California Behavioral Health Planning Council

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May 6, 2021 **Systems and Medicaid Committee May 2021 Letter to DHCS**

Jacey Cooper, State Medicaid Director
California Department of Health Care Services
1501 Capitol Avenue Sacramento, CA 95814

Dear Ms. Cooper:

The California Behavioral Health Planning Council thanks you for the opportunity to comment on the proposed CalAIM 1115 and 1915(b) waivers. Pursuant to state law, the Council serves as an advisory body to the Legislature and Administration on the policies and priorities that this state should be pursuing in developing its behavioral health system. Our membership includes persons with lived experience as consumers and family members, professionals, providers, and representatives from state departments whose populations touch the behavioral health system.

- Advocacy
- Evaluation
- Inclusion

The Council's Systems and Medicaid Committee (SMC) supports the CalAIM Initiative as it strives to improve quality outcomes through payment reform and value-based strategies, increases flexibility and reduces complexity in the current system. Given the revisions made to CalAIM in January 2021 as well as the significant changes proposed for the renewal and amendment of the 1115 and 1915(b) waiver authorities, the SMC has developed recommendations in addition to previous input submitted to DHCS in March 2020 and December 2020.

We believe the following recommendations will strengthen the CalAIM proposals to ensure consumers of the public behavioral health system are able to access and receive high-quality services to lead full and purposeful lives. These recommendations encompass providing culturally appropriate and responsive care with respect to all populations including but not limited to immigrant and refugees, children and families, LGBTQI2S and ethnic populations.

Listed below are the Systems and Medicaid Committee (SMC) recommendations for the proposed CalAIM 1115 and 1915(b) waivers on behalf of the California Behavioral Health Planning Council:

- Amplify and expand services provided by Natural Helpers and Traditional Healers to all cultural communities for the Drug Medi-Cal Organized Delivery System (DMC-ODS), Specialty Mental Health Services (SMHS), Managed Care Plans (MCPs), and contracted entities providing behavioral health services.

- Enhance information sharing capabilities to promote effective care coordination and transitions between delivery systems. DHCS may consider utilizing a health information exchange vehicle to help facilitate information sharing across entities.

- Provide specific guidance to Managed Care Plans (MCPs) and county Mental Health Plans (MHPs) to coordinate care, particularly

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for populations receiving the Enhanced Care Management (ECM) and In Lieu of Services (ILOS) benefits.

- Utilize and exchange a single coordination of care document in electronic medical records (EMRs) across entities statewide to leverage and ensure the timely exchange of pertinent patient information.
- Create greater efficiencies to eliminate duplication of certification requirements between mental health and substance use disorder (SUD) systems of care.
- Ensure that the CalAIM proposals result in reduced documentation requirements in order to promote sufficient time for patient care.
- Allow Medi-Cal beneficiaries to receive coordinated services outside of their county of residence to strengthen the No Wrong Door approach to improve access and timeliness of care.

A comprehensive description for each recommendation is provided below:

Recommendation: Amplify and expand services provided by Natural Helpers and Traditional Healers to include all cultural communities for the Drug Medi-Cal Organized Delivery System (DMC-ODS), Specialty Mental Health Services (SMHS), Managed Care Plans (MCPs), and contracted entities providing behavioral health services.

The SMC is supportive of the proposed expansion of services to California's diverse population by allowing Medi-Cal reimbursement for Natural Helpers and Traditional Healers for DMC-ODS, as this policy seeks to improve equity and reduce racial disparities in health outcomes. However, this policy excludes payment for culturally-responsive services and healing practices for the Asian and Pacific Islander, Hispanic, African American, and several other ethnic and cultural communities.

CalAIM also signifies that services provided by Natural Helpers and Traditional Healers are reimbursable in the Drug Medi-Cal Organized Delivery System but no other delivery systems. County Mental Health Plans (MHPs) currently provide culturally-specific services through community-defined practices but are not reimbursed through Medi-Cal. Instead, counties rely on Mental Health Services Act (MHSA), Realignment, and other local funding sources to pay for these services. Inequities and disparities in access and quality of care are likely to persist if Medi-Cal reimbursement for community-defined cultural practices applies only to one delivery system (DMC-ODS), as it disregards populations with co-occurring disorders or varying degrees of mental illness.
In order to ensure equity and reduce health disparities across all communities, the SMC is requesting DHCS to seek Medicaid

reimbursement for cultural healing and community-defined practices for all ethnic and cultural communities throughout multiple delivery systems. While the California Behavioral Health Planning Council's focus is aimed towards publicly-funded services delivered to individuals with severe behavioral health conditions, it is important to include these services in Managed Care, in addition to county MHPs, for consistency in care as beneficiaries frequently utilize multiple health care delivery systems.

