

California Behavioral Health Planning Council

Systems and Medicaid Committee Agenda

Thursday, January 16, 2020
Holiday Inn San Diego Bayside
4875 North Harbor Drive San Diego, CA 92106
Point Loma Room
8:30 am – 12:00 pm

8:30 am	Welcome and Introductions <i>Liz Oseguera, Chairperson</i>	
8:40 am	Approve October 2019 Meeting Minutes <i>Liz Oseguera, Chairperson</i>	Tab 1
8:45 am	California Advancing and Innovating Medi-Cal (CalAIM) Presentation <i>Michelle Doty Cabrera, Executive Director</i> <i>County Behavioral Health Directors Association of California (CBHDA)</i>	Tab 2
10:00 am	Public Comment	
10:05 am	Break	
10:20 am	Nominate 2020 Chair-elect <i>Liz Oseguera, Chairperson and All Members</i>	Tab 3
10:30 am	Review Recommendations from Behavioral Health 2020 Stakeholder Event <i>Liz Oseguera, Chairperson and All Members</i>	Tab 4
11:00 am	Public Comment	
11:05 am	Discuss SMC Recommendations for CalAIM Proposal <i>Liz Oseguera, Chairperson and All Members</i>	Tab 5
11:40 am	Public Comment	
11:45 am	Wrap Up/Next Steps <i>Liz Oseguera, Chairperson and All Members</i>	
11:55 am	Public Comment	
12:00 pm	Adjourn	

If reasonable accommodations are required, please contact the Council at (916) 323-4501, not less than 5 working days prior to the meeting date.

California Behavioral Health Planning Council

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

Systems and Medicaid Committee Members

Liz Oseguera, Chairperson

Veronica Kelley

Deborah Pitts

Dale Mueller

Cheryl Treadwell

Marina Rangel

Catherine Moore

Celeste Hunter

Noel O'Neill

Tony Vartan

Daphne Shaw

Walter Shwe

Karen Baylor

Hector Ramirez

Monica Nepomuceno

Susan Wilson

Kathi Mowers-Moore

Karen Hart

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**California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, January 16, 2020**

Agenda Item: Approve October 2019 Meeting Minutes

Enclosures: October 2019 Systems and Medicaid Committee Draft Meeting Minutes

Background/Description:

The Committee members will review the draft meeting minutes for October 2019.

Motion: Accept and approve the October 2019 Systems and Medicaid Committee minutes.

Bill Walker stated that Realignment monies to the counties are typically the funding source for IMD-type services.

The committee reviewed the facility types for psychiatric care from the *IMD Exclusion and the California Mental Health Continuum of Care* chart provided in the handouts. Committee members asked clarifying questions as they discussed each facility type and implications for IMD-status.

Bill Walker clarified that services provided by psychiatric health facilities (PHFs) include involuntary and voluntary acute psychiatric stays but do not include services for physical ailments. He further indicated that PHFs open a door into acute care and can be combined with other facilities such as Mental Health Rehabilitation Centers (MHRCs).

The County Behavioral Health Directors Association (CBHDA) created a *Crisis Continuum Geo-map* of all psychiatric hospitals in a given area throughout California. The committee reviewed the following information:

- Each map is designated by facility type.
- Each icon on the map shows the facility name, county, number of beds, address, and contact information.
- The maps show the geographic spread of facilities by hundreds of miles, posing challenges for individuals to access care.
- Areas with small population size typically had fewer facilities due to challenges in funding and limited staffing.
- Expensive, highly-populated areas are closing facilities due to high cost and found it more advantageous and cost-effective to run different types of facilities.

Noel O'Neill suggested the inclusion of an Adult Residential Facilities (ARFs) map. Bill Walker stated that next steps include the creation of a non-crisis continuum of care chart to show data on facilities, such as ARFs, with different licensing requirements.

The committee reviewed the *CBHDA Crisis Continuum October 2019* handout describing facility types in each county. Bill Walker illustrated barriers to operating the full crisis care continuum by showing how some counties, such as Alameda and Alpine counties, are similar geographic size but vary significantly in population.

Bill Walker presented the story of a Kern County facility that changed its licensing to become an acute psychiatric hospital in order to reduce staffing ratios and increase profits. The facility did not notify the county of this change or reduce the number of beds, therefore, individuals between 21-65 years old were not able to claim FFP due to the IMD exclusion. This had implications for the county as it was now responsible to pay approximately \$1 million to deliver services to 3 clients.

Bill Walker indicated that Kern County submitted a letter to remove the IMD exclusion. He emphasized the idea of separating acute care from chronic care and identified himself as a proponent of IMDs for acute care which is typically less than 30 days.

Kern County is currently planning to build two PHFs with a capacity for over 16 beds over the next 3 years; one facility for adults and one for children. Additionally, the California Mental Health Services Authority (CalMHSA) is planning to build one 225 bed facility to meet the needs of individuals who are waiting in jails for inpatient treatment.

Bill Walker expressed that individuals may receive the least restrictive but most effective care by providing crisis services along a continuum. He walked through the Kern County crisis care continuum to demonstrate this process:

Mobile evaluation systems will alert law enforcement to direct first responders to a call location for an individual experiencing a psychiatric crisis.



If the call is for a non-emergency reason, the individual will be transported to a crisis stabilization unit (CSU) rather than an emergency room to receive a physical evaluation.

If the call requires emergency transportation, the individual will be taken to the closest medical facility and then transported a CSU for stabilization.



During the stabilization period at the CSU, the crisis team will determine if the individual requires hospitalization while providing support to the individual.

The Transfer Referral Coordinator (TRC) is the single contact for the client over a 12-hour period and will coordinate the individual's care and referrals to prevent the loss of information through the referral process.



If the individual is in Kern County's hospital system, the crisis stabilization team will support them throughout their hospital stay and ensure that they attend their initial physical and/or behavioral health appointments.

Due to higher risks of suicide after hospitalization, a transfer team will meet with the individual if they are not in the Kern County hospital system and work with them to gain access to the system.



The individual will be placed within the Kern County care continuum matrix, which includes acute general hospitals, PHFs, MHRCs, CSUs, crisis residential facilities, mobile evaluation teams, and adult and children wraparound teams.

Bill Walker concluded his presentation and invited the committee to ask questions.

Karen Baylor asked why the bed limit for IMDs is 16 beds, how the 21-65 age group are designated, and what happens to an individual when they turn 66. Bill Walker said he is not aware of how the rules were initially made but reported that few counties have acute services for minors. He indicated that these minors are more likely to stay in emergency rooms.

Veronica Kelley added that the decisions that initiated the waiver were based on the needs at the turn of the century and indicated that the counties are working with DHCS to modernize the definition of medical necessity. She stated that facilities cannot bill for services when an individual turns 66 due to licensing, which causes issues for that individual's treatment, and expressed the need to work on licensing to limit disruptions to service delivery.

Tony Vartan echoed Bill Walker's comments of providing treatment in the least restrictive environment. He indicated that wraparound services in the community are effective, however, there are individuals who need a higher level of care to stabilize. The IMD exclusion can hinder wraparound supports because it results in clients seeking services external to the county. Tony provided an example of San Joaquin County reducing its number of beds due to the IMD exclusion, which limited capacity to provide treatment and drove individuals to seek care outside of the county.

Noel O'Neill stated that clinics with 24 hour psychiatric walk-ins with social workers, therapists, rehabilitation specialists, and other supports can provide acute care. Bill Walker stated that Kern County has a crisis walk-in clinic with 24 hour access and that many counties have services to build a continuum of care.

Dale Mueller asked if there is a need to expand MHRCs for youth because children have been contracted out of state to receive services. Bill Walker stated that care should return to the local environment by determining the standard of care for children and their wraparound system. He stated that this is an area of interest to address in partnerships with probation as they are often the decision makers for this population.

Veronica Kelley agreed that there are not enough placements partially due to the fact that the childrens' system of care has changed radically and indicated that counties do not control this system. She added that the bulk of county services are outpatient but are still responsible when individuals require inpatient care.

