California Behavioral Health Planning Council

Systems and Medicaid Committee Agenda

Thursday, April 21, 2022
Sonesta Silicon Valley Hotel
1820 Barber Lane Milpitas, CA 95035
Oak Creek Room
8:30 a.m. – 12:00 p.m.

8:30 am **Welcome and Introductions**
Karen Baylor, Chairperson and All Members

8:35 am **Approve January 2022 Draft Meeting Minutes** **Tab 1**
Karen Baylor, Chairperson and All Members

8:40 am **Review and Finalize SMC 2022-2023 Work Plan** **Tab 2**
Karen Baylor, Chairperson and All Members

8:50 am **Public Comment**

8:55 am **County Perspectives on CalAIM Implementation** **Tab 3**
Edwin Poon, Deputy Director of Managed Care, Santa Clara County Behavioral Health Services
Michelle Cabrera, Executive Director, County Behavioral Health Directors Association (CBHDA)
Paula Wilhelm, Director of Policy, CBHDA
Jennifer Hallman, Quality Assurance Unit, Los Angeles County Department of Mental Health (DMH)

9:40 am **Public Comment**

9:45 am **Break**

10:00 am **Overview of Enhanced Care Management (ECM) and Community Supports** **Tab 4**
Bambi Cisneros, Assistant Deputy Director of Managed Care Health Care Delivery Systems, Department of Health Care Services

10:20 am **Local Perspectives on ECM and Community Supports** **Tab 5**
Linnea Koopmans, Chief Executive Officer, Local Health Plans of CA
Michelle Cabrera, Executive Director, CBHDA
Paula Wilhelm, Director of Policy, CBHDA
Yvette Willock, Chief of Social Services, Los Angeles County DMH

11:15 am **Public Comment**

11:20 am **Planning of CalAIM Presentation for General Session** **Tab 6**
Karen Baylor, Chairperson and All Members

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

California Behavioral Health Planning Council

11:45 am **Public Comment**

11:50 am **Behavioral Health Updates** **Tab 7**
Ashneek Nanua, SMC staff

11:55 am **Wrap Up/Next Steps**
Karen Baylor, 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

Karen Baylor, Chairperson Uma Zykofsky, Chair-Elect

Veronica Kelley	Celeste Hunter	Deborah Pitts
Tony Vartan	Catherine Moore	Karen Hart
Noel O'Neill	Walter Shwe	Liz Oseguera
Dale Mueller	Marina Rangel	Cheryl Treadwell
Daphne Shaw	Susan Wilson	Joanna Rodriguez
Steve Leoni	Jessica Grove	Sutep Laohavanich

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

TAB 1

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, April 21, 2022

Agenda Item: Approve January 2022 Draft Meeting Minutes

Enclosures: January 2022 Draft SMC Meeting Minutes

Background/Description:

Committee members will review the draft meeting minutes for the January 2022 Quarterly Meeting.

Motion: Accept and approve the January 2022 Systems and Medicaid Committee draft meeting minutes.

Systems and Medicaid Committee

Meeting Minutes (DRAFT)
Quarterly Meeting – January 20, 2022

Members Present:

Karen Baylor, Chairperson	Uma Zykofsky, Chair-Elect	Catherine Moore
Veronica Kelley	Walter Shwe	Celeste Hunter
Noel O'Neill	Susan Wilson	Daphne Shaw
Karen Hart	Deborah Pitts	Steve Leoni
Dale Mueller	Marina Rangel	Liz Oseguera
Jessica Grove (DOR)	Sutep Laohavanich (CDA)	

Staff Present:
Ashneek Nanua, Jane Adcock, Jenny Bayardo, Gabriella Sedano

Presenters:
Allie Budenz, Heather Parson

Public Attendees:
Stacy Dalgleish, Tiffany Carter, Andrea Crook, Hannah Bichkoff, Matt Gallagher

Meeting Commenced at 8:30 a.m.

Item #1 Approve October 2021 Draft Meeting Minutes

The Systems and Medicaid Committee (SMC) reviewed the October 2021 draft meeting minutes. Steve Leoni requested a strikeout of the last sentence of his public comment on Page 3. Celeste Hunter motioned approval of the SMC October 2021 meeting minutes with the correction. Susan Wilson seconded the motion. Veronica Kelley, Dale Mueller, and Steve Leoni abstained. The motion to approve the minutes passed.

Action/Resolution

SMC staff will make the requested correction. The October 2021 SMC Meeting Minutes are approved.

Responsible for Action-Due Date

Ashneek Nanua – April 2022

Item #2 Revise and Finalize SMC 2022-2023 Work Plan

SMC Chairperson, Karen Baylor, introduced the goals from the draft SMC 2022-2023 Work Plan. SMC staff reviewed changes made to the Work Plan including the format of the plan. The Work Plan has goals delineated by phases which organizes the activities for each objective that involves a multi-year initiative. Committee members provided the following input for the draft Work Plan:

- Deborah Pitts expressed that Phase 1 for Objective 1.1 fits into the focus and scope of this committee while Phase 2 fits better for the Workforce and Employment Committee. She stated that the SMC should differentiate between the peer certification opportunity and the Medi-Cal billing. Karen Baylor expressed recognition of the overlap of Peer Support Specialist activities between the SMC and WEC but that SMC would focus on the financing piece of peer certification.
- Uma Zykofsky suggested the following language change on Objective 1.1 Phase 2: “Monitor billing and differences as a new Medi-Cal service category.” She stated that one of the interests for the SMC is to track how peer certification is operationalized as one of the different staffing categories via Medicaid implementation.
- For Objective 1.2, Steve Leoni stated that there is a current division of labor between services to the mild-to-moderate population and severely mentally ill (SMI) population. He expressed interest to track the coordination and implementation of Enhanced Care Management (ECM) and Community Supports (In Lieu of Services) since these services represent the Mental Health Services Act (MHSA) value of “whatever it takes” wraparound services. These services will be administered through Managed Care Plans (MCPs) that serve the mild-to-moderate mental health population.
- Catherine Moore expressed interest to monitor the tools that will be developed to track CalAIM data.
- Deborah Pitts stated that it will be helpful to have county behavioral health directors share how CalAIM is implemented at the county level over time rather than focusing on DHCS staff presenting the state level perspective. For example, the changes to documentation requirements designed to reduce workload are meaningful. It is important to see if frontline workers experience it that way.
- Walter Shwe stated that it would be helpful to have Managed Care Plan representatives on the Planning Council to hear the Council’s perspective. Karen Baylor agreed that it will be helpful to invite key partners to future meetings.
- Noel O’Neill suggested that the SMC utilize the 2020 Data Notebook on the telehealth topic as it contains useful information for Objective 1.3.
- For Objective 2.1, Catherine Moore asked what measures are already in place to support the Children and Youth Behavioral Health Initiative (BHI). Karen Baylor

stated that MCPs must respond to DHCS with letters of intent for the school-based initiative under the Behavioral Health Continuum Infrastructure Program (BHCIP).

- Uma Zykofsky stated that many initiatives on the Work Plan such as tracking CalAIM and No Wrong Door policy involve the coordination of care. She suggested that SMC agendas may be crafted in a way where members can study the evolution of how coordination is handled by MCPs. Studying the county Medicaid side will help the committee understand what is happening at the Managed Care level. Uma added that it may be helpful to have a presentation on the categories of ECM target population at future meetings.
- Noel O'Neill pointed out that there was a tremendous amount of federal dollars to support COVID-19 response efforts and the Mental Health Services Oversight and Accountability Commission (MHSOAC) awarded substantial grants to counties. These are non-Medicaid services that will apply to the whole family. MCPs will provide treatment that may be Medi-Cal billable or billable to the health plan. Regarding schools, there is $4 million for the Children and Youth BHI as well as MCP efforts in schools. Noel emphasized that virtual education has heavily impacted children and there is a great need at the school sites.
- On Objective 2.2, Karen Baylor stated that DHCS plans to apply for the Institutes for Mental Disease (IMD) Waiver in Fall 2022.
- Steve Leoni expressed that Objective 2.2 is focused on the Lanterman-Petris Short (LPS) Act system and it is also important to build out the lower levels of care. He stated that the MHSA Full Service Partnerships (FSPs) focus on having better lower levels of care and would like to see this build out in counties. Steve added that we need to rethink our data systems in order to do this correctly.
- Steve Leoni asked the SMC to consider holding interim meetings in order to accomplish the Work Plan. Karen Baylor stated that the Work Plan has been expanded to multiple years to acknowledge the robust Work Plan.

Action/Resolution

SMC staff and Committee Officers will make changes to the SMC Work Plan based on the committee's input.

Responsible for Action-Due Date

Ashneek Nanua, Karen Baylor, Uma Zykofsky – April 2022

Item #3 Overview of CalAIM Changes Re: Criteria to Access Specialty Mental Health Services (SMHS)

Veronica Kelley presented an overview of changes to the criteria to access Specialty Mental Health Services (SMHS) under the CalAIM Initiative. Director Kelley first reviewed the CalAIM implementation timeline for all behavioral health proposals and

stated that the timeline is fluid and subject to change. She added that counties do not yet have all of the regulations needed for implementation.

DHCS is updating the way SMHS are provided for adults and individuals under age 21 via a consolidated 1915(b) waiver. Assembly Bill 133 allows the state to make these changes and Welfare and Institutions Code (WIC) 14184.04 states that you do not need a diagnosis to deliver SMHS.

