California Behavioral Health Planning Council

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Noel J. O'Neil, LMFT
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January 11, 2023

Tyler Sadwith
Deputy Director of Behavioral Health
California Department of Health Care Services

Dear Mr. Sadwith,

The California Behavioral Health Planning Council (CBHPC) thanks the Department of Health Care Services (DHCS) for the opportunity to comment on the California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration Concept Paper to inform the development of the Medicaid Section 1115 Waiver Application to the Centers for Medicare and Medicaid Services (CMS). 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. Their perspectives, particularly those provided by individuals with lived experience as members of our committee, are essential to our view on the challenges and successes of behavioral health services and best practices in California.

- **Advocacy**
- **Evaluation**
- **Inclusion**

The CBHPC appreciates the department's efforts in creating the CalBH-CBC concept paper and stakeholder process as this proposal strives to expand capacity and the continuum of community-based behavioral health services in California. The Planning Council's Systems and Medicaid Committee (SMC) provides the comments and recommendations for the CalBH-CBC Concept Paper in the categories below:

Intersection of Assertive Community Treatment (ACT) and Full Service Partnerships (FSP)

Existing Full Service Partnerships (FSP) have state-funded authority which are informed by Assertive Community Treatment (ACT). It is unclear as to why ACT is being named in the concept paper as a separate and distinct service from FSPs. The SMC asks DHCS to clarify whether the utilization of ACT in the Medicaid Section 1115 Demonstration Waiver is a federal or state requirement and if counties may propose the use of other evidence-based practices or Community Defined Evidence (CDE) practices such as strength-based models for opting into this requirement. The SMC requests that DHCS broaden this requirement and also provide examples of community-defined practices for ACT in subsequent guidance to counties. The SMC is also seeking clarity on whether counties will have both FSP and ACT models or if FSP teams will need to adopt the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT model to draw down federal funds. This is also an important consideration for CARE Court participants who will be directed to FSPs.

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The committee requests that there be clarification on the interaction between FSP and ACT, as well as how these models will be used in community-defined and evidence-based practices for the populations of focus (children/youth, justice-involved, unhoused).

We would like to recommend reexamination of the original design of the FSPs as developed by Mark Ragins at the Village in Long Beach and use this already developed framework as part of this demonstration proposal to address differences between ACT and FSPs, as well as provide flexibility in allowing counties to utilize existing FSPs based on evaluations, experiences, and reports on best practices.

Short Term Residential Treatment Programs (STRTP) as Institutes for Mental Disease (IMD)

The concept paper states that CMS has allowed states to seek expenditure authority for services provided to children and youth involved in the foster care system in qualified STRTPs that are IMDs with an exemption on the length-of-stay limitations. It is important that the requirements of this proposal do not result in the loss of STRTP capacity that currently exists if a county chooses not to opt-in. The SMC asks DHCS to clarify whether STRTPs that are considered IMDs will be a county opt-in benefit or a statewide benefit via the Medicaid Section 1115 Demonstration Waiver, and requests that the department takes steps to ensure that current STRTP capacity is maintained irrespective a county's opt-in status. The committee recommends that STRTPs be included as a statewide benefit as this will assist counties, particularly small counties, to benefit from this waiver proposal.

Small and Rural County Administrative Challenges and Solutions

The SMC finds that some requirements provided in the concept paper may result in increased administrative burden for small counties as these counties must already attend to CalAIM and other initiatives that result in major administrative changes. For instance, the bottom of Page 21 states, *"Specifically, DHCS anticipates amending the county MHP contract to (1) establish key performance expectations and accountability standards, (2) build on goals and standards included in the state's Medi-Cal Comprehensive Quality Strategy and other quality and evaluation initiatives, and (3) outline incentive payment opportunities. For example, DHCS may amend the contract to include demonstration-related coordination requirements with the MCPs and other entities;"* This requirement highlights the increased administrative burden to small counties who do not have adequate staffing levels to comply with the current requirements let alone the additional reporting and penalties being added. Therefore, it will be challenging for small and rural counties to participate in the optional benefits. This occurred initially with the Drug Medi-Cal Organized Delivery System as well as the Whole Person Care Projects where the reporting was too cumbersome for small counties,

resulting in these innovative practices occurring in larger or more urban areas.

The SMC would like to propose the inclusion of regional models to assist small and rural counties with limited resources and capacity to participate in county opt-in benefits, as well as the SMI/SED IMD component which requires counties to participate in all opt-in benefits proposed in the concept paper. The committee believes the use of innovative regional models would incentivize small and rural counties to opt-in and increase the availability of services statewide by providing these counties with the flexibility needed to increase service capacity. Please refer to the hypothetical example provided under the "County Opt-In Requirements for Medicaid Reimbursement" section of this letter which provides insight on how DHCS may consider approaching regional models to expand IMD capacity for small and rural counties.

County Opt-In Requirements for Medicaid Reimbursement

The SMC appreciates efforts for DHCS to provide flexibility to counties to participate in opt-in benefits that will offer Medicaid reimbursement for services that many counties already offer via other funding mechanisms. Any reimbursement through Federal Financial Participation would assist county budgets and expand service capacity, especially for small counties where placing an individual in an inpatient or IMD setting is extremely costly and dependent on Realignment or other local funds.

