LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
Virtual Meeting
Tuesday, June 21, 2022
1:00PM-3:00PM (PST)

Agenda and meeting packet will be available on the Commission's website at:
http://hiv.lacounty.gov/Planning-Priorities-and-Allocations-Committee

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LOS ANGELES COUNTY
COMMISSION ON HIV

AGENDA FOR THE VIRTUAL MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

PLANNING, PRIORITIES, AND ALLOCATIONS COMMITTEE

TUESDAY, June 21, 2022|1:00 PM – 3:00 PM

To Join by Computer:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/onstage/g.php?MTID=e13614accef7ef869490851e95aaaa7be

**Link is for non-committee members only*
To Join by Phone: 1-415-655-0001
Access code: 2598 164 2523

Planning, Priorities and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Al Ballesteros, MBA, Co-Chair	Frankie Darling Palacios	Felipe Gonzalez
Joseph Green	Karl T. Halfman, MS	William King, MD, JD	Miguel Martinez, MPH, MSW
Anthony M. Mills, MD	Derek Murray	Jesus "Chuy" Orozco	LaShonda Spencer, MD
Michael Green, PhD			
QUORUM:	7		

AGENDA POSTED: June 16, 2022

VIRTUAL MEETINGS: Assembly Bill (AB) 361 amends California's Ralph M. Brown Act Section 54953 to allow virtual board meetings during a state of emergency. Until further notice, all Commission meetings will continue to be held virtually via WebEx. For a schedule of Commission meetings, please click here.

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically via https://www.surveymonkey.com/r/PUBLIC_COMMENTS. All Public Comments will be made part of the official record.

ATTENTION: Any person who seeks support or endorsement from the Commission on any official action may be subject to the provisions of Los Angeles County Code, Chapter 2.160 relating to lobbyists. Violation of the lobbyist ordinance may result in a fine and other penalties. For information, call (213) 974-1093.

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other

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SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located at 510 S. Vermont Ave. 14th Floor, one building North of Wilshire on the eastside of Vermont just past 6th Street. Validated parking is available.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

External stakeholders who would like to participate in the deliberation of discussion of a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity, may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Committee leadership and staff will make every effort to accommodate reasonable scheduling and timing requests—from members or other stakeholders—within the limitations and requirements of other possible constraints.

Call to Order | Introductions | Statement – Conflict of Interest 1:00 PM – 1:02 PM

I. ADMINISTRATIVE MATTERS 1:02 PM – 1:04 PM

1. Approval of Agenda **MOTION #1**
2. Approval of Meeting Minutes **MOTION #2**

II. PUBLIC COMMENT 1:04 PM – 1:14 PM

3. Opportunity for members of the public to address the Committee on items of interest that is within the jurisdiction of the Committee.

III. COMMITTEE NEW BUSINESS 1:14 PM – 1:19 PM

4. Opportunity for Committee members to recommend new business items for the full body or a committee level discussion on non-agendized matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency situation, or where the need to take action arose subsequent to the posting of the agenda.

IV. REPORTS

5. EXECUTIVE DIRECTOR'S/STAFF REPORT 1:19 PM – 1:25 PM
   a. Operational Update
   b. Comprehensive HIV Plan 2022-2026

6. CO-CHAIR REPORT 1:25 PM – 1:30 PM

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) 1:30 PM – 1:40 PM
   a. Fiscal and Program Updates
   b. Revised PY 32 Ryan White Service Category Funding Allocations **MOTION #3**

8. PREVENTION PLANNING WORKGROUP 1:40 PM – 1:45 PM
   a. Meeting Update

V. DISCUSSION

9. Planning for July Meeting | Comprehenive HIV Plan, Data, and System Changes Affecting Ryan White 1:45 PM – 2:55 PM
   a. Develop meeting objectives/desired outcomes
   b. Identify key data requests and speakers

VI. NEXT STEPS 2:55 PM – 2:58 PM

11. Task/Assignments Recap
12. Agenda Development for the Next Meeting

VII. ANNOUNCEMENTS 2:58 P.M. – 3:00 P.M.

13. Opportunity for Members of the Public and the Committee to Make Announcements

VIII. ADJOURNMENT 3:00 P.M.

14. Adjournment for the Meeting of June 21, 2022.

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	Approve the Agenda Order, as presented or revised.
MOTION #2:	Approve meeting minutes as presented or revised.
MOTION #3:	Approve revised PY 32 Ryan White service category funding allocations as presented or revised.

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 6/6/22

The following list identifies "conflicts-of-interest" for Commission members who represent agencies with Part A/B –and/or CDC HIV Prevention-funded service contracts with the County of Los Angeles. According to Ryan White legislation, HRSA guidance and Commission policy, Commission members are required to state their "conflicts-of-interest" prior to priority- and allocation-setting and other fiscal matters concerning the local HIV continuum of care, and to recuse themselves from discussions involving specific service categories for which their organizations have service contracts.

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ALVIZO	**Everardo**	Long Beach Health & Human Services	Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			HIV and STD Prevention
			HIV Testing Social & Sexual Networks
			HIV Testing Storefront
ARRINGTON	**Jayshawnda**	Unaffiliated consumer	No Ryan White or prevention contracts
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services
			Medical Care Coordination (MCC)
			Ambulatory Outpatient Medical (AOM)
			Transportation Services
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
DANIELS	**Michele**	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	**Frankie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FULLER	**Luckie**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
GARTH	**Gerald**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
GATES	**Jerry**	AETC	Part F Grantee
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Thomas**	APAIT (aka Special Services for Groups)	HIV Testing Storefront
			Mental Health
			Transportation Services
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MORENO	**Carlos**	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Oral Healthcare Services
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
OROZCO	**Jesus ("Chuy")**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
PRECIADO	**Juan**	Northeast Valley Health Corporation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Oral Healthcare Services
			Mental Health
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
			Transportation Services
ROBINSON	**Mallery**	We Can Stop STDs LA (No Affiliation)	No Ryan White or prevention contracts
RODRIGUEZ	**Isabella**	No Affiliation	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Medical Care Coordination (MCC)
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
STEVENS	**Reba**	No Affiliation	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WALKER	**Ernest**	No Affiliation	No Ryan White or prevention contracts

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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Presence at virtual meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges and must verbally acknowledge their attendance in order to vote. Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES

May 17, 2022

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Al Ballesteros, MBA	P	Anthony M. Mills, MD	P
Frankie Darling Palacios (LOA)	EA	Derek Murray	A
Felipe Gonzalez	P	Jesus "Chuy" Orozco	P
Joseph Green	A	LaShonda Spencer, MD	EA
Michael Green, PhD, MHSA	P	Bridget Gordon	P
Karl T. Halfman, MS	P		
William King, MD, JD	EA		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Jose Rangel-Garibay, Sonja Wright, AJ King			
DHSP STAFF			
Pamela Ogata, Jane Rohde Bowers, Victor Scott, Sine Y.			