The medical necessity and level of care behavioral health information notice (BHIN) was published in December 2021. There are also information notices for how to access care for Drug Medi-Cal Organized Delivery System (DMC-ODS) that aligns with the No Wrong Door policy and BHIN for the triennial review protocols. Additional BHINs are needed for regulations and for EPSDT services under DMC-ODS.

Veronica Kelley reviewed medical necessity rules for SMHS for individuals over age 21 as well as youth under age 21. She indicated that the major change for access for adults is that the individual may have a suspected mental health disorder that is not yet diagnosed and allows the provider flexibility to provide services while determining a diagnosis. The provider will be able to bill for these services immediately.

For individuals under 21, the major change is that youth may be eligible for services if they have experienced trauma, homelessness (which may include imminent risk of homelessness or attempting to flee domestic violence), involved in child welfare or the justice system, and/or have a suspected mental health disorder that is not yet diagnosed. Veronica stated that these expansion of requirements increases prevention and early intervention efforts by serving individuals with risk factors and being paid for it.

Responsibilities for MCPs and Fee-for-Service (FFS) delivery systems remain the same. Providers of SMHS will still be reimbursed for services provided before arriving to the mild-to-moderate diagnosis. The trauma screening tools are still under development. The state is providing the International Classification of Disease (ICD) codes that can be used for billing.

Q & A:

Deborah Pitts stated that the change from diagnosis to impairment regarding service eligibility may give space for occupational therapists (OTs) working in the public mental health system to "open the case." Until now, the diagnostic obligation has sometimes been the rationale given for not having OTs as Licensed Practitioners of the Healing Arts (LHPAs). Traditionally OTs have not conducted medical diagnosis despite having the clinical judgement to do so.

Karen Baylor asked what counties need to implement the change to access criteria for SMHS. Veronica Kelley stated that counties do not have the regulations that would be provided by DHCS and are unaware if the billing codes have been activated. She added that counties will need to consider staffing issues, change in policies and procedures to reflect the new rules, as well as work with Managed Care partners who are responsible for administering Enhanced Care Management.

Catherine Moore asked for clarification on diagnosis options. Veronica Kelley indicated that child-serving agencies were looking at Adverse Childhood Experiences (ACEs) for point-of-reference while county behavioral health uses resiliency as a point-of-reference. She added that other child welfare entities may serve children who experience trauma if they are equipped with more education.

Noel O'Neill asked if there will be additional conversations for ECM and Community Supports. He stated that Anthem Blue Cross Health Plan and other MCPs will identify Medi-Cal beneficiaries that are eligible for ECM and well as providers who may come from the county to be certified through MCPs. He asked if county behavioral health agencies who already have contracts with DHCS to provide wraparound services and asked what the firewall is between the county and MCP systems. Veronica Kelley stated that every county is doing ECM differently. In Orange County, the behavioral health department negotiated a per-member-per-month (PMPM) rate for ECM services and created different codes for ECM so that counties will know that the individual is enrolled in ECM and will not bill the case manager for this service unless the billing resources have already been exhausted for the individual. She added that there is no standardized way for ECM to be developed but it is strongly recommended for MCPs to work with county behavioral health agencies.

Uma Zykofsky asked if it is possible for an individual to be in ECM and FSPs. She stated that quantity is not better than quality so the issue of duplication of services comes up. She also asked how counties are educating the public, consumers, and providers about the changes. Veronica Kelley stated that FSP clients will not be included for ECM, and that the change should be seamless for the beneficiaries so that they receive services immediately.

Steve Leoni stated that individuals often go back and forth between the SMHS and MCP systems of care. He stated that the documents related to this are based on acuity but people sometimes need ongoing support. Steve expressed concerns that individuals are moved to a system when their acuity is better to a system that does not support their needs. He stated that this is not aligned with access and there is no concept for long term supports for the SMI population. Veronica Kelley stated that this proposal will likely open more doors to treatment rather than individuals being shifted around.

Catherine Moore asked for clarification on what the difference is between ECM and SMHS and how individuals make the transition. Veronica Kelley stated that an individual had to meet a high level of medical necessity for counties to serve them or disallowances could occur under the old rule, whereas now counties can serve the individual until stabilization and then the individual would move to the MCP.

Action/Resolution

N/A

Responsible for Action-Due Date

N/A

Item #4 Public Comment

Allie Budenz, California Primary Care Association (CPCA), asked for clarification on the three visit limit for ECM. Veronica Kelley stated that metric is specific to Orange County. Every county will administer ECM differently because each MCP has its own metrics to meet.

Action/Resolution

N/A

Responsible for Action-Due Date

N/A

Item #5 County Perspective Re: Criteria to Access SMHS

Karen Baylor, Chairperson, introduced a panel of representatives from county behavioral health departments and the California Primary Care Association (CPCA) to present on the activities, successes, and challenges of CalAIM implementation, specifically for the new criteria for individuals to access Specialty Mental Health Services (SMHS). Veronica Kelley presented on behalf of Orange County and highlighted the following items regarding CalAIM implementation:

- CalAIM implementation is a heavy lift for counties but health care reform has been done before when Proposition 63 passed as well as the Affordable Care Act's Medicaid expansion.
- The Governor's Budget includes one-time monies and counties must put up a 10% cash match for drawing down funds. This is very time-limited money.
- Counties currently get paid 6-10 years after rendering services so payment reform will allow payments in 30 days. However, there are concerns with the cost settlements as part of the shift from cost-based reimbursement to intergovernmental transfers (IGT) because Orange County is currently doing cost settlements for Fiscal Year (FY) 2013-2014 and the state would like to begin settlements from FY 2018-2019 which does not account for the money owed to counties for cost settlements prior to 2018.
- There are many changes in policies and procedures which will need to be communicated to staff. This involves many changes in paperwork and processes.
- The pandemic has changed beliefs about the world and reduced the workforce which is difficult because behavioral health providers typically interact face-to-face. Providers have not been able to see patients in person which also impacts the advancement of Medi-Cal reform.

Heather Parson represented the San Diego County Behavioral Health Department Quality Management Unit. She highlighted the following elements in her presentation:

- San Diego County has many contracted providers. Methods of communication regarding CalAIM changes involves a variety of ways to trickle down information throughout the county. This includes virtual meetings with quality improvement partners, leadership meetings with staff, and system of care meetings with specific programs. There are also email notifications via newsletter, memos, and general e-mail box where providers can reach out to the Quality Management Unit. The Optum website is a public website that allows anyone in San Diego County to find documents, forms, trainings, policies and procedures, etc.
- The Quality Management team has formed workgroups to handle quality improvement areas in the behavioral health system in the county. Workgroups involve tracking specific items, uploading items to the Optum website, and describing the revision and corresponding dates for CalAIM changes.
- Potential changes to county processes include the removal of ICD-10 diagnosis codes, updates to reasons for recoupment, and eligibility through medical necessity.
- San Diego County has reviewed the provider operations handbook, documentation trainings and webinars, and medical record review tools.
- Successes in CalAIM implementation include a robust information sharing process and a team approach to divide and complete tasks.
- Challenges regarding CalAIM implementation include the limited time between information notices being finalized and implementation expectations by DHCS. Many providers are asking about the impacts of changes on documentation.

Allie Budenz, Deputy Director of Quality Assurance at the California Primary Care Association, presented on the primary care perspective for CalAIM implementation. She first provided an overview of federally qualified health centers (FQHCs) and how these organizations deliver a comprehensive set of medical, dental, vision, and behavioral health services to a diverse population of clients in underserved areas. FQHCs are authorized under Section 330 of the Public Health Services Act which allows health centers to provide behavioral health services across all levels of acuity. In 2021, 94% of health centers offered co-located behavioral health service with primary care, however, FQHCs are not resourced to provide the same type of care as Managed Care Plans. FQHCs are included in SMHS and Drug Medi-Cal and DMC-ODS health network and FQHC and SMHS providers can do better in coordinating care for patients in both systems and during transitions to care.

Ms. Budenz highlighted the following elements of CalAIM behavioral health implementation from the FQHC perspective:

- CPCA is supportive of the removal of diagnosis in the criteria to access SMHS and specified that it is necessary to have more support and engagement from

DHCS as well as increased communication and coordination between county Mental Health Plans (MHPs) and MCPs to implement this change.

- There are concerns about the new trauma screening tool not aligning with ACEs Aware as health centers experienced success with ACEs in behavioral health.
- There needs to be more clarification on the non-duplication of services and direction to county MHPs and MCPs on data sharing.
- Key considerations include how to reflect a diverse and culturally-humble behavioral health workforce and how to innovate and build trust between MHPs and MCPs.

Q & A:

Liz Oseguera asked the panelists to describe what type of supports they need to implement CalAIM that can reduce the stress and difficulties in the implementation process. She invited presenters to bring any issues they are dealing with to the Planning Council so that the Council can help support them and advocate changes to the DHCS. Allie Budenz stated that an alternative payment modality and flexibilities for FQHCs would have an impact of alternative touch points and workforce capacity. Allie also expressed a need for additional time to implement the CalAIM policies. Veronica Kelley stated that listening to counties and individuals who are making these changes about what they need is helpful to meet the end goal. Heather Parson stated that more time is needed for counties to realistically produce the changes due to the amount of work needed to implement changes in a thoughtful manner.

