# California Behavioral Health Planning Council

## Systems and Medicaid Committee Agenda

Thursday, October 21, 2021
https://us02web.zoom.us/j/89619831699?pwd=am9VZlhzcG5raldJd3Y0TXVpL2Z3UT09
**Meeting ID:** 896 1983 1699 **Passcode:** SMC2021
**Join by phone:** 1-669-900-6833 **Access code:** 8015627
10:30 a.m. – 12:00 p.m.

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|---|---|---|
| **10:30 am** | **Welcome and Introductions**<br>*Liz Oseguera, Chairperson* | |
| **10:35 am** | **Approve June 2021 Draft Meeting Minutes**<br>*Liz Oseguera, Chairperson and All Members* | **Tab 1** |
| **10:40 am** | **Revise SMC 2021-2022 Work Plan**<br>*Liz Oseguera, Chairperson and All Members* | **Tab 2** |
| **10:55 am** | **Public Comment** | |
| **11:00 am** | **Nominate 2022-2023 SMC Chair-Elect**<br>*Liz Oseguera, Chairperson and All Members* | **Tab 3** |
| **11:05 am** | **Break** | |
| **11:10 am** | **Discussion of General Session CalAIM Presentation**<br>*Liz Oseguera, Chairperson and All Members* | **Tab 4** |
| **11:50 am** | **Public Comment** | |
| **11:55 am** | **Wrap Up/Next Steps**<br>*Liz Oseguera, Chairperson and All Members* | |
| **12:00 pm** | **Adjourn** | |

*The scheduled times on the agenda are estimates and subject to change.*

**Systems and Medicaid Committee Members**

Liz Oseguera, Chairperson    Karen Baylor, Chair-Elect

| | | |
|---|---|---|
| Veronica Kelley | Celeste Hunter | Deborah Pitts |
| Tony Vartan | Catherine Moore | Karen Hart |
| Noel O'Neill | Walter Shwe | Uma Zykofsky |
| Dale Mueller | Marina Rangel | Cheryl Treadwell |
| Daphne Shaw | Susan Wilson | Joanna Rodriguez |

**Committee Staff**: Ashneek Nanua, Council Analyst; Jane Adcock, Executive Officer

If reasonable accommodations are required, please contact the Council at (916) 701-8211, not less than 10 working days prior to the meeting date.

**TAB 1**

# California Behavioral Health Planning Council
# Systems and Medicaid Committee
## Thursday, October 21, 2021

**Agenda Item:** Approve June 2021 Draft Meeting Minutes

**Enclosures:** June 2021 Draft SMC Meeting Minutes

**Background/Description:**

Committee members will review the draft meeting minutes for the June 2021 Quarterly Meeting.

**Motion**: Accept and approve the June 2021 Systems and Medicaid Committee draft meeting minutes.

# Systems and Medicaid Committee

Meeting Minutes (DRAFT)

Quarterly Meeting – June 17, 2021

**Members Present:**

| | | |
|---|---|---|
| Liz Oseguera, Chairperson | Karen Baylor, Chair-Elect | |
| Catherine Moore | Joanna Rodriguez | |
| Walter Shwe | Celeste Hunter | Uma Zykofsky |
| Noel O'Neill | Susan Wilson | Daphne Shaw |
| Veronica Kelley | Tony Vartan | Deborah Pitts |

**Staff Present:**

Ashneek Nanua, Jane Adcock, and Jenny Bayardo

**Public Attendees:**

Steve Leoni

**Meeting Commenced at 10:30 a.m.**

## Item #1 Approve April 2021 Draft Meeting Minutes

The Systems and Medicaid Committee (SMC) approved the April 2021 Draft Meeting Minutes. Noel O'Neill motioned approval. Celeste Hunter seconded the motion.

**Action/Resolution**

The April 2021 SMC Meeting Minutes are approved.

**Responsible for Action-Due Date**

N/A

## Item #2 Update Systems and Medicaid Committee Charter

The SMC provided revisions to the committee Charter during the April 2021 Quarterly Meeting. Committee staff reviewed the following changes to the SMC Charter:

- Additional language in regards to addressing equity
- Integration of Goal #2 of the SMC Work Plan into the Charter
- Additional language to indicate the presence of virtual meetings
- Addition of the CA Department of Aging to the list of systems that intersect with behavioral health.

Uma Zykofsky motioned approval of the revised SMC Charter. Catherine Moore seconded the motion. Deborah Pitts abstained. The SMC Charter has been approved.

**Action/Resolution**

SMC staff will finalize the changes to the SMC Charter and post the approved Charter to the CBHPC website.

**Responsible for Action-Due Date**

Ashneek Nanua – October 2021

## Item #3 Update SMC 2021-2022 Work Plan

SMC staff reviewed the revised SMC Work Plan for 2021-2022. The goals are broadly defined and delineated into specific objectives, activities, and timelines. Staff requested that committee members prioritize which goals and activities they would like to pursue in 2021 and which activities are appropriate to address in 2022 and subsequent years.

Committee members provided the following feedback for the SMC Work Plan:

- Uma Zykofsky requested that the Work Plan objectives be reordered chronologically by due date. She recommended prioritizing education to CBHPC on the CalAIM Initiative and peer certification as it relates to CalAIM. Activities for peer certification may include assistance with financial support for peers who are interested in certification but do not have the funding to help accomplish this goal. Uma added that Objective 1.3 regarding criminal-justice behavioral health populations is heavily focused on recidivism and should also include concepts of recovery and social equity.
- Noel O'Neill expressed interest in prioritizing the topic of conservatorship, Children and Youth Behavioral Health Initiative (BHI), guidance to DHCS on the

CalAIM Initiative as well as educating all Council members on CalAIM, and peer certification. He recommended postponing the criminal-justice and value-based payment efforts to a later year.