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.
*Members of the public may confirm their attendance by contacting Commission staff at hivcomm@lachiv.org.
*Meeting minutes may be corrected up to one year from the date of approval.

Meeting agenda and materials can be found on the Commission's website. Click HERE.

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST
Kevin Donnelly Committee Co-Chair, called the meeting to order at approximately 1:05 PM. Members, attendees introduced themselves, and declared their conflicts of interest.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA
Motion #1: Approved the Agenda Order. (**Passed by Consensus**)

2. APPROVAL OF MEETING MINUTES
MOTION #2: The Committee approved the April 19, 2022, meeting minutes. Minutes can be amended up to 1 year after approval. **(Passed by Consensus)**

II. PUBLIC COMMENT

3. Opportunity for members of the public to address the Committee on items of interest that is within the jurisdiction of the Committee. *There were no public comments.*

III. COMMITTEE NEW BUSINESS ITEMS

4. Opportunity for Committee members to recommend new business items for the full body or a committee level discussion on non-agendized matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency, or where the need to take action arose subsequent to the posting of the agenda.

There were no new business items.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

Operational and Staffing Update

- C. Barrit reported that the Commission on HIV (COH) meetings will continue to be held virtually until further notice. The Board of Supervisors has agendized a continuation of virtual meetings for 30 days for their May 17 meeting.
- She formally recognized Dawn McClendon's return from leave and thanked staff for supporting each other to ensure smooth operations for the COH in times of staff vacancies and extended leaves. C. Barrit will serve as the lead support staff for the PP&A Committee until the staff vacancy is filled.
- Finally, she reminded Committee/COH members whose seats are up for renewal, to submit renewal applications and statements of qualification forms to Sonja Wright by June 10.

Comprehensive HIV Plan (CHP)

- AJ King, the CHP consultant, provided the report. The HIV workforce capacity surveys (1 for providers and 1 for consumers) are slated to be disseminated by the end of the week. The surveys are being pilot tested and translated into in Spanish.
- AJ King acknowledged discussions held the by PP&A Committee to hold community engagement or listening sessions to help inform the development of the CHP. He has assembled a mini team to plan the logistics with the goal of holding the listening sessions in late June or July. The group will likely meet 4 to 6 times and look at health districts disproportionately affected by HIV.
- The plan includes a data snapshot section. He suggested that he could present the data snapshot, and possibly the situational analysis, to the Committee if the group decides to hold a data summit in July.
- AJ King reported that he had met with Dr. P. Gounder on collaborating with his office in sharing Hepatitis C data and exploring shared and/or intersecting goals for the plan. Dr. Gounder's office is also working on 5-year Hepatitis C action plan that is anticipated to be completed in December 2022.
- AJ King will be meeting with the Black Caucus this week to get their input on the CHP and ensure that the broad goals of the CHP are inclusive and reflective of the Black African American Community Task Force recommendations and address the community's concerns.
- Lazara Paz-Gonzalez from Facente Consulting, consultants working with the Office of AIDS to develop

the Integrated Plan, noted that her team is happy to continue to collaborate with AJ King and share data from the Office of AIDS with Los Angeles County to help shape the CHP.

- C. Barrit noted that historically the PP&A Committee hosted a data summit in July to help determine Ryan White (RW) service rankings and funding allocations as part of the annual RW grant application process. However, RW has moved into a 3-year funding cycle beginning in Program Year 32 (2022). She suggested that PP&A discuss options to use the July Committee meeting for the CHP, or the expansion of Medi-Cal to people over 50 years of age regardless of immigration document status, CalAIM, and the potential impacts on the RW service delivery system. She noted that the PP&A Committee will need to work with DHSP to determine what data might be available and most useful for the Committee, depending on the objectives of the July meeting. Another option is to have a more in-depth review of the new DHSP STD and HIV Data interactive dashboard.
- AJ King noted the importance of helping the community truly understand the data that is presented to them. Data presentations with clear explanations of implications are important for community planning.

6. CO-CHAIR REPORT

a. Co-Chair Nominations/Elections

K. Donnelly reported that Bridget Gordon nominated Alvaro Ballesteros for PP&A Co-Chair at the May COH meeting. A. Ballesteros accepted the nomination and offered to mentor other Committee members to assume a leadership position for the Committee. Since there were no other nominees, the Committee unanimously approved A. Ballesteros for PP&A Co-Chair.

7. DIVISION OF HIV AND STD PROGRAMS (DHSP)

a. Fiscal and Program Updates

- Dr. M. Green provided a brief report. He noted that DHSP is still waiting to hear from the Health Resources Services Administration (HRSA) about the County's notice of award for Program Year (PY) 32 for Part A and Minority AIDS Initiative (MAI). There were no additional fiscal updates as DHSP provided the information at the April PP&A meeting. Dr. Green indicated that he will be sending an updated solicitations list to C. Barrit which may be shared with PP&A and Standards and Best Practices (SBP) Committees.
- A. Ballesteros stated that he asked M. Perez at the May COH meeting if he anticipates any savings from RW dollars due to the transition of people over 50 to Medi-Cal under its latest expansion. M. Perez noted that he has some ballpark numbers of what that figure might look like. A. Ballesteros noted that it would be helpful for the Committee to know when those projections might materialize. Given this major change in the system of care in California, it is important for the Committee to know what service categories would be impacted, how many RW clients might move to Medi-Cal, and what funding reallocations the Committee may need to perform to maximize grant funds. He inquired when the data would be available and what programmatic changes might be doable within the current RW program year given that the Medi-Cal expansion has already begun. This shift may present opportunities to move funding to other service categories.
- Dr. M. Green responded that DHSP has started to look at existing RW clients who may be eligible and move to Medi-Cal. They are waiting for data on a couple of specific service categories on what CalAIM will cover for eligible clients. Once they have this data, DHSP would be able to calculate their estimated savings based on estimated projections. He expects that DHSP should be able to complete the projections in 60 days. DHSP is examining data for ambulatory outpatient medical (AOM), oral health,

and mental health. He stated that service utilization for mental health has been low due to the dearth of mental health service providers.