The committee would like to note that inpatient hospitals serve individuals outside of the county in addition to in-county residents. Therefore, the SMC asks DHCS to consider innovative ways to approach county opt-in requirements if a county is not able to or chooses not to opt-in to all services required to receive Medicaid funding for IMDs. A hypothetical example would be that all in-patient stays within the established IMD criteria would qualify for IMD opt-in if at least one county using the psychiatric hospital opts in. The idea is to ensure that maximum value to California is achieved in these settings and all placed patients are part of any evaluation of that hospital, rather than only at an opt-in county level. The SMC also requests that DHCS release guidance to clarify how bundled services (i.e. ACT, FACT, Coordinated Specialty Care, etc.) interface with Medicaid reimbursement.

Availability of Residential Facilities/Treatment Beds

Page 27 of the concept paper states *that "DHCS proposes requiring all mental health inpatient and residential facilities in opt-in counties to have accreditation from a nationally recognized entity, except for psychiatric hospitals that are certified by the California Department of Public Health (CDPH)…"* The SMC would like to note that many group homes closed when the state required them to be accredited as this was an expensive

and onerous process. The committee recommends that DHCS provide the funding and assistance needed for accrediting mental health inpatient and residential facilities in opt-in counties to ensure that this requirement does not result in losing residential treatment beds due to the inability for facilities to become accredited. The committee would like to receive information and status updates in regards to DHCS' efforts to track the availability of inpatient and crisis stabilization beds on a statewide basis.

County Implementation Plans

There is a statement on Page 32 of the concept paper that states that opt-in counties **may** be required to submit and secure DHCS approval of an implementation plan that outlines how each county will meet the requirements for securing IMD funding. The SMC recommends that counties be mandated to submit implementation plans in order to be eligible for IMD funding. We support any administrative flexibilities in this area to assist small county involvement in the demonstration.

Transitions to Community-Based Care

The SMC supports efforts in the CalBH-CBC concept paper to establish transitions and care coordination from inpatient hospitals and residential treatment settings to community-based care. The committee asks DHCS to clarify whether there will be a creation of a transition tool that assists beneficiaries from inpatient hospitals or if the standard transition tool for adults via the CalAIM Initiative will be used for this purpose. The SMC also requests that DHCS provide additional guidelines for transitions to community-based care outside of the transition tool when flexibilities are warranted as individualized approaches remain critical for successful engagement.

Community Health Worker (CHW) Benefit

The SMC would like to thank DHCS for proposing the Community Health Worker (CHW) Benefit as a county opt-in benefit as CHWs may serve individuals with serious mental illness (SMI) and children with serious emotional disturbances (SED). However, the committee would like to see this benefit be extended statewide to help meet the needs of all individuals with SMI/SED.

Additionally, clarification is needed on how this benefit interfaces with rehabilitation workers and Peer Support Specialists with similar functions. The SMC recommends that DHCS provides guidance to counties that highlights the similar and distinct functions between CHWs and Peer Support Specialists and whether CHWs and peers may be used interchangeably at the local discretion when operating similar functions. This recommendation may assist counties with maximizing the use of CHWs and peers to expand capacity for individuals served by the public behavioral health system.

Supported Employment
The SMC asks DHCS to clarify which elements of supported employment will be funded by Medicaid since not all supported employment programs are administered by the county or the evidence-based Individual Placement and Supports (IPS) model. This proposal would require a significant shift in how counties understand and fund supported employment programs. Additionally, recipients of supported employment often need long-term supports as behavioral and social factors will continue to change after an individual secures employment. Therefore, the committee asks DHCS to consider how counties that opt-in to supported employment will conduct long-term services of supported employment such as job coaching as well as how those costs would be recouped when individuals need services several months after being placed in a job.

Centers of Excellence (COEs)
The SMC appreciates the proposal to establish and fund Centers of Excellence in the Medicaid Section 1115 Demonstration Waiver application to support statewide practice transformations. The committee asks DHCS to provide additional clarity on how COEs will interface with county behavioral health organizations and community-based organizations. It may be helpful to define and clarify the vision for the COE proposal in subsequent guidance and planning efforts.

Rent/Temporary Housing Availability
The SMC supports efforts to provide up to six months of rent/temporary housing for beneficiaries who are homeless or at risk of homelessness after receiving treatment in an institutional setting, and meet access criteria for Specialty Mental Health Services, Drug Medi-Cal, and DMC-ODS services. However, many counties do not have an adequate supply of housing units to place the beneficiary. The SMC suggests that DHCS leverage funding and resources to ensure that individuals with SMI/SED have supported housing and community supports after leaving residential settings. The timing of building adequate affordable housing options will determine the success of this proposal at the local level to assist this population and meet outcomes measures. There is concern that six months of funding for rent/temporary housing is a short window of assistance without any clarity on what occurs after the six month period is complete. The committee asks DHCS to provide more information regarding this topic so that CBHPC may further support this initiative.

Older Adult Population
The SMC asks DHCS to consider the addition of older adults with behavioral health needs to the populations of focus. These individuals often need supports to develop resiliency. It is particularly important to increase access to initial assessments for older adults as an entryway point

to SMHS and should follow a similar process to the assessment and entry point into child welfare on Page 17 of the concept paper.

In addition to the recommendations above, the SMC requests DHCS to ensure that there is a local stakeholder process to implement the proposed programs in the concept paper, including a stakeholder process for any regional models that counties choose to adopt. Consumer and family member involvement in the development of policies is highly encouraged. The committee also suggests that abundant training be provided for the focus on moving towards the use of evidence-based programs.

We hope that the recommendations put forth in this letter are taken into consideration as the Department of Health Care Services assembles the Medicaid Section 1115 Demonstration Waiver Application. 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,

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Chairperson

cc: Paula Wilhelm, Assistant Deputy Director of Behavioral Health
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