- Veronica Kelley stated that conservatorship involves multiple systems of care such as the courts. She cautioned the committee about the Governor's May Revise revoking the ability for conservatees to go to the Department of State Hospitals. This change denotes that the highest level of care would need to be provided in community which does not currently exist. Veronica stated that many objectives in the SMC Work Plan have specific funding amounts which may change based on the Governor's final budget. She reiterated earlier comments that the focus around justice-involved behavioral health populations should be centered on improving quality of care versus re-arrests/recidivism. Additionally, telehealth is an "in addition to" service rather than a replacement for in-person services. Veronica Kelley also expressed interest in tracking CalAIM.
- Catherine Moore stated that activities relating to peer certification can be directed towards the implementation process and ensuring the peer specializations are used appropriately in the system of care such that parent peers support parent peers and lived experience peers assist peers, without overlap between categories. On conservatorship, Catherine indicated that Patient Rights Committee is deliberating on if there should be a study to determine outcomes and provide guidance on where to fill the gaps in conservatorship, as well as determining the effectiveness of long-term versus acute psychiatric holds. She indicated that the SMC may weigh in on the Institutes for Mental Disease (IMD) aspect of conservatorship. Dr. Moore identified that the top priority for the SMC would be to help guide the CalAIM data process to determine what components will be measured and how to track outcomes prior to implementation.
- Deborah Pitts stated that another focus of the SMC may involve determining how to reconcile Medicaid Peer Support Specialist services with other reimbursed services that a peer might provide but that is not considered Peer Support.
- Susan Wilson stated that the Performance Outcomes Committee released the 2020 Data Notebook addressing telehealth. She expressed that it is important for CBHPC to track efforts around telehealth and indicated that telehealth has changed the ability for populations in rural geographies to access services.
- Committee members expressed the importance for the SMC and Planning Council to follow efforts for the Children and Youth Behavioral Health Initiative (BHI). Executive Officer, Jane Adcock, indicated that the California Health and Human Services Agency (CHHS) will institute workgroups on different aspects of the BHI with opportunities for CBHPC to participate in such efforts.

The SMC discussed timelines to conduct a presentation on the CalAIM Initiative during an upcoming General Session Council Meeting. Committee members decided to invite Dr. Kelly Pfeifer, DHCS Deputy Director of Behavioral Health, to provide a high-level,

general overview during the October Quarterly Meeting with an in-depth presentation to follow during the January Quarterly Meeting.

Committee members discussed their potential role in the upcoming implementation of peer certification programs. The SMC expressed that billing and documentation in the Medicaid system is an item of interest as well as expanding ways to fund peer support activities that are not billable by Medi-Cal but fit into the delivery of care.

**Action/Resolution**

SMC staff will revise the 2021-2022 Work Plan based on the feedback provided by committee members and deliver an updated draft at the next quarterly meeting.

**Responsible for Action-Due Date**

Ashneek Nanua, Liz Oseguera, Karen Baylor – October 2021

## Item #4 Public Comment

Steve Leoni indicated that the federal government will have a public comment period for the CalAIM Initiative. He indicated that the SMC may want to organize a response during the federal public comment period. Mr. Leoni also requested public comment after each agenda item during committee meetings.

**Action/Resolution**

N/A

**Responsible for Action-Due Date**

N/A

## Item #5 Wrap Up/Next Steps

**Action/Resolution**

SMC staff will notify committee members about upcoming opportunities to comment on the CalAIM federal comment period and participate in workgroups for the Children and Youth Behavioral Health Initiative. SMC staff will update the 2021-2022 Work Plan.

**Responsible for Action-Due Date**

Ashneek Nanua, Liz Oseguera, Karen Baylor – October 2021

Meeting Adjourned at 12:05 p.m.

**TAB 2**

# California Behavioral Health Planning Council
# Systems and Medicaid Committee
## Thursday, October 21, 2021

**Agenda Item:** Update SMC 2021-2022 Work Plan

**Enclosures:** Draft SMC 2021-2022 Work Plan

**<u>How This Agenda Item Relates to Council Mission</u>**
*To review, evaluate and advocate for an accessible and effective behavioral health system.*

The Work Plan is an instrument to guide and monitor System and Medicaid Committee activities in its efforts to uphold its duties within the framework of the Planning Council.

**Background/Description:**

The purpose of the Work Plan is to establish the objectives and goals of the SMC, as well as to map out the necessary tasks to accomplish those goals. The SMC will modify the 2021-2022 SMC Work Plan.

# California Behavioral Health Planning Council
# Systems and Medicaid Committee (SMC)
# Work Plan 2021-2022

[*Draft Revised 8/18/21*]

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**Goal #1:** *Educate the Council on Behavioral Health System reform*

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**Objective 1.1:** Educate all Council members on state-level policy changes proposed in the California Advancing and Innovating Medi-Cal (CalAIM) Initiative.