Action/Resolution

N/A

Responsible for Action-Due Date

N/A

Item #4

Discuss IMD Exclusion Waiver

Chairperson Veronica Kelley opened the floor for SMC members to discuss their thoughts on the IMD Exclusion Waiver to determine if the committee should write a letter of support or opposition on the waiver to DHCS.

Veronica Kelley indicated that the counties that operate the Drug Medi-Cal Organized Delivery System (DMC-ODS) currently have an 1115 waiver that partially waives the IMD exclusion to bill the federal government for substance use services in residential facilities with more than 16 beds. In order to bill for these services, the state matched \$20 million from the State General Fund to draw down federal dollars. She stated that the purpose of the IMD Exclusion Waiver would be to help individuals who are currently in treatment and are not responsive to lower levels of care.

Hector Ramirez discussed the concern of equity in IMD facilities and expressed the need for health parity. He provided an example of his own treatment experience in a Kern County facility and indicated that he was identified as a high-utilizer because many of the services he needed were not present in that facility. Hector stated he would like to see peer respite and substance use disorder services included in IMDs.

Deborah Pitts indicated that Medicaid is funded less than Medicare and private insurance which makes the IMD conversation about money rather than the quality of care. Bill Walker agreed with the notion to advocate for the lower level of care within the continuum and expressed that he advocates for both high-level and low-levels of care.

Daphne Shaw asked for clarification on why non-forensic individuals with the Lanterman-Petris-Short (LPS) Conservatorship are waiting for treatment in jails. Bill Walker stated that this population often ends up in jail and state hospitals often do not provide the level of care needed. Veronica Kelley added that there is penal code that allows jails to bypass LPS Conservatorship which allows Medicaid billing without involving patient rights advocates. She stated that individuals who are incompetent to stand trial are being housed in jails because they do not have another place to go.

Karen Baylor stated that safeguards requiring states to abide by terms and conditions can prevent the institutionalization of individuals. She provided examples of this such as assigning a case manager to track monthly progress for a patient as well as forming an internal placement committee to review progress on a continuous basis.

Catherine Moore expressed the limited 30 day reimbursement acts as a financial incentive to prevent long-term institutionalization.

Tony Vartan indicated that every service provided has a financial component regardless if it is provided within or outside of counties. He stated that many acute general

hospitals and psychiatric inpatient units are often privately-owned. Tony expressed that IMD exclusion waiver can expand capacity for counties to provide these services by drawing down more federal dollars.

The committee decided to continue discussing the IMD Exclusion Waiver at the January SMC meeting once members have more information from DHCS on what the waiver will be composed of.

Susan Wilson suggested continuing the IMD conversation to reach consensus on whether or not the committee will advocate for IMD Exclusion Waiver. She proposed inviting Kelly Pfeiffer, DHCS Deputy Director for Behavioral Health, to gather her thoughts and work with her if there is a misalignment between the committee's knowledge and Dr. Pfeiffer's views on the waiver. Susan expressed the importance of partnering with Dr. Pfeiffer to properly educate individuals and establish the full continuum of care.

Deborah Pitts commended the inclusion of information for long-term community-based services supported by the Olmstead Act in the meeting materials. Ashneek Nanua provided details for the next Olmstead Advisory Committee meeting to expand SMC knowledge on long-term care services in a community setting. Kathi Mowers-Moore stated that the contact person for the Olmstead meeting is not up-to-date on the website and will follow-up for the correct information.

Action/Resolution

- Review DHCS CalAIM proposal to determine if the IMD Exclusion is included in the Medi-Cal waiver renewals.
- Provide SMC members with the updated Olmstead Advisory Committee meeting details.
- Discuss the possibility of inviting Kelly Pfeiffer to a committee meeting to identify their understanding of the IMD exclusion waiver.

Responsible for Action-Due Date

Ashneek Nanua, Naomi Ramirez, Veronica Kelley, Liz Oseguera – January 2020

Item #5

Final Update/Next Steps: Behavioral Health 2020 Presentation

Ashneek Nanua reviewed the Behavioral Health 2020 agenda. No changes to the agenda were requested.

The committee reviewed a sample evaluation form to send to the attendees. There were no requested changes to the sample evaluation form.

SMC members discussed a timeline to collect and deliver stakeholder feedback to the Department of Health Care Services. The committee decided to evaluate the comments to compile into recommendations once DHCS releases the CalAIM proposal for the new waivers.

Action/Resolution

- Send post-event evaluation form to Behavioral Health 2020 event attendees.
- Compile recommendations provided at the event for SMC review.
- Identify similarities and differences between DHCS CalAIM proposal and Behavioral Health 2020 stakeholder recommendations.

Responsible for Action-Due Date

Ashneek Nanua and Naomi Ramirez – January 2020

Item #6 **Public Comment**

No public comment was given.

Action/Resolution

N/A

Responsible for Action/Due Date

N/A

Item #7 **Select Chair-Elect for 2020**

Hector Ramirez volunteered as the 2020 SMC chair-elect. Susan Wilson motioned approval. Catherine Moore seconded. Motion passed.

Jane Adcock, Executive Officer, reminded the SMC that the chair-elect has the additional responsibility to serve on the Council's Executive Committee. Naomi Ramirez added that the chair-elect acts as the chairperson when the chairperson is absent.

Action/Resolution

The chair-elect nomination will be submitted to the Executive Officers for confirmation.

Responsible for Action/Due Date

CBHPC Executive Officers

Item #8

Wrap Up/Next Steps

SMC members will continue the IMD Exclusion waiver discussion after obtaining information from DHCS on the waiver's contents and requirements.

The committee will assess the feedback collected from the Behavioral Health 2020 stakeholder meeting to formulate recommendations to DHCS on the Medi-Cal 1915(b) and 1115 waiver renewals.

Action/Resolution

- Follow DHCS stakeholder discussions on the IMD Exclusion waiver.
- Attend the SAC and BH-SAC meetings on October 29, 2019.
- Review the CalAIM proposal to identify future 1915(b) and 1115 waiver components.
- Compile Behavioral Health 2020 recommendations and compare recommendations to CalAIM proposal for SMC feedback.
- Provide Olmstead Advisory Committee meeting details to the committee.

Responsible for Action/Due Date

Ashneek Nanua, Naomi Ramirez, Veronica Kelley, Liz Oseguera – January 2020

Meeting adjourned at 12:00 p.m.

California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, January 16, 2020

Agenda Item: California Advancing and Innovating Medi-Cal (CalAIM) Presentation

Enclosures: [DHCS CalAIM Executive Summary](#)
[Crosswalk of Medi-Cal 2020 Components to CalAIM Proposal](#) (pg. 106 – 108)
[CalAIM Workgroup Schedule](#)
[Mental Health America of California \(MHAC\) Analysis: CalAIM and Behavioral Health Strategic Considerations for Change](#)

How This Agenda Item Relates to Council Mission

To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item provides the opportunity for committee members to evaluate the CalAIM proposal and stakeholder workgroups created by the Department of Health Care Services (DHCS) for the Medi-Cal 1115 and 1915(b) waiver renewals. Committee members will create policy recommendations on the proposal to ensure that the new waivers are designed to improve accessibility and quality of care to recipients of California's Public Behavioral Health System.

Background/Description:

Michelle Cabrera is the Executive Director for the County Behavioral Health Directors Association of California (CBHDA), a statewide non-profit association representing all fifty-eight county behavioral health directors and two city mental health programs (Berkeley and Tri-City). CBHDA is dedicated to advocating for public policy and services on behalf of individuals who live with substance use disorders and mental illness. Ms. Cabrera is also a member of the DHCS Behavioral Health Stakeholder Advisory Committee (BH-SAC), a stakeholder advisory group created with the purpose of advising DHCS on behavioral health components of the Medi-Cal program as well as broad behavioral health policy issues.

DHCS released the California Advancing and Innovating Medi-Cal (CalAIM) proposal at the BH-SAC meeting on October 28, 2019 as a framework for the renewing 1115 and 1915(b) Medi-Cal waivers. DHCS established CalAIM stakeholder workgroups to collect input that improves upon the concepts in the proposal.

Ms. Cabrera will provide a summary of the CalAIM proposal and CalAIM stakeholder workgroups to equip committee members with knowledge required to make appropriate policy recommendations on the proposal.