Steve Leoni expressed interest in listening to consumers of the system, to hear their perspective and experiences about the changes occurring from CalAIM. Allie Budenz stated that DHCS has released a Comprehensive Quality Strategy which includes goals to increase beneficiary representation in DHCS goals and activities. Allie expressed that the Planning Council may want to consider responding to this document.

Deborah Pitts stated that FQHCs can consider broadening their definition of who can provide a behavioral health services. Occupational therapists are not billable providers in FQHCs but are an increasing part of primary care teams in several countries. Liz Oseguera indicated that CPCA is leading efforts to create an alternative payment method that would remove barriers that exist under their prospective payment system, including removing the requirement that limits the billable providers that FQHCs can have. Thus, community health centers would be able to bill for any provider type including peers, Community Health Workers, and OTs.

Uma Zykofsky asked the panelists if they have seen any changes to alcohol and drug providers in terms of impacts from COVID-19 and the changes from CalAIM. Veronica Kelley stated that there is an increased need for residential substance use disorder (SUD) services and there have been an increase in fentanyl overdoses. She added that COVID-19 positive individuals have impacted residential facilities as well. She stated that moving DMC-ODS into the 1915(b) waiver provides flexibility that can offer more parity. Heather Parson deferred committee members to the SUD unit in San Diego

County to acquire that information. Allie Budenz stated that FQHCs want to hire SUD counselors who have an understanding of both mental health and SUD systems but this is an area that needs more work. Additionally, there has been an increase in demand for SUD providers but there has been a decrease in supply due to a decrease in workforce and appointment availability.

Action/Resolution

N/A

Responsible for Action-Due Date

N/A

Item #6 Overview of Peer Support Specialist Medi-Cal Benefit

SMC staff provided an overview of the Peer Support Specialist (PSS) certification requirements outlined by the Department of Health Care Services in the Behavioral Health Information Notice 21-041. Staff then reviewed state, county, and certification program roles and responsibilities as well as available funding streams for the SMHS, DMC-ODS, and Drug Medi-Cal systems for peer support services. Staff provided background on the California Mental Health Services Authority (CalMHSA) role as one of the lead entities for peer certification for counties that opt into the program, and shared dates and timelines for CalMHSA's upcoming listening sessions that will include defining the certification exam questions and specializations for parent peers, crisis, homeless, and justice-involved populations. SMC staff concluded the presentation by providing the committee with some items to consider such as data collection efforts, Peer Support Specialist exam pass rates, diversity achieved, and areas of needed improvement. Staff provided members with the CalMHSA and DHCS Peer Support Services web links for additional information.

Q & A:

Steve Leoni stated that the peer certification is built around the counties and need to consider the mild-to-moderate population. He asked if MCPs are utilizing peers. Steve added that we cannot get outcomes data from Kaiser Permanente for services because they consider this information proprietary.

Deborah Pitts stated that the SMC is more concerned with the delivery of Medi-Cal PSS services and penetration rates rather than the pass rates which is more of an issue for the Workforce and Employment Committee. The SMC may want to know to whom services are delivered and when this is happening in relationship to other mental health services.

Action/Resolution

Committee members will utilize the information presented to engage in Objective 1.1 on the SMC Work Plan.

Responsible for Action-Due Date

January 2022 - ongoing

Item #7 Public Comment

Andrea Crook, Director of Advocacy for ACCESS California, stated that ACCESS submitted a comprehensive plan for peer certification to DHCS and it was approved. She stated that it was a frustrating process due to the lack of clarity provided by DHCS to CalVoices and the counties. DHCS requested CalMHSA and other organizations to provide, in writing, the counties that would like to sign on for peer certification by January 17, 2022. Several counties chose to opt in with ACCESS. Andrea stated that Dr. Sherin from Los Angeles County wrote a supportive letter that L.A. Department of Mental Health has worked hard to incorporate the peer voice in all levels of the system and it is essential to have more than one representing agency for the provision of Medi-Cal PSS certification, and encouraged DHCS to issue a clarification to counties on this matter. DHCS did not submit legal counsel of clarification prior to the January 17th deadline. Andrea stated that CalMHSA has created a monopoly for counties and she would like autonomy for a peer-run organization to represent counties. She stated that DHCS shared that CalMHSA will open up to more diverse entities.

Tiffany Carter, Statewide Advocacy Liaison for CalVoices, supported and echoed Andrea Cook's comments and encouraged the Planning Council to have more peer-run organizations present on their findings, successes, and barriers to increase the peer perspective, experience, and value in regards to the PSS training. Additionally, CalMHSA selection as the certifying and training body for peer certification is problematic as no other certification in the state has the same certifying and training body. CalVoices is asking DHCS to decouple the peer certification training and education delivery from the certification program administration to ensure the ongoing viability of existing peer training providers throughout the state. For all other professions, the licensing and certifying body is separate from the entities providing education so CalVoices has asked DHCS to provide that same framework to peer certification and that DHCS recognize all trainings that meet the standards and requirements to ensure that smaller peer training programs that lack infrastructure or resources to serve the state have a meaningful opportunity to participate.

Action/Resolution

N/A

Responsible for Action-Due Date

N/A

Item #8 Wrap Up/Next Steps

Karen Baylor and SMC staff summarized the following next steps for the Systems and Medicaid Committee:

- Plan steps to present the impact of CalAIM implementation to the entire Planning Council body
- Continue responding to draft Behavioral Health Information Notices (BHINs) released by DHCS
- Operationalize activities on the SMC 2022-2023 Work Plan
- Keep track of Peer Support Specialist implementation

Committee members provided the following input for next steps:

- Track the shift in ICD codes and payment defined by DHCS to bring more simplicity and clarity to the delivery systems while being cognizant of the time needed for counties to operationalize payment reform
- Receive current updates for the Work Plan objectives
- Gather perspectives from multiple counties regarding CalAIM implementation
- Ask counties about their experiences with the shift to Enhanced Care Management (ECM) and have a better understanding of this benefit to better comprehend how it impacts the delivery systems as well as how MCPs will coordinate these services with county MHPs

Action/Resolution

The action items are outlined above.

Responsible for Action-Due Date

Ashneek Nanua, Karen Baylor, Uma Zykofsky – April 2022

Meeting Adjourned at 12:00 p.m.

TAB 2

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, April 21, 2022

Agenda Item: Review and Finalize SMC 2022-2023 Work Plan

Enclosures: Draft SMC 2022-2023 Work Plan

How This Agenda Item Relates to Council Mission
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 based on committee feedback provided during the October 2021 Quarterly Meeting.

Motion: Approve the Systems and Medicaid Committee 2022-2023 Work Plan

The draft SMC 2022-2023 Work Plan is provided on the next page. Proposed new language is designated by underline and proposed deletion is designated with ~~cross-out~~.

California Behavioral Health Planning Council
Systems and Medicaid Committee (SMC)
Work Plan 2022-2023

[*Draft Revised 12/10/21*]

Goal #1: *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*

Objective 1.1: Participate in efforts relating to Peer Support Specialist Certification in California.

Phase 1: Explore options to make recommendations on financing and regulations for California's Peer Support Specialist Certification law.

Timeline: January - December 2022

Activities:

- Invite the Department of Health Care Services and other involved public entities such as the County Behavioral Health Directors Association (CBHDA) or the California Mental Health Services Authority (CalMHSA) to discuss the implications of Senate Bill 803 implementation from a program, financing and oversight perspective

Phase 2: Track the billing, reimbursement ~~implementation~~ and the impact of Peer Support Specialists as a new Medi-Cal ~~Certification in California~~ provider category to~~and~~ identify issues and provide recommendations to the Department of Health Care Services.~~on areas of needed improvement.~~

Activities:

- Track implementation activities through CalMHSA and county sources to understand how peer certification is operationalized to help ensure that peer specializations are appropriately assigned and billed ~~utilized~~ in the Medi-Cal system
- Monitor Medi-Cal billing and difference ~~implementation of incorporation of~~ between peer services in~~to~~ California's Medicaid system and non-Medicaid funding streams for peers
    - Review results of the triennial reviews to identify the impact of peers in the system and any key problem areas in order to provide recommendations for improving implementation of this program

Timeline: January 2023 – Ongoing

Peer Support Specialist Certification Implementation Timeline	
Activity	**Date**
CalMHSA identifies criteria for specializations for providers, crisis, unhoused, and justice-Involved persons	January – March 2022

California Behavioral Health Planning Council
Systems and Medicaid Committee (SMC)
Work Plan 2022-2023
[*Draft Revised 12/10/21*]

Go-Live with Peer Certification	May - July 2022
DHCS to obtain federal approvals for Peer Support Services reimbursement	July 2022

Objective 1.2: Monitor implementation of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative and assess successes and challenges in order to provide policy recommendations ~~for areas of improvement~~ to the Department of Health Care Services.

Phase 1: Keep Council members and public stakeholders informed about the CalAIM behavioral health proposals that will result in major changes at the local level for county systems and providers operating in the Medi-Cal behavioral health system.

Activities:

- Provide updates on timelines and changes occurring from the implementation of CalAIM's behavioral health proposals during General Session meetings
- Distribute existing or staff-developed handouts to help Council members and public stakeholders understand the CalAIM changes and impact at the local level
- Track activities of the DHCS CalAIM Behavioral Health Workgroup

Timeline: January – December 2022

Phase 2: Track implementation of the CalAIM behavioral health proposals and provide recommendations to the Department of Health Care Services throughout the CalAIM implementation period, particularly for measuring and tracking outcomes.