Knowledge development will include but is not limited to:

- An overview of the CalAIM behavioral health proposals in the Medicaid 1915(b) and 1115 waiver renewals
- Identification of strengths and areas where improvements are needed
- The committee's views and recommendations on the proposed behavioral health policy changes

**Activities**

- Compile information to include in the presentation and identify presenters
- Utilize the information gathered to develop an interactive method of presenting to inform the Council members
- Coordinate with the Executive Committee to secure the presentation date and time during the January 2022 Quarterly Meeting General Session

**Timeline:** January 2022-2023

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**Goal #2:** *Leverage the Council's role in the State of California to influence policy changes the committee identifies as necessary to improve the state's behavioral health system*

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**Objective 2.1:** Explore options to 1) make recommendations on financing and regulations for California's Peer Support Specialist Certification law and 2) identify and expand ways to fund peer support activities that fit into the delivery of care but are not billable by the Medicaid system

**Activities**:

- Research and review legislation on Senate Bill 803 to gain an understanding of the provisions for Peer Support Specialist Certification in California
- Invite the Department of Health Care Services to discuss the implications of SB 803 implementation from a financing and oversight perspective
- Utilize knowledge and information gathered to provide input to DHCS on the regulations and financing for Peer Specialist Certification

- Determine how peer certification will be executed through the CalAIM Initiative
- Recommend the state collect data on Peer Specialist Certification such as the number of Peer Specialists practicing across the state, cost-benefit analysis of using peers versus higher salary providers, feedback and outcomes from consumers who utilized Peer Support Specialists, and other information to support the continuation and participation of this program
- Collaborate and consult with the Workforce and Employment Committee (WEC) to ensure consensus among the Planning Council's views and recommendations
- Explore ways to provide financial assistance for peers who are interested in certification but do not have the funding to help accomplish this goal
- Determine how to reconcile Medicaid Peer Support Specialist services with other reimbursed services that a peer might provide but that is not considered Peer Support
- Track implementation activities and ensure that peer specializations are appropriately assigned and utilized

**Timeline:** October 2021 – January 2022

**<u>Objective 2.2:</u>** Provide recommendations to the Department of Health Care Services throughout the CalAIM implementation period, particularly for measuring and tracking outcomes for the CalAIM behavioral health proposals.

**Activities:**

- Invite presenters and hold conversations regarding data and outcomes for individuals with SMI and substance use disorders
- Determine how CalAIM will be measured and how to track outcomes prior to implementation
    - Work with DHCS, CBHDA, and other collateral partners to identify data points that all counties will collect
    - Identify measurement tools that are compatible across systems to analyze whether programs and services rendered under CalAIM are effective
- Participate in DHCS meetings and stakeholder engagement sessions relating to CalAIM behavioral health proposals that will be developed after January 2022 in order to continue efforts to reform California's public behavioral health system
- Participate in CalAIM stakeholder sessions regarding the proposal to initiate Medi-Cal pre-release application and services for individuals 30 days prior to release from incarceration

**Timeline**: October 2021 – December 2022

**<u>Objective 2.3</u>:** Advocate for funding and resource allocation to address disparities in accessing technology for Medi-Cal behavioral health services, known as the "digital

divide," in order to improve health equity and outcomes for unserved and underserved Medi-Cal populations.

**Activities:**

- Gather information on factors contributing to the digital divide in Black, Indigenous, and People of Color (BIPOC) communities and other unserved and/or underserved communities
- Hold a stakeholder convening to collect feedback from consumers, family members, behavioral health advocates, and other stakeholders in order to inform policies to reduce barriers to accessing telehealth services
- Utilize information gathered to compile a white paper or recommendation letter advocating for additional funding, resources, and technical assistance needed to reduce the digital divide
- Provide recommendations to DHCS, as applicable, regarding the Governor's proposed funding allocation to expand and make permanent telehealth flexibilities authorized during the COVID-19 public health emergency

**Timeline**: TBD

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**Goal #3:** *Collaborate with other entities on behavioral health system reform, including issues with the current system, recommendations for policy change and current efforts to influence the change*

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**Objective 3.1:** Collaborate with state, county, and health plan partners to appropriately direct the Governor's proposed funding allocations towards behavioral health services and student mental health services for children and youth who experience or are at-risk of experiencing a behavioral health condition.

**Activities:**

- Work with key entities including, but not limited to, the California Department of Education (CDE), Department of Health Care Services (DHCS), County Behavioral Health Directors Association (CBHDA), Mental Health Services Oversight and Accountability Commission (MHSOAC), county Mental Health Plans (MHPs) and Managed Care Plans (MCPs) on issues relating to the coordination of student mental health services and behavioral health services for children and youth, particularly to provide guidance to MCPs who will be responsible for overseeing capacity and infrastructure development for student mental health
- Participate in stakeholder sessions and provide policy recommendations to support a robust behavioral health service delivery system for children and youth

**California Behavioral Health Planning Council**
**Systems and Medicaid Committee (SMC)**
**Work Plan 2021-2022**
[*Draft Revised 8/18/21*]

- Assist California Health and Human Services Agency with community outreach and stakeholder forums to ensure that the consumer and family voice is represented in the design and policy development of the Children and Youth Behavioral Health Initiative
- Track activities related to MHSA funding allocation to the MHSOAC to augment the MHSA Partnership Grant Program which will fund partnerships between county MHPs and school districts
- Collaborate and provide input to CBHDA on the Proposition 98 funds to innovative partnerships with county behavioral health departments to support student mental health services
- Provide recommendations to DHCS and CHHS as necessary relating to:
    - Development of a Behavioral Health Service Virtual Platform that provides children and youth with access to virtual behavioral health services and interactive tools and supports
    - Development and sharing of evidence-based practices to improve outcomes for children and youth at high risk for behavioral health conditions
    - Addition of dyadic services, an integrated model of physical and behavioral health screening and services to the whole family
    - Creation of a public education campaign to reduce the stigma on behavioral health needs to build a common understanding of ACES and toxic stress and encourage children and families to seek care before a crisis occurs
    - Design and implementation of the behavioral health continuum of care infrastructure
- Participate in System of Care (Assembly Bill 2083) efforts as appropriate
- Gather information about various funding sources, activities, challenges, and best practices for behavioral health and school mental health services

**Timeline:** TBD

**Objective 3.2:** Support efforts to make improvements in the conservatorship system in California including following the implementation of the Institutes for Mental Disease (IMD) Exclusion Waiver and tracking efforts for the use of the Behavioral Health Continuum Infrastructure funding.