- A. Ballesteros inquired if community-based care might be impacted especially with the possibility of case management services being covered under this service category. Will there be potential impacts on specialty care contracts? Dr. Green stated that the PP&A Committee/COH does not allocate funds specifically for specialty care; the COH's allocation to specialty care is lumped in with the AOM allocations. This will be considered in DHSP's analysis and projections. Home-based case management is one of the services that DHSP is waiting to get more information on to determine what CalAIM will cover.

8. PREVENTION PLANNING WORKGROUP

- M. Martinez reported that PPW is in the process of developing a baseline survey on the COH's understanding, capacity, and comfort in engaging in prevention-focused conversations. Examples of areas of inquiry for the survey include understanding of prevention concepts such as status status-neutral activities, knowledge, attitudes, and beliefs about prevention services. A draft of the survey will be presented to the PPW on May 25. PPW is also reviewing its workplan to determine a more realistic set of objectives for the remainder of the year.
- Dr. Green inquired if there has been any consideration to changing the PPW's meeting time. M. Martinez replied that the PPW discussed the matter but did not make a final decision. The group will discuss the meeting again time again at its next meeting.

V. DISCUSSION

9. COMPREHENSIVE PROGRAM DIRECTIVES TO DHSP

a. PY 32, 33, and 34 Ryan White Part A, MAI, and Prevention Programs MOTION #3

Motion passed by roll call vote: *(Ayes: K. Donnelly, F. Gonzalez, B. Gordon, M. Martinez, A. Mills C. Orozco; No: 0; Abstain: M. Green, K. Halfman)*

K. Donnelly led the Committee through a review of the updated final draft of the Comprehensive Program Directives to DHSP for PY 32, 33, and 34. Refer to the packet for the document. The Committee discussed the following revisions:

- Under 4e, recognize that food insecurity affects all individuals regardless of HIV status. Add a separate similar directive that supports prevention services providers to have access to food and refer clients to resources. Dr. Green noted the DHSP does not have funding to support food/nutritional support for HIV-negative individuals. Funds may potentially come from Net County Cost (NCC) funds.
- Add as prevention directive, "identify resources for prevention around benefits counseling and encourage agencies to leverage existing funds for prevention."
- Under #7, add, "food delivery services".
- Under #14, add "women living with HIV."

VI. NEXT STEPS

10. Task/Assignment Recap

- Move approved directives with revisions to the Executive Committee for approval.

11. Agenda Development for the Next Meeting

- Focus the June meeting on planning for the July data summit.

VII. ANNOUNCEMENTS

12. Opportunity for Members of the Public and the Committee to Make Announcements

There were no announcements.

VIII. ADJOURNMENT

a. Adjournment:

The meeting was adjourned by K. Donnelly.

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
RYAN WHITE PART A, MAI YR 31 AND PART B YR 31 EXPENDITURES BY RWP SERVICE CATEGORIES
Expenditures reported by June 7, 2022

1	2	3	4	5	6	7		8	9	10	11	
SERVICE CATEGORY	YEAR TO DATE EXPENDITURES PART A	YEAR TO DATE EXPENDITURES MAI	TOTAL YEAR TO DATE EXPENDITURES PART A AND MAI (Total Columns 2+3)	FULL YEAR ESTIMATED EXPENDITURES PART A	FULL YEAR ESTIMATED EXPENDITURES MAI	FULL YEAR ESTIMATED EXPENDITURES PART A + MAI (Total Columns 5+6)	PART A + MAI EXPENDITURES %	YEAR TO DATE EXPENDITURES PART B	FULL YEAR ESTIMATED EXPENDITURES PART B	TOTAL YEAR TO DATE EXPENDITURES FOR RWP SERVICES (Total Columns 4+8)	COH YR 31 ALLOCATIONS %	NOTES
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 7,488,414	$ -	$ 7,488,414	$ 7,488,414	$ -	$ 7,488,414	20.34%	$ -	$ -	$ 7,488,414	24.13%	AOM YR 31 expenditures were below COH YR 31 due to fiscal review of provider invoices that may not be complete prior to YR 31 Part A closeout.
MEDICAL CASE MGMT (Medical Care Coordination)	$ 9,548,597	$ -	$ 9,548,597	$ 9,665,226	$ -	$ 9,665,226	26.26%	$ -	$ -	$ 9,548,597	31.73%	MCC YR 31 expenditures were below COH YR 31 due to fiscal review of provider invoices that may not be complete prior to YR 31 Part A closeout.
ORAL HEALTH CARE	$ 6,345,543	$ -	$ 6,345,543	$ 6,714,168	$ -	$ 6,714,168	18.24%	$ -	$ -	$ 6,345,543	13.81%	
MENTAL HEALTH	$ 370,775	$ -	$ 370,775	$ 370,775	$ -	$ 370,775	1.01%	$ -	$ -	$ 370,775	0.69%	
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 2,318,710	$ -	$ 2,318,710	$ 2,318,710	$ -	$ 2,318,710	6.30%	$ -	$ -	$ 2,318,710	7.02%	
NON-MEDICAL CASE MANAGEMENT-Benefits Specialty Services	$ 1,404,191	$ -	$ 1,404,191	$ 1,404,191	$ -	$ 1,404,191	3.81%	$ -	$ -	$ 1,404,191	3.49%	
NON-MEDICAL CASE MANAGEMENT-Transitional Case Management	$ 527,592	$ 239,270	$ 766,862	$ 527,592	$ 239,270	$ 766,862	2.08%	$ -	$ -	$ 766,862	0.79%	
HOUSING-RCFCI, TRCF	$ 112,042	$ -	$ 112,042	$ 122,502	$ -	$ 122,502	0.33%	$ 3,859,442	$ 3,859,442	$ 3,971,484	1.05%	
HOUSING-Temporary and Permanent Supportive with Case Management	$ 1,761,117	$ 1,214,192	$ 2,975,309	$ 1,761,117	$ 1,214,192	$ 2,975,309	8.08%	$ -	$ -	$ 2,975,309	7.73%	
SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ -	$ -	$ -	$ -	$ -	0.00%	$ 744,825	$ 744,825	$ 744,825	--	
MEDICAL TRANSPORTATION	$ 448,840	$ -	$ 448,840	$ 451,884	$ -	$ 451,884	1.23%	$ -	$ -	$ 448,840	2.06%	
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 2,504,284	$ -	$ 2,504,284	$ 2,504,284	$ -	$ 2,504,284	6.80%	$ -	$ -	$ 2,504,284	7.27%	
EMERGENCY FINANCIAL ASSISTANCE	$ 1,051,759	$ -	$ 1,051,759	$ 1,051,759	$ -	$ 1,051,759	2.86%	$ -	$ -	$ 1,051,759	--	funded by HRSA EHE but after review, EFA was included in YR 31 to help maximize YR 31 Part A Award.
REFERRAL/OUTREACH (LINKAGE AND REENGAGEMENT PROGRAM)	$ 609,446	$ -	$ 609,446	$ 609,446	$ -	$ 609,446	1.66%	$ -	$ -	$ 609,446	--	Linkage and Reengagement Program expenditures were historically charged to Part A in prior fiscal years. In YR 32 LRP expenditures will be charged to HRSA EHE.
LEGAL	$ 369,106	$ -	$ 369,106	$ 369,106	$ -	$ 369,106	1.00%	$ -	$ -	$ 369,106	0.23%	
SUB-TOTAL DIRECT SERVICES	$ 34,860,416	$ 1,453,462	$ 36,313,878	$ 35,359,174	$ 1,453,462	$ 36,812,636	100.00%	$ 4,604,267	$ 4,604,267	$ 40,918,145	100.00%	
YR 31 ADMINISTRATION (INCLUDING PLANNING COUNCIL)	$ 4,034,450	$ 363,270	$ 4,397,720	$ 4,034,450	$ 363,270	$ 4,397,720		$ 395,733	$ 395,733	$ 4,793,453		
YR 31 CLINICAL QUALITY MANAGEMENT (HRSA Part A Legislative Requirement)	$ 950,878	$ -	$ 950,878	$ 950,878	$ -	$ 950,878		$ -	$ -	$ 950,878		
TOTAL EXPENDITURES	$ 39,845,744	$ 1,816,732	$ 41,662,476	$ 40,344,502	$ 1,816,732	$ 42,161,234		$ 5,000,000	$ 5,000,000	$ 46,662,476		
TOTAL GRANT AWARD				**$ 40,344,502**	**$ 3,632,709**	**$ 43,977,211**			**$ 5,000,000**			
VARIANCE				0	(1,815,977)				0			
Estimated MAI Carryover from YR 21 to YR 22	**$**	**1,815,977**										