Activities:

- Determine how CalAIM will be measured and how to track behavioral health outcomes
  - Work with DHCS, CBHDA, and other ~~collateral~~ partners to identify data points that all counties will collect
  - Review and provide feedback on measurement tools that are compatible across systems to analyze whether programs and services rendered under CalAIM are effective
- Invite state and local-level presenters such as county behavioral health directors, Managed Care Plans, providers, and consumers to provide updates on successes and challenges of CalAIM implementation to determine the impact on individuals with Serious Mental Illness (SMI) and Substance Use Disorders (SUD)
- Participate in DHCS CalAIM Behavioral Health Workgroup meetings and stakeholder engagement sessions relating to CalAIM behavioral health proposals
- Provide recommendations to DHCS regarding identified challenges to access and quality of care for individuals with SMI and SUD

California Behavioral Health Planning Council
Systems and Medicaid Committee (SMC)
Work Plan 2022-2023
[*Draft Revised 12/10/21*]

- Track the coordination and implementation of Enhanced Care Management (ECM) and Community Supports as these services for individuals with complex health and social needs will be administered by Managed Care Plans that normally serve mild-to-moderate behavioral health populations.
- Track CalAIM stakeholder sessions regarding the proposals to initiate a Medi-Cal pre-release application and services for individuals 30 days prior to release from incarceration

Timeline: July 2022 – Ongoing

CalAIM Behavioral Health Initiatives Timeline Update

Policy	Go-Live Date
Criteria for Specialty Mental Health Services	January 2022
Drug Medi-Cal Organized Delivery System 2022-2026	January 2022
Drug Medi-Cal ASAM Level of Care Determination	January 2022
Updated Annual Review Protocol and Reasons for Recoupment FY 2021-2022	January 2022
Documentation Redesign for Substance Use Disorder & Specialty Mental Health Services	July 2022
Co-Occurring Treatment	July 2022
No Wrong Door	July 2022
Updated Annual Review Protocol and Reasons for Recoupment FY 2022-2023	October 2022
Standardized Screening & Transition Tools	January 2023
Behavioral Health CPT Coding Transition	July 2023
County Behavioral Health Plans Transition to Fee-for-Service and Intergovernmental Transfers	July 2023
Administrative Behavioral Health Integration	January 2027

<u>Objective 1.3</u>: Track efforts that increase access to Medi-Cal behavioral health services via telehealth modalities to help reduce disparities and improve health equity and outcomes among unserved and underserved Medi-Cal populations.

Activities:

- Gather and present information on factors relating to the digital divide in Black, Indigenous, and Persons of Color (BIPOC) and other unserved or underserved communities
    - Utilize information gathered, including the Planning Council's 2020 Data Notebook, to compile a white paper or recommendation letter advocating for additional funding, resources, and technical assistance needed to reduce the digital divide

California Behavioral Health Planning Council
Systems and Medicaid Committee (SMC)
Work Plan 2022-2023
[*Draft Revised 12/10/21*]

- Track implementation and outcomes of the DHCS Telehealth Policy regarding behavioral health services and provide recommendations to DHCS Telehealth Advisory Workgroup

Timeline: March 2022 and ongoing ~~TBD~~

Goal #2: *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*

Objective 2.1: Collaborate with state, county, and health plan partners to participate in priority initiatives that work towards increasing and improving behavioral health services and student mental health services for children and youth.

Phase 1: Participate and provide recommendations for upcoming key initiatives for children and youth as appropriated in the Governor's 2021-2022 Budget.

Activities:

- Assist California Health and Human Services Agency (CalHHS) 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
- Participate in stakeholder sessions and provide policy recommendations to DHCS and CalHHS as necessary relating to:
  - Children and Youth Behavioral Health Initiative, including but not limited to coordinating with key entities to provide guidance to Managed Care Plans who will be responsible for overseeing capacity and infrastructure development for student mental health services
  - Medi-Cal Dyadic Services, an integrated model of physical and behavioral health screening and services to the whole family
  - Behavioral Health Continuum Infrastructure Program (BHCIP)

Timeline: January – December 2022

Phase 2: Continue participation in efforts to improve the system of care for children and youth.

- Participate in efforts to implement *Assembly Bill 2083 (2018): Children and Youth System of Care*, which requires each county to develop and implement a Memorandum of Understanding (MOU) outlining the roles and responsibilities of the various local entities that serve children and youth in foster care who have experienced severe

trauma. ****Please note that CalHHS is delaying submission requirements for the finalized MOUs until further notice*

- Engage in stakeholder sessions and provide recommendations for the Children and Youth Behavioral Health Initiative, BHCIP, and other initiatives impacting the intersection of behavioral health and children's system of care

Timeline: January 2023 – Ongoing

Objective 2.2: Support efforts to make improvements to the conservatorship system in California including tracking the implementation of the Institutes for Mental Disease (IMD) Exclusion Waiver as well as the utilization 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 in order to fulfill the requirements under the IMD Exclusion Waiver in California
    - Includes tracking data systems and programs that build out the lower levels of care such as Full Service Partnerships (FSPs) and other Mental Health Services Act (MHSA) programs along the continuum of care

Timeline: Fall 2022 ~~TBD~~

TAB 3

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, April 21, 2022

Agenda Item: County Perspective on CalAIM Implementation

Enclosures: Presenter materials will be provided closer to the meeting date.
DHCS CalAIM Behavioral Health Workgroup Webpage
DHCS CalAIM Webpage and Behavioral Health CalAIM Webpage

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

The purpose of this agenda item is to provide the SMC with the perspective of local partners who are implementing the behavioral health aspects of the CalAIM Initiative at the county level. Committee members will utilize this information to determine the impact at the local level and educate Council members and community partners about the changes occurring that impact the behavioral health system.

Background/Description:

The California Advancing and Innovating Medi-Cal (CalAIM) Initiative became operational in January 2022, staggering the implementation of various proposals through 2024. CalAIM has a number of behavioral health proposals that aim to expand access and improve quality of care for individuals receiving services in California's public behavioral health system.

Behavioral health directors and leaders in CalAIM behavioral health implementation efforts will offer their perspective on the implementation of CalAIM in their county since January 2022. The panelists will also speak about the challenges, successes, and opportunities brought forth from these changes. Committee members will have the opportunity to ask questions regarding implementation and discuss best practices for the CalAIM Initiative moving forward.

Please contact SMC staff at Ashneek.Nanua@cbhpc.dhcs.ca.gov for copies of the presentation materials.

Presenter Biographies:

<u>Edwin Poon, PhD, Deputy Director of Managed Care, Santa Clara County Behavioral Health Services</u>

Dr. Edwin Poon is the Deputy Director of Managed Care at Santa Clara County Behavioral Health Services Department. He oversees the managed care functions of the County Mental Health Plan and Drug Medi-Cal Organized Delivery System. He is responsible for planning, directing, and evaluating the operations and the staff across corresponding divisions including Quality Management and Analytics & Reporting.

Dr. Poon is a Licensed Psychologist in the state of California and has over 15 years of clinical experience in various settings including community mental health, physical rehabilitation, forensic, and inpatient mental health. In 2014, Dr. Poon took a management position at CalOptima to support the expansion of Medi-Cal and behavioral health benefits under the Affordable Care Act. He joined LA Care in 2015 as the Director of Behavioral Health Clinical Services and later returned to CalOptima to be the Director of Behavioral Health Services. During his tenure at CalOptima, Dr. Poon was responsible for designing and implementing behavioral health initiatives, integrated care strategies, and community partnerships.

Dr. Poon earned his PhD in Clinical Psychology from Michigan State University. He completed his postdoctoral trainings at Rancho Los Amigos National Rehabilitation Center and Patton State Hospital. He is also a fellow at the California Health Care Foundation Health Care Leadership Program.

<u>Michelle Cabrera, Executive Director, County Behavioral Health Directors Association</u>

Michelle Doty Cabrera joined CBHDA as Executive Director in May 2019. Prior to joining CBHDA she served as the Healthcare Director for the California State Council of the Services Employees International Union (SEIU California), where she advocated on behalf of healthcare workers and consumers, including SEIU California's county behavioral health workforce, on issues related to the implementation of the Affordable Care Act, Health Equity, Health4All, and cost containment, among others. She served as a Senior Consultant for the Assembly Human Services Committee, where she specialized in child welfare issues and staffed legislation which extended foster care in California to age 21. Ms. Cabrera also served as a Program Officer for the California Healthcare Foundation, working as a liaison on state health policy in Sacramento.

Ms. Cabrera served as a member of Governor Newsom's Council of Regional Homeless Advisors and was recently appointed to the California Disability and Aging Community Living Advisory Committee, representing the needs of individuals with behavioral health conditions. Ms. Cabrera has been an inaugural member of the National Quality Forum's Standing Committee on Disparities and has served on the California Pan-Ethnic Health Network (CPEHN) Board of Directors since 2015.