**Activities:**

- Invite key stakeholders to initiate committee discussion regarding current issues around conservatorship as well as the barriers and strategies to meet the needs of individuals defined as gravely disabled or needing care in an IMD facility
- Track and participate in efforts relating to the use of Behavioral Health Continuum of Care Infrastructure funding to ensure a robust continuum of care

for individuals with behavioral health conditions to fulfill the requirements under the IMD Exclusion Waiver in California

- Collaborate with key stakeholders and legislators to create or amend a bill to designate a lead entity equipped with resources to oversee conservatorship, mandate data collection by all public guardian offices, issue reports with analysis of the data and ensure the data is transparent for the public

**Timeline:** TBD

**TAB 3**

# California Behavioral Health Planning Council
# Systems and Medicaid Committee
## Thursday, October 21, 2021

**Agenda Item:** Nominate 2022-2023 SMC Chair-Elect

**Enclosures:** None

**How This Agenda Item Relates to Council Mission**
*To review, evaluate and advocate for an accessible and effective behavioral health system.*

This agenda item provides the opportunity for committee members to nominate the next Systems and Medicaid Committee (SMC) Chair-Elect. The Chair-Elect is responsible for supporting the Chairperson with leading committee activities.

**Background/Description:**
Each standing committee shall have a Chairperson and Chair-Elect. The Chairperson serves a term of 1 year with the option for re-nomination for one additional year.

Karen Baylor is slated to become the Chairperson for the Systems and Medicaid Committee at the January 2022 Quarterly Meeting. The committee members shall nominate a Chair-Elect to be submitted to the Council's Officer Team for appointment.

The role of the Chair-Elect is outlined below:

- Facilitate the committee meetings as needed, in the absence of the Chairperson
- Assist the Chairperson and staff with setting the committee meeting agendas and other committee planning
- Participate in the Executive Committee Meetings on Wednesday mornings during the week of quarterly meetings
- Participate in the Mentorship Forums when the Council resumes meeting in person.

**Motion**: Nomination of a committee member as the SMC Chair-Elect.

**TAB 4**

# California Behavioral Health Planning Council
# Systems and Medicaid Committee
## Thursday, October 21, 2021

**Agenda Item:** Discussion of General Session CalAIM Presentation

**Enclosures:** CalAIM Webpage – Full Proposal and Executive Summary
SMC CalAIM Recommendation Letter (March 2020)
SMC CalAIM Recommendation Letter (May 2021)
July 2021 BH-SAC Presentation Slides (Page 6)
CBHPC Overview of July 2021 BH-SAC Meeting
CHCF Fact Sheet – CalAIM: Behavioral Health Proposals
CHCF Fact Sheet – CalAIM Explained: A Five-Year Plan to Transform Medi-Cal

**How This Agenda Item Relates to Council Mission**
*To review, evaluate and advocate for an accessible and effective behavioral health system.*

The discussion is intended to assist committee members in creating a presentation to inform all Council members on the behavioral health system reform in California via the CalAIM Initiative. The presentation will provide background needed to identify gaps in the present system and allow council members to discuss and make appropriate policy recommendations to legislators throughout the CalAIM implementation period.

**Background/Description:**
The Systems and Medicaid Committee identified the need to educate and engage the Council on upcoming changes to the public behavioral health system initiated by the CalAIM Initiative. SMC members will present key CalAIM behavioral health proposals over several sessions during the Council's General Session Quarterly Meetings. The SMC will determine the following items for the January 2022 General Session CalAIM presentation:

- **Content of presentation**
  - Overview of prioritized CalAIM proposals (Medical Necessity/No Wrong Door and changes to Drug Medi-Cal Organized Delivery System)
  - Summary of SMC's recommendations to DHCS
  - Discussion questions following the presentation for future implications on the behavioral health system
- **Method of training** e.g.) PowerPoint presentation, breakout rooms, etc.
- **Presenters**
- **Timeline to present CalAIM proposals to be implemented in July 2022 and January 2023**

CHAIRPERSON
Lorraine Flores

EXECUTIVE OFFICER
Jane Adcock

- Advocacy
- Evaluation
- Inclusion

March 4, 2020

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 changes to the Medi-Cal waivers and California Advancing and Innovating Medi-Cal (CalAIM) Initiative. 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 are essential to our view on the challenges and successes of behavioral health services and best practices in California.

The Council's Systems and Medicaid Committee (SMC), in collaboration with various stakeholders across California, have evaluated barriers to effective care in California's public behavioral health system and created recommendations for the CalAIM Initiative. In October 2019, the SMC hosted a stakeholder forum with the goal of gathering stakeholder input on how to improve California's behavioral health system and sharing these with DHCS. We've incorporated some of that feedback in our comments below. The 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 mass changes that the CalAIM is considering, the SMC felt that it would be more appropriate and time-effective to provide comments in two specific areas, Medical Necessity and the Administrative Integration of Mental Health and Substance Use Disorder Services as they impact the immediate and proper care of individuals with behavioral health conditions. We believe the following recommendations will strengthen these 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.

MS 2706
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Sacramento, CA 95899-7413
916.323.4501
fax 916.319.8030

These recommendations encompass providing culturally appropriate and competent care with respect to all populations including but not limited to immigrant and refugees, children and families, LGBTQI2S and ethnic populations.

***Recommendations for Medical Necessity***

The SMC recommends the following changes to improve the Medical Necessity proposal:

1) Support the proposal to amend Medical Necessity requirements to enable providers to deliver and be paid for services prior to determining a diagnosis.

2) Strongly recommend that the No Wrong Door policy be applicable to both adults and children.