SMC members will use the information provided to evaluate the CalAIM proposal and discuss opportunities for stakeholder involvement in the CalAIM workgroups.

**California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, June 20, 2020**

Agenda Item: Nominate 2020 Chair-elect

Enclosures: None

How This Agenda Item Relates to Council Mission

To review, evaluate and advocate for an accessible and effective behavioral health system.

This agenda item provides the opportunity for committee members to select the next Systems and Medicaid Committee (SMC) Chair-elect for the current year, 2020. The Chair-elect is responsible for supporting the Chairperson with leading committee activities.

Background/Description:

CBHPC committees nominate a Council member during the October Quarterly Meeting each year for the following year. Once a member is chosen, the Council's Executive Officer provides the nomination to the Officer team for approval.

Council members are required to serve a minimum of one year on the Planning Council before they are eligible to be nominated as the Chair-elect of a committee. Therefore, SMC members will identify a new chair-elect for 2020. The 2020 Chair-elect will support SMC activities and be the Chairperson of the committee in 2021.

Motion: Nomination for the 2020 SMC Chair-elect.

**California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, January 16, 2020**

Agenda Item: Review Recommendations from Behavioral Health 2020 Stakeholder Event

Enclosures: Behavioral Health 2020 Key Themes Document
Behavioral Health 2020 Meeting Minutes (Recommendations only)
Crosswalk of Behavioral Health 2020 Recommendations and CalAIM 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 offers an opportunity for committee members to review feedback provided at the Council's Behavioral Health 2020 event in order to advocate stakeholder responses and create policy recommendations on the renewing 1115 and 1915(b) Medi-Cal waivers to the Department of Health Care Services (DHCS).

Background/Description:

The purpose of the Behavioral Health 2020 stakeholder event was to build knowledge on the expiring Medi-Cal 1115 and 1915(b) Waivers, identify gaps in California's public behavioral health system, and assist the Council and stakeholders in making appropriate policy recommendations to DHCS on the renewing Medi-Cal waivers.

DHCS released the CalAIM proposal on October 28, 2019 as framework for the renewing Medi-Cal waivers and established stakeholder workgroups to gather input on the proposal. California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year initiative to improve the quality of life and health outcomes of California's population by implementing broad delivery system, program and payment reform across the Medi-Cal program.

SMC members will address the following tasks:

- Review and evaluate Council member and public stakeholder recommendations collected from the Behavioral Health 2020 event
- Identify similarities and differences between the Behavioral Health 2020 recommendations and the CalAIM proposal
- Determine method to package Behavioral Health 2020 responses into policy recommendations for the Department of Health Care Services

Key Themes

Regional models

- Implement a center or joint-power authority to allow counties to work together to provide better services through a full continuum of care
 - Reduces distance traveled for client to receive services
 - Beneficial for small and rural counties

Continuity of care

- Reduce gaps in Medi-Cal service delivery when an individual changes counties
- Assign one person or team to follow an individual throughout their treatment i.e.) moving between mild-to-moderate and intensive services
 - Prevents the loss of trust between the client and provider
- Consider client and their families as a unit
 - Reduces feelings of isolation and trauma from separation between family and client as the client receives multiple levels of care

Person-centered care

- Recognize unique qualities and needs of each individual when providing care
- Build qualities and skills that an individual already has within them
 - Cost-effective approach that provides better care
- Target mental health dollars to recovery outside of medicalized treatment
 - Social Determinants of Rural Mental Health Innovation Project

Culturally competent services

- Increase stakeholder engagement of cultural groups
 - Hold sessions in the cultural group's community to ensure a comfortable environment
 - Ask groups what works and what they would like to see happen within the system
- Provide technical assistance to persons of color and cultural groups
- Invest in successful models
 - Promotoras Project: Peer with lived experience in the community
 - Friendship Bench: training elders in the community as mentors

Community-based services

- Facilitate community-driven stakeholder processes
- Account for social determinants of health
- Include wrap-around services
- Use a psychosocial approach
 - Protect against feelings of isolation or a loss in social identity

Data sharing and data systems integration

- Implement a unified system for data collection
 - Potential avenues for unification include the use of:
 - Electronic Health Registry to track data and reduce duplicate data entries
 - Standardized questionnaires to collect data and measure outcomes
- Increase data sharing through coordination of multiple systems
 - Right to Shelter Program (New York City) involves coordination between Emergency Services, Outreach, and Social Services Departments to share data and coordinate treatment for unsheltered individuals

Flexible reimbursement system

- Increase flexibility across funding streams to serve both Medi-Cal and non Medi-Cal populations
- Reduce documentation burden to county programs and community based organizations
- Taper IMD reimbursement
 - i.e.) providing a percentage of reimbursement for the first month of IMD treatment and lower this percentage in each consecutive month to incentivize moving individuals out of facilities

Coordination and transparency at state and local levels

- This will increase understanding of areas to prioritize in the system and how to prioritize these areas

Additional populations to consider

- Children and families
- Children and adults with autism and developmental disorders
- Immigrant and refugee populations
- Transition-age youth (TAY)

1 waiver.

2 (Applause.)

3 (Off the record at 11:10 a.m.)

4 (On the record at 11:20 a.m.)

5 MS. OSEGUERA: All right, folks, we are going to go ahead and
6 get started so if folks could take their seats. Again, we are starting very soon,
7 take your seats. The very exciting portion of the conversation will be starting,
8 where we get to hear from all of you.

9 All right. Well thank you everyone for being here and taking time
10 on a Friday. We are going to start the stakeholder engagement process in the
11 sense of we want to hear from all of you as to how you believe the behavioral
12 health system could be revamped through the waivers to make the changes that
13 we want to see and be able to provide the care that we would like to provide to
14 our communities.

15 So there are a couple of ways that you could give us feedback.
16 Right now you could do it verbally. We will allow three minutes for folks to be
17 able to kind of give us your thoughts. We want to be respectful of everyone's
18 time, we want to make sure that we stay to the clock, so three minutes will be
19 enforced.

20 But there is also a way to submit your comments in written. So if
21 you don't get to say everything you wanted to say right now we do encourage
22 you to please, please, please submit your comments in written format to us, to
23 Ashneek, and her email is here on the white board. And even if you provide
24 verbal comments and you want to do written we welcome that too.

25 So with that, if you would like to kind of just express what are your

1 viewpoints as to how to create the perfect behavioral health system, big
2 question, raise your hand and we will bring a microphone to you. And please
3 speak into the microphone, we are recording the session to make sure we
4 capture every comment. And with that we will get started.

5 MS. WILSON: I'm Barbara Wilson from Los Angeles County,
6 advocate. So one of the things, I really just appreciate this forum because I have
7 never really understood why things happen the way they happen.

8 And one of my concerns is this business of meeting medical need,
9 medical necessity. And so how I see it has worked is to the detriment of
10 continuity of care for a client, particularly TAY. So when they get better the price
11 of getting better is that they get graduated, quote, and then they have to start with
12 all new providers, a whole new care team, so then the attachment is lost and
13 then they -- at least sometimes they never reengage with anybody because that
14 trust is lost. So continuity of care.

15 At one time we did have a continuity of care system where there
16 was one person or one team that followed a person throughout all their
17 engagement with all the other programs that they had to engage with, and that
18 has been lost. I wonder if there is somehow that could be brought back into
19 present time, maybe revised. Thank you.

20 MS. OSEGUERA: Thank you.

21 Any other thoughts, comments?

22 MR. O'NEILL: Having worked in a rural county for a long time I
23 would really like the new waiver to reflect a provision where there could be some
24 kind of regional models. There might be either a center or a joint power authority
25 allowing three or four counties to be able to work together. I know we see that

1 already in Sutter-Yuba. But it just seems like it would be a way to really allow
2 better services in the outback.

3 MS. OSEGUERA: Awesome.

4 MR. NEILSEN: Dave Neilsen with the California Mental Health
5 Advocates for Children and Youth. I would hope that the exploring options for
6 system transformation include how the behavioral health system can engage
7 families and those children that are recently on the planet before they have
8 symptoms, before they qualify, before we are arguing about medical necessity,
9 before we are discussing who owns it. But how in the future, looking at what we
10 know about families in distress today, how can we begin meeting them?