<u>Recommendation:</u> Enhance information sharing capabilities to promote effective care coordination and transitions between delivery systems. DHCS may consider utilizing a health information exchange vehicle to help facilitate information sharing across entities.

The SMC highly appreciates the inclusion of a "No Wrong Door" approach to service delivery as it seeks to expand access to care and limit confusion and hardship for the beneficiary when navigating entry into the public behavioral health system. However, it is unclear on how patient records will be shared between providers in varying systems of care under the proposed No Wrong Door policy. Each system of care has its own confidentiality requirements around sharing patient health information. Additionally, physicians and health care providers use many different technologies to exchange data and bill for the services they render.

Limitations around patient record and data sharing hinders efforts to improve continuity and coordination of care that is envisioned in CalAIM and ultimately impacts the quality of care that a beneficiary receives. California needs to enhance its robust health care data exchange to achieve greater care coordination and continue moving the health care system toward value-based care.

The success of No Wrong Door relies on having infrastructure in place that enables providers and health care systems to communicate when managing, coordinating, and transferring an individual's care. One way that DHCS can help facilitate providers and health systems to effectively coordinate care for beneficiaries who access multiple systems or move within levels of care is through the implementation of a health information exchange vehicle. In order to protect the rights and privacy of the individual receiving care, this recommendation includes the option for the beneficiary to choose which entities may access their information.

We also encourage DHCS to review Senate Bill 371 for information on how to leverage funding and resources to implement data sharing and bidirectional communication between various health care entities and systems. DHCS may also want to consider viewing regional approaches for data sharing among behavioral health entities as mentioned in Assembly Bill 1132. Additionally, we request that DHCS work with stakeholders to develop strategies to mitigate the barriers to information sharing as it

relates to care coordination for individuals who access multiple care systems.

<u>Recommendation:</u> Provide specific guidance to Managed Care Plans (MCPs) and county Mental Health Plans (MHPs) to coordinate care, particularly for populations receiving the Enhanced Care Management (ECM) and In Lieu of Services (ILOS) benefits.

The SMC recognizes that CalAIM builds in the expansion of providers at the local level by leveraging Managed Care Plans to make services more accessible to our most vulnerable communities through the ECM and ILOS benefits. However, MCPs historically have not had sufficient experience in case management for populations with complex behavioral health needs who often require care in multiple settings and delivery systems. Additionally, it may be difficult for MCPs to navigate outreach and coordination of services to certain populations such as individuals who are homeless and are experiencing a behavioral health condition.

County MHPs and their contracted entities have abundant experience in outreach, coordinating, and delivering care for populations with complex physical and behavioral health care needs. While the proposed inclusion of contracted ECM Lead Care Managers who will serve as a single point of contact for the beneficiary is helpful, the SMC recommends that the state implement clear and detailed guidance between MCPs and MHPs to coordinate care for high-risk, vulnerable populations such as those who will participate in the ECM and ILOS benefits. The guidance would include examples of case management from MHPs and how individuals will effectively move within levels of care.

The guidance would also initiate conversations and planning between MCPs and counties on how to coordinate care for populations that reside in both MCP and MHPs. Conversations may include the development of data sharing agreements, discussions on cost and billing, and partnerships with hospitals and other entities. While the SMC recognizes that these care coordination activities are determined at the local level, the SMC believes that this recommendation will provide MCPs with the direction and support needed to effectively administer case management and care coordination for our most vulnerable populations including but not limited to individuals who are homeless, justice-involved, child welfare recipients, and/or experience SMI, substance use, or co-occurring disorders. We would like to call special attention to care coordination for the Transition-Age Youth (TAY) population as they transition to the adult system of care after the age of 21 to prevent these individuals from falling through the cracks of the system once they are disqualified from the EPSDT benefit.

<u>Recommendation:</u> Utilize and exchange a single coordination of care document in electronic medical records (EMRs) across entities statewide to leverage and ensure the timely exchange of pertinent patient information.