3) Support the No Wrong Door approach by allowing care to be provided and paid for at the initial health setting that the client presents to receive care to mitigate the “ping-pong” effect of moving individuals between Managed Care Plans (MCPs) and County Mental Health Plans (MHPs).

4) We recommend the following to generate a true No Wrong Door approach for client transitions between systems of care:

    - Create statewide standards to operationalize warm-handoffs and referrals in the Memorandum of Understanding (MOU) between MCPs and MHPs.

    - Use Health Information Exchanges (HIEs) for client information sharing.

    - Implement a transition process that includes client agreement and active communication between providers through the use of a lean standardized transition tool.

5) Implement a lean standardized assessment tool to prevent duplicative assessments and re-traumatizing of clients when determining the appropriate level of care for a client.
    - We recommend the assessment tool be equipped with the option for providers to include additional elements to the assessment.

***Recommendations for the Administrative Integration of Mental Health and Substance Use Disorder Services***

The SMC recommends the following changes to improve the Administrative Integration of Mental Health and Substance Use Disorder Services proposal:

1) Strongly recommend the implementation of statewide peer specialist certification and training for community mentor programs.

2) Allow licensed providers to deliver both mental health and substance use disorder services if they possess the education and training to treat multiple diagnoses.

3) Increase flexibility for the provider enrollment process and reduce the rigidity for provider enrollment applications.
    - We support DHCS increasing resources and staffing to reduce the backlog in enrolling and licensing providers.

4) Implement a statewide integrated data system and provide technical assistance to counties and community-based organizations to transition into one system.

5) Streamline licensing reviews in facilities for mental health and substance use disorder services simultaneously.

## Reasoning for Medical Necessity

Please find below details regarding our suggestions for improving the Medical Necessity Proposal.

1. Support the proposal to amend Medical Necessity requirements to enable providers to deliver and be paid for services prior to determining a diagnosis.

Requiring a diagnosis directly correlated to eligibility within a particular system often causes confusion and misinterpretation that may restrict a client's access to care and lead to disallowed claims. We support the proposal as it would expand access to care and allow providers more time to determine treatment options before diagnosing a client, which can lead to better treatment outcomes. Additional time allows for the provider to conduct assessments and explore the client's symptoms, risk factors, and level-of-functioning to validate their diagnosis after the initial appointment takes place. Additionally, the provider may be incentivized to deliver value-based care when payment is ensured.

2. Strongly recommend that the No Wrong Door policy be applicable to both adults and children.
The No Wrong Door approach aims to mitigate the bifurcation of the behavioral health system and allow clients to access care at any entry point. This will help ensure services are received more immediately and without the risk of losing the client through the process.

All individuals should have access to care wherever they present in the system. Families should be considered in the treatment process to reduce potential feelings of isolation and trauma that may come from separation as the client moves through various levels of care.

3. Support the No Wrong Door approach by allowing care to be provided and paid for at the initial health setting that the client presents to receive care to mitigate the "ping-pong" effect of moving individuals between MCPs and MHPs.
When a client currently presents in a care setting and needs to be triaged into a different care system, the provider will refer this individual to what they believe is the appropriate care setting. This becomes problematic if the new provider rejects the referral and sends the client back to the system in which the client originally presented, thus creating a "ping-pong" effect and contributing to lack of access and negative outcomes for the client.

The No Wrong Door approach has the capacity to avoid a back-and-forth effect between services provided in MCPs and MHPs as it allows for services to be provided through multiple entities and varying levels of care simultaneously. We support the ability for clients to receive care through multiple care settings and recommend that MCP and MHP entities are in active communication to ensure non-duplicative services as outlined in their Memorandum of Understanding (MOU).

To strengthen the No Wrong Door approach and mitigate the "ping-ponging" between systems of care, we agree with DHCS' proposal to allow providers to deliver and be paid for services in the initial care setting while triaging clients to the appropriate system of care, before a diagnosis is determined. We support the use of a standardized screening tool to be used before triaging to different care systems and request that MOUs between MCPs and MHPs include details on how information will be shared across systems and providers.

4. Generate a true No Wrong Door approach for client transitions between systems of care.
It is common for a client's symptoms to improve or worsen throughout the course of treatment. In attempting to navigate the bifurcated behavioral health system, clients may find themselves lost in the transition process

between MCPs and MHPs when the systems themselves do not communicate or have standardized procedures in place for warm hand-offs and client information sharing. This often results in barriers to access as well as negative health outcomes for the client who is unable to maneuver successfully through complex and disconnected systems.

In order to ensure successful client transitions, we recommend that the state develop standards detailing the elements that must be included in the Memorandum of Understanding to facilitate referrals. The MOU between MCPs and MHPs should include a detailed plan on how they will work to triage clients who move between levels of care or receive their care at both MCPs and county systems. This includes a process to allow for warm hand-off referrals between MCP contracted providers such as community clinics and county providers.

We recommend the use of Health Information Exchanges (HIE) to facilitate communication between MCPs and MHPs. HIEs can increase collaboration between multiple systems to improve timeliness and access to services.

We recommend the following guidelines to ensure a successful transition process:

- The therapeutic alliance between a provider and client is unique. Therefore, we support the requirement for client agreement to change providers before a transition process is initiated (as outlined in the instructions for Sacramento County's Bi-Directional Medi-Cal Transition of Care Request Form).

- The clinical impression of the provider following an assessment of the client's current symptoms, risk factors, and level of functioning should be determined prior to transition. We support the use of a lean standardized assessment tool containing core elements to assess level of functioning to ensure that providers across systems have similar determinations of the client's level of impairment.