11 And I hope the Planning Council engages professionals that can
12 bring in their advice to how our system can transform. Because these are really
13 just system improvements that you're talking about all morning, that we have
14 been talking about for 30 years and they're wonderful. But the system
15 transformation would be, where would behavioral health engage so that families
16 know from the get-go where they go for assistance? Because once they get in
17 trouble we know that they wander alone, so I hope that can happen. Thank you.

18 MS. OSEGUERA: So I am hearing a lot of integration, continuity
19 and collaboration.

20 Any other comments, thoughts?

21 MR. RAMIREZ: Thank you. Hector Ramirez, Los Angeles County,
22 a very small, little county in the state (laughter).

23 I think one of the things that I would really like to see is the
24 implementation and inclusion in all this process of cultural, the cultural elements.
25 We are the most diverse, which is a beautiful, rich thing. But the inclusion of our

1 cultural communities in this process so that it meets the cultural needs as well.
2 So taking into consideration the linguistic and cultural needs of our communities
3 because we are so diverse, and particularly our communities of color. So that is
4 definitely something that I really think we have an opportunity to revamp, to
5 improve, especially with our communities that are not necessarily English-
6 speakers, our monolinguals. And something also reflective of our new immigrant
7 and refugee communities as well since the state of California particularly has
8 been targeted the most these past couple of years. So definitely to help address
9 and ameliorate the trauma that these communities are experiencing.

10 MS. OSEGUERA: Thank you.

11 NOAH: Good morning, my name is Noah with Mental Health
12 America of Northern California.

13 Speaking from a person with lived experience, one of the things
14 that I think about in that experience was the idea of how I identified in the
15 community and what it meant to lose that sense of identity and put myself in
16 isolation or that idea of loss concept or recognition of where I fit. And I think that
17 is an element that can be appreciated if we integrate more cultural elements in
18 the way that people incorporate their community elements and the way that they
19 recognize full wraparound services with their elder community members, their
20 leaders in the community as well as their family members and social identity.

21 And a lot of that also incorporates the idea of playing into
22 community health in the way that we recognize behavioral health being a
23 symptom of psychosocial elements that are very representative in the social
24 determinants of health. And to see a behavioral health system that looks at root
25 causes that really can aim to prevent elements of isolation and loss of identity or

1 loss of sense of place from that psychosocial element will really help in a system
2 that sees people for a part of the community rather than an individual with a
3 problem.

4 MR. LEONI: Thanks. Steve Leoni on the Planning Council, from
5 San Francisco. I'll try to condense quickly two points.

6 One is that I was the author of the IMD question earlier on the
7 panel and I was glad that the guy from Kern brought up the idea of the difference
8 between acute units and chronic. It's the chronic part that really worries me the
9 most. I think many counties have general hospitals and they have psych
10 hospitals adjunct to that so it doesn't fall under the IMD exclusion, and if you
11 build a PHF that does then that doesn't seem fair, I want to keep people close to
12 home.

13 But one of the things that struck me was the idea of like partial
14 reimbursement for the long-term IMDs. I am no fan of this, but this total
15 exclusion doesn't seem to have, actually incentivize much of any change. And
16 one thing that actually might is perhaps partial in the sense that the first month
17 you're in there that you get, say, 40 or 45 percent of reimbursement of the cost,
18 and then in successive months the longer they're there it shrinks down to zero.
19 So that would be incentive. There might even be competition between the IMDs
20 to provide services within the IMD to help people get out. Because there is
21 something more tangible about reducing reimbursement than just, there is none.
22 I'm hoping. Just an idea that could be chewed over.

23 And the other thing -- I don't know how much -- is there a clock
24 someplace? I'd like to know how much time I've got left. Okay.

25 The other one is some kind of incentives built in, maybe an 1115

1 kind of thing, for better data collection and sharing, better use. I mean, it's
2 expensive and it's not what the data does but maybe some perks in there
3 somehow. For not only that but for data system integration between counties
4 and between mental health and substance use. They all have their different data
5 systems and they can't talk to each other. We can't -- and that needs to change.
6 And somehow maybe some incentives built in to counties that when they change
7 somehow something is easier for them or whatever.

8 MS. OSEGUERA (OFF MIC): Samira and then (pointed).

9 MS. PINGALI: Hi everyone. My name is Samira Pingali, I work at
10 Community Health Center Network, which is a network of eight federally qualified
11 health centers in Alameda County, we are a managed care organization.

12 And what I would hope for the waiver is in the spirit of bridging
13 these different silos I think one group that is often left behind is children and
14 adults with autism and developmental disorders. And trying to assist those
15 families in maneuvering the system is incredibly difficult so to just incorporate
16 that population into the planning.

17 SPEAKER: The thing that I am seeing, and it does dovetail on the
18 question that I was fortunately -- got to ask earlier is it seems imperative that
19 there is some kind of unified data system. If you are going to integrate
20 something and you can't connect with any of the other systems, it is really
21 important to have that. And it would seem to me that within those data systems,
22 of course, you are going to have to have these opt-ins or passwords or
23 something for specific systems that have higher levels of protection.

24 And in addition, the data collection ought to be built into that. I
25 mean, goodness knows Google does that and that is certainly, I would assume,

1 something that we are looking at on a statewide level. And I think that is very
2 important both to have the protections that people need for privacy as well as the
3 ability to do data collection. But also to, with patient permission, connect
4 everything else, sign in once, you know. Give your -- show your card and
5 whatever agency you enter -- again that's any door is the right door kind of
6 system.

7 MS. OSEGUERA: Any other hands?

8 NOAH: Also building on the data sharing thing is that one of the
9 successes of New York City's right-to-shelter program is the communication
10 between social services, emergency services and outreach communities and the
11 way that they share data about those with diagnoses that are on the streets or
12 unsheltered. They have a sheltered rate of about 90 percent, compared to
13 California's over 60 percent unsheltered. Again, the demographics are a little bit
14 different, they are mostly families that are sheltered, whereas ours are a lot more
15 individuals. But the outreach that they have and the integration that they have
16 between emergency services, outreach and social services allows that
17 communication to expand all links in the chain to be able to provide the most
18 comprehensive service when each person is approached, wherever they are
19 approached.

20 And one of the things that I heard the other day from an advocate
21 was that the loss of communication between her daughter being housed in
22 Sonoma County and her living in Santa Cruz County was a true detriment to the
23 way that care was being able to operate or transition away from the housing
24 system into the community.

25 MS. TATUM: Yes, Iris Tatum with the Planning Council. So

1 thinking in terms of the issue of isolation that was brought up, the changes in
2 terms of TAYs being from one system to the adult system of care, et cetera.

3 Think in terms of families. So you have mild-to-moderate goes to
4 Beacon, SMI goes to the facility. Then you have family members. Sure, the
5 service providers are talking to each other, but in terms of no wrong door just be
6 thinking about not having the families in silos but working together as a unit.
7 Which also brings up the issue that you just stated which is, a family member is,
8 for reasons of no bed available, is sent out of county. Then the family is here,
9 they are there. Again, the separations of family. Then the trauma because of
10 the crisis and the additional trauma of the separation and separation anxiety that
11 is happening into families. One is classified mild-to-moderate, the other one is
12 SMI, and it just -- it really places a burden on families. So I'm thinking as the
13 offers go forward to be thinking in terms of serving the family unit.

14 MS. OSEGUERA: I want to kind of poke your brains a little bit
15 more and see how. How are we going to be able to achieve some of these
16 goals? If we want to provide more cultural competency care how are we going to
17 do it? Or how are we going to make sure that the silos are removed? So any
18 thoughts or feedback on the, how?

19 MR. RAMIREZ: In LA County we have started to do a project
20 where we created a series of under-served cultural community competency
21 committees. We have right now nine different ones. We have one, you know, it
22 is a stakeholder involvement project where we have our Latino stakeholders and
23 community members. We have one for people with disabilities because most of
24 our services sometimes are not very accessible for people with disabilities. We
25 have an older adults, a veterans, one for our African-American community, our

1 API community, which is our Asian-Pacific Islander community, and then a
2 variety of other ones.

3 And what we have done, because LA County is so huge and it is
4 very difficult to kind of meet the needs, is we have those groups and they meet in
5 different parts at different times, and we engage the community to look at what
6 their needs are and what are some of the things that they have seen that have
7 been working or not.