Paula Wilhelm, MPP/MPH, Director of Policy, County Behavioral Health Directors Association

Paula is responsible for leading policy analysis and administrative advocacy efforts to advance CBHDA's priorities for county behavioral health services. Areas of focus include the Medi-Cal Specialty Mental Health and Drug Medi-Cal programs, substance use disorder services and drug policy, California's 1915(b) and 1115 Medicaid waivers, and the implementation of federal managed care and parity regulations.

Prior to joining CBHDA, she worked for the U.S. Department of Health and Human Services, California Association of Public Hospitals and Health Care Safety Net Institute (CAPH/SNI), the Women's Community Clinic in San Francisco, and the Feminist Women's Health Center in Atlanta, Georgia.

Jennifer Hallman, LCSW/MPA, Los Angeles County Department of Mental Health

Jennifer Hallman is a Licensed Clinical Social Worker for the County of Los Angeles-Department of Mental Health (LAC-DMH). She received a Bachelor of Science Degree in Public Management and Criminal Justice and a Bachelor of Arts Degree in Psychology from the University of Arizona, and a dual Masters Degree in Public Administration and Social Work from the University of Southern California.

Jennifer entered the field of social work serving non-profit agencies as a Case-Aid Volunteer and Visitation Supervisor for Child Protective Services in Arizona. Later, as a social work intern, she worked with victims of gender-based harm at the USC Center for Women and Men and with clinical policies and procedures under the Office of the Medical Director at LAC-DMH. After receiving her Masters, Jennifer worked for Edelman Children's Mental Health Clinic and then Edelman Adult Mental Health Clinic within LAC-DMH for 4 years providing assessment, therapy, and case management services to clients with severe emotional and behavioral mental health issues. Jennifer has been working within the Quality Assurance Unit of LAC-DMH for the past 12 years and has overseen the Policy & Technical Development Team for 5 years. Within this capacity she has become a recognized Departmental expert on Medi-Cal documentation and claiming practices and training, QA-related policies and procedures, mental health procedure coding, the electronic record, and the management of clinical records. Jennifer is also responsible for managing the Departments implementation of and compliance with the State and Federal regulatory requirements, including the Federal Final Rule Network Adequacy Certification and Access to Care mandates.

TAB 5

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, April 21, 2022

Agenda Item: Overview of Enhanced Care Management and Community Supports

Enclosures: CalAIM Enhanced Care Management and Community Supports PowerPoint Presentation

Background Materials: Enhanced Care Management (ECM) Fact Sheet
Community Supports Fact Sheet
DHCS ECM and Community Supports Webpage

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

The purpose of this agenda item is to provide the SMC with an overview of the Enhanced Care Management (ECM) benefit and Community Supports optional benefit under the CalAIM Initiative from the Department of Health Care Services (DHCS). Committee members will utilize this information to inform the full Planning Council about these proposals as well as provide recommendations on how to improve coordination, access, and quality of care of these services to individuals with serious mental illness (SMI) and substance use disorders (SUD).

Background/Description:

The California Advancing and Innovating Medi-Cal (CalAIM) Initiative has a number of behavioral health proposals that aim to expand access and improve quality of care for individuals receiving services in California's public behavioral health system. Enhanced Care Management (ECM) is a proposal that builds off the Whole Person Care Pilots to serve individuals with complex physical, behavioral, and social needs through Managed Care Plans (MCPs) who typically serve the mild-to-moderate mental health population in California. ECM will address clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services. Community Supports are a set of 14 optional services provided by Medi-Cal MCPs as cost-effective alternatives to traditional medical services or settings. Community Supports are designed to address social drivers of health.

The Department of Health Care Services will present a high-level overview of ECM and Community Supports as they pertain to the high-needs SMI and SUD populations in California. Committee members will have the opportunity to ask questions in order to have an understanding of these benefits to share with the Planning Council as well as make any recommendations to DHCS on the implementation of these services.

Presenter Biography

Bambi Cisneros, Assistant Deputy Director of Managed Care - Health Care Delivery Systems, Department of Health Care Services:

Bambi Cisneros has been with the Department of Health Care Services (DHCS) since 2013 and currently serves as the Assistant Deputy Director – Managed Care, Health Care Delivery Systems (HCDS). HCDS is comprised of three divisions: Managed Care Operations Division, Managed Care Quality and Monitoring Division, and Integrated Systems of Division. Bambi works collaboratively with the HCDS Deputy Director to oversee the Medi-Cal managed care health plans, coordinate program and policy development associated with the managed care delivery system, and ensure that Medi-Cal beneficiaries have access to high quality care.

CalAIM Enhanced Care Management and Community Supports

CA Behavioral Health Planning Council
Systems and Medicaid Committee

April 21, 2022

DHCS

CalAIM Enhanced Care
Management

Enhanced Care Management (ECM)

Leveraging its managed care authority, DHCS began implementing ECM for populations with complex health and social needs via the Medi-Cal managed care contract in January 2022 and will phase in through 2023.

Benefit Overview

» ECM is a **new, statewide Medi-Cal benefit** providing intensive care management to address **clinical and non-clinical needs** of Medi-Cal's **highest-need enrollees**, primarily through in-person engagement where enrollees live, seek care, and choose to access services

» ECM builds off the successful community-based care management programs piloted in the Medi-Cal 2020 waiver's Whole Person Care (WPC) Pilots and Health Homes Program (HHP)

» In addition to ECM, enrollees may have connections to **Community Supports** to address social drivers of health (to the extent their plan elects to provide)

For more information and the full "populations of focus", see DHCS' ECM webpage and the ECM Fact Sheet.

ECM Implementation Timeline

ECM go-live is occurring in stages, by Population of Focus

ECM Populations of Focus	Go-Live Timing
1. Individuals and Families Experiencing Homelessness 2. Adult High Utilizers 3. Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD) 4. Incarcerated and Transitioning to the Community (some WPC counties)	**January 2022** (Whole Person Care/Health Home Program counties); **July 2022** (all other counties)
5. Incarcerated and Transitioning to the Community (all other counties) 6. At Risk for Institutionalization and Eligible for LTC 7. Nursing Facility Residents Transitioning to the Community	**January 2023**
8. Children / Youth Populations of Focus	**July 2023**

Community Supports

Resources

- DHCS' Community Supports webpage
- Community Supports Fact Sheet
- Community Supports Policy Guide
- CalAIM Incentive Payment Program FAQ

Community Supports

DHCS received federal authority to provide 14 state-proposed Community Supports beginning in January 2022.

Service Overview

- Community Supports refer to 14 **new services** proposed by DHCS and approved by CMS **designed to address social drivers of health and advance health equity.**
- Benefits will be offered by a local community provider as a **medically appropriate, cost-effective alternative to traditional medical services or settings.**
- Medi-Cal managed care plans are **encouraged to offer as many of the Community Supports as possible**, which are voluntary for managed care plans to offer and for members to use.

For more information about the Community Supports that managed care plans have opted to provide and when, see DHCS' Community Supports webpage , Community Supports Fact Sheet, and the CalAIM Incentive Payment Program FAQ.

Community Supports (Cont'd)

Service Overview

» Approved menu of Community Supports:

- Housing transition navigation services
- Housing deposits
- Housing tenancy and sustaining services
- Caregiver respite services
- Day habilitation programs
- Nursing facility transition/diversion to assisted living facilities
- Short-term post-hospitalization housing
- Community transition services/nursing facility transition to a home
- Personal care and homemaker services
- Environmental accessibility adaptations
- Medically supportive food/meals/medically-tailored meals
- Sobering centers
- Asthma remediation
- Recuperative care (medical respite)

Community Supports (Cont'd)

Service Overview

» For all 14 Community Supports :

– Consistent with current contract requirements, **a provider at the plan or network level will be required to document medical appropriateness** of each Community Support for each enrollee, including documenting that the Community Support is likely to reduce or prevent the need for acute care or other Medicaid services.

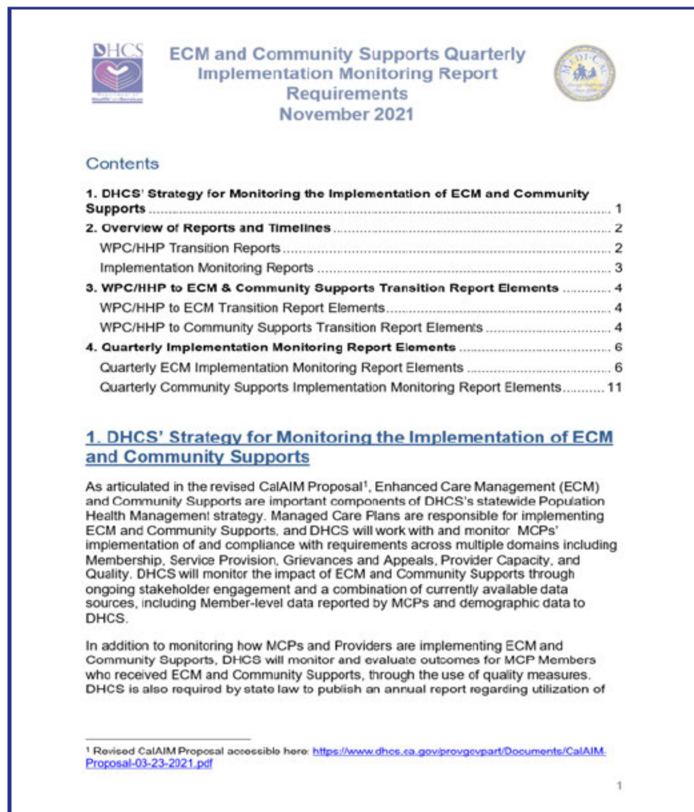
– **Reporting requirements apply**, including related to oversight, monitoring, and cost effectiveness.