- Active communication between MCPs and MHPs is necessary to ensure continuity of care during client transitions. We recommend that the state develop standards detailing the elements that must be included in MOUs to facilitate referrals. Health information exchanges can also facilitate communication between MCPs and MHPs and increase collaboration between multiple systems to improve timeliness and access to services.

- We support DHCS' proposal to standardize the Sacramento County Bi-Directional Medi-Cal Transition of Request Form as the transition tool between providers in different systems of care.

- To ensure continuity of care, providers should be required to obtain the client's first appointment information during the transition process.
- A patient-signed disclosure document should be implemented to ensure that client information is protected during transitions. This document would allow for information sharing solely on items that the client feels comfortable disclosing to new providers.
- Clients should be able to move their own health record during the transition from one provider to another.

5. Implement a lean standardized assessment tool to prevent duplicative assessments and re-traumatizing of clients when determining the appropriate level of care.

The SMC would like providers to have the option to ask more information from clients if the assessment done by the previous provider does not already include those details.

We support the implementation of a lean standardized assessment tool shared between MCPs and MHPs which would include a section for clinicians to include their own elements to the assessment as needed. Standards for the assessment tool should reiterate the minimum data elements needed by the state with the option to add to it as needed. We also request that DHCS field staff and compliance be trained to understand the tool to clearly differentiate added elements. We request that entities are only held to the core standards in the assessment tool.

To ensure sensitivity to client needs, we recommend that providers inform clients of the information that will be shared if a transition between the systems of care is initiated. Clients should be given the opportunity to choose what sensitive information they would like to disclose such as immigration status (if shared) or sexual orientation.

## Reasoning for the Administrative Integration of Mental Health and Substance Use Disorder Services

Please find below details regarding our suggestions for improving the Administrative Integration of Mental Health and Substance Use Disorder Services Proposal.

1. Strongly recommend the implementation of statewide peer specialist certification and training for community mentor programs.

The use of peer specialists embodies community-based recovery and is a natural and cost-effective resource. Therefore, we support statewide peer specialist certification programs. In addition to peer specialists, community leaders and mentors should receive training to support individuals who

reside in cultural and rural communities. Models such as the Promotoras Project and Friendship Bench are examples of these community mentor programs.

<u>2. Allow licensed providers to deliver both mental health and substance use disorder services if they possess the education and training to treat multiple diagnoses.</u>
Licensed providers are often equipped with the skills to provide treatment for multiple conditions but are only able to provide treatment for a primary diagnosis. This can be problematic if a client presents with a secondary diagnosis because the provider must defer to another agency to provide that service. To help ensure a successful No Wrong Door policy, licensed providers should be able to provide all services that reside within their clinical scope.

We recognize that a level of specialization is needed to provide adequate treatment. We recommend that providers be trained to deliver a wide range of services while maintaining a level of specialization and refer to higher levels of care when needed.

<u>3. Increase flexibility for the provider enrollment process and reduce the rigidity for provider enrollment applications. We recommend that DHCS increase resources and staffing to reduce the backlog in enrolling and licensing providers.</u>
Counties face challenges in meeting network adequacy requirements when there is an insufficient quantity of qualified providers registered to deliver services. It is recommended that DHCS reduce the stringent review of provider enrollment applications involving minor errors that result in rejected applications. The provider enrollment process should be shortened and simplified with added flexibility so that providers do not wait years before they are enrolled. We support DHCS increasing resources and staffing to reduce the backlog in enrolling and licensing providers.

<u>4. Implement a statewide integrated data system and provide technical assistance to counties and community-based organizations to transition into one system.</u>
Currently, the separate data systems and confidentiality rules around protected patient health information pose challenges to coordinate care for clients. To improve care coordination across systems, we recommend the implementation of a statewide integrated data system. Electronic Health Records should be used in a way to track data and reduce duplicative data entries. Standardized questionnaires may help providers collect data and measure outcomes as well.

We encourage DHCS to help counties and health plans navigate 42CFR confidentiality requirements for substance use disorder services so that client information can be shared while protecting client confidentiality.

The shift from the current administrative processes may create challenges for current staff in county behavioral health departments and community-based organizations to adapt to new processes proposed in the CalAIM Initiative. Technical and financial assistance should be provided to counties and cultural communities to assist with the merging of administrative processes to reduce any confusion or backlog that may occur with the transition.

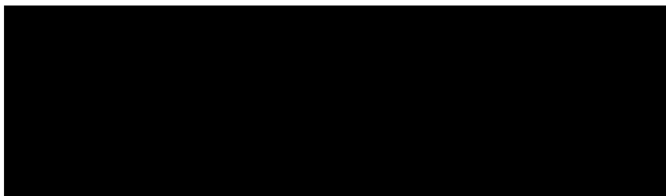
5. Streamline licensing reviews in facilities for mental health and substance use disorder services simultaneously.

Under the current system, it can take several years to license providers and behavioral health facilities to provide care to clients with high-level needs for care. Therefore, the process to license facilities should be streamlined for both mental health and substance use disorder services. It is also critical to recognize that mental health and substance use disorder services are not integrated in nature but rather two issues that are closely tied together.

We hope that the recommendations put forth in this letter are taken into consideration as the Department of Health Care Services makes amendments to the CalAIM Initiative. 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
California Department of Health Care Services

Sincerely,



Lorraine Flores
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May 6, 2021

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.

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

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.

