California Behavioral Health Planning Council

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Deborah Starkey

EXECUTIVE OFFICER
Jenny Bayardo

February 17, 2023

Tyler Sadwith, Deputy Director of Behavioral Health
California Department of Health Care Services
1501 Capitol Avenue Sacramento CA 95811

Dear Mr. Sadwith:

The CBHPC appreciates the department's efforts in putting together this proposal within the CalAIM Initiative as it strives to improve the beneficiary experience and reduce administrative burden at the county and provider level. The Planning Council's Systems and Medicaid Committee (SMC) provides the comments and recommendations for the CalAIM Behavioral Health Administrative Integration Concept Paper in this letter.

The SMC supports integration efforts aimed to serve individuals with both mental health and substance use disorders in a seamless manner and improve behavioral health services. The committee emphasizes the need for behavioral health integration to be done in a way that does not create additional administrative burden or result in overload that impacts both beneficiary care and other parallel direct care initiatives requiring concurrent implementation (i.e. payment reform, 988, CARE Act, etc.). These initiatives and others will also require administrative supports to ensure proper tracking and collecting information on outcomes across systems and administrative processes to align mental health and SUD provider networks on the same cycles. We want to ensure that no population gets left behind, such as complex-needs and diverse populations, when counties and providers are faced with growing administrative expectations from the state. Additionally, the SMC would like to note that the definition for mental health recovery differs from substance use disorder recovery so it is important to consider the implications for integration and be mindful of not losing the distinction of these services for beneficiaries being served. Therefore, **the SMC asks DHCS to provide clarification in subsequent guidance on how administrative integration improves the beneficiary experience.** For instance, it may be helpful to mention how less administrative burden would allow counties to have a greater focus on the delivery and quality of care.

The SMC recommends that the implementation timeline for the CalAIM Behavioral Health Administration proposal be changed from calendar year to fiscal year to align with county cost reporting requirements. All counties are required to conduct cost reports based on the fiscal year. Per this proposal's current structure, counties will have to conduct cost reports for administrative integration in January and then again for the fiscal year. Additionally, the counties would have to find creative ways to finalize contracts in January per the calendar year requirement despite the budget hearings being held mid-calendar year. This would require counties to make predictions about the second half of the fiscal year or make multiple contract amendments. Therefore, requiring counties to implement this program on a calendar year basis creates duplicative processes which adversely impacts the goal of integration in

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reducing administrative burden. The SMC seeks clarification on why calendar years are being used and kindly requests that DHCS consider changing the timeline to align with current county reporting requirements per the fiscal year rather than mandating counties to adjust their reporting to the calendar year schedule if appropriate.

The committee requests that DHCS assemble lessons learned from the Drug Medi-Cal Organized Delivery System (DMC-ODS) including challenges and best practices of implementation as well as the outcomes of the demonstration. It would be helpful to gather this information from a provider perspective as well as the county perspective and compare the challenges, successes, and outcomes. SMC members have expressed instances where DMC-ODS resulted in losing providers, closing businesses, and creating additional access issues at the county level despite the state's good intent. The SMC would like to ensure that policies and practices that did not work under DMC-ODS are not duplicated in the CalAIM Behavioral Health Administrative Integration proposal in order to avoid the adverse outcomes that occurred with DMC-ODS. Lessons learned from DMC-ODS would inform stakeholders and counties, and serve as an indicator of whether the CalAIM Behavioral Health Administrative Integration proposal will be effective in practice.

The committee would like to submit the following comments and questions regarding the **payment rate structure** for this proposal:

- Administrative integration depends on the rate structure. **The SMC inquires whether the rates are sufficient to allow for the complexities of integration. Transparency is required for the rate structures at both the county and provider level prior to integration.** Therefore, CalAIM payment reform will require robust conversations with subject matter experts and stakeholders as it intersects with the administrative integration of mental health and substance use disorder services.

- The committee is aware that the funding sources will not change under this proposal, however, **we ask DHCS if there is an opportunity to adjust existing Fee-For-Service (FFS) rates for counties operating in the Drug Medi-Cal (DMC) system as the current FFS rates are low.** Payment reform is needed in order for small counties to leverage their resources and staffing to effectively operate these services.