– As planned, services will be included in **managed care rates.**

Monitoring Framework

Monitoring ECM & Community Supports in 2022

MCPs are required to submit a Quarterly Implementation Monitoring Report on ECM and Community Supports beginning in May, in addition to encounters.



DHCS

ECM and Community Supports Quarterly Implementation Monitoring Report Requirements
November 2021

Contents

1. DHCS' Strategy for Monitoring the Implementation of ECM and Community Supports 1
2. Overview of Reports and Timelines 2
   WPC/HHP Transition Reports 2
   Implementation Monitoring Reports 3
3. WPC/HHP to ECM & Community Supports Transition Report Elements 4
   WPC/HHP to ECM Transition Report Elements 4
   WPC/HHP to Community Supports Transition Report Elements 4
4. Quarterly Implementation Monitoring Report Elements 6
   Quarterly ECM Implementation Monitoring Report Elements 6
   Quarterly Community Supports Implementation Monitoring Report Elements 11

1. DHCS' Strategy for Monitoring the Implementation of ECM and Community Supports

As articulated in the revised CalAIM Proposal[1], Enhanced Care Management (ECM) and Community Supports are important components of DHCS's statewide Population Health Management strategy. Managed Care Plans are responsible for implementing ECM and Community Supports, and DHCS will work with and monitor MCPs' implementation of and compliance with requirements across multiple domains including Membership, Service Provision, Grievances and Appeals, Provider Capacity, and Quality. DHCS will monitor the impact of ECM and Community Supports through ongoing stakeholder engagement and a combination of currently available data sources, including Member-level data reported by MCPs and demographic data to DHCS.

In addition to monitoring how MCPs and Providers are implementing ECM and Community Supports, DHCS will monitor and evaluate outcomes for MCP Members who received ECM and Community Supports, through the use of quality measures. DHCS is also required by state law to publish an annual report regarding utilization of

[1] Revised CalAIM Proposal accessible here: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-03-23-2021.pdf

1

- MCPs will submit data across six dimensions
  1. ECM Members & Services
  2. ECM Requests for Services and Outreach
  3. ECM Provider Capacity
  4. Community Supports Members and Services
  5. Community Supports Provider Capacity
  6. Community Supports Requests and Denials

> Member date of birth is a required reporting field; thus, DHCS will be able to track the total number of children and youth receiving ECM & Community Supports

- ECM & Community Supports providers will be responsible for providing MCPs with the information needed to complete many of the reporting requirements
- This report also contains specifications for a **one-time Transition Report** that MCPs will submit about members that have transitioned from the **HHP and/ or WPC Pilot**

The first Quarterly Implementation & Monitoring Report and Transition Report is due from MCPs on May 15, 2022.

Questions?

TAB 5

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, April 21, 2022

Agenda Item: Local Perspectives on ECM and Community Supports

Enclosures: Presenter materials will be provided closer to the meeting date.

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

The purpose of this agenda item is to provide the SMC with the perspective of local partners and health plans responsible for implementing the Enhanced Care Management (ECM) and Community Supports benefits at the county level. Committee members will utilize this information to determine the impact at the local level in order to make sound recommendations to DHCS and educate Council members and community partners about the changes occurring through the CalAIM Initiative.

Background/Description:

Committee members will have an opportunity to hear from the Local Health Plans of California (LHPC) and the County Behavioral Health Directors Association (CBHDA) on the Managed Care and county perspective for the implementation of the CalAIM Initiative's Enhanced Care Management and Community Supports benefits. Committee members will ask questions to be further informed about the implementation of these proposals for the SMI/SUD population in California, as well as provide recommendations and best practices to better serve this population.

Please contact SMC staff at Ashneek.Nanua@cbhpc.dhcs.ca.gov for copies of the presentation materials.

Presenter Biographies:

Linnea Koopmans, MSW, Chief Executive Officer, Local Health Plans of California (LHPC)

Linnea brings many years of experience working on different aspects of the Medi-Cal program and has particular expertise in behavioral health. Immediately prior to coming to LHPC, Linnea was a Senior Policy Analyst for the County Behavioral Health Directors Association (CBHDA) where she served as the organization's expert on California's Section 1915(b) waiver, Section 1115 waiver programs, and the intersection of criminal

justice and mental health. She provided successful advocacy on behalf of CBDHA members on state policy, legislative, and budget issues. Linnea also previously worked on health care reform implementation for the Los Angeles County Department of Mental Health. She started her career working in housing and homelessness in Santa Barbara.

Linnea earned a Bachelor of Arts degree from Westmont College and a Master of Social Welfare from UCLA.

Michelle Cabrera, Executive Director, County Behavioral Health Directors Association

Michelle Doty Cabrera joined CBHDA as Executive Director in May 2019. Prior to joining CBHDA she served as the Healthcare Director for the California State Council of the Services Employees International Union (SEIU California), where she advocated on behalf of healthcare workers and consumers, including SEIU California's county behavioral health workforce, on issues related to the implementation of the Affordable Care Act, Health Equity, Health4All, and cost containment, among others. She served as a Senior Consultant for the Assembly Human Services Committee, where she specialized in child welfare issues and staffed legislation which extended foster care in California to age 21. Ms. Cabrera also served as a Program Officer for the California Healthcare Foundation, working as a liaison on state health policy in Sacramento.

Ms. Cabrera served as a member of Governor Newsom's Council of Regional Homeless Advisors and was recently appointed to the California Disability and Aging Community Living Advisory Committee, representing the needs of individuals with behavioral health conditions. Ms. Cabrera has been an inaugural member of the National Quality Forum's Standing Committee on Disparities and has served on the California Pan-Ethnic Health Network (CPEHN) Board of Directors since 2015.

Paula Wilhelm, MPP/MPH, Director of Policy, County Behavioral Health Directors Association

Paula is responsible for leading policy analysis and administrative advocacy efforts to advance CBHDA's priorities for county behavioral health services. Areas of focus include the Medi-Cal Specialty Mental Health and Drug Medi-Cal programs, substance use disorder services and drug policy, California's 1915(b) and 1115 Medicaid waivers, and the implementation of federal managed care and parity regulations.

Prior to joining CBHDA, she worked for the U.S. Department of Health and Human Services, California Association of Public Hospitals and Health Care Safety Net Institute (CAPH/SNI), the Women's Community Clinic in San Francisco, and the Feminist Women's Health Center in Atlanta, Georgia.

Yvette Willock, LCSW, Los Angeles County Department of Mental Health

Yvette Willock has over 25 years of diverse clinical social work practice. She earned a Bachelor of Arts in Psychology from Loyola Marymount University and holds two graduate degrees: A Master of Social Work from the University of Southern California and a Master of Arts in Human and Organizational Systems from Fielding Graduate University.

Ms. Willock has worked in both the private and public sectors, where she has applied the core values and ethical principles of Social Work Practice to instill hope in the individuals and families she worked with on their respective journeys of recovery and healing. During her career, Ms. Willock has engaged in micro Social Work Practice where she provided direct services to support the emotional and psychological wellbeing of individuals and advocated for needed services from systems that impact the health and wellbeing of individuals. Additionally, she has engaged in macro Social Work Practice with a focus on improving organizational processes and workflows which ultimately benefit individuals, families and groups.

During her tenure as Quality Improvement and Compliance Director of Training and Education at Pacific Clinics, and Quality Improvement Manager at Magellan Health Services, she utilized elements of Continued Quality Improvement (CQI) and Lean Six Sigma to facilitate needed changes in workflows and service delivery. Ms. Willock is also an international speaker, presenting on methods of Child Protection via a mental health lens, at multiple Child Abuse and Neglect conferences. Ms. Willock is currently Chief of Social Services for the Los Angeles County Department of Mental Health, where one of her roles is serving as the CalAIM Lead. In this role she works collaboratively intra-departmentally, as well as inter-departmentally with other Los Angeles County Departments to attain goals of CalAIM that include but not limited to the provision of Enhanced Care Management (ECM) and Community Supports (CS) Services, and readiness for Behavioral Health Payment Reform.

TAB 6

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, April 21, 2022

Agenda Item: Planning of CalAIM Presentation for General Session

Enclosures: CalAIM Webpage / CalAIM Behavioral Health Webpage
CalAIM Full Proposal and Executive Summary
July 2021 BH-SAC Presentation Slides (Page 6)
SMC CalAIM Recommendation Letter (March 2020)
SMC CalAIM Feedback Re: Medical Necessity (Jan 2021) **Contact staff for copy*
SMC CalAIM Recommendation Letter (May 2021)
CalAIM 1115 Demonstration and 1915(b) Waiver Webpage
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.

This agenda item provides the opportunity for the Systems and Medicaid Committee to plan an educational presentation to Council members regarding changes to Medi-Cal through the California Advancing and Innovating Medi-Cal (CalAIM) Initiative. The Initiative contains behavioral health proposals that aim to improve quality outcomes, address social determinants of health, and reduce complexities for individuals served in California's public behavioral health system.