As Whole Person Care pilots and the Health Homes Program are transitioned to Enhanced Care Management and In Lieu of Services, Managed Care Plans will be responsible for more case management and coordination activities for high-risk, high-needs Medi-Cal beneficiaries. The coordination of care process becomes complex for counties with more than one MCP as each entity operating in the public behavioral health system has its own system for electronic medical records. With the existence of multiple EMRs for both counties and MCPs, there must be a vehicle in place that is commonly used among all parties responsible for managing and coordinating the care for Medi-Cal beneficiaries. Common on-the-ground tools such as standardized screening and transition tools are necessary and helpful in the coordination of care. Aside from these tools, coordination of care documents can be leveraged within existing EMRs to mitigate the likelihood of beneficiaries falling through the cracks when receiving care in multiple settings.

In addition to the recommendation above requesting specific guidance between MCPs and MHPs to strengthen the coordination of care for behavioral health populations with complex needs, the SMC encourages entities to form a standardized process for sharing patient information. The inclusion of a single coordination of care document within EMRs can allow MCP and MHP providers to relay vital information regarding patients who access multiple care systems and services. Therefore, the SMC is requesting that a single coordination of care document be implemented and exchanged across entities statewide in order to improve coordination and timeliness of quality care for Medi-Cal beneficiaries who are likely to access multiple care systems

<u>Recommendation:</u> Create greater efficiencies to eliminate the duplication of certification requirements between mental health and substance use disorder (SUD) systems of care.

CalAIM seeks to reduce complexity and create greater efficiencies in Medi-Cal through system reform and integration strategies. The administrative integration of mental health and substance use disorder services and moving DMC-ODS into a comprehensive 1915(b) waiver supports CalAIM's vision to move Medi-Cal to a more consistent and seamless system. However, there is an existing duplication of effort between the state and the county for provider certification. The process to certify mental health providers is completed at the local level through the county system and then submitted to the state. Certification and provider enrollment for substance use disorder services, however, is completed at the state level for DMC-ODS and Drug Medi-Cal. The SUD certification process often

results in delays and is more difficult to certify at the local level when compared to certification for mental health providers.

Many mental health providers have the knowledge and training to provide services to patients who experience co-occurring substance use disorders but may not have the clearance to treat them due to a lag in DMC-ODS or Drug Medi-Cal certification. Administrative efficiencies should benefit county systems, providers, and patient care. Therefore, the SMC is requesting DHCS to reimagine the certification process for substance use disorder providers so that it is parallel to the mental health certification at the local level.

***Recommendation:* Ensure that the CalAIM proposals result in reduced documentation requirements in order to promote sufficient time for patient care.**

While CalAIM seeks to streamline and reduce the documentation burden, the shift to new processes includes additional monitoring, reporting requirements, timelines, and other administrative activities which can result in spending more time on documentation and less time for patient care. This can impact CalAIM's vision to align system transformation with improved quality outcomes. The SMC requests that DHCS ensure that CalAIM has reasonable documentation requirements to ensure effective monitoring while not adversely impacting direct patient care. The committee would like to review any additional detail regarding documentation, monitoring, and reporting requirements in order to provide further input and recommendations.

***Recommendation:* Allow Medi-Cal beneficiaries to receive coordinated services outside of their county of residence to strengthen the No Wrong Door approach to improve access and timeliness of care.**

The No Wrong Door approach seeks to ensure that individuals receive the care they need no matter how they enter the system by allowing the delivery of services prior to a diagnosis or completion of an assessment. However, the No Wrong Door policy does not apply on a cross-county basis. There are individuals who may temporarily require non-emergency services outside of their county of residence. These individuals do not have the option to see a Medi-Cal provider outside of their home county unless they go to the Emergency Room which is likely to result in long wait times and higher costs or the care need is inappropriate for the ER.

The inability for Medi-Cal beneficiaries to temporarily receive health services outside of their county impacts access and timeliness to services. The SMC suggests that DHCS implement protocols that allow Medi-Cal beneficiaries to temporarily receive coordinated care between an

individual's county of residence and the county in which they are seeking care. We believe this practice will strengthen the proposed No Wrong Door policy to reduce disruptions in care and ensure that individuals receive services regardless of the delivery system and county of residence.

We hope that the recommendations put forth in this letter are taken into consideration as the Department of Health Care Services seeks federal approval of the CalAIM 1915(b) and 1115 waiver authorities. We appreciate the opportunity to submit comments, and ask to be included in conversations hosted on this topic. If you have any questions, please contact Jane Adcock, Executive Officer, at Jane.Adcock@cbhpc.dhcs.ca.gov.

cc: Kelly Pfeifer, M.D., Behavioral Health Deputy Director
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