- **The SMC is seeking clarification on how equity is considered for rate development and integration.** For instance, how will small counties utilizing a FFS model via DMC administer services

equitably as compared to DMC-ODS counties if they, DMC, has low payment rates.

The SMC would like to express the following comments in regards to **data integration and interoperability**:

- Databases vary by county instead of there being one statewide integrated data system. This poses difficulties for providers effectively serving beneficiaries with co-occurring disorders or individuals receiving services in multiple systems as they do not have access to the beneficiary's complete chart. Therefore, **the committee would like to see data systems have the ability to communicate with each other (with respect to patient confidentiality rules), and with physical health systems for beneficiaries that would be treated in multiple systems.** Any guidance or technical assistance that DHCS can provide on this area would be helpful and greatly appreciated.

- The Early Psychosis Intervention (EPI) Plus Program at the Mental Health Services Oversight and Accountability Commission (MHSOAC) has 34 counties with Coordinated Specialty Care (CSC) and are working on evaluation systems as well as the data and outcomes for those specific programs. The MHSOAC also has an innovation program with participation from 23 counties who look at integration in respect to data and communication between data systems. The CalAIM Behavioral Health Administrative Integration concept paper's efforts to integrate mental health and SUD is fragmented in the sense that there are multiple integration projects occurring concurrently, none of which are statewide. **The SMC asks the state to acknowledge that any unification of data between mental health and SUD be taken at a broader perspective.** There is a need to articulate the big picture of data integration across all fields and funding sources with consideration to counties, Managed Care Plans, and private health care sector.

The committee would like to express the following comments for consideration in regards to the **workforce crisis** and **provider contracts**:

- The complexity of the Behavioral Health Administrative Integration proposal requires extensive staff investments at the county and provider levels. The proposal initiates county level change but the provider level change must also be considered. The existing timelines are ambitious for these changes considering the current workforce shortage and staff requirements to fulfill duties for recent

and upcoming initiatives that require major local-level adjustments (i.e. CalAIM, Children and Youth Behavioral Health Initiative, etc.). **The workforce shortage and level of burnout that exists currently will need to be addressed in order to ensure the success of this proposal**.

- The SMC supports efforts to reduce redundancy and inefficiency in the process to certify providers and recommends that most decision-making is held at the local level. **There is a need to pilot this streamlined certification process prior to the full implementation in January 2027.** This testing process will help reduce barriers to provider certification and the workforce crisis.

- From the committee's understanding, counties will contract with providers who will then have to rewrite contracts to align with this integration proposal. This practice would create duplicative work. Therefore, **the SMC recommends that DHCS provide clear and specific guidance to counties on provider contracts for providers delivering both mental health and SUD services as well as providers delivering solely a MH or SUD service.**

- The committee supports significant pre-training for integration to providers but have concerns that the time required for training reduces time spent on direct services. **The SMC would like the state to ensure that the number and quality of services to both mental health and SUD clients does not suffer negative impacts in the integration process.**

The committee recognizes efforts for DHCS to consult with stakeholders via the landscape assessment in the development of this proposal. The success of this proposal will require ongoing conversations with counties, providers, and consumers and take action based on the needs and recommendations of these stakeholders. **It is highly recommended that DHCS works with stakeholders through the planning and implementation process to consider concerns and find solutions in a collaborative manner.**

Additionally, **the SMC requests that DHCS provide clear instructions in the guidance released in regards to this proposal. Lack of clarity may cause duplication.** For instance, prior guidance stated that SUD may not be required to do No Wrong Door screening, however, SUD providers at the local level were mandated to do screenings because they have not been told otherwise. We ask there be universal standardization, expectations, and guidelines across all the counties.

We hope that the recommendations put forth in this letter, as well as prior recommendations provided in the Systems and Medicaid Committee's CalAIM recommendation letter (March 2020), are taken into consideration as the Department of Health Care Services implements the CalAIM Behavioral Health Administrative Integration proposal. 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 Jenny Bayardo, Executive Officer, at Jenny.Bayardo@cbhpc.dhcs.ca.gov.

Sincerely,

[redacted]

Deborah Starkey
Chairperson

cc: Paula Wilhelm, Assistant Deputy Director of Behavioral Health
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