Background/Description:

The CalAIM Initiative is a framework to improve access and quality of care through broad delivery system, program, and payment reform across the Medi-Cal program. The Systems and Medicaid Committee has worked with behavioral health administrators, consultants, partner-agencies, advocates, individuals with lived experience, and other entities to evaluate barriers and best practices in the California's public behavioral health system and have provided recommendations to the Department of Health Care Services through the CalAIM planning process.

It is imperative that Council members are informed about the proposed system changes under CalAIM as this Initiative impacts how services will be delivered and paid for in California's public behavioral health system. The SMC will present an overview of the CalAIM Initiative during the June 2022 Quarterly Meeting to provide the Council with information about the state and local impacts of CalAIM.

Committee members will address the following items as part of the planning process for the presentation:

- Identify which CalAIM behavioral health proposals are critical to present to the Council and when e.g.) *potentially staggering presentation of proposals over multiple General Sessions*
- Adopt a method to present the information e.g.) *PowerPoints, handouts, panel presentations, etc.*
- Determine who will present the information e.g.) *committee members, subject matter experts, direct providers, etc.*
- Designate timeframes for presentation and Q&A components

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
PO Box 997413
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.

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

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.

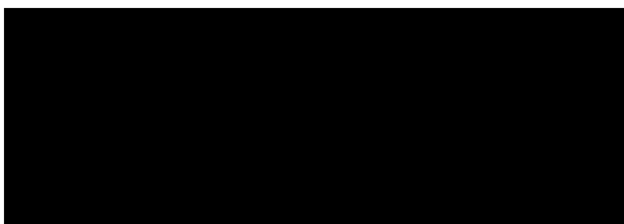
The shift from the current administrative processes may create challenges for current staff in county behavioral health departments and community-based organizations to adapt to new processes proposed in the CalAIM Initiative. Technical and financial assistance should be provided to counties and cultural 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
Chairperson

California Behavioral Health Planning Council

CHAIRPERSON
Noel J. O'Neill, LMFT

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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.**

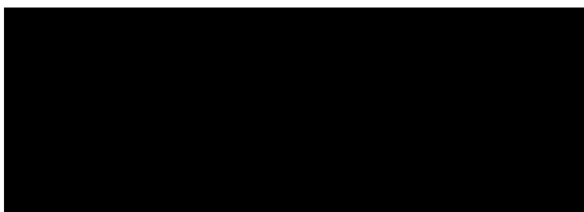
The No Wrong Door approach seeks to ensure that individuals receive the care they need no matter how they enter the system by allowing the delivery of services prior to a diagnosis or completion of an assessment. However, the No Wrong Door policy does not apply on a cross-county basis. There are individuals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

TAB 7

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, April 21, 2022

Agenda Item: Behavioral Health Updates

Enclosures: SMC Recommendation Letter Re: DHCS Telehealth Policy Proposal

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 committee members with information about the activities of advocates and stakeholders involved in developing behavioral health policies for California's most vulnerable populations. The SMC will use this information to stay up-to-date with current initiatives and plan future activities to advocate for policies that improve access to high-quality health care in California's public behavioral health system (PBHS).

Background/Description:

Systems and Medicaid Committee staff will provide a high-level update on current activities, initiatives, and efforts towards transforming the PBHS in California to better serve individuals with behavioral health conditions. Committee members will use this information for the ongoing effort to track various behavioral health policy meetings, engage in advocacy and make recommendations to the state for Medi-Cal beneficiaries with serious mental illness and substance use disorders.

Updates for various stakeholder meetings are provided below. *Please note that this list is not inclusive of all behavioral health policy meetings.*

Behavioral Health Stakeholder Advisory Committee (BH-SAC)

The Behavioral Health Stakeholder Advisory Committee (BH-SAC) was created as part of the ongoing DHCS effort to integrate behavioral health with the rest of the health care system, and incorporates existing groups that have advised DHCS on behavioral health topics. Following the model of the Stakeholder Advisory Committee, the BH-SAC advises the DHCS Director on the behavioral health components of the Medi-Cal program as well as behavioral health policy.

Updates: The meeting included a briefing on the CalAIM Section 1115 demonstration and CalAIM Section 1915(b) waivers. This briefing reviewed the approved initiatives and components included in the CalAIM demonstration and waiver, provided an update on pending CalAIM waiver requests, and provided an opportunity for the public to offer comment on the progress of the demonstration. The meeting also included an update on the quality/equity roadmap measures and metrics.

DHCS also delivered a presentation on the Contingency Management pilot going live on July 1, 2022 through March 2024. The pilot will cover Contingency Management as a Medi-Cal benefit in select Drug Medi-Cal Organized Delivery System (DMC-ODS) counties with the intention of informing the design for a statewide benefit to treat stimulus use disorders.

Seven counties have been approved to participate in Phase 1 of the Contingency Management pilot program, including Los Angeles, Marin, Orange, Riverside, Sacramento, San Francisco, and Ventura. Phase 1 counties will be launching contingency management services for Medi-Cal members as soon as July 2022.

Additionally, DHCS presented a high-level overview of their Behavioral Health Assessment Report. The assessment defines the elements of a strong and effective behavioral health system that is person-centered, offers a full array of services, focuses on equity, and is culturally competent. The assessment provides a framework to describe the core continuum of behavioral health care services in order to compare making it possible to compare “what is" in California to “what should be” and discusses the implications for DHCS' work and for California's broader efforts to strengthen the behavioral health system.

BH-SAC February 2022 Presentation Slides

Next meeting date: May 12, 2022 at 9:30 a.m. - 1:30 p.m.

California Health and Human Services Agency (CalHHS) Behavioral Health Taskforce

The California Health and Human Services (HHS) Agency announced Governor Newsom’s Behavioral Health Taskforce to address urgent mental health and substance use disorder needs across California. The Taskforce consists of stakeholders including individuals with lived experience, family members, advocates, providers, health plans, counties, and state agency leaders. The mission of the task force is to develop recommendations for the Governor about how California can provide timely access to high-quality behavioral health care for all.

Updates: Behavioral Health Taskforce members reviewed and provided feedback on their Charter. Then, Melissa Stafford Jones, Director of the Children and Youth Behavioral Health Initiative (CYBHI), provided an update on the Initiative, stakeholder engagement process, and timelines. Taskforce members answered discussion questions regarding the Initiative in virtual breakout rooms and reported their thoughts to the overall Taskforce after the breakout sessions. Topics for discussion included children, youth, and family engagement approaches and strategy and development of CYBHI outcomes.

Behavioral Health Taskforce – March 2022 Presentation

Next meeting date: June 14, 2022

Children and Youth Behavioral Health Initiative (CYBHI)

The Children and Youth Behavioral Health Initiative was announced in July 2021 with a $4.4B investment to enhance, expand and redesign the systems that support behavioral health for children and youth. The goal of the Children and Youth Behavioral Health Initiative is to reimagine mental health and emotional well-being for ALL children, youth, and families in California by delivering equitable, appropriate, timely and accessible behavioral health services and supports. The CYBHI comprises multiple workstreams led by five departments and offices of CalHHS – Department of Health Care Services, Department of Health Care Access and Information, Department of Managed Health Care, California Department of Public Health, and Office of the Surgeon General.

Updates: The CYBHI is currently in Phase 1, which involves setting goals and standing up to the project infrastructure. Major areas of focus include defining specific goals that support the overall Initiative, establishing a performance infrastructure, developing a comprehensive approach for convening and engaging stakeholders, understanding the current landscape of programs and initiatives across health and education, and preparing for detailed planning and future-state ecosystem design.

CalHHS and the five departments and offices are in the process of convening internal experts and stakeholders, conducting research to understand the current behavioral health landscape and identify needs, and beginning the detailed planning and design required for each work stream. Please view the February 2022 Children and Youth Behavioral Health Initiative Stakeholder Update and Children and Youth BHI Webpage for additional updates.

Children and Youth Behavioral Health Initiative Brief

DHCS Telehealth Advisory Committee Workgroup

For the purpose of informing the 2022-23 proposed Governor's Budget, Assembly Bill (AB) 133 (Committee on Budget), Chapter 143, Statutes of 2021, requires DHCS to convene an advisory group consisting of consultants, subject matter experts, and other affected stakeholders to provide recommendations to inform DHCS in establishing and adopting billing and utilization management protocols for telehealth modalities to increase access and equity and reduce disparities in the Medi-Cal program.

Updates: The Telehealth Advisory Committee reviewed the proposed Telehealth Policy which will make permanent the telehealth flexibilities provided during the COVID-19 public health emergency. DHCS invited stakeholders to provide feedback on the proposed policies. The SMC reviewed and provided recommendations for the Telehealth Policy Proposal via a letter to the Telehealth Advisory Committee.

Telehealth Advisory Workgroup – February 2022 Presentation

Next meeting date: TBD

Behavioral Health Continuum Infrastructure Program (BHCIP)

The Behavioral Health Continuum Infrastructure Program (BHCIP) provides the Department of Health Care Services (DHCS) funding to award competitive grants to qualified entities to construct, acquire and rehabilitate real estate assets or to invest in mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources. A portion of the funding is available for increased infrastructure targeted to children and youth 25 years of age and younger.

Updates: DHCS is in the planning process of Round 4 of the BHCIP grants. Through this fourth round of competitive grants, DHCS will award $480.5 million for children and youth-focused behavioral health infrastructure projects. DHCS held a listening session in March 2022 to gather information from stakeholders on BHCIP Round 4.