***Recommendation:*** ***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.**

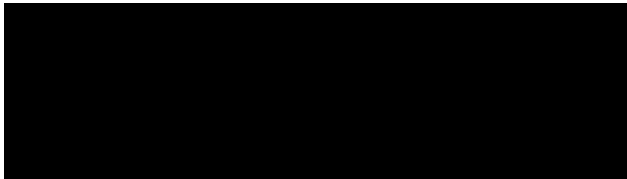
The No Wrong Door approach seeks to ensure that individuals receive the care they need no matter how they enter the system by allowing the delivery of services prior to a diagnosis or completion of an assessment. However, the No Wrong Door policy does not apply on a cross-county basis. There are individuals 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
California Department of Health Care Services



Noel J. O'Neill, LMFT
Chairperson

# California Behavioral Health Planning Council Overview of DHCS Behavioral Health Stakeholder Advisory Committee: July 2021 Meeting

The Behavioral Health Stakeholder Advisory Committee (BH-SAC) was created as part of the ongoing effort to integrate behavioral health with the rest of the health care system. The BH-SAC provides the Department of Health Care Services (DHCS) with coordinated input regarding behavioral health activities and is intended to be focused at a system-wide and policy level to improve the behavioral health system.

This document includes a high-level summary of the July 2021 BH-SAC Meeting.

## Director's Update:

*Approved FY 2022 State Budget and Implications*

State Medicaid Director, Jacey Cooper, provided an update on the approved state budget for Fiscal Year (FY) 2021-2022. Primary elements of the state budget pertaining to DHCS include the following:

- ***Full scope Medi-Cal coverage for undocumented adults age 50 and older (effective no sooner than May 2022)***
  - $67.3 million ($48 million General Fund) in 2021-22 and $1.5 billion ($1.3 billion GF) ongoing upon full enrollment

- ***California Advancing and Innovating Medi-Cal (CalAIM) Initiative***
  - $1.6 billion ($650.7 million GF) increasing to $1.5 billion ($812.5 million GF) by 2023-24 and decreasing to $900 million ($480 million GF) in 2024-25 and ongoing.
  - One-time $315 million ($31.5 million GF) to provide population health management services that would centralize administrative and clinical data from DHCS, health plans, and providers
  - One-time $200 million ($100 million GF) for Medi-Cal Providing Access and Transforming Health Payments (PATH) to build capacity for effective pre-release care for justice-involved populations to enable coordination with justice agencies and Medi-Cal coverage of services 30 days prior to release

- ***Behavioral Health Continuum Infrastructure Project***
  - $755.7 million ($445.7 million GF and $310 million Coronavirus Fiscal Recovery Fund) in 2021-22, $1.4 billion ($1.2 billion GF and $220 million Coronavirus Fiscal Recovery Fund) in 2022-23 and $2.1 million GF in 2023-24 for competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in mobile crisis infrastructure ($150 million) to expand the community continuum of behavioral health treatment resources

- ***Community Health Worker Benefit***
  - $16.3 million ($6.2 million GF) increasing to $201 million ($76 million GF) by 2026-27 to add community health workers as Medi-Cal providers

**California Behavioral Health Planning Council Overview of DHCS Behavioral Health Stakeholder Advisory Committee: July 2021 Meeting**

- ***Children and Youth Behavioral Health Initiative***
  - $1.4 billion ($1 billion GF, $100 million Coronavirus Fiscal Recovery Fund, $222 million federal funds, and $105 million Mental Health Services Fund) in 2021-22, $1.5 billion ($1.4 billion GF and $124 million federal funds) in 2022-23, and $431 million ($300 million GF and $131 million federal funds) in 2023-24 and ongoing to transform California's behavioral health system for children and youth into an innovative and prevention-focused system where all children and youth are routinely screened, supported, and served for emerging and existing behavioral health needs regardless of payer

- ***Telehealth Flexibilities***
  - $151.1 million ($53.3 million GF) in 2021-22 for the extension of telehealth flexibilities allowed during the federal public health emergency—including payment parity for audio-only modalities through December 2022 and coverage of remote patient monitoring and $106.4 million ($37.2 million GF) ongoing for remote patient monitoring

- ***Medi-Cal Asset Test***
  - $394 million ($197 million GF) in 2022-23 and ongoing to increase the Medi-Cal asset limit to $130,000 for an individual (plus $65,000 for each additional household member) no sooner than July 1, 2022 and to fully eliminate the asset limit no sooner than January 1, 2024
  - Asset test will help expand Medi-Cal coverage to seniors, individuals with disabilities, and communities of color

Additionally, Jacey Cooper indicated that there are funds in the state budget for DHCS to build resources and dashboards for health equity mapping.

*Update on CalAIM and 1115 and 1915(b) Waiver Processes*

Shaina Zurlin, Chief of Medi-Cal Behavioral Health Division, provided an update on the CalAIM Initiative and announced the following modified implementation timelines:

| Policy | Go-Live Date |
|---|---|
| Changes to eligibility criteria for SMHS | January 2022 |
| DMC-ODS 2022-2026 | January 2022 |
| Documentation redesign for SUD/SMHS | July 2022 |
| No Wrong Door | July 2022 |
| Standard screening and transition tools | January 2023 |
| Payment Reform | July 2023 |

The staggered timeline allows for counties and providers to know about and adjust to changes initiated by CalAIM.

The documentation redesign for the Specialty Mental Health Services (SMHS) and Substance Use Disorders (SUD) systems has been pushed back to July 2022. DHCS is currently looking to structure the assessment process in a way that will give providers flexibility on what assessment to use. DHCS is also looking to replace treatment plans with problem lists which aligns how Managed Care Plans (MCPs) and other entities use documentation. Additionally, DHCS is determining what content should be included in progress notes.

The policy involving the development of a standard screening and transition tool has been pushed back to January 2023 because there is currently a workgroup developing these tools. There will be beta testing for screening and assessments to see how these tools interact in practice and ensure that individuals are being placed in the correct system of care. Additionally, more time is needed to develop and launch the children and youth screening tool with extensive testing before statewide implementation occurs. DHCS would like to ensure that the there is enough data to ensure that the tool is culturally-competent and successful in placing individuals regardless of county size.