8 For example, one of our most successful programs has been our
9 *Promotoras* project. And we have seen that as being a really good success
10 model and so we have adopted it to meet the needs of those particular
11 communities. We also have a Native American one. So we have like a Native
12 American *Promotoras* program that we are piloting up because we wanted to
13 have something similar.

14 And that is one of the ways that we saw that it was a pretty good
15 way to not only engage the community but also have our cultural competency
16 goals being really addressed and having our communities really come up to our
17 county and saying, these are the programs that kind of really work for us, these
18 are what we would like.

19 Like we are having a wellness taco project, which is a way of
20 having community engagement in a way that the community feels comfortable by
21 going to events but also having food available. We have our *Promotoras* also
22 doing some soft engagement to really try to engage our communities. We have
23 like a Zumba program as well.

24 We have ideas, we have feedback from the community of what
25 they like already, what they are comfortable with, and we engage them. So that

1 is perhaps an attempt. Perhaps if we have across the state a similar type of
2 community engagement where we address the needs of our cultural
3 communities and having them advise. What it is that you have seen that works,
4 what it is that you would like us to do, rather than us coming up with, oh, we read
5 this great project, we have wonderful data, let's try it on you. We want the
6 communities -- I think perhaps community driven projects like that, which is what
7 the MHSA kind of suggested, really would be to have. So that would be my
8 suggestion.

9 MS. OSEGUERA: Awesome, thank you. And *Promotoras*, does
10 everyone know what that is?

11 SPEAKER (OFF MIC): No.

12 MS. OSEGUERA: No. I'll explain it. *Promotoras* are kind of -- the
13 way that I explain it is, think of a peer, a behavioral health peer that has that life
14 experience. Well *Promotoras* have the cultural experience, they come from the
15 communities. Okay, so I saw a couple of hands up so right (pointed), yes.

16 SPEAKER: So in response to your question; I am from LA County.

17 I think a couple of the presenters have touched upon it is, really
18 addressing taking the opportunity to look at the documentation requirements.
19 And I think it has been well documented and stated about how burdensome it is
20 for both the county-operated programs as well as the community-based
21 organizations. And I think tied to that is, of course, the reimbursement
22 methodology. And having more flexibility across funding streams to be able to
23 serve not just Medi-Cal consumers but also those who are non-Medi-Cal.

24 SPEAKER: I was thinking that -- going back to how do we get the
25 POC, people of color, cultural piece into the programs. I think we deserve like a

1 technical assistance on how to apply, what to do, so technical assistance is one.

2 And another is like, have RFPs that have incentives to reach out to
3 the communities for innovative. It may not be evidence-based but it works for
4 the community that we are there to serve. So some type of incentives for both
5 like FQHCs, schools, any settings where our community is, if we have that.

6 MR. BLACK: I'm right here, I have the mic. My name is John
7 Black from the Central Valley and I represent Peer Recovery Art Project. And
8 one of the things that always sends me back when I am in meetings is the
9 intense focus on the problems that those of us with mental illness challenges
10 have and never a discussion on what qualities that we would need to build on
11 that already exist within us. That is a natural resource that is cost-effective and
12 is, in fact, better care.

13 If you accent and spend money on to build what is good in our
14 populations instead of conversations about what is wrong you can change the
15 mindset, which is important for a behavioral health system that is being
16 restructured. Change the mindset from the crisis, it's all wrong with us, to build
17 on the love, the kindness, the unique characteristics that those of us with lived
18 experience have, and lift us up in our general communities and keep us out of
19 the public mental health system.

20 MS. BAYLOR: Karen Baylor from Behavioral Health Concepts, the
21 EQRO, and a Council Member.

22 We keep hearing that when a client moves out of county it takes 90
23 days to get their Medi-Cal changed over. Medi-Cal is an entitlement. You
24 should be able to access Medi-Cal no matter where you live and it should not
25 take clients to have to wait 90 days for treatment just because they moved.

1 MS. WILSON: Barbara Wilson from LA County. You know, I work
2 a lot with aging parents who have an adult child with serious mental illness. And
3 one of the reasons that I come to these meetings and I am so grateful to have
4 this voice for them on their behalf is to say, if you want to know how to do it, one
5 way to do it would be to have a point person or a point team. Maybe establish a
6 pilot project to see how it works. But to have a continuing care services model
7 so that as their loved ones go in and out of hospitals, go in and out of IOPs, go in
8 and out of whatever, job training programs, care managers, FSP programs. If
9 you are going to keep graduating people at least have one person or one office
10 where they can call and just relate to that. And that would really help reduce the
11 stress and I think would also result in better communication between the family
12 who has a lot of information to give and the client who may or may not be always
13 reliable or may or may not want to have their family have that much involvement.

14 And second thing, just to piggyback on what somebody else said,
15 regional approaches. Because in the high desert area, which is part of Los
16 Angeles County, we have three counties that come together. But every single
17 county, depending upon the ZIP code of a person on a 5150 hold, travels by
18 ambulance or sheriff to a distance at least 75 to 100 miles one way. And that
19 means that the family very often is excluded from treatment, and we know that
20 treatment outcomes are better when the family can be included.

21 And we also have an Air Force base up there that we could partner
22 with perhaps and have a regional tri-county mental health acute treatment
23 center, and that is not even talking about the children that need treatment.
24 That's one how-to.

25 MANDY: Mandy from the California LGBTQ Health and Human

1 Services Network and the Out 4 Mental Health team. I wanted to echo what
2 Hector had said about *Promotoras* and I wanted to add to that too that there's a
3 lot of really unique cultures in California that I think we could do something about
4 that.

5 So there's ideas like *Promotoras* in every culture. In Filipino culture
6 you have your aunties. In Zimbabwe a PhD did what he called the Friendship
7 Bench, which is in the US now for students as well where they taught
8 grandmothers. They took them and they invested in training these community
9 mentors and community loved ones that have a history of supporting their
10 cultural communities. And then they brought them back to the community to
11 provide that service because those are folks that aren't moving out.

12 It's a really great model, not just for cultural communities but rural
13 communities as well because those are the folks that aren't going to be moving
14 out of the community anytime soon, they are there to support. And I really think
15 we need to invest more within our system in our cultural community strengths
16 and elders and mentors in each of those communities. And definitely, obviously,
17 for the LGBTQ community too, our trans elders and queer elders have so much
18 to offer us.

19 NOAH: So one of the things that I mentioned earlier was the social
20 determinants of health. And one of the conversations that I have heard at the
21 state level is how to facilitate communication between counties about innovation
22 programs that are happening as well.

23 Colusa County had an innovation program approved in 2018 that
24 was to focus specifically on rural social -- it is called social determinants of rural
25 mental project, so that is something as a project to look at as far as how they are

1 targeting mental health dollars that could be used for other aspects of recovery
2 rather than just medicinal treatment or medical treatment.

3 And one of the things that I continually have to circle back to is that
4 we are working with a new administration and he made a lot of big ideas in his
5 inaugural State of the State address and what his goals were and that was also
6 highlighted in Medi-Cal for All. Not Medi-Cal for All but California for All policies
7 and including possible universal health care or moving that way.

8 So knowing with greater transparency about what goals look like
9 now and how they translate to goals four years, three years down the line,
10 maybe into eight, who knows, but in the way that we look at the system now to
11 say, like, okay, what are working towards. We are going to have a better
12 understanding of what to prioritize or how to prioritize if there is coordination and
13 transparency between all systems of state level and county level and advocates
14 along the way.

15 MR. LEONI: Thank you. Thank you. I am not sure how much of
16 this is specifically for a waiver but I don't know, there are so many rules out there
17 that maybe we need something in there to make sure we can do this or what, but
18 I am going to bring it up. You were asking for like, how do we do stuff. And this
19 is around the data stuff again and this is something that occurred to me about
20 ten years ago when I learned about some stuff.