Please visit the BHCIP Webpage for additional information and updates.

DHCS Strategy to Support Children and Families

On March 2, DHCS released Medi-Cal's Strategy to Support Health and Opportunity for Children and Families. The strategy includes eight action areas with key initiatives illustrating where DHCS is strengthening its focus on children and families enrolled in Medi-Cal. These initiatives include improved preventive care, the Early and Periodic Screening, Diagnostic, and Treatment Medi-Cal benefit; addressing health disparities in children's care and outcomes; engaging with families to better include their voices in decision making; and addressing the youth behavioral health crisis.

Medi-Cal's Strategy to Support Health and Opportunity for Children and Families – March 2022

CalAIM Justice-Involved Advisory Workgroup

The DHCS CalAIM Justice-Involved Advisory Group is a broad-based body to solicit stakeholder input on policy and implementation matters regarding the CalAIM Justice-Involved initiative. The Justice-Involved Advisory Group convenes a diverse and visible stakeholder advisory group of leaders and representatives from key sectors, including counties, prisons, jails, providers, consumers, health plans, and policy organizations. The Justice-Involved Advisory Group offers regular input on key policy and implementation issues to support the launch and ongoing success of the CalAIM Justice-Involved initiative. The group will meet from October 2021 to July 2023.

Updates: In March 2022, the CalAIM Justice-Involved Advisory Workgroup received information about the Providing Access and Transforming Health (PATH) funding for the justice-involved population to support the CalAIM proposal to establish a pre-release application for individuals 90 days prior to release from jails and prisons. Members

engaged in Q & A and providing their recommendations to inform the development of this supportive funding for the justice-involved population.

CalAIM Justice-Involved Advisory Workgroup Webpage

Next meeting date: TBD

CARE Courts Briefing

In March 2022, the California Health and Human Services Agency (CalHHS) held a briefing following the Governor's announcements of CARE Courts, a proposed framework to deliver mental health and substance use disorder services to the most severely impaired Californians who too often suffer from homelessness or incarceration.

Please view the CARE Courts Framework and webpage for more information.

Council on Criminal Justice and Behavioral Health (CCJBH)

CCJBH is a 12-member council chaired by the secretary of CDCR and comprised of representatives from the Department of State Hospitals (DSH), the Department of Health Care Services (DHCS), and appointed experts from criminal justice and behavioral health fields. The council is tasked with several statutory goals including: investigating, identifying, and promoting cost-effective strategies that prevent adults and juveniles with behavioral health needs from becoming incarcerated; identifying incentives for state and local justice and health programs to adopt such approaches; reporting activities to the legislature; and providing recommendations for improving the cost-effectiveness of existing behavioral health and criminal justice programs.

Updates: The CCJBH January 2022 Full Council Meeting featured a presentation by DHCS on the Behavioral Health Assessment Report. Additionally, CCJBH members had the opportunity to engage in discussion on their tasks and priorities for the 2022 year. Potential priorities included strengthening the workforce across multiple sectors serving the justice-involved behavioral health population including the use of forensic Peer Support Specialists, exploring opportunities to share data across sectors, advocate for prioritization of available affordable housing including cross-system education and collaboration, and support the development and implementation of primary care and behavioral health treatment and identifying strategies to best deliver services through CalAIM, CYBHI, BHCIP, diversion programs, and more.

Please visit the CCJBH webpage for more information.

January 2022 CCJBH Full Council Meeting Presentation

CCJBH's 20th Annual Legislative Report

Next meeting date: April 29, 2022 at 2:00-4:30 p.m.

CCJBH Diversion and Reentry Workgroup

The Diversion and Reentry Workgroup is a subset of the Council on Criminal Justice and Behavioral Health. This workgroup is specifically tasked with strategizing ways to reduce recidivism and improve the transition for individuals with behavioral health conditions leaving jails and prisons into the community.

Updates: The March 2022 CCJBH Diversion/Reentry Workgroup featured a presentation on Riverside County's Whole Person Care Program that was designed to assist complex, high needs clients with behavioral health conditions who are involved with the justice system, and which has now transitioned to implement the new Enhanced Care Management and Community Supportsi benefit under the recent CalAIM waiver. The presentation focused on the history of the program, highlighting successes and outcomes. The video recording for this meeting is now available.

Please visit the Diversion and Reentry Workgroup March 2022 Meeting webpage for additional information.

Next meeting date: May 20, 2022 at 1:00-3:00 p.m.

California Behavioral Health Planning Council

CHAIRPERSON
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March 15, 2022

DHCS Telehealth Advisory Workgroup
California Department of Health Care Services
1501 Capitol Avenue Sacramento, CA 95814

Dear Telehealth Advisory Workgroup:

The California Behavioral Health Planning Council thanks you for the opportunity to comment on the Telehealth Policy Proposal. 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 use of telehealth as it strives to improve access, equity, and increases flexibility for service delivery in the public behavioral health system. The committee appreciates having an opportunity to review this proposal and are providing input and recommendations that we believe will strengthen the Telehealth Policy Proposal 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 various cultural and ethnic populations.

Provided below are the committee's recommendations for the proposed Telehealth Policy on behalf of the California Behavioral Health Planning Council:

Policy Areas: Payment Parity and Virtual Communications and Check-ins

The SMC appreciates the policy to have parity for in-person and video communications across delivery systems. However, the committee ***opposes*** the proposal to exclude payment parity for virtual communications such as web-based modalities/interfaces, live chats, e-consults, etc. The policy proposal indicates that brief virtual communications are allowed for physical health but there is no mention for behavioral health.

Recommendation: The SMC requests that there be parity between behavioral health and physical health systems. Behavioral health service delivery should have parity to reimburse for brief virtual communications. This will support parity with the physical health system as well as existing consumer needs for similar brief exchanges.

Policy Area: Establish New Patients via Telehealth

The SMC is supportive of the exception for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) to establish new patients via video, audio-only, or asynchronous telehealth modalities. The committee supports continuing to allow new patients to be established through these modalities as this policy strives for equity in accessing care.

The SMC ***opposes*** the proposal to prohibit the establishment of new patient relationships via audio-only telehealth modalities in non-FQHC/RHC delivery systems. Some patients have very limited data plans on their mobile devices, do not have mobile phones with video, experience limited broadband, or have poor digital literacy. These patients include but are not limited to individuals of historically underserved racial and ethnic backgrounds, older adults, LGBTQIAS populations, and patients who live in hard-to-reach areas. Thus, the exclusion of audio-only telehealth becomes a barrier to equity in accessing high-quality health care.

Recommendations:

- The SMC requests that audio-only telehealth be allowable to establish new patients across delivery systems, including county Mental Health Plans. This will increase access to services for California's most underserved or unserved populations and help bridge gaps in equity to accessing high-quality health care.
- School mental health services have expanded telehealth modalities through Managed Care Plans, FQHCs, and other contracted providers during the public health emergency. Therefore, we are seeking DHCS to clarify the exceptions to the audio-only telehealth policy.
- The SMC requests that DHCS also clarify the definition of "certain protections" to establish a relationship with new patients in-person or via video telehealth visits. We are unclear on what these certain protections are.

Policy Area: Telehealth Modifiers

The policy states that there is no distinct modifier guidance for audio-only encounters and Specialty Mental Health, Drug Medi-Cal, and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties are required to bill for services delivered via video and audio-only using specific modifiers.

Recommendation: The SMC recommends that DHCS add a modifier for audio-only encounters rather than create a difference in parity for physical health and behavioral health billing and services. This will help support the goal to align and streamline modifier use across all delivery systems, as well as support parity across delivery systems.

Policy Area: Third Party Corporate Telehealth Providers

The policy states that DHCS has a different reporting and oversight infrastructure than the Department of Managed Health Care, which oversees implementation of AB 457 for Knox-Keene licensed plans.

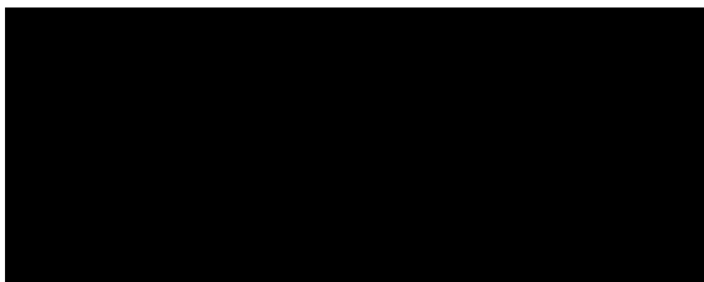
Recommendation: The SMC requests clarification on what the difference is for telehealth practices for county Mental Health Plans (MHP) and Managed Care Plans (MCPs). There is likely to be confusion for beneficiaries if the No Wrong Door Policy via telehealth is implemented differently by providers. For example, is a first telehealth visit in schools allowable via the MCP but not allowable under the MHP? We ask that DHCS clarify this policy and align the policy to support the principles of the CalAIM Initiative's No Wrong Door Policy.

We hope that the recommendations put forth in this letter are taken into consideration as the Department of Health Care Services finalizes the Telehealth Policy Proposal. It is promising to see many policies that were first introduced during the COVID-19 pandemic be made permanent through this policy 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 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

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

Shaina Zurlin, Chief of Medi-Cal Behavioral Health Division
California Department of Health Care Service



Noel J. O'Neill, LMFT
Chairperson