DHCS is looking to provide technical assistance to counties for payment reform prior to the new implementation date in July 2023. The payment reform go-live date has been extended to ensure enough time for technical assistance and financial modeling. DHCS will need to understand a long history of policies and statute prior to making significant changes to payment. Additionally, DHCS would like to ensure that payment methodologies are equitable to counties. The timeline for county cost reporting and settling will be set up over the next 18 months with assistance from the County Behavioral Health Directors Association (CBHDA).

*COVID-19 Vaccination Disparities in Medi-Cal*

DHCS shared data that indicates that COVID-19 vaccination rates among Medi-Cal members is low compared to vaccination rates among the general California population. DHCS saw similarities across all age categories and race. For instance, 31% of children in Medi-Cal are vaccinated compared to 43% of children vaccinated who are not on Medi-Cal and 30% of African Americans on Medi-Cal are vaccinated compared to 46% of African Americans who are not on Medi-Cal. DHCS would like to convene a workgroup to brainstorm innovative ways to promote vaccine education and outreach.

**Managed Care Procurement Update:**

DHCS is leveraging the MCP procurement process to drive improvements in quality of and access to care, focus on health equity and reducing health care disparities, increase accountability and oversight of subcontractors, and improve administrative and health care delivery efficiency. Managed Care Plans will be encouraged and/or required to use value based arrangements with providers to better align payment with quality of care, improve care coordination and management, assess and track social determinants of health, integrate behavioral health with physical health care, and engage local entities to work with specific populations.

**California Behavioral Health Planning Council Overview of DHCS Behavioral Health Stakeholder Advisory Committee: July 2021 Meeting**

DHCS is currently reviewing and analyzing stakeholder feedback on the draft Request for Proposal (RFP). The final RFP will include contract requirements for the following policy items:

- May 2021 Budget Revisions
- Population Health Management
- Enhanced Care Management
- In Lieu of Services
- Health Disparities and Health Equities
- Behavioral Health (BH) Reforms including but not limited to, No Wrong Door
- School-based services including but not limited to, preventative early intervention for behavioral health services by school-affiliated health providers

For additional information regarding MCP Procurement, please view slides 8-23 of the July 2021 BH-SAC Meeting Presentation.

## Children and Youth Behavioral Health Initiative:

The state budget includes over $4 billion over 5 years to transform California's children and youth (age 0-25) behavioral health system into a world-class, innovative, up-stream focused, ecosystem where all children and young adults are routinely screened, supported, and served for emerging behavioral health needs. The Children and Youth Behavioral Health Initiative (BHI) will make services available to children statewide regardless of insurance status.

Key components of the Children and Youth BHI include the following:

- Behavioral health service virtual platform and e-consult
- Capacity/infrastructure – health plans, county mental health plans, community-based organizations (CBOs), and schools
- Develop and scale-up behavioral health evidence based programs
- Building continuum of care infrastructure
- Enhance Medi-Cal benefits
- School behavioral health counselor and behavioral health coach workforce
- Broad behavioral health workforce capacity
- Pediatric, primary care, and other healthcare providers
- Public education and change campaign
- Coordination, subject matter expertise and evaluation

The first year of the Initiative will involve research, planning, and convening stakeholders and subject matter experts. To learn more about the Children and Youth BHI, please view slides 25-34 of the July 2021 BH-SAC Meeting Presentation.

**California Behavioral Health Planning Council Overview of DHCS Behavioral Health Stakeholder Advisory Committee: July 2021 Meeting**

**Health Equity Roadmap:**

The California Health Care Foundation (CHCF), on behalf of DHCS, engaged Sellers Dorsey to complete an assessment of DHCS' efforts related to health disparities and equity and to propose a roadmap for future activities and initiatives. A summary of Sellers Dorsey's recommendations to DHCS is provided on slides 39-43 of the July 2021 BH-SAC Meeting Presentation.

The Department of Health Care Services developed a health equity roadmap based on the feedback provided from Sellers Dorsey. The roadmap is organized into 6 areas:

- ***Health equity culture and structure***
  - Leadership and governance
  - Cultural competency, training, and education
- ***Community partnerships and collaboration***
  - Stakeholder engagement
  - Collaboration/partnerships
- ***Program policy changes and interventions***
- ***Measurement and analytics***
  - Data and data collection
  - Measures and disparities identification
- ***Performance monitoring and evaluation***
  - Reporting
  - Compliance activities
  - Accountability mechanisms
- ***Payment structures and fiscal strategies***

The following items are current and planned DHCS initiatives to address health equity:

- Assess recommendations from Sellers Dorsey's comprehensive report in light of conceptual framework
- Identify areas of overlap and alignment with existing DHCS efforts including CalAIM, NCQA health equity requirements, new benefits including doulas and community health workers, re-design of cultural competence plans for county mental health plans and Community Mental Health Equity Project, and identify gaps in existing efforts and create strategies to address them to inform the Health Equity Roadmap which will be a part of DHCS' Comprehensive Quality Strategy

Palav Babaria, Deputy Director and Chief Quality Officer of Quality and Population Health Management, is leading efforts for DHCS' health equity roadmap. Palav will meet with each county individually to define common goals as well as goals that are unique to specific programs. She indicated that there will be working sessions with subject matter experts and stakeholders as well.

The next Behavioral Health Stakeholder Advisory Committee Meeting is scheduled on ***October 21, 2021 at 9:30 a.m. – 12:30 p.m.*** Please visit the BH-SAC webpage or contact DHCS at BehavioralHealthSAC@dhcs.ca.gov or (916) 440-7660 with questions regarding the meeting.