21 There is something out there called a registry, it is an electronic
22 health record, that is used in a lot of medical practices. If they get a vaccination
23 for flu and then they later get the flu they enter that in and it goes into a data
24 matrix in which it is identified with the person, it is kind of like its matrix in the
25 computer. And later on if you are doing report-outs you could say, how many

1 people in your practice got a vaccination and how many of those people got the
2 flu? It's just kind of press the button and it does it. You don't have to do
3 separate data entry for all the different reports. Once you enter it in, in the
4 process of working with the person in the room in treatment, then it is in there for
5 all other uses.

6 And that could greatly simplify all this duplicative data entry over
7 and over and over again for these different kinds of things. This first came up for
8 me when they were talking about having much better recording of ethnicity.
9 Typically something like Asian-Pacific Islander, it's almost meaningless except
10 perhaps for discrimination purposes kind of thing. Somebody from India,
11 somebody from Samoa, somebody from Taiwan are very different people, you
12 know. And so can we enter more in? Oh my God, the data entry alone, because
13 you're thinking of multiple way. But if it is just there in the computer and it's
14 done -- the provider wants to know that stuff so they enter it in, and then it's done
15 for everything else.

16 And you could have programs that would condense the data. Like
17 if you wanted API each of these would be -- well, that's API so you could have a
18 report that lists API, you know. So you can keep it very, very simple. And you
19 could have that data warehouse be in each county, you could have it hosted by
20 DHCS. Although I was told by someone very knowledgeable that DHCS
21 currently has a very antiquated computer system that could not handle this. I
22 don't know whether we put some incentive in the waiver for that or talk to the
23 Governor, because that would be one-time costs, you know, to replace that
24 computer system. Oh, we can't afford that. Well, we can't afford not to. And
25 this would give so many benefits. And this is, I think -- my personal feeling is it's

1 a very practical way.

2 I was at a meeting in Alameda County with Toby and people from
3 the OAC and Toby actually -- they had a computer expert in the room and Toby
4 said, is he right, can you do this with like the data entry. So I'm sitting with
5 sweaty palms, you know, the smart guy is on the hot seat. And the guy said,
6 yes. He said, I can see political problems with it but you can do it. So toss it
7 about.

8 SPEAKER: Just to follow on the same topic. Most organized
9 systems of care are required to have data systems that allow them to do
10 evaluation of how they are working.

11 And one of the other things that is very useful in the mental health
12 field, since we don't have a hemoglobin A1C to measure across our population
13 and see how we are doing on treating diabetes or preventing diabetes and
14 measuring those things on a regular basis or getting them all vaccinated, is there
15 are a number of standardized questionnaires that are used pretty commonly.

16 I don't like the idea of reducing treatment to questionnaire
17 treatment, but I use it in my practice and my EHR supports it and my people who
18 use services from me, actually most of them who are able, fill it out at home
19 ahead of time. And that provides a really good kind of symptom list so I don't
20 have to ask them all the details about how the sleep is going or I can follow-up
21 on where the positives are without doing every one of these questions, and
22 actually have more time to spend finding out what is going on in their life.

23 So that actually both is good for data collection because you can
24 use it for the evaluation of your practice or the evaluation of your health care
25 service delivery system depending on what level you are at. And so as we are

1 talking about -- I think it is going to be essential to somehow build a data
2 collection system that allows people to access in multiple places. And I would
3 think having the ability for the persons using the services to have input, it gives
4 you more health care data outcomes to measure how everything is doing.

5 So that is my first comment to follow with Steve's comments. And
6 yes, it can be done but it is expensive and it will take a lot of years before it really
7 is there and especially if you wanted to cover the whole state of California.

8 Anyway, that said, one of the things that was mentioned by
9 Michelle Cabrera regarding how the state is looking at things was looking at
10 things from a population basis. And I guess my concern, and I don't think they
11 are mutually exclusive any more than my questionnaires are exclusive from
12 treating my patients as individuals, but one of my concerns is that if you look at --
13 I think that is how you look at your strategies and what you need to approach.

14 But when the individual comes in you have to recognize that they
15 don't fit into those kind of population standards, the individuals have very
16 distinctive needs. You can say that in general depression responds as well to
17 Prozac as it does to Trintellix, the last, more brand new one. But you cannot say
18 that everybody is going to respond to Prozac. You can't limit your formulary in
19 that way, you can't limit your treatment options in those ways.

20 So while I applaud looking at where you need to target I wouldn't
21 want to see the individualized treatment and the need to approach different
22 people different ways with different kinds of rehab services or different levels of
23 services and all those things to be put into any kind of cookie-cutter, one-size-
24 fits-all. So that was my kind of concern and caution with the presentation.

25 MS. OSEGUERA: Thank you.

1 So we have reached our time. We want to thank really everyone
2 for your feedback and do encourage folks to please submit written comments.
3 And when you're submitting please let us know kind of how, how is it that we
4 would like to fix, and if you have any examples as to programs that are already
5 kind of maybe addressing it in a certain way. Please let us know because we will
6 look into them.

7 And so with that I hand it over to Ronnie to close us off.

8 DR. KELLEY: So once again thank you guys very much for
9 spending time here with us. It is really important that we get everyone's ideas.
10 We will be compiling the information, we are going to take it back to our
11 subcommittee, the Medicaid Systems Committee. We will organize it and then
12 we will be able to give it back to you. I think that is really important, especially
13 from a cultural perspective. We often go and take people's ideas and then we
14 leave them in the dust and we are not going to do that. We want you to see
15 what we are doing with the information and then we are going to be providing
16 that information to DHCS in some form.

17 But again, we want to thank you all. Everyone's voice is really
18 important.

19 And we do want to thank our panelists who we kind of put on the
20 spot here. So for Margaret from Partnership, for Len Finocchio from Blue Sky, to
21 Phebe Bell from Nevada County and the State of California, Bill Walker and his
22 ukulele, and Michelle Cabrera.

23 So again thank you all and have a great rest of your day.

24 (Applause.)

25 (Thereupon, the meeting adjourned at 11:57 a.m.)

Crosswalk of Behavioral Health 2020 Stakeholder Recommendations to CalAIM Proposal

Behavioral Health 2020 Concept	Behavioral Health 2020 Event Recommendation	CalAIM Proposal	Page	Proposal Description	Timeline
Medical necessity	Meet medical need and continuity of care for the client.	3.8 Medical Necessity Criteria for Specialty Mental Health (SMHS) and Substance Use Disorder Services (SUD)	74-79	<p>This proposal would allow counties to provide and be paid for SMHS and SUD that meet a beneficiary’s mental health and SUD needs prior to determination of covered diagnosis.</p> <p>This includes the development of a statewide, standardized level of care assessment tool used by counties and managed care plans to assess the client’s needs for services and determine the appropriate delivery system.</p>	January 1, 2021
Continuity of care	<p>Implement a system where one provider or team follows an individual throughout their treatment including transitions from different levels of care.</p> <p>Reduce gaps in Medi-Cal service delivery when an individual changes counties.</p>	<p>2.1 Population Health Management Program</p> <p>3.1 Managed Care Benefit Standardization</p>	23-37, 57-58	<p>2.1 - The population health management program would ensure a cohesive plan to address beneficiary needs across the continuum of care. Managed care plans will be required to annually provide the state with a description of how it plans to meet the program’s core objectives.</p> <p>One core objective includes managing member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination on the continuum of behavioral, developmental, and oral health, and long term services and supports. This includes tracking referrals and referral outcomes. Managed care plans must also include a description on how it will provide assistance</p>	January 1, 2021

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				<p>to members navigating multiple delivery systems.</p> <p>The case management portion of the program requires a lead care coordinator be assigned to a member if they receive care coordination from multiple entities, such as care that is outside of Medi-Cal managed care.</p> <p>If a member transitions to a new case management system or different level of care, the managed care plan is also responsible for coordinating this transition and ensuring that the member has all medically-necessary services covered.</p> <p>3.1- The managed care benefit standardization would ensure that all beneficiaries, regardless of county, would receive the same set of benefits through their managed care plan as they would in another county or plan. This would reduce the confusion that occurs when moving counties/plans and finding that there are a different set of benefits covered by the new plan or that they have to navigate a new delivery system.</p>	