Note: Amount in ( ) means that the amount of estimated expenditures is less than the grant award

PROPOSED REVISIONS TO THE PY 32 (FY 2022) RW Part A and MAI ALLOCATIONS-- LOS ANGELES COUNTY DIVISION OF HIV AND STD PROGAMS
For Planning, Priorities, and Allocations Committee Approval on 6/21/22

PY 32 Priority #	Service Category	COH Part A Percent	COH MAI Percent	COH Part A and MAI Percent	Proposed Part A Percent	Proposed MAI Percent	Proposed Part A and MAI Percent	Notes
1	Housing Services	1.0%	87.39%	8.33%	0.97%	88.18%	8.30%	
2	Case Management (Non-Medical)	2.4%	12.61%	3.30%	2.47%	11.82%	3.26%	
3	Outpatient/Ambulatory Health Services	25.5%	0.00%	23.33%	25.87%	0.00%	23.70%	
4	Emergency Financial Assistance (EFA)	**0.0%**	0.00%	**0.00%**	**4.05%**	0.00%	**3.70%**	EFA was previously supported by HRSA Ending the HIV Epidemic grant. However, this service is a better fit under HRSA Part A
5	Psychosocial Support	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
6	Medical Case Management (Medical Care Coordination)	**28.9%**	0.00%	**26.41%**	**23.87%**	0.00%	**21.87%**	The difference between the proposed allocation and the original COH allocation is due to 1) addition of EFA service category and 2) minor changes because our final award was not exactly the same as the requested amount on the application.
7	Mental Health Services	4.1%	0.00%	3.72%	4.13%	0.00%	3.78%	
8	Outreach (Linkage and Re-engagement Program)	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
9	Substance Abuse Outpatient	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
10	Early Intervention Services	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
11	Medical Transportation	2.2%	0.00%	1.99%	2.20%	0.00%	2.01%	
12	Nutrition Support-Food Bank and Home Delivered Meals	9.0%	0.00%	8.19%	9.07%	0.00%	8.31%	
13	Oral Health	17.6%	0.00%	16.30%	17.86%	0.00%	16.36%	
14	Child Care Services	1.0%	0.00%	0.87%	0.96%	0.00%	0.88%	
15	Legal Services	1.0%	0.00%	0.92%	1.02%	0.00%	0.93%	
16	Substance Use Residential	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
17	Health Education Risk Reduction	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
18	Home and Community Based Case Managem	6.8%	0.00%	6.21%	6.87%	0.00%	6.30%	
19	Home Health Care	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
20	Referral	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
21	Health Insurance Premium	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
22	Language Services	0.7%	0.00%	0.60%	0.66%	0.00%	0.60%	
23	Medical Nutritional Therapy	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
24	Rehabilitation	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
25	Respite Care	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
26	Local Pharmacy Assistance	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
27	Hospice	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	
		100.0%	100.00%	100.17%	100.00%	100.00%	100.00%	

LOS ANGELES COUNTY COMMISSION ON HIV
APPROVED ALLOCATIONS FOR
PROGRAM YEARS (PYs) 33 AND 34 (Approved by COH 01-13-2022; PY 32 Approved by COH Sept 2021)

