment; Clubhouse Services; Transitional Rent; Community Health Worker Services**
  - BH Bridge Housing
  - ECM
  - Community Supports
  - Traditional Healers
- Peer and Recovery Services:
  - **Peer Support Services**

Implementation Timeline

DHCS will implement the BH-CONNECT demonstration using a phased approach beginning January 2025. Behavioral Health Plans (BHPs) and MCPs may opt in to participate in select initiatives on a rolling basis.

January 2025 (*Demonstration Effective*)

- BHPs opt-in on a rolling basis: IMD opportunity, BH-CONNECT EBPs, Community Transition In-Reach Services
- Launch Access, Reform and Outcomes Incentive Program
- Develop guidance on evidence-based family therapies
- Identify Centers of Excellence to support training and fidelity monitoring

July 2025

- Launch Activity Funds
- Launch Workforce Initiative
- Implement initial joint child welfare/behavioral health visit
- MCPs may cover Transitional Rent as an optional benefit

January 2026

- MCPs must cover Transitional Rent as a mandatory benefit for BH Population of Focus (POF) Coverage for other eligible populations remain optional

December 2026

- Implement service to track availability of inpatient and crisis stabilization beds

Questions?

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Justice Involved (JI): Federal Requirements Under Consolidated Appropriations Act of 2023

DHCS

Federal Consolidated Appropriations Act of 2023

- The Federal Consolidated Appropriations Act (CAA), passed in December 2022, includes two provisions that impact incarcerated youth populations:

- **Section 5121:** Requires pre- and post-release case management and screening/diagnostic services for post-disposition youth, is mandatory for all states.
- **Section 5122:** Gives states the option to cover full scope Medicaid for pre-disposition youth.
- Source: CMS, "Provision of Medicaid and CHIP Services to Incarcerated Youth," 24-004 State Health Official Letter (July 23, 2024).

Mandatory Requirement: Section 5121

Under Section 5121 of the CAA, Medicaid and CHIP programs must provide certain services to Medicaid/CHIP eligible youth who are incarcerated post-disposition.

- In the 30 days prior to release, or within one week or as soon as practicable after release, certain screenings and diagnostic services in accordance with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements for Medicaid or the approved CHIP state plan, including behavioral health screenings or developmental, vision, hearing and dental screening, diagnostic services, and appropriate immunizations to eligible juveniles who are post adjudication in public institutions.
- In the 30 days prior to release and for at least 30 days post release, targeted case management (TCM) services for Medicaid, and case management services otherwise available under the approved CHIP state plan. This includes referrals to appropriate care and services in the geographic region of the home or residence for the eligible juvenile, where feasible.

Because of the significant overlap of this requirement and the JI Reentry Initiative, DHCS received approval from the federal government to subsume this requirement into the JI Reentry Initiative. *More information in next section.*

Optional Provision: Section 5122

Under Section 5122, states have the option to provide full scope Medicaid and CHIP coverage to eligible youth who are incarcerated in a public institution during the pre-disposition (e.g., pre-adjudication) period.

- California, like most states across the country, intends to first roll-out the Reentry Initiative, which will subsume the CAA Section 5121 requirements, as described in subsequent slides.
- As DHCS implements this Demonstration in all facilities, DHCS will assess where Reentry Initiative operational implementation is going well and where there are opportunities for improvement.
- Throughout the course of this assessment, DHCS will analyze and evaluate options and considerations related to implementation of the CAA.

DHCS will continue to work with the state's probation departments to determine the best course of action for this optional provision.

Alignment of CAA and JI Reentry Initiative Requirements

CAA Required Services and Impacted Populations

Required Services and Alignment Approach

- Coverage for certain screenings and diagnostic services in accordance with Medicaid requirements – including behavioral health screenings or developmental, vision, hearing and dental screening and diagnostic services will be covered under the JI Reentry Initiative clinical consultation service.
- Coverage of case management services in accordance with Medicaid requirements prior to release and for at least 30 days post release will be covered under the JI Reentry Initiative case management service.

Impacted Populations

- Medicaid/CHIP eligible youth who are:
- Under 21 or
- Former foster youth up to age 26

AND

- Post-adjudication

Correctional facilities will be deemed to meet CAA requirements if they receive approval/conditional approval during the Readiness Assessment process to go-live with JI Reentry Initiative services.

Reentry Initiative and CAA Crosswalk: Eligible Populations

JI Reentry Initiative

Pre/Post-Adjudication

- Adults, children, and youth who are:
- Enrolled in Medicaid or CHIP;
- Incarcerated pre- or post-adjudication; and,
- Adults who are diagnosed with a mental illness; substance use disorder (SUD); a chronic condition; intellectual/developmental disability (I/DD); traumatic brain injury (TBI); HIV/AIDS; or are pregnant or postpartum. Youth do not need to meet a health care need criteria.

CAA Mandatory Youth Reentry Services (§ 5121)

Post-Adjudication

- Children and youth who are:
- Enrolled in Medicaid or CHIP;
- Under 21 years old or between 18 and 26 under the mandatory former foster care eligibility group; and,
- Incarcerated post-adjudication.

Implications for California

- To establish full alignment, DHCS updated the definition of youth from incarcerated in a youth correctional facility to any youth who meets the CAA age definition of youth.
- Because the CalAIM Initiative is for pre- and post-adjudicated individuals, correctional facilities will not need to distinguish between these populations.

Reentry Initiative and CAA Crosswalk: Scope of Facilities

JI Reentry Initiative / CAA Mandatory Youth Reentry Services (§ 5121)

- State prisons (CDCR)
- County jails
- Youth correctional facilities

Implications for California

Scope of facilities is already aligned across Reentry Initiative and CAA.

Reentry Initiative and CAA Crosswalk: Scope of Services

JI Reentry Initiative

- Services include:
- Care management
- Physical and behavioral health clinical consultation services;
- Laboratory and radiology services
- Medications and medication administration
- Medications for SUD
- CHW services
- 30-day supply of medications and DME at release

CAA Mandatory Youth Reentry Services (§ 5121)

Mandatory services include:

- Targeted case management (TCM) in 30 days pre-release and for at least 30 days post-release
- Screening and diagnostic services 30 days pre-release (including behavioral health screenings or developmental, vision, hearing and dental screening, diagnostic services, and appropriate immunizations)

Implications for California

CAA services (care management and screening and diagnostic services) are closely aligned with the JI Reentry Initiative services. Correctional facilities are responsible for ensuring access to all screening and diagnostic services (including dental exams and appropriate immunizations) for CAA eligible youth.

Deeper Dive: Care Management Service Definition

The JI Reentry Initiative will fully subsume the Case Management service requirements under CAA 5121.

JI Reentry Initiative Care Management Overview

- Comprehensive health risk assessment
- Development of a reentry care plan

CAA Mandatory Youth Reentry Services (§ 5121) Case Management Overview

- Needs Assessment
  - Comprehensive needs assessments (health, behavioral health, health-related social needs)
- Care Plan
  - Development of a person-centered care plan—including social, educational, and other underlying needs

Deeper Dive: Care Management Service Definition

The JI Reentry Initiative will fully subsume the Case Management service requirements under CAA 5121.

JI Reentry Initiative Care Management Overview

- Facilitate warm handoffs and/or behavioral health links to post-release case managers and community-based services.
- Schedule/arrange necessary appointments for services provided in the community.
- Coordinate stabilizing treatment prior to release.

CAA Mandatory Youth Reentry Services (§ 5121) Case Management Overview

- Care Coordination
  - Referrals and related activities (e.g., appointment scheduling) to link individuals to needed services in the community

Deeper Dive: Care Management Service Definition

The JI Reentry Initiative will fully subsume the Case Management service requirements under CAA 5121.

JI Reentry Initiative Care Management Overview

- Follow-up with the individual and community-based providers to ensure post-release engagement was made with individual no later than 30 days from release.
- Obtaining of informed consent, when needed, to furnish services and/or share information.

CAA Mandatory Youth Reentry Services (§ 5121) Case Management Overview

- Follow-Up: Monitoring and follow-up activities (e.g., follow-up with service providers) to ensure the care plan is implemented.
- Informed Consent: Not applicable - This is an additional requirement under the JI Reentry Initiative.

Deeper Dive: Case Management Pre- and Post-Release Timing

JI Reentry Initiative
Care management timing requirements

Pre-Release Timing: 90 days prior to expected release

Post-Release Timing:

- ECM providers should meet the individual within two business days of release. A second follow-up appointment is also required within one week of release (Refer to **Section 13.5 of the Policy and Operational Guide** for more information).
- Post-release ECM authorized for 12 months post-release for all managed care members.
- FFS members will receive case management in the community under FFS Bundle 5 for 28 calendar days post-release(Refer to **Section 10.2.e of the Policy and Operational Guide** for more information).

CAA Mandatory Youth Reentry Services (§ 5121)
Case management timing requirements

Pre-Release Timing: 30 days prior to expected release

Post-Release Timing: At least 30 days post-release

Facilities will be able to bill for all services, inclusive of CAA services, during the 90-day pre-release period. If screening and diagnostic services occur at intake and outside 90-day pre-release window, these services cannot be billed to Medicaid; individuals should only be re-screened in the pre-release period as clinically appropriate.

Deeper Dive: Screening and Diagnostic Services Definitions

The JI Reentry Initiative will fully subsume the Case Management service requirements under CAA 5121.

JI Reentry Initiative Clinical Consultation Review

- Screening Services
  - Physical, behavioral health, and dental examinations
- Diagnostic Services
  - Behavioral health assessments, physical health evaluations and some procedures, and immunizations

CAA Mandatory Youth Reentry Services (§ 5121) Case Management Overview

- Screening Services
  - Comprehensive health, developmental history, and unclothed physical examinations
  - Appropriate vision, hearing, and lab testing
  - Dental screening services
- Diagnostic Services
  - Diagnosis of defects in vision and hearing, dental, and immunizations

Deeper Dive: Screening and Diagnostic Services Definitions

The JI Reentry Initiative will fully subsume the Case Management service requirements under CAA 5121.

JI Reentry Initiative Clinical Consultation Review

- Treatment
  - Outpatient clinician services to treat or stabilize individuals, such as behavioral health therapy, physician-administered medications, or the prescribing of medications.

CAA Mandatory Youth Reentry Services (§ 5121) Case Management Overview

- Treatment
  - N/A - This is an additional requirement under the JI Reentry Initiative.

Questions?

DHCS

Providing Access and Transforming Health (PATH) Capacity and Infrastructure Transition, Expansion, and Development (CITED) Round 4 Overview

DHCS

CITED Overview: Refresher

- The CITED initiative offers grant funding to providers, Community Based Organizations (CBOs), county agencies, hospitals, Tribes and Indian health care providers, and others that are contracted or plan to contract with a managed care plan for capacity and infrastructure needs for ECM and Community Supports.
- Application windows are available in rounds. CITED is currently in Round 4 **open until May 2, 2025.**
- Eligible applicants can apply for funding through the PATH Third-Party Administrator's website here: https://www.ca-path.com/cited.

PATH CITED Round 4: Funding Priorities

DHCS will prioritize Round 4 applications related to:

- County-Specific ECM/Community Support gaps
- Statewide ECM/Community Support gaps
  - Birth Equity, Justice-Involved, and Transitional Rent
- Tribes and Indian health care providers
- Rural counties
- Entities operating in counties with lower funding in prior CITED rounds
- Entities serving individuals whose primary language is not English
- Local CBOs
- Counties providing Transitional Rent

PATH CITED Round 4 Open Window

Application Opened

January 6, 2025

CITED Round 4 Awardees Announced

Fall 2025

May 2, 2025

Deadline to apply is 11:59 p.m. PST

Helpful Links for PATH CITED Round 4 Application

- Guidance Document
- Application
- Funding Request Workbook
- Sample ECM/Community Supports Budget
- Sample Hub Budget
- Sample Day Habilitation Budget
- GrantsConnect FAQ

All resources can be found on the PATH CITED webpage

Contact Us

- cited@ca-path.com
- 1115Path@dhcs.ca.gov
- (866) 529-7550
- PATH CITED Website

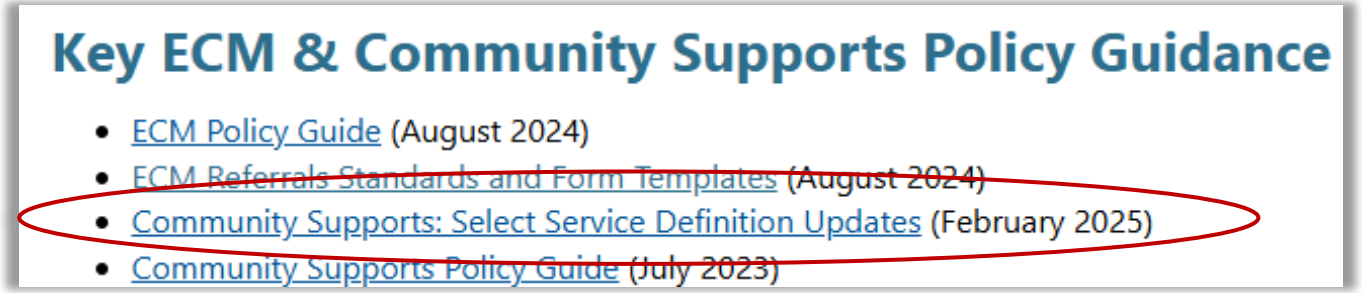
Questions?

DHCS

Community Supports: Select Service Definition Refinements

DHCS Releases Refined Community Supports Service Definitions

- **DHCS has released refined service definitions for four Community Supports:**
  - Nursing Facility Diversion/Transition to Assisted Living Facilities (ALFs)
  - Community Transitions/Nursing Facility Transition to a Home
  - Asthma Remediation
  - Medically Tailored Meals/Medically Supportive Foods
- These new service definitions will be **effective July 1, 2025**.
  - Note: Select components of Asthma Remediation go into effect January 1, 2026.
- The bundle on the DHCS Community Supports website includes the updated service definitions and a summary of the changes with corresponding stakeholder feedback for each Community Support.



Refinement Highlights

Nursing Facility Transition/Diversion to ALFs

DHCS aims to increase utilization of the Nursing Facility Transition/Diversion to ALFs with additional clarifications on service components, eligibility, and overlap with other housing-related Community Supports and 1915(c) waivers.

Context Leading to Revisions

- Nursing Facility Transition/Diversion to ALFs continues to be one of the least utilized Community Supports (429 Members in Q2 2024).
- Stakeholders have requested that DHCS clarify several aspects of this service definition, including eligibility criteria, service components, and overlapping enrollment with other Community Supports, 1915(c) waivers, and the California Community Transitions.

Revision Highlights

- Clearly outline that the Community Support includes two components that must be made available to Members: transition services and expenses **and** ongoing assisted living services.
- Clarified that Members transitioning from public subsidized housing and Members already residing in an ALF who meet Nursing Facility Level of Care are eligible for the Community Support.
- Clarified enrollment with other Community Supports (e.g. Housing Transition Navigation) and Assisted Living Waiver.

Community Transition Services/Nursing Facility Transition to Home

DHCS aims to increase utilization of the Community Transitions Service with additional clarifications on service components, allowable expenses and overlap with other housing-related Community Supports.

Context Leading to Revisions

- Community Transition Services continues to be one of the least utilized Community Supports (241 Members in Q2 2024).
- DHCS received requests to clarify eligibility and to further specify allowable expenses under the one time set up expenses to support Members in establishing a household when they transition from a nursing facility.

Revision Highlights

- Clearly outline that the Community Support includes two components – transition services and household set up expenses up to a $7,500 lifetime maximum.
- Household set up expenses can include security deposits, utility set up fees, pest eradication, one time cleaning fees, heaters, air conditioners as necessary to establish a household.
- The service definition also clarifies overlap policy with key Community Supports (e.g., Housing Transition Navigation, Housing Deposits, Home Modifications).

Asthma Remediation

DHCS' vision is that the Asthma Remediation Community Support will become a wraparound service for physical modifications and supplies relative to the Asthma Preventive Services (APS) Benefit.

Context Leading to Revisions

- As originally launched, the Asthma Remediation Community Support included assessment, self-management education, and home remediations.
- Launched in 2023, the APS Benefit also covers one asthma self-management education and two in-home environmental trigger assessments.
- Community Supports should supplement, not supplant, state plan services.

Revision Highlights

- In-home environmental trigger assessments and asthma self-management education will be phased out of coverage under Asthma Remediation Community Support, effective January 1, 2026. Both services will be covered under the APS Benefit.
- Asthma Remediation will cover physical modifications and supplies.
- DHCS strongly encourages MCPs to work with Providers to streamline access to the Community Support from the APS Benefit. *(MCP Technical Assistance session in March)*

Medically Tailored Meals (MTM)/Medically Supportive Food (MSF)

DHCS heard the need to improve the standardization and quality of MTM/MSF interventions based on stakeholder feedback and continue to refine the Community Support in alignment with national standards.

Context Leading to Revisions

- As originally launched, the MTM/MSF services did not include specific descriptions or expectations for each “medically tailored” or “medically supportive” service, leading to disparate interpretations and implementation across the state.
- Without clear standards for evaluating the quality and evidence base of MTM/MSF services, MCPs face challenges overseeing providers.
- Stakeholders provided feedback that the original eligibility criteria were broad and ambiguous, allowing varying interpretations by MCPs and Providers.
- CMS released an updated Health Related Social Needs Framework Bulletin in December 2024 that includes requirements for states to establish protocols to ensure that MCPs and MTM/MSF Providers are delivering high quality services that are appropriately tailored to address the nutrition-sensitive health conditions.

Medically Tailored Meals/Medically Supportive Food

DHCS aims to increase the provisions of evidence-based MTM/MSF services to individuals with nutrition-sensitive conditions that can be positively impacted by MTM/MSF services.

Revision Highlights:

- Eligibility Criteria has been streamlined to **focus eligibility solely on whether the Member has a nutrition-sensitive health condition** appropriate for MTM/MSF services.
- "Medically Tailored" and "Medically Supportive" Service packages must be **designed specifically for the identified target nutrition-sensitive health conditions.**
- **Medically tailored services must include an individual nutrition assessment conducted or overseen by an RDN** to inform the development of a nutritional plan and connection to the appropriate evidence-based medically tailored services for the Member. Medically tailored services must also at least two-thirds of the daily nutrient and energy needs of an average individual.
- **Medically supportive service food package design must follow evidence-based guidelines** appropriate for the targeted condition and be overseen/signed off by an RDN or another appropriate clinician
- Nutrition Education **may not** be provided as a standalone service
- **Provider and Meal/Food Package Oversight requirements** are outlined for MCPs to ensure Members receive high quality and effective MTM/MSF services.

Next Steps

- July 1, 2025: Refined Service Definitions Take Effect
- *Refinements to Housing Trio + Transitional Rent to be released in April 2025*

Questions?

Questions can be submitted CalAIMECMILOS@dhcs.ca.gov using the email subject line “Community Supports Service Definitions”

Break
Return @ 11:50

Birthing Care Pathway Overview and Next Steps

DHCS

Agenda

- Birthing Care Pathway Development and Community Engagement
- Birthing Care Pathway Policy Roadmap
- Looking Ahead
- Transforming Maternal Health (TMaH) Model Update
- Q&A

Birthing Care Pathway Development and Community Engagement

DHCS' Vision for Maternity Care in Medi-Cal

With the launch of the Birthing Care Pathway, DHCS envisions a future in which:

- Medi-Cal members have access to a comprehensive menu of maternity care providers and services, regardless of where they live.
- Members can access risk-appropriate care and are empowered to choose the provider team and birthing location that align with their needs and preferences.
- All members feel respected and heard throughout their pregnancy and postpartum journeys.
- Members are educated about the services available to them and receive the navigational support they need for all aspects of their care.
- Behavioral health services and social supports are accessible to all members, their newborns, and their families.
- Data collection and sharing are improved to strengthen care for pregnant and postpartum members.

Birthing Care Pathway

» Comprehensive **policy and care model roadmap** that will cover the journey of all pregnant and postpartum Medi-Cal members from conception through 12 months postpartum

» Roadmap includes a series of **policy solutions that address members' physical, behavioral, and health-related social needs**

» Goals include **reducing maternal morbidity and mortality** and **addressing significant racial and ethnic disparities**

Report Overview

DHCS published the **Birthing Care Pathway Report** in February 2025.

The Report:

- Summarizes the current state of maternal health in Medi-Cal
- Shares findings from Birthing Care Pathway Medi-Cal member engagement
- Provides an overview of partner engagement conducted to date
- Discusses the policies DHCS has implemented/is implementing for the Birthing Care Pathway and shares progress to date
- Identifies strategic opportunities for further exploration

The Birthing Care Pathway is generously supported by the California Health Care Foundation and the David & Lucile Packard Foundation.

Report Development

To develop the Birthing Care Pathway DHCS:

- **Conducted a landscape assessment** to review California's existing maternal health policies and initiatives, and identify evidence-based programs, policies, and interventions
- **Engaged Medi-Cal members** through a Member Voice Workgroup, interviews, and member journaling to ensure their lived experiences shaped the design of the Birthing Care Pathway
- **Interviewed** more than 25 state leaders, providers, CBOs, associations, health plans, and advocates to inform the design of the Birthing Care Pathway
- **Launched** the **Clinical Care Workgroup, Social Drivers of Health Workgroup,** and **Postpartum Sub-Workgroup** to identify challenges and opportunities in perinatal care and develop and validate policy options for the Birthing Care Pathway

Engaged Medi-Cal Members

- DHCS engaged 30 members who were either currently pregnant or up to 24 months postpartum to share their lived experience.
- Medi-Cal members were selected to represent a diversity of experiences, especially the lived experiences of groups that experience health disparities.

Activity	Description
Interviews	Conducted **1:1 interviews** with **six** members.
Journaling	Invited **six** members to submit five biweekly **journal entries** about their perinatal experience.
Member Voice Workgroup	Launched a **Member Voice Workgroup** with **18** members and held three workgroup meetings.
All members were compensated for their participation.	

Birthing Care Pathway Medi-Cal Member Engagement Key Findings (1 of 2)

- **Feeling respected and heard by health care providers is critical** to a member's perinatal experience in Medi-Cal. Members often feel that their birth plans and breastfeeding choices are not respected. However, members feel like midwives and doulas listen to their needs and preferences.
- Some members **experienced discrimination in their health care encounters** during all three perinatal phases. Members felt connected to their health care providers and better supported when they received racially concordant care.
- **Key moments for trust building with members are often missed**, particularly around mindful discussions on behavioral health screening results and referrals to services, trauma-informed approaches to intimate partner violence (IPV) screenings, smooth hospital discharges after birth, and timely access to high-quality breast pumps.

Birthing Care Pathway Medi-Cal Member Engagement Key Findings (2 of 2)

- Medi-Cal members often felt like the **onus was on them to independently navigate and coordinate many aspects of their perinatal care** – ranging from coordinating their care across different health care providers to ensuring Medi-Cal coverage for themselves and their newborns.
- **Finding mental health providers that accept Medi-Cal, are taking new patients, and have perinatal experience is difficult**. Medi-Cal members want more frequent and intensive mental health supports.
- Medi-Cal members often **do not understand what Medi-Cal benefits and public benefits/social services are available** to them in pregnancy or during the postpartum period (e.g., doula services; ECM; Women, Infants, and Children Program (WIC)/CalFresh; and transportation services).

Key Informant Interviews

DHCS interviewed more than 25 state leaders, perinatal care providers, advocates, and representatives from CBOs, associations, and health plans to inform the development of the Birthing Care Pathway.

Category	Interviewees
Provider Associations	Representatives from the American College of Obstetricians and Gynecologists (ACOG), California Nurse-Midwives Association, and California Association of Licensed Midwives.
Individual Providers	OB/GYNs; family and addiction medicine physicians; certified nurse midwives (CNM); licensed midwives (LM); freestanding birth center (FBC) providers; pediatricians; reproductive psychiatrists; lactation consultants, doulas, and CHWs.
County Leaders	Representatives from Black Infant Health, WIC, and Maternal, Child, Adolescent Health programs.
CBO Leaders & Advocates	Individuals focused on LGBTQ+ health; IPV services; and birth justice and supports for Black, American Indian/Alaska Native, and Pacific Islander individuals.

Birthing Care Pathway Workgroups

Workgroup	Participant Charges	Composition
Clinical Care	Identifying what needs to happen in the hospital, birthing center, provider office, and other community settings from a Medi-Cal member's perspective.	Physicians; midwives; lactation consultants; doulas; Tribal health providers; FBC, behavioral health, and federally qualified health center (FQHC) providers; MCPs; and local public health.
Social Drivers of Health	Identifying best practices and needs from programs and providers that currently work to address perinatal health-related social needs.	CHWs; doulas; violence prevention organization representatives; local public health and social service program representatives; home visitors; and providers with Black birthing expertise.
Postpartum Sub-Workgroup	Designing a clinical pathway for what providers can do during the postpartum period to achieve positive health outcomes.	Cross-representation from the Clinical Care and Social Drivers of Health Workgroups, as well as additional physicians.

All three workgroups met throughout 2023 and 2024 to discuss key challenges with the Medi-Cal birthing experience and provide feedback on proposed policy solutions. Workgroup members who indicated financial barriers to participation were compensated for each meeting they attended.

Birthing Care Pathway Partner Engagement Key Findings (1 of 2)

- Access to maternity hospitals in rural communities is **rapidly diminishing.**
- Midwives and lactation consultants face **barriers to Medi-Cal provider enrollment and reimbursement**, impeding member access.
- Limited qualified providers and long appointment wait times hinder access to **perinatal behavioral health care.**
- Improved collaboration, integration, and data sharing among perinatal providers and health systems are needed to deliver **coordinated care** to pregnant and postpartum Medi-Cal members.
- The **group care model** provides a team-based, whole-person approach to birthing care and builds community.

Birthing Care Pathway Partner Engagement Key Findings (2 of 2)

- **The Comprehensive Perinatal Services Program (CPSP) should be modernized** to bolster access to comprehensive perinatal services to all pregnant and postpartum members.
- Pregnant members are not consistently being connected to **providers and facilities that meet their risk level.** Screenings should be updated and streamlined to better assess a member's risk level, connect members to services, and prevent screening fatigue.
- There are **limited housing programs** available to pregnant Medi-Cal members.
- **Medi-Cal members would benefit from additional educational resources** on how to navigate the perinatal period.

Additional Input for the Birthing Care Pathway

DHCS received additional input on the Birthing Care Pathway from maternity care and social services providers, state leaders, MCP representatives, Tribal health providers, local public health, and birth equity advocates.

Tribes and Indian Health Program (IHP) Representatives

Medi-Cal MCPs

Midwifery Access California

Local Maternal, Child, and Adolescent Health Directors

DHCS Doula Implementation Stakeholder Workgroup

Birthing Care Pathway Policy Roadmap

Birthing Care Pathway Policy Roadmap

Policies DHCS Has Implemented/Is Implementing

10 completed

27 in progress

5 not started

The Report also includes **Strategic Opportunities for Further Exploration** which **require additional assessment and planning to determine if implementation is feasible and would be contingent on external factors** (e.g., additional state budget resources).

Focus Areas of Policies DHCS Has Implemented/Is Implementing (1/2)

- **Provider Access and MCP Oversight:** Expanding access to a range of maternity providers – including doctors, midwives, and doulas; enhancing oversight of maternity services delivered through Medi-Cal MCPs; and improving communication to Medi-Cal members on available benefits and provider types.
- **BH:** Enhancing trauma-informed care and increasing access to mental health and substance use services.
- **Risk Assessment:** Identifying pregnant and postpartum Medi-Cal members who are high risk and connecting them to needed services and supports; and strengthening intimate partner violence screening.
- **Care Management and Social Drivers of Health:** Delivering whole-person care; addressing social needs, including housing and nutrition; and strengthening partnerships with community providers that have perinatal expertise.

Focus Areas of Policies DHCS Has Implemented/Is Implementing (2/2)

- **JI Care:** Facilitating enrollment in Medi-Cal and ensuring access to services before and after release from prison or jail.
- **Payment Redesign:** Increasing reimbursement rates for a range of maternity care providers and supporting value-based maternity care.
- **Data and Quality:** Building integrated systems for data sharing; supporting cross-enrollment of Medi-Cal members into crucial safety net supports; and creating new performance metrics to improve the quality of Medi-Cal maternity care.
- **State Agency Partnerships:** Coordinating across different California programs for maternal health – such as home visiting and Paid Family Leave – to boost member awareness and access.

Focus Areas of Strategic Opportunities for Further Exploration

The opportunities for future discussion for the Birthing Care Pathway are in the following six focus areas:

- Provider Access and MCP Oversight and Monitoring
- BH
- Maternal Care Models and Access
- Provider Resources
- Data and Quality
- State Agency Partnerships

Looking Ahead

Continued Community Engagement on Birthing Care Pathway

- The Birthing Care Pathway is a **multi-year initiative.**
- **DHCS aims to continue to engage a diverse set of partners** to implement and further develop the Birthing Care Pathway.

Transforming Maternal Health (TMaH) Model Update

TMaH Model Overview

In January 2025, the federal CMS announced California as one of 15 states selected to implement the **TMaH Model**.

- TMaH is a **ten-year delivery and payment model** designed to test whether evidence-informed interventions, sustained by a **value-based payment (VBP) model**, can improve maternal outcomes and reduce Medicaid and CHIP program expenditures.
- DHCS will implement TMaH in five Central Valley counties: **Fresno, Kern, Kings, Madera, and Tulare.**
- DHCS will receive **$17 million in federal funding** and targeted technical assistance.

TMaH Model Partners

- DHCS will partner with providers, care delivery locations, and other partner organizations, including MCPs and CDPH, to implement various TMaH elements in the model test region. DHCS has already been engaging with many of these partners through the Birthing Care Pathway.

Partner Providers:

- OB/GYNs, midwives, physicians, maternal-fetal medicine specialists, nurses, and other clinical and support staff, such as doulas, lactation consultants, and perinatal CHWs.

Partner Care Delivery Locations:

- Hospitals, OB/GYN and family medicine practices, safety set providers (FQHCs and RHCs), Tribal sites, birth centers, and other sites of care.

Partner Organizations:

- MCPs, CDPH, California Maternal Quality Care Collaborative (CMQCC), California Perinatal Quality Care Collaborative (CPQCC), Pregnancy-Associated Review Committee (PARC), universities, CBOs, and other non-clinical partners.

TMaH Model Timeline

Pre-Implementation Period: Model Years 1-3 January 2025-December 2027	Implementation Period: Model Years 4-10 January 2028-December 2034
» Model Years 1-3: DHCS receives technical assistance to develop the TMaH Model and achieve pre-implementation milestones. » Model Year 3: Infrastructure payments are made to providers.	» Model Years 4-10: DHCS implements the TMaH Model » Model Year 4: Quality & Performance Incentive Payments are made to eligible providers. » Model Year 5: DHCS will transition to a VBP model.

Questions?

Contact us at BirthingCarePathway@dhcs.ca.gov with any questions.

Community Advisory Committee (CAC) Overview

DHCS

CAC Background

- Historically, Medi-Cal MCPs have been required to maintain a CAC, which had served to inform the MCPs cultural and linguistic services program.
- DHCS has enhanced existing processes and created new channels, including the CAC, to improve engagement opportunities for Medi-Cal Members, families, and the community.
- DHCS has worked to elevate the MCPs CACs to maximize participation and involvement by clarifying:
  - The CACs role in providing feedback
  - Member composition of the CAC
  - The MCPs role in planning and facilitating meetings in order to maximize participation and involvement
- The CAC is intended to empower Medi-Cal Members to become active participants in their care and for necessary stakeholders to be involved in the feedback loop.

CAC Selection Committee

- MCPs are required to convene a selection committee and must demonstrate a good faith effort to ensure that the selection committee is comprised of a variety of persons as listed in the MCP contract to bring different perspectives, ideas, and views to the CAC.
- The selection committee is required to:
  - Ensure CAC membership is composed of the MCP's members and reflective of the general member population in the MCP's service area including specific groups as listed in the contract
  - Ensure diverse and hard-to-reach populations are represented on the CAC, emphasizing on persons that are representative of or serving populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities
  - Should a CAC member resign, reach their term limit (if applicable), or be otherwise unable to serve on the CAC, the MCP must make its best effort to promptly replace the vacant seat within 60 calendar days of the vacancy

CAC Coordinator

- MCPs are required to designate a CAC coordinator. The coordinator may be an employee of the MCP, subcontractor, or Downstream Subcontractor but must not be a member of the CAC or a member enrolled with the MCP.
- The CAC coordinator duties include, but are not limited to:
  - Ensuring CAC meetings are scheduled, and agendas are developed with the input of the CAC
  - Conduct outreach, recruitment, and onboarding of new members
  - Actively facilitating communications and connections between the CAC and MCP leadership, including ensuring CAC members are informed of decisions relevant to the work of the CAC
  - Ensuring that CAC meetings are accessible to all participants
  - Ensuring compliance with all CAC reporting and public posting requirements

CAC Meeting Requirements

- Meetings must be held at least quarterly.
- Meetings are open to the public, and MCPs are required to post meeting information on MCPs website 30 calendar days prior to the meeting.
- MCP must provide necessary tools and materials to run meetings, including, but not limited to, making the meetings accessible and providing accommodations to allow individuals to attend and participate in the meetings.
- Written meeting minutes must be posted on MCPs website and submitted to DHCS no later than 45 calendar days after each meeting.

CAC Duties

- Identifying and advocating for Preventive Care practices to be utilized by MCP
- Participate in developing and updating cultural and linguistic policy
- Advise on necessary Member or Provider targeted services, programs, and trainings
- Provide recommendations to MCPs regarding the cultural appropriateness of communications, partnerships, and services
- Review Population Needs Assessment (PNA) findings and have a process to discuss improvement opportunities with an emphasis on Health Equity and Social Drivers of Health
- MCP must provide sufficient resources for the CAC to support the required CAC activities outlined above, including supporting the CAC in engagement strategies such as consumer listening sessions, focus groups, and/or surveys
- MCP must demonstrate and provide a feedback loop to show that CAC input is considered in annual reviews and updates to relevant policies and procedures

Topics Reviewed by the CAC

- Culturally appropriate service or program design
- Priorities for health education and outreach program
- Member satisfaction survey results
- Findings of the PNA
- Plan Marketing Materials and Campaigns
- Communication of needs for Network development and assessment
- Community resources and information
- PHM
- Quality
- Health Delivery Systems Reforms to improve health outcomes
- Carved Out Services
- CoC
- Health Equity
- Accessibility of Services

CAC Reporting

- MCPs must submit an Annual Demographic Report by April 1, each year, which contains
  - Demographic composition, diversity of members, data sources
  - Barriers and challenges to aligning CAC membership with service area demographics
  - Efforts to address barriers and challenges
  - Description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped MCP initiatives and/or policies

Questions?

DHCS

Open Discussion

If you have questions or comments please email: advisorygroup@dhcs.ca.gov

Appendix: Birthing Care Pathway

Appendix: Policies DHCS Has Implemented/Is Implementing

Provider Access and MCP Oversight and Monitoring (1 of 4)

Problem Statements

- **Limited racial and ethnic diversity of maternity care providers** in Medi-Cal today.
- Members face **delays in obtaining breast pumps.**
- **Smoother hospital discharges are needed after birth.**

Policy Solutions	Status
Leverage CalHealthCares education **loan repayment program** to build pipeline and increase diversity of OB/GYN and family medicine workforce.	In Progress
Streamline requirements and improve access to a range of **high-quality breast pumps**.	In Progress
Create guidance and/or technical assistance for MCPs on supporting pregnant and postpartum members **transferring to different care settings and levels of care**.	In Progress

Provider Access and MCP Oversight and Monitoring (2 of 4)

Problem Statements

- Members and providers are often **unaware of the full array of available maternity care services.**

Policy Solutions	Status
Create and enhance **member-facing communications materials** and outreach strategies on perinatal Medi-Cal benefits and provider types to bolster awareness during and after pregnancy.	In Progress
Issue a **standing recommendation for doula services** for all pregnant and postpartum Medi-Cal members to increase access to doula services and launch a **Doula Directory** for use by Medi-Cal members, providers, and MCPs to identify doulas in their community/network.	Completed
Establish a **Doula Implementation Stakeholder Workgroup** comprised of doulas, Black birthing justice experts, Tribal representatives, local health departments, advocates, and provider associations to inform DHCS' doula benefit design and reimbursement approach.	In Progress

Member Fact Sheets

Doctors, Midwives, and Doulas: Finding the Right Care Team for Your Pregnancy

Doctors, Midwives, and Doulas:

Finding the Right Care Team for Your Pregnancy

Medi-Cal

Do you think you might be pregnant? Choose your care team early to help you navigate your pregnancy and birthing journey. Medi-Cal pays for medical professionals (like doctors and midwives), doulas, and other care providers to help with your needs.

	Who They Are:	What They Do:
	**DOCTORS, like OB-GYNS and some Family Doctors** Medical professionals who help with every part of pregnancy, including prenatal checkups, childbirth, and postpartum care.	» Specialize in maternal health, providing checkups, tests, and prescriptions » Monitor high-risk pregnancies » Usually deliver babies in hospitals » Can perform surgeries (like C-sections)
	**MIDWIVES** Specially trained health professionals who care for people with healthy, low-risk pregnancies—including prenatal checkups, childbirth, and postpartum care. Some midwives are also nurses.	» Provide prenatal checkups, advice, and emotional support » Support personalized approaches to pregnancy and childbirth » Can deliver babies in hospitals, birth centers, or at home » Do not perform surgeries (like C-sections)
	**DOULAS** Birth workers who help with physical, emotional, and non-medical support before, during, and after birth. They do not provide medical treatment or deliver babies.	» Teach you about pregnancy, childbirth, and caring for a newborn » Empower you and help you speak up for what you want during pregnancy and childbirth » Provide breathing, relaxation, and other support during childbirth

Ready to support a healthy pregnancy and start your baby's journey off strong?

Scan the QR code or visit **https://www.dhcs.ca.gov/services/Pages/Maternal-Perinatal.aspx** to learn more about picking the right care team for you and your family.

Services for Pregnant People and New Parents

Services for Pregnant People and New Parents

Medi-Cal

If you have Medi-Cal and are pregnant or just had a baby, you have access to free health care and services to keep you and your baby healthy and safe.

Medi-Cal Programs and Services

Health Care
Medi-Cal covers health care for you and your baby—from pregnancy until at least one year postpartum. That includes labor and delivery, doctor visits, hospital stays, emergency care, medical supplies, medications, family planning, dental, vision, and more.

Care Coordination
Get help managing your health care before and after your baby is born, including follow up doctor's visits, rides to the doctor, and specialty care referrals.

Mental Health & Addiction
Talk to a therapist and get help for common issues like postpartum depression or anxiety, mental health needs, or alcohol and drug treatment.

Classes for Health, Childbirth & Parenting
Learn how to stay healthy during pregnancy, make a birth plan, and take care of your new baby.

Breastfeeding & Nutrition
Get help with breastfeeding coaching, free breast pumps, nutrition counseling, and vitamins.

Community Supports
If you qualify, you can get help with housing, healthy food, and other needs along with your health care.

American Indian Maternal Support Services
American Indian mothers can get health care, education, emotional support, and home visits before and after having a baby.

Other Programs and Services

Paid Family Leave
Get up to eight weeks of paid leave for each parent to care for your family within a 12-month period.

Women, Infants, and Children
Get healthy foods, breastfeeding help, and checkups for you and your baby.

CalFresh
For members who want to add to their budget to put healthy and nutritious food on the table.

Black Infant Health
Black pregnant and postpartum people can get both one-on-one and group help.

Ready to support a healthy pregnancy and start your baby's journey off strong?

Scan the QR code or visit **www.dhcs.ca.gov/services/Pages/Maternal-Perinatal.aspx** to explore these free services and find the right support for you and your family.

Provider Access and MCP Oversight and Monitoring (3 of 4)

Problem Statements

- Members and providers are often **unaware of the full array of available maternity care services.**

Policy Solutions	Status
Survey MCPs on promising practices to promote covered perinatal benefits among members and providers and reduce administrative burden for providers.	In Progress
Consolidate and update Medi-Cal perinatal policies through a single All Plan Letter and update provider manuals **to clearly define perinatal benefits and provider enrollment requirements** for midwives, birth centers, and doulas. Encourage MCPs to incentivize network providers to offer group perinatal care models to members.	In Progress

Provider Access and MCP Oversight and Monitoring (4 of 4)

Problem Statements

- Medi-Cal provider enrollment requirements created **potential barriers for midwives participating in Medi-Cal.**
- **Downstream subcontracting arrangements** can create barriers to perinatal services.

Policy Solutions	Status
Remove administrative barriers to Medi-Cal provider enrollment and reimbursement requirements **for midwives** by ensuring alignment with state licensing and scope of practice requirements.	Completed
Clarify MCP **network adequacy requirements for CNMs, LMs, and FBCs** as mandatory provider types and strengthen thresholds that must be met.	In Progress
Enhance oversight of network agreements and/or delegated arrangements for maternity/perinatal care services to ensure covered benefits are clearly outlined.	In Progress

Behavioral Health and Trauma-Informed Care (1 of 2)

Problem Statements

- Members face **challenges accessing timely behavioral health care** with limited mental health providers who accept Medi-Cal, are taking new patients, and have perinatal experience.

Policy Solutions	Status
Raise awareness of CYBHI ongoing investments to **provide behavioral health services to children and their parents**.	Completed
Review MCP and behavioral health contracts to identify opportunities for **strengthening existing language to ensure pregnant and postpartum members have access to qualified behavioral health providers**.	In Progress

Behavioral Health and Trauma-Informed Care (2 of 2)

Problem Statements

- Some providers are **confused around how long a pregnant or postpartum member can receive residential SUD treatment.**
- **Trauma can negatively impact a member's physical and mental health outcomes,** relationships with health care providers, and adherence to treatment.

Policy Solutions	Status
Reinforce communication of **existing Medi-Cal coverage policy of no maximum stay** (e.g., 60 days) **for members** – including pregnant and postpartum members – **receiving residential SUD treatment**.	Completed
Update and disseminate SUD Perinatal Practice Guidelines for providers that deliver SUD treatment to pregnant and parenting women.	Completed
Reframe services in a trauma-informed context, acknowledging how care needs to be delivered to pregnant and postpartum members who are experiencing or have experienced Adverse Childhood Experiences (ACEs), IPV, community violence, and racism.	In Progress

Risk Stratification and Assessment

Problem Statements

- **Lack of standardization for how MCPs use risk stratification algorithms,** employ risk tiers, and connect members to services.
- **IPV screening is inconsistent** with limited follow-up care or support.

Policy Solutions	Status
Develop an RSST process in Medi-Cal Connect to identify pregnant and postpartum members who are high risk. The RSST will identify members who may benefit from connections to additional social support and clinical care.	In Progress
Incorporate IPV screening as part of Medi-Cal assessments performed by providers and clinical care managers.	In Progress

Medi-Cal Maternity Care Payment Redesign (1 of 2)

Problem Statements

- Partners explained that **Medi-Cal's reimbursement rates for licensed and non-licensed maternity care providers are not high enough** to incentivize participation in Medi-Cal.
- The existing FQHC and rural health clinic (RHC) reimbursement methodology **does not incentivize clinics to provide dyadic services.**

Policy Solutions	Status
Increase rates for maternity care providers and enhance supplemental payments for Labor-and-Delivery and hospital-based birthing center services.	Completed
Expand Quality Incentive Pool for Designated Public Hospitals and District and Municipal Public Hospitals.	Completed
Strengthen implementation of dyadic services by establishing an alternative payment methodology (APM) allowing FQHCs, RHCs, and Tribal Health Programs (THP) to be reimbursed for dyadic services at the Medi-Cal fee-for-service (FFS) reimbursement rate in addition to the FQHC/RHCs' Prospective Payment System (PPS) reimbursement rate and THPs' All-Inclusive Rate (AIR) for an eligible visit.	In Progress

Medi-Cal Maternity Care Payment Redesign (2 of 2)

Problem Statements

- FBCs and midwives providing home births face **challenges being recognized and reimbursed for their birthing approaches.**
- Providers are not incentivized to **appropriately transfer a patient to a higher level of care** based on their needs.

Policy Solutions	Status
Redesign how Medi-Cal pays for maternity care services to create a new birthing care payment model that rewards value-based care, incentivizes best practices for pregnant and postpartum members, and supports the goals of the Birthing Care Pathway.	In Progress
Develop billing/reimbursement guidance for Medi-Cal providers as well as MCPs and their subcontractors on LM services, including home births, and FBC services.	Not Started

Care Management and Social Drivers of Health (1 of 3)

Problem Statements

- **Homelessness and housing insecurity** contribute to adverse maternal and infant outcomes.

Policy Solutions	Status
Encourage utilization of Transitional Rent under the California BH-CONNECT Section 1115 waiver demonstration as a Community Supports service **for eligible Medi-Cal members** – i.e., those who (1) meet one or more of the qualifying clinical risk factors (e.g., pregnancy and up to 12 months postpartum), are (2) experiencing or at risk of homelessness, and (3) fall within one or more of the transitioning populations (e.g., transitioning out of a hospital after giving birth).	In Progress
Encourage **MCPs to consider working with facilities that offer rooming in with short-term post-hospitalization stays** to provide Recuperative Care (medical respite) or Short-Term Post-Hospitalization Housing to members experiencing homelessness and who meet clinical criteria.	Not Started

Care Management and Social Drivers of Health (2 of 3)

Problem Statements

- **ECM and Community Supports providers** serving pregnant and postpartum members **need perinatal expertise.**
- Some **members are unaware of what ECM and Community Supports cover** and how they can find out if they are eligible.

Policy Solutions	Status
Conduct outreach to WIC, **home visitors, CBOs, and county behavioral health and nutrition services providers with perinatal expertise** to become ECM providers.	In Progress
Encourage **MCPs to build partnerships with IPV CBOs** to serve as ECM and Community Supports providers.	Not Started
Encourage **MCPs to partner with housing providers that meet the needs of perinatal populations** from pregnancy through 12-months postpartum **to serve as ECM and Community Supports providers**.	Not Started

Care Management and Social Drivers of Health (3 of 3)

Problem Statements

- Providers need **technical assistance, support, and educational materials around the ECM Birth Equity POF** as well as **education on which Community Supports can best support** their patients.

Policy Solutions	Status
Expand ECM referral pathways, particularly from social services and BH providers, for pregnant and postpartum members.	In Progress
Leverage **PATH** to support ECM Birth Equity providers by providing technical assistance and prioritize ECM Birth Equity providers for **CITED** **Initiative awards**.	Completed

Perinatal Care for Justice-Involved Individuals

Problem Statements

- While some jails provide medications for opioid use disorder (MOUD) during pregnancy, many individuals are **abruptly discontinued** from these medications postpartum.

Policy Solutions	Status
Ensure pregnant and postpartum individuals are **enrolled in Medi-Cal pre-release**.	Completed
Ensure eligible pregnant and postpartum individuals **receive 90-day pre-release services**.	In Progress
Encourage **connection to ECM upon release**.	In Progress

Data and Quality (1 of 2)

Problem Statements

- California **does not have a statewide technology platform for maternity care providers, programs, and MCPs to easily and safely share patient data** and help members manage their medical, behavioral, and social needs.
- Eligibility and enrollment **data sharing across public benefits and programs are inconsistent** in California causing gaps in care and service delivery.

Policy Solutions	Status
Leverage Medi-Cal Connect to support whole person care and provide population insights by **safely sharing integrated health care and social data and insights about members among providers, delivery systems, programs, and state agencies** that support Medi-Cal members.	In Progress
Leverage learnings from pilot programs aimed at **cross-enrolling Medi-Cal members into crucial safety net supports** upon pregnancy through 12-months postpartum to inform strategies to facilitate cross-enrollment and the ongoing rollout of Medi-Cal Connect.	In Progress

Data and Quality (2 of 2)

Problem Statements

- **Maternity care quality metrics** that are used for MCP quality improvement and accountability processes **are limited.**

Policy Solutions	Status
Identify opportunities to **leverage and integrate existing California maternity data centers with Medi-Cal data** to more comprehensively measure and monitor birth outcomes.	In Progress
Create **key performance indicators to track the efficacy of maternity care** and monitor adherence to Birthing Care Pathway policies.	Not Started

State Agency Partnerships (1 of 2)

Problem Statements

- California's **home visiting programs** are not coordinated across state agencies, causing a **lack of member awareness and underutilization.**
- Low-income individuals in California are less likely to take advantage of the state's **Paid Family Leave (PFL) program.**

Policy Solutions	Status
Collaborate with California Department of Public Health (CDPH), California Department of Social Services (CDSS), and MCPs to **promote home visiting for Medi-Cal members** and ensure eligible members can access home visiting programs.	In Progress
Partner with the Employment Development Department (EDD) and Legal Aid at Work (LAAW) to **develop a resource guide for perinatal providers** on how their pregnant and postpartum patients can **access the state's PFL and State Disability Insurance (SDI) programs**.	Completed

State Agency Partnerships (2 of 2)

Problem Statements

- Lack of **access** and links to **risk-appropriate care.**
- **Siloed** services, programs, and interventions.

Policy Solutions	Status
Partner with CDPH, Office of the California Surgeon General (OSG), and California Maternal Quality Care Collaborative (CMQCC) to develop the **statewide Maternal Health Strategic Plan.**	In Progress
Leverage the Family First Prevention Services Act (FFPSA) to **support SUD and mental health treatment** services for pregnant and postpartum individuals at risk of child welfare involvement.	In Progress
Continue to support the OSG Strong Start & Beyond movement through participation in the **Perinatal Advisory Group**.	In Progress

Appendix: Strategic Opportunities for Further Exploration

Provider Access and MCP Oversight and Monitoring (1 of 2)

Problem Statements:

- **Access issues persist** despite MCPs meeting existing Medi-Cal network adequacy standards.
- **Significant racial and ethnic disparities** in maternal health outcomes persist.

Potential Opportunities:

- **Strengthen oversight and monitoring of network adequacy standards for maternal providers**, including adopting an appropriate threshold for accepting Alternative Access Standards requests.
- Require MCPs to participate in a **joint performance improvement project** in which all MCPs are required to participate, focused on **reducing disparities for Black, American Indian/Alaska Native, and Pacific Islander** pregnant and postpartum members.

Provider Access and MCP Oversight and Monitoring (2 of 2)

Problem Statements:

- Many perinatal providers **lack the training to conduct IPV screening.**
- Only physicians, registered nurses, and dieticians working under the supervision of a physician can provide **lactation services** in Medi-Cal today.

Potential Opportunities:

- Require MCPs to **incorporate IPV training into required network provider training** and **promote universal IPV education** in health care settings.
- Update lactation policy to **recognize International Board-Certified Lactation Consultants and Certified Lactation Counselors as a provider type** that can bill Medi-Cal.

BH (1 of 2)

Problem Statements:

- Members face **challenges accessing behavioral health providers** that have perinatal training and appointment availability.

Potential Opportunities:

- Develop **statewide perinatal BH consultation line** for maternal providers and therapists without perinatal training to receive consultations from qualified mental health and SUD providers with perinatal expertise for pregnant and postpartum members living with BH needs.
- Support implementation of **perinatal workforce training on trauma-informed, culturally relevant crisis care** and integration of county BH services into obstetric provider practices for pregnant members living with SUD or serious mental health needs.
- Support CBOs serving pregnant and postpartum individuals living with behavioral health needs by providing counties with a **list of proposed uses for Behavioral Health Services Act funds** that address gaps identified for this population.

BH Continued (2 of 2)

Problem Statements:

- Parents must be allowed to **stay with their infants** while undergoing **treatment for neonatal abstinence syndrome (NAS).**

Potential Opportunities:

- Support postpartum members to **stay in the hospital with their newborns (e.g., rooming in) while the newborn is being treated for NAS/Neonatal Opioid Withdrawal Syndrome** and not be discharged until their newborn is discharged.

Maternal Care Models and Access (1 of 2)

Problem Statements:

- **Limited oversight of** the **CPSP and insufficient data to track utilization** of CPSP services.
- **Separate CPSP provider enrollment process** with CDPH is burdensome.
- Existing CPSP payment structure for FQHCs/RHCs **encourages clinics to maximize service volume** over reducing member burden.

Potential Opportunities:

- **Enhance the delivery of comprehensive perinatal services** across the FFS delivery system and Medi-Cal MCPs, including:
  - Aligning with the most recent clinical guidelines;
  - Updating benefit delivery structure;
  - Improving state oversight with data-driven monitoring;
  - Modernizing the payment and billing code structure.

Maternal Care Models and Access Continued (2 of 2)

Problem Statements:

- There is **no perinatal specialization for CHWs.**
- **More racially concordant providers**, including midwives, are needed.
- **Short-term housing solutions** are needed for high-risk pregnant members to be closer to risk-appropriate care.

Potential Opportunities:

- Develop **perinatal specialization for CHWs.**
- Develop **loan repayment program** to increase diversity and rural representation of **midwives**.
- Provide **short-term housing for high-risk pregnant members** who live in remote counties that is near hospitals equipped to care for complex maternal and fetal medical conditions and obstetric complications.

Provider Resources

Problem Statements:

- **Additional Medi-Cal provider education is needed on the programs and services for which** pregnant and postpartum members may be eligible.

Potential Opportunities:

- Require MCPs to **augment provider training requirements to include a focus on Medi-Cal perinatal benefits, perinatal mental health, and SUD.**

Data and Quality

Problem Statements:

- There is a **need for additional maternity care quality metrics** beyond those currently tracked.
- DHCS does not currently require reporting on **patient-reported measures around access and patient experience** for perinatal care and services.

Potential Opportunities:

- Develop **technical workgroup to advise** on perinatal health and birth outcome **quality measures.**
- Identify quality metrics and require reporting **on patient-reported outcome measures** around access and patient experience for perinatal care and services.

State Agency Partnerships (1 of 3)

Problem Statements:

- **Members and providers may be unaware of which birth setting would be best suited** based on their level of risk during pregnancy.
- Members are also often **unaware of the impact their current health has on pregnancy outcomes** until they attend their first prenatal appointment.

Potential Opportunities:

- Partner with CDPH to **require birthing hospitals to have a verified ACOG Levels of Maternal Care designation.**
- Partner with OSG to promote community education and **pregnancy risk awareness.**

State Agency Partnerships Continued (2 of 3)

Problem Statements:

- Low-income individuals in California are **less likely to take advantage** of the state's **PFL program.**
- California faces **maternal health care workforce shortages** across multiple provider types.
- **None** of California's **home visiting programs** are available **statewide**, and each has **differing eligibility criteria.**

Potential Opportunities:

- Explore options to **obtain data from EDD to improve outreach** to pregnant and postpartum Medi-Cal members **about the state's PFL and SDI programs**.
- Coordinate with the California Department of Health Care Access and Information to fund **workforce development strategies for perinatal providers**.
- Collaborate with CDPH, CDSS, and MCPs to **provide at least one voluntary home visit to every newly pregnant Medi-Cal member** and develop a standard to identify members who would benefit from more than one home visit in the prenatal and postpartum periods.

State Agency Partnerships Continued (3 of 3)

Problem Statements:

- **Stigma around SUD treatment** results in many members **forgoing necessary care for fear of prosecution or child protective services involvement.**

Potential Opportunities:

- Examine opportunities to partner with state agencies to **protect pregnant and postpartum individuals from prosecution** for drug-related offenses that may be initiated after they seek SUD treatment.
- Partner with CDSS to **educate health care partners on child welfare policy nuances** that may inadvertently require or permit revoking custody from the parent due to use of medications for SUD treatment and consider modifications to the policies.
- Collaborate with CDSS on **training for labor and delivery clinical care teams and child welfare case managers about perinatal SUDs** to reduce stigma, misinformation, and barriers to treatment.