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Behavioral Health 2020 Concept	Behavioral Health 2020 Event Recommendation	CalAIM Proposal	Page	Proposal Description	Timeline
Regional Models	Implement a center or Joint Power Authority for counties to work together in providing services through a full continuum of care.	3.10 Behavioral Health Regional Contracting	86-87	DHCS is encouraging counties to develop regional approaches to administer and deliver SMHS and SUD services via Joint Power Authority or contracting with a third-party administrator to create administrative efficiencies across multiple counties. DHCS is interested in discussions with counties not participating in substance use managed care (Drug Medi-Cal Organized Delivery System) to see if they would be willing to participate in DMC-ODS through regional approaches.	Seeking input from stakeholders
Person-centered and family-centered care	<p>Recognize unique qualities and needs of each client when providing care.</p> <p>Target mental health dollars to recovery outside of medicalized treatment. i.e. Social determinants of rural mental health innovation project</p> <p>Consider clients and their families as a unit. Reduce feelings of</p>	<p>2.1 Population Health Management Program</p> <p>2.2 Enhanced Care Management</p> <p>2.3 In Lieu of Services</p>	24, 37-45, 45-48	<p>2.1- The population health management program requires managed care plans to submit a program description to the state annually on how it plans to meet core objectives. One of the core objectives includes identifying and mitigating social determinants of health and reducing health disparities or inequities.</p> <p>The description should include strategies to address individual needs to mitigate social determinants of health issues and partner with appropriate community-based providers to support individual members, families, and caregivers in managing care. Descriptions should include how to use a person-</p>	<p>Population-based Management Program- January 1, 2021</p> <p>Enhanced Care Management Benefit – January 1, 2021 and 2023 for individuals transitioning</p>

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Behavioral Health 2020 Concept	Behavioral Health 2020 Event Recommendation	CalAIM Proposal	Page	Proposal Description	Timeline
	isolation and trauma that come with separation of client from their families when navigating multiple levels of care.			<p>centered and family-centered approach for care planning.</p> <p>2.2- The enhanced care management benefit is designed to provide a whole-person approach to care to address the clinical and non-clinical needs of high-cost, high-need Medi-Cal beneficiaries enrolled in managed care plans. Care managers are required to develop relationships with the client and their families and engage them in the needs assessment and care planning process.</p> <p>2.3- In lieu of services are designed to provide members with complex medical and behavioral health needs who also experience socioeconomic conditions that impede achievement of their health goals. These services focus on medical conditions and social determinants of health and avoid higher, more costly levels of care.</p>	<p>from incarceration</p> <p>In lieu of services – January 2021</p>
Community-based services	<p>Use a psychosocial approach and account for social determinants of health.</p> <p>Include wrap-around services.</p>	<p>2.1 Population Health Management Program</p> <p>2.2 Enhanced Care Management</p>	23-48	<p>2.1 & 2.2- See box above for considerations to social determinants of health.</p> <p>2.3- DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a managed care plan will integrate into its population health strategy.</p>	January 1, 2021

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	Facilitate community-driven stakeholder processes.	2.3 In Lieu of Services		<p>Examples of in lieu of services include but are not limited to housing transition and sustaining services, recuperative care, respite, home and community based wrap around services for beneficiaries to transition or reside safely in their home or community, and sobering centers.</p> <p>CalAIM is holding stakeholder workgroups for population health management, full integration plans, enhanced care management and in lieu of services, behavioral health, and NCQA accreditation. However, there is no mention of community-driven stakeholder processes.</p>	
Culturally-competent services	<p>Increase stakeholder engagement of cultural groups in the community setting.</p> <p>Provide technical assistance to persons of color and cultural groups.</p> <p>Invest in successful models. e.g. Promotoras Project; Friendship Bench</p>	<p>2.1 Population Health Management Program</p> <p>3.9 Administrative Integration of Specialty Mental Health and Substance Use Disorder Services</p>	25-26, 30-31, 84	<p>2.1- The population health management program includes a member contact screening in the initial risk assessment. One element this screening includes assessing health literacy and cultural and linguistic needs of the member. This program also has a stakeholder process through the CalAIM population health management work group but not does provide stakeholder engagement in the community setting.</p> <p>Case management to medium to high risk members includes the delivery of services that addresses cultural and linguistic needs by interacting with a member and his/her</p>	<p>Population health management – January 2021</p> <p>Administrative SMHS/SUD Integration - 2026</p>

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				<p>family in their primary language when possible.</p> <p>3.9- For administrative SMHS and SUD integration, counties would have only one integrated cultural competency plan rather than two separate plans.</p> <p>DHCS will provide technical assistance to counties and managed care plans when required.</p>	
<p>Data sharing and data systems integration</p>	<p>Implement a unified system for data collection.</p> <p>Increase data sharing through coordination of multiple systems. e.g. Right to Shelter Program (New York City)</p>	<p>2.1 Population health management program</p> <p>2.6 Full Integration Plans</p> <p>3.9 Administrative Integration of Specialty Mental Health Services and Substance Use Disorder Services</p>	<p>35, 53, 83</p>	<p>2.1- The population health management program requires managed care plans to implement health information technology to coordinate and integrate care across the delivery system. MCPs will develop data exchange protocols including member information sharing protocols before initiating services with a contracted entity. Protocols must support integrated behavioral and physical health coordination via sharing claims and pharmacy data and treatment or care plans to coordinate service delivery.</p> <p>2.6- Full integration plans would combine physical health, behavioral health, and oral health under one contracted entity. This would result in administrative simplification</p>	<p>Population health management- January 2021</p> <p>Full integration plans - Implementation in January 2024</p> <p>Administrative integration of SMHS/SUD- January 2026</p>

Crosswalk of Behavioral Health 2020 Stakeholder Recommendations to CalAIM Proposal

Behavioral Health 2020 Concept	Behavioral Health 2020 Event Recommendation	CalAIM Proposal	Page	Proposal Description	Timeline
				<p>and improve access to data sharing among providers, plans, and DHCS.</p> <p>3.9- Through SMHS/SUD integration, DHCS would like to explore the data-sharing process to address barriers with privacy protections.</p> <p>DHCS would like to pursue administrative integration for electronic health records (EHRs) depending on counties abilities to create a compliant design and collaborate with their vendors to make multiple, timely modifications to their EHRs.</p>	
<p>Flexible reimbursement system</p>	<p>Increase flexibility across funding streams to serve both Medi-Cal and non Medi-Cal populations.</p> <p>Reduce documentation burden to county programs and community-based organizations.</p>	<p>3.7 Behavioral Health Payment Reform</p> <p>3.9 Administrative Integration Of Specialty Mental Health and Substance Use Disorder Services</p> <p>No information found on non Medi-Cal populations.</p>	<p>71-74, 80-85</p>	<p>3.7- This proposal would move reimbursement from Certified Public Expenditure (CPE) methodologies to other rate-based/value-based structures that use intergovernmental transfers (IGT) to fund the county non-federal share. Rates will be set by peer grouping counties with similar costs to deliver services.</p> <p>Two phases:</p> <ul style="list-style-type: none"> • Transition SMHS and SUD services from Healthcare Common Procedure Coding System (HCPCS) Level 2 coding to Level 1 coding. Counties will also be required to use Current Procedural Technology (CPT) codes for services provided by physicians. 	<p>DHCS will work with counties and stakeholders on timeline. Earliest transition date is January 2021.</p>

Crosswalk of Behavioral Health 2020 Stakeholder Recommendations to CalAIM Proposal

Behavioral Health 2020 Concept	Behavioral Health 2020 Event Recommendation	CalAIM Proposal	Page	Proposal Description	Timeline
				<ul style="list-style-type: none"> • Establish reimbursement rates and methodology for updating rates for the updated codes with non-federal and state share being provided by counties from CPEs to IGTs. <p>3.9- DHCS is proposing to integrate SMHS and SUD services into a single behavioral health managed care plan structure, resulting in a single prepaid inpatient health plan in each county or region. This will streamline state and federal requirements and reduce administrative burden to counties. Clinical integration would include:</p> <ul style="list-style-type: none"> • Integrated MH/SUD treatment plan rather than having separate treatment plans for each. • One assessment rather than separate assessments for MH and SUD. <p>Administrative integration would include:</p> <ul style="list-style-type: none"> • One contract per county to cover MH and SUD services. • Counties developing and operationalizing a consolidated quality improvement plan, single quality improvement committee, and comprehensive list of performance measures for MH/SUD services. 	

Crosswalk of Behavioral Health 2020 Stakeholder Recommendations to CalAIM Proposal

Behavioral Health 2020 Concept	Behavioral Health 2020 Event Recommendation	CalAIM Proposal	Page	Proposal Description	Timeline
				<ul style="list-style-type: none"> • One external quality review organization (EQRO) review report for each county. • Consolidated compliance reviews into one review with an integrated protocol with a focus on documentation requirements. • One network for MH/SUD to improve network adequacy. • Streamline licensing and certification requirements. 	
Coordination and transparency at state and local levels	Increase understanding of areas to prioritize in the system.	No mentions of state and local transparency. However, the proposal aims to create a more consistent and seamless system with programs that aim to better coordinate care.	N/A	Programs within the CalAIM proposal are designed to improve care coordination through managed care plans and local entities. The state is willing to work with counties and managed care plans throughout the planning and implementation processes and provide technical assistance once implemented.	January 2021
Additional Populations to consider	Children and families Children and adults with autism and developmental disorders	2.7 Long Term Plan for Foster Care 3.14 Enhancing County Oversight	55, 98-100, 23-48	2.7- Children and youth in foster care often present with complex medical, behavioral, oral and developmental health problems rooted in their history of childhood trauma and adverse childhood experience and frequently navigate multiple systems of care.	Long term plan for foster youth - Workgroup discussions in 2020.

Crosswalk of Behavioral Health 2020 Stakeholder Recommendations to CalAIM Proposal

Behavioral Health 2020 Concept	Behavioral Health 2020 Event Recommendation	CalAIM Proposal	Page	Proposal Description	Timeline
	<p>Immigrant and refugee populations</p> <p>Transition-age youth (TAY)</p>	<p>and Monitoring: CCS and CHDP</p> <p>2.1 Population Health Management Program</p> <p>2.2 Enhanced Care Management Benefit</p> <p>2.3 In Lieu of Services (Housing Tenancy and Sustaining Services, Housing Deposits, Short-term Post-Hospitalization Housing, Housing Transition Navigation Services</p>		<p>DHCS will hold workgroups to determine if there is a need to develop a new model of care for children and youth in foster care.</p> <p>3.14- DHCS intends to provide enhanced monitoring and oversight of all 58 counties to ensure continuous and optimal care for children by developing a robust strategic compliance program for the California Children Services (CCS) and Child Health and Disability Prevention (CHDP) programs. DHCS will develop auditing tools, identify gaps, update oversight policies and procedures, and implement best practices.</p> <p>2.1 & 2.2- Children and families have considerations in the population health management program and enhanced care management programs.</p> <p>2.3 - Transition-age youth are included in In Lieu of Services. No specific mention of immigrant and refugee populations and individuals with autism and developmental disorders.</p>	<p>CCS/CHDP oversight- Jan 2020-October 2022</p> <p>Population-based management, enhanced care management, and in lieu of services – January 2021</p>

**California Behavioral Health Planning Council
Systems and Medicaid Committee
Thursday, January 16, 2020**

Agenda Item: Discuss SMC Recommendations for CalAIM Proposal

Enclosures: [CalAIM Implementation Timeline](#) (pg. 115-117)
Crosswalk of SMC Recommendations to CalAIM 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 the opportunity to create policy recommendations for the California Advancing and Innovating Medi-Cal (CalAIM) proposal to advocate for an 1115 and 1915(b) waiver framework that improves access and quality of care to individuals served by California's Public Behavioral Health System.

Background/Description:

California Advancing and Innovating Medi-Cal (CalAIM), is a multi-year initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of California's population by implementing broad delivery system, program and payment reform across the Medi-Cal program.

DHCS released the CalAIM proposal as a framework for the upcoming 1115 and 1915(b) waiver renewals and is currently holding stakeholder engagement processes through the following workgroups: Behavioral Health, Enhanced Care Management, Full Integration Plans, Population Health Management Strategy and Plan Enrollment, and NCQA Accreditation.

Committee members will address the following tasks:

- Discuss priority areas to address in CalAIM proposal
- Review the Crosswalk of SMC Recommendations to CalAIM Proposal document
- Create SMC policy recommendations for the CalAIM proposal
- Merge SMC policy recommendations with Behavioral Health 2020 recommendations
- Determine a method and timeline to deliver policy recommendations on the CalAIM proposal to the Department of Health Care Services

Systems and Medicaid Committee Recommendations to CalAIM Proposal (DRAFT)

Topic	CalAIM Proposal	Page	CalAIM Proposal Description	Timeline	Recommendation to DHCS
Medical Necessity	3.8 Medical Necessity Criteria for Specialty Mental Health (SMHS) and Substance Use Disorder Services (SUD)	74-79	This proposal would allow counties to provide and be paid for SMHS and SUD that meet a beneficiary's mental health and SUD needs prior to determination of covered diagnosis. This includes the development of a statewide, standardized level of care assessment tool used by counties and managed care plans to assess the client's needs for services and determine the appropriate delivery system.	January 1, 2021	Provide flexibility to medical necessity requirement to ensure clients are receiving care and providers and MHPs are reimbursed for providing services.
Continuum of care	2.1 Population Health Management Program 2.3 In Lieu of Services 2.5 Institutes for Mental Disease (IMD) Waiver 3.10 Regional Contracting	23-37; 45-48; 50-52; 86-87;	2.1 - The population health management program would ensure a cohesive plan to address beneficiary needs across the continuum of care. Managed care plans will be required to annually provide the state with a description of how it plans to meet the program's core objectives which include: <ul style="list-style-type: none"> • Focus on prevention wellness • Ongoing identification and assessment of member risk • Management of member safety and outcomes during transitions, across delivery 	Population health management and In lieu of services, – January 1, 2021 DHCS is seeking input for the IMD Exclusion Waiver and Regional Contracting	Provide clients with access to the full continuum of care in the service delivery system. Ensure clients are appropriately placed within the continuum. Create regional contracts to allow clients in small and rural counties access to any service along the continuum and reduce time and distance traveled for services.

Systems and Medicaid Committee Recommendations to CalAIM Proposal (DRAFT)

Topic	CalAIM Proposal	Page	CalAIM Proposal Description	Timeline	Recommendation to DHCS
			<p>systems or settings, through effective care coordination</p> <ul style="list-style-type: none"> • Identification and mitigation of social determinants of health and reducing health disparities or inequalities <p>Clients will undergo a risk assessment and stratification and be reassessed annually to ensure they are placed in the appropriate care setting.</p> <p>2.3 - In lieu of services are wrap-around services designed to provide members with complex medical and behavioral health needs who also experience socioeconomic conditions that impede achievement of their health goals. These services focus on medical conditions and social determinants of health and avoid higher, more costly levels of care. The framework for this proposal allows for regions with limited infrastructure to build network capacity that meets the unique needs of their clients.</p> <p>2.5 – The IMD Exclusion Waiver would allow claims for federal financial participation. This</p>		

Systems and Medicaid Committee Recommendations to CalAIM Proposal (DRAFT)

Topic	CalAIM Proposal	Page	CalAIM Proposal Description	Timeline	Recommendation to DHCS
			<p>additional funding would provide opportunities to improve service delivery and outcomes across a robust continuum of care from inpatient to community-based settings. Availability of additional federal matching funds would free up other local resources, such as realignment funds, that counties may then reinvest in strengthening other mental health services and further build the continuum of care in the community.</p> <p>3.10 - DHCS is encouraging counties to develop regional approaches to administer and deliver SMHS and SUD services via Joint Power Authority or contracting with a third-party administrator to create administrative efficiencies across multiple counties. DHCS is interested in discussions with counties not participating in the Drug Medi-Cal Organized Delivery System to see if they would participate through regional approaches.</p>		

Systems and Medicaid Committee Recommendations to CalAIM Proposal (DRAFT)

Topic	CalAIM Proposal	Page	