	FY 2022 RW Allocations (PY 32)[1]					FY 2023 RW Allocations (PY 33)[2]			FY 2024 RW Allocation (PY 34)[2]		
PY 32 Priority #	Core/ Support Services	Service Category	Part A %	MAI %	Total Part A/ MAI %	Part A %	MAI %	Total Part A/ MAI % [3]	Part A %	MAI %	Total Part A/ MAI % [3]
1	S	Housing Services RCFCI/TRCF/Rental Subsidies with CM	0.96%	87.39%	8.33%	0.96%	87.39%		0.96%	87.39%	
2	S	Non-MedicalCase Management - BSS/TCM/CM for new positives/RW clients	2.44%	12.61%	3.30%	2.44%	12.61%		2.44%	12.61%	
3	C	Ambulatory Outpatient Medical Services	25.51%	0.00%	23.33%	25.51%	0.00%		25.51%	0.00%	
4	S	Emergency Financial Assistance	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
5	S	Psychosocial Support Services	0.00%	0.00%	0.00%	0.00%	0.00%		1.00%	0.00%	
6	C	Medical Care Coordination (MCC)	28.88%	0.00%	26.41%	28.88%	0.00%		28.00%	0.00%	
7	C	Mental Health Services	4.07%	0.00%	3.72%	4.07%	0.00%		4.07%	0.00%	
8	S	Outreach Services (LRP)	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
9	C	Substance Abuse Outpatient	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
10	C	Early Intervention Services	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
11	S	Medical Transportation	2.17%	0.00%	1.99%	2.17%	0.00%		2.17%	0.00%	
12	S	Nutrition Support Food Bank/Home-delivered Meals	8.95%	0.00%	8.19%	8.95%	0.00%		8.95%	0.00%	
13	C	Oral Health Services	17.60%	0.00%	16.13%	17.60%	0.00%		17.48%	0.00%	
14	S	Child Care Services	0.95%	0.00%	0.87%	0.95%	0.00%		0.95%	0.00%	
15	S	Other Professional Services - Legal Services	1.00%	0.00%	0.92%	1.00%	0.00%		1.00%	0.00%	
16	S	Substance Abuse Residential	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
17	S	Health Education/Risk Reduction	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
18	C	Home Based Case Management	6.78%	0.00%	6.21%	6.78%	0.00%		6.78%	0.00%	
19	C	Home Health Care	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
20	S	Referral	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
21	C	Health Insurance Premium/Cost Sharing	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
22	S	Language	0.65%	0.00%	0.60%	0.65%	0.00%		0.65%	0.00%	
23	C	Medical Nutrition Therapy	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
24	S	Rehabilitation	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
25	S	Respite Care	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
26	C	Local Pharmacy Assistance	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
27	C	Hospice	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	
		Overall Total	**100.0%**	**100.00%**	**100%**	**100.0%**	**100.0%**	**0.00%**	**100.0%**	**100.00%**	**0.00%**

Footnotes:

1 - Service Category Rankings and Allocation Percentages Approved by the Commission on 09/09/2021

2 - PY 33 and 34 Allocation percentages approved by PP&A on 11/16/2021, Executive Committee on 12/09/2021, and COH on 1/13/22

3 - To determine total percentages, funding award amounts for Part A and MAI must be known.

County of Los Angeles Public Health

Medi-Cal Expansion: Preliminary Analysis on the Impact to Los Angeles County's Ryan White Program

June 21, 2022 PP&A Meeting

Los Angeles County Department of Public Health
Division of HIV and STD Programs

Medi-Cal Eligibility

Prior to May 1, 2022

- Persons 65 years or older *
- Child/ Youth (under age 26)
- Pregnant woman
- Other (in a skilled nursing or intermediate care home*, blind, disabled, etc.)

*** Must have legal residence status & Earn less than or equal to 138% FPL**

Beginning May 1, 2022

- **Persons 50 years or older***
- Child/Youth
- Pregnant woman
- Other (in a skilled nursing or intermediate care home, blind, disabled, etc.)

***Earn less than or equal to 138% FPL**

Methodology/Approach

Methodology/Approach

Data Source: RW utilization data for March 1, 2020 to February 28, 2021 as reported in HIV Casewatch and paid for by the Division of HIV and STD Programs (DHSP)

1. Describe utilization and expenditures for the three RW service categories that will be most impacted by the 2022 Medi-Cal expansion; Ambulatory Outpatient Medical (AOM), Oral Health (general), and Mental Health services.
2. Estimate average cost per client for each RW service.
3. Estimate the number of RW clients aged 50 and older with income at or below 138% FPL.
4. Estimate savings by multiplying the number of clients that may transfer out of the RWP to Medi-Cal by the average per client cost for each RW service.

Review of 2020 RW Utilization Data

- 16,960 persons living with HIV (PLWH) accessed one or more RW service
  - 27% (n=4,639) were 50 to 59 years of age
  - 15% (n=2,491) aged 60 and older
  - 43% (n=7,272) were not born in the US
  - 60% (n=10,211) had an income at or below the FPL.

Step 1: Review of 2020 RW Utilization Data

Table 1. Overview of Service Utilization and Expenditures for Ryan White Program AOM, Oral Health, and Mental Health Services, Los Angeles County, March 1, 2020 to February 28, 2021.

RW Service Category	Number of Clients	Number of Service Units	Part A/ MAI	Part B	HIV NCC	Total FY 2020 Expenditures
AOM	5,653	16,973 visits	$8,252,137	$0	$0	$8,252,137
Mental Health	312	3,168 sessions	$408,834	$0	$1,072	$409,906
Oral Health General	3,119	18,752 procedures	$5,005,012	$0	$0	$5,005,012
Specialty	2,698	10,672 procedures	$1,582,509	$0	$0	$1,582,509

Step 2: Estimation of Average Cost per Client

Table 2. Average Cost per Client for Ryan White Program AOM, Oral Health, and Mental Health Services, Los Angeles County, March 1, 2020 to February 28, 2021.

RW Service Category	Number of Clients	Total FY 2020 Expenditures	Average Cost per Client
AOM	5,653	$8,252,137	$1,460
Mental Health	312	$409,906	$1,314
Oral Health General	3,119	$5,005,012	$1,605
Specialty	2,698	$1,582,509	$587

Step 3: Estimation of Number of Clients 50 years or older and <= 138% FPL

Table 3. Number of Clients aged 50 to 64 Years and Percent FPL for AOM, Oral Health, and Mental Health Services March 1, 2020 to February 28, 2021.

RW Service Category	Number of Clients Age 50-64	Less than or equal to 138% FPL	Greater than 138% FPL
AOM	1,734	1,174 (67.7%)	559 (32.2%)
Mental Health	111	87 (78.4%)	24 (21.6%)
Oral Health General	1,389	936 (67.4%)	453 (32.6%)
Specialty	1,243	837 (67.4%)	405 (32.6%)

Clients may receive one or more service so the total of clients now eligible for Medi-Cal may be less than 2,197. More assessment is needed to determine the impact of Medi-Cal or Denti-Cal expansion on RW specialty oral health services. Some specialty services such as implants are not covered by Denti-Cal

Step 4: Estimation of Potential RWP Cost Savings

Table 4. Estimated Savings from Medi-Cal Expansion among Clients Aged 50 and older (estimated using 2020 data and expenditures)

RW Service Category	Number of Clients age 50-64, <=138% FPL	Number of non-legal immigrants age 65 and older, <=138% FPL	Number of Clients Transitioning to Medi-Cal	Average Cost per Client	Total EstimatedSavings per RW Service
AOM	1,174	91	1,265	$1,460	$1,846,900
Mental Health	87	7	94	$1,314	$123,516
Oral Health General	936	215	1,251	$1,605	$2,007,855

Total Estimated Savings= $3,978,271

Limitations of Forecasting Analysis

Limitations and Next Steps

- More information is needed on Medi-Cal covered behavioral health services and specialty oral health
- RW will need to cover some costs for Medi-Cal expansion eligible clients while Medi-Cal eligibility is being verified in FY 2022
- Legal immigration status is not collected in Casewatch
- Analysis used FY 2020 RW Casewatch data and expenditures. RW utilization patterns in FY 2020 may be different compared to FY 2021 or 2022 due to the impact of COVID-19.
- Changes in the cost of services will affect total estimated savings
- Re-run analysis using FY 2021 RW Care Utilization Data and Expenditures in July 2022
- How can WE (OA, DHSP, COH, PP&A, service providers, etc.) help or support clients through this transition?
- Need to assess how CalAIM changes will impact RWP utilization and expenditures. Continued collaboration and open communication with OA is critical.

Questions and Discussion

Required Section	Section Description (Comprehensive HIV Plan 2022-2026)
1. Executive Summary	Describe approach to preparing the Integrated Plan submission; and list and describe all documents used to meet submission requirements.
2. Community Engagement and Planning Process	Describe how we approached the planning process and engaged community members and stakeholders.
3. Contributing Data Sets and Assessments	Epidemiologic Snapshot HIV Prevention, Care and Treatment Resource Inventory Needs Assessment
4. Situational Analysis	Overview of strengths, challenges, and identified needs with respect to Diagnose; Treat; Prevent; Respond.
5. Goals and Objectives	How we will diagnose, treat, prevent and respond to HIV. Should reflect strategies that ensure a unified, coordinated approach for all HIV funding.
6. Integrated Planning Implementation, Monitoring and Follow Up	Infrastructure, procedures, systems, and/or tools that will be used to support the key phases of planning. How to ensure the success of goals and objectives through Implementation; Monitoring; Evaluation; Improvement; Reporting and Dissemination
7. Letters of Concurrence	Specify how the planning body was involved in the Integrated Plan development.

Older Adult Full Scope Expansion

Full Scope Medi-Cal for Individuals 50 Years of Age or Older

April 14, 2022

DHCS

Authority

- Assembly Bill (AB) 133 (Chapter 143, Statutes of 2021), amen Welfare and Institutions Code section 14007.8 to expand elig for full scope Medi-Cal to individuals who are 50 years of age older, regardless of citizenship or immigration status, if other eligible.
- Implementation May 1, 2022
- Policy Guidance is posted in ACWDL 21-13 https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/21-13.pdf

Populations Impacted

- **New enrollee population** – Includes individuals 50 year age or older who are eligible for Medi-Cal, do not have satisfactory immigration status for full scope Medi-Cal, (unable to verify citizenship) and are not yet enrolled in M Cal.
- **Transition population** – Includes individuals 50 years of older who are currently enrolled in restricted scope Med

Age Policy
New Enrollee & Transition Populations

Individuals who turn 50 anytime in the month will be e
for the entire month.

» For example, individuals who turn 50 years of age betwe
1, 2022 and May 31, 2022 are considered age 50 for the
month of May 2022, and are eligible for full scope covera
under the Older Adult Expansion. The same rule applies
applicants and beneficiaries that turn 50 years old in
subsequent months.

Scope of Benefits

- **Restricted Scope Medi-Cal**
  - Often called emergency Medi-Cal
  - Covers limited services: emergency, pregnancy related, and long term care
- **Full Scope Medi-Cal**
  - Provides the full range of benefits available to M Cal beneficiaries

Full Scope Benefits

- Alcohol and drug use treatment
- Dental care
- Emergency care
- Family planning
- Foot care
- Hearing aids
- Medical care
- Medicine
- Medical supplies
- Mental health care
- Personal attendant care and c services that help people stay nursing homes
- Referrals to specialists, if neec
- Tests
- Transportation to doctor and visits and to get medicine at t pharmacy
- Vision care (eyeglasses)

Retroactive Medi-Cal Eligibility

New enrollees can request retroactive Medi-Cal benefit up to three months prior to the month of application.

- Restricted scope retroactive Medi-Cal benefits will be ava for the months prior to the Older Adult Expansion implementation.
- Full scope retroactive Medi-Cal benefits will be available beginning the month of the Older Adult Expansion implementation, **May 1, 2022**.

First Notice

- General Information Notice and FAQ
- Was mailed to the restricted scope population expected
  transition to full scope on May 1, 2022
- Mailed March 7 through March 11, 2022
- Counties will provide the First Notice & FAQ to individua
  apply after February 23, 2022 and up until implementati
  May 1, 2022.

Second Notice
Notice of Action

Existing Beneficiaries:

» Triggered by the SAWS batches to transition restricted sc
beneficiaries into full scope.

» Will be generated beginning April 9, 2022

New Applicants:

» Will be generated when an eligibility determination is ma

Third Notice
Managed Care Enrollment Notice

Managed Care Enrollment Notice and FAQ

- Will be mailed to the restricted scope population expecte transition to full scope on May 1, 2022
- Expected to be mailed April 18 through April 29, 2022

Managed Care Plan Selection Cut-off Dates

- For May 1, 2022 Managed Care Plan effectuation, a plan selection must be made prior to April 25, 2022.
- For June 1, 2022 Managed Care Plan effectuation, a plan selection must be made prior to May 23, 2022.
- For July 1, 2022 Managed Care Plan effectuation, a plan selection must be made prior to June 23, 2022.
  - If no plan is selected prior to June 23, 2022, individuals will def a Managed Care Plan on July 1, 2022.

Outreach

- Medi-Cal Eligibility Division Information Letter MEDIL 22-02 https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I22-02.pdf provides global outrea messaging for the Older Adult Expansion and is posted on the DH website.
- DHCS highly recommends counties utilize the messaging and inte into their outreach and social media campaigns.
- DHCS has shared the global outreach language broadly for use by Cal Managed Care Plans, other State departments, Medi-Cal provi and other community partners for use in their outreach activities.

Questions about immigration and the Medi-Cal program

The Department of Health Care Services (DHCS) cannot answer questi about immigration or "public charge".

- The California Department of Social Services (CDSS) funds qualified non organizations to give services to immigrants who live in California. There of these organizations at https://bit.ly/immigration-service-contractors
- For immigration information and resources, go to California's Immigrant https://immigrantguide.ca.gov/
- To learn about public charge, go to the California Health and Human Se Agency Public Charge Guide at https://bit.ly/calhhs-public-charge-guide
- Guía de carga pública de la California Health and Human Services Agen español en https://bit.ly/calhhs-Public-Charge-Guide-Spanish

Older Adult Expansion Contact Information

OlderAdultExpansion@dhcs.ca.gov

For More Information

http://www.dhcs.ca.gov/services/medical/eligibility/Pages/OlderAdultEx

CHCF Fact Sheet

CalAIM Explained: Overview of New Programs and Key Changes

California Advancing and Innovating Medi-Cal — more commonly known as CalAIM — is a far-reaching, multiyear plan to transform California's Medi-Cal program and enable it to work more seamlessly with other social services. Led by the California Department of Health Care Services (DHCS), the goal of CalAIM is to improve outcomes for the millions of Californians covered by Medi-Cal, including those with the most complex needs. Pending federal approval, CalAIM would add new programs and make important reforms to many existing programs, bringing in significant federal matching dollars in addition to the $782 million allocated from the general fund in the 2021–22 budget and more in future budget years. This explainer provides an overview of all the changes proposed.

Who CalAIM Will Help

CalAIM's broad reach is intended to help all Medi-Cal enrollees through a focus on population health and greater emphasis on prevention and overall wellness. In addition, there are several specific reforms to improve care for people with the most complex needs. In general, this group includes:

- People with significant behavioral health needs, including people with mental illness, serious emotional disturbance, or substance use disorder
- Seniors and people living with disabilities
- People experiencing homelessness who also have complex physical or behavioral health needs
- People transitioning from jail or prison back to the community who also have complex physical or behavioral health needs
- Children with complex medical conditions, such as cancer, epilepsy, or congenital heart disease
- Children and youth in foster care

For examples of how CalAIM will impact the lives of Medi-Cal enrollees, see *CalAIM Explained: A Five-Year Plan to Improve Medi-Cal*.[1]

New Programs

Under CalAIM, DHCS would create several new Medi-Cal programs to improve care for populations with complex health needs. These build on the Whole Person Care Pilots[2] and Health Homes Program,[3] which are ending in 2021.

- **Enhanced Care Management (ECM).** Today, Medi-Cal is highly fragmented, with some enrollees needing to access care paid for by six or more delivery systems, which can make it difficult for people to navigate across providers and services. For example, a person living with agoraphobia who is unable to leave their home but needs dental care, medical care, and mental health care would need to seek authorization for home-based care from three organizations. In response, a new ECM benefit would provide a high-touch care coordinator for Medi-Cal managed care enrollees with multiple complex needs. If successfully implemented, this benefit would ensure that enrollees with complex needs are identified and engaged by someone who understands their goals, develops a plan in partnership with them and their providers, and actively connects them with the clinical and nonclinical services and resources that help them meet those goals. DHCS has designated a dozen specific populations of focus[4] (PDF) for the ECM benefit, and managed care plans can add to that list at their discretion.

- **Community Supports (or "In Lieu of Services").** Medi-Cal's coverage may be comprehensive when it comes to health care services like doctor's visits, hospital or nursing home stays, or medications and equipment. There are, however, situations where traditional health care services on their own are not enough to support well-being. For example, a person experiencing homelessness who is diagnosed with cancer may not be able to tolerate chemotherapy if they don't have a safe place to stay, rest, and recover from treatment. Traditionally, Medi-Cal has not covered that safe place

to recuperate, instead only covering a nursing home or hospital, which is more than what is needed. In response, DHCS is proposing to give managed care plans the option to substitute new clinical and non-clinical services for traditionally covered services like care in a nursing home or hospital. This would give plans the financial flexibility to meet the needs of members in new, more patient-focused ways. These services, selected based on evidence that they can improve outcomes, are also intended to prevent or limit the kinds of health complications that require more expensive interventions.

DHCS has given plans the option of providing the following community supports[5] (PDF):

Housing supports

- Housing transition navigation services (e.g., assistance applying for and finding housing, signing a lease, securing resources for setup, utilities, moving in)
- Housing deposits
- Housing tenancy and sustaining services (e.g., early intervention around behaviors that might jeopardize housing, dispute resolution with landlords and neighbors, recertification support)

Short-term recovery supports

- Short-term, posthospitalization housing
- Recuperative care[6] (medical respite)
- Respite services for caregivers (such as those caring for people with dementia or children with disabilities) who need short-term relief
- Sobering centers[7]

Independent living supports

- Day habilitation programs (e.g., training on independent living skills like cooking, cleaning, and shopping)
- Nursing facility transition/diversion to assisted living facilities, such as residential care facilities for the elderly and adult residential facilities
- Community transition services / nursing facility transition to a home
- Personal care and homemaker services
- Environmental accessibility adaptations (home modifications)
- Medically tailored meals / medically supportive food
- Asthma remediation

- **Prerelease/in-reach care for people who are incarcerated.** People who are incarcerated are much more likely to be living with chronic illness and/or behavioral health conditions — like mental illness and substance use disorder — compared to people who are not incarcerated. Federal law prohibits Medi-Cal coverage for people while they are incarcerated. Instead, the jail or prison health service delivers and finances most care in facilities. However, people transitioning from incarceration face increased risk of adverse health events, including death. Research shows former prisoners are 129 times more likely than the general public to die of a drug-involved overdose in the two weeks after release,[8] and are also at higher risk for suicide after release.[9] As part of CalAIM, DHCS is seeking federal authority to expand coverage for key Medi-Cal services in the 90 days prior to release from jail or prison to ensure adequate planning for a smooth transition. Services while incarcerated include care management / care coordination, physical and behavioral health consultation services, and medication-assisted treatment for addiction. Following release, DHCS proposes to provide a 30-day supply of medication as well as durable medical equipment needed post-release, such as a walker or a glucometer. In addition, DHCS would mandate that counties implement a prerelease application process by January 1, 2023. The hope is that by enrolling people in Medi-Cal nearing their release and providing some targeted services early, CalAIM can help ease transition back to the community and prevent physical health and behavioral health complications, including the risk of post-release homelessness.

- **Providing Access and Transforming Health (PATH).** To successfully implement CalAIM, many providers will need to increase capacity and capabilities up front. For example, many of the providers that serve CalAIM's populations of focus have never contracted

with managed care plans. In fact, many have never interacted with the Medi-Cal program. Some parts of California may not even have enough providers, and those that do may need to train their workforce in delivering care and services in a coordinated way. The data sharing needed to support that coordination will also require investment in technical infrastructure. To address those needs, DHCS is seeking federal support for infrastructure improvements and technical assistance for community-based providers and correctional facilities. This PATH initiative would be able to cover assistance with contracting and payment processes, workforce development, and staff training. It would cover investments in delivery system infrastructure, such as certified electronic health record technology, care management document systems, closed-loop referral, billing systems and services, and onboarding and enhancements to health information exchange capabilities. PATH would also provide resources for county sheriff departments and state prisons to help with the design and launch of prerelease services. These services include IT services and infrastructure to enable jails and prisons to more easily enroll people in Medi-Cal and to begin coverage and care before they are released.

- **Population health management.** While many of CalAIM's reforms are focused on those with the most complex needs, getting to equitable outcomes requires identifying and addressing issues before they become bigger problems. With that in mind, DHCS has proposed requiring managed care plans to develop a comprehensive population health management program. Plans would need to prioritize prevention and wellness in the following ways: assessing member risk consistently and equitably, ensuring effective care coordination to safeguard members during transitions across settings and systems, and ensuring that plans provide services to address social risk factors (e.g., housing, nutrition) and to meet needs outside the managed care delivery system (e.g., behavioral and oral health). DHCS has also recognized that with data housed in many different places, it can be difficult to proactively identify who needs what services. In response, the agency proposes developing a new technology platform to expand access to medical, behavioral, and social service data — both at the individual member level and for aggregate use by plans.

Key Changes to Existing Programs

CalAIM also proposes other key changes to Medi-Cal, including the following:

- **Behavioral health reforms.** The Medi-Cal behavioral health system today is divided three ways, with substance use services and specialty mental health services administered by counties, often across different departments or agencies, and non-specialty mental health services for people with mild to moderate illness administered by managed care plans. These divisions, and the different rules for payment and documentation surrounding them, make it difficult for patients to find the care they need, and for providers to respond in a patient-centered way. While maintaining the fundamental structure of behavioral health services in Medi-Cal, DHCS proposes reforms to ensure that patients can get treatment wherever they seek care — even before they receive a formal diagnosis — and to clarify the division of responsibility for mental health services between managed care plans and county mental health plans. It would also introduce a reimbursement system for behavioral health services based on the type of care provided, rather than the cost of the care, similar to reimbursement in the physical health system. DHCS also proposes streamlining clinical documentation requirements for specialty mental health and substance use disorder treatment services, with the goal of reducing administrative burden and supporting clinicians to focus more on patient care. Finally, CalAIM would help facilitate the integration of specialty mental health and substance use services at the county level into one behavioral health managed care program and proposes a new benefit — known as contingency management — for people with stimulant use disorder.

- **Aligned incentives and integrated care for seniors and people with disabilities.** Fragmentation of care and services is particularly acute for seniors and people with disabilities.[10] Medicare plays a significant role in paying for health care services for these populations. At the same time, they also receive important services, like nursing home care and personal care attendants,

that are paid for by Medi-Cal and are typically carved out of managed care. Under CalAIM, DHCS proposes reforms and incentives to make it easier for managed care plans to help seniors and people with disabilities stay in their homes and communities rather than move to nursing homes. It would also require plans to provide aligned Medicare and Medi-Cal plans for people eligible for both programs,[11] thereby supporting better integration and coordination of services. These reforms would build on lessons learned from the Coordinated Care Initiative.[12]

- **Standardized and enhanced requirements for managed care.** California has many different models of managed care today, each with a unique set of benefits and covered populations. In addition, there is variation in what plans do around population health management, data sharing, and voluntary accreditation. DHCS proposes a new requirement for managed care plans to proactively reach out to their members based on their needs, share data with other organizations and agencies providing care, and become accredited by the National Committee for Quality Assurance.[13] At the same time, DHCS would also introduce an aligned set of benefits and populations for all managed care plans to standardize their offerings and enable regional rate-setting.

- **More flexible payment for public hospitals that care for the uninsured.** Since 2015, public hospitals have been paid differently for care they provide to the uninsured, moving away from a system that focused on acute and emergency care to one focused on preventive care, including primary care and behavioral health. CalAIM would make the Global Payment Program a stronger tool for addressing health inequities by allowing participating public hospitals to be reimbursed for providing additional nontraditional services that address social determinants of health and improve population health outcomes and health equity. If these reforms are successfully implemented, uninsured patients would receive more preventive care, outreach, and care management services and be less likely to have complications that require an emergency room or hospital visit.

- **Enhanced oversight of county eligibility and enrollment processes.** Today, California delegates many functions of Medi-Cal to counties, including the determination of eligibility for Medi-Cal. There is variation in the degree to which counties successfully fulfill state and federal requirements for these functions. Under CalAIM, DHCS would do more to ensure that county eligibility and enrollment processes are compliant with federal and state regulations. The department plans to convene a workgroup to improve the collection of enrollee contact and demographic information in Medi-Cal and other public assistance programs.

- **Enhanced oversight of county California Children's Services programs.** The California Children's Services program is the primary way that Medi-Cal provides case management services and diagnostic and treatment services — as well as physical and occupational therapy services — to children and youth with eligible medical conditions, like cerebral palsy and diabetes. This program is administered by California's 58 counties. Through CalAIM, the state will enhance its oversight of counties to ensure they comply with applicable state and federal requirements.

- **Model of care for foster youth.** CalAIM would also develop a strategy for a fully integrated model of care for foster youth. DHCS has convened a workgroup[14] to determine short- and long-term policy recommendations for coordinating and improving care for this population.

Timeline for Implementation of CalAIM

DHCS maintains a calendar[15] (PDF) with updated time frames for when different reforms will go live. That should be the primary reference for those seeking more information about the timing of specific CalAIM programs.

This is the second in a series of explainers on CalAIM. The first, *CalAIM Explained: A Five-Year Plan to Transform Medi-Cal*, provides a basic overview of the initiative. Additional publications and resources from CHCF can be found in the CalAIM Collection. Additionally, the Department of Health Care Services has information on CalAIM on its website.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. *CalAIM Explained: A Five-Year Plan to Transform Medi-Cal*, CHCF, October 2021.
2. "Whole Person Care Pilots," California Dept. of Health Care Services (DHCS), last modified September 7, 2021.
3. "Health Homes Program," DHCS, last modified June 16, 2021.
4. *CalAIM Enhanced Care Management Policy Guide* (PDF), DHCS, September 2021.
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10. Giselle Torralba et al., *Meeting the Moment: Strengthening Managed Care's Capacity to Serve California's Seniors and Persons with Disabilities*, CHCF, April 2021.
11. Amber Christ and Georgia Burke, *A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care*, CHCF, September 2020.
12. "Coordinated Care Initiative Overview," DHCS, last modified October 19, 2021.
13. "Health Plan Accreditation," National Committee for Quality Assurance.
14. "Foster Care Model of Care Workgroup," DHCS, last modified September 15, 2021.
15. *DHCS Major Program Initiatives - Go-Live Dates (pending readiness and federal approvals)* (PDF), DHCS, last updated October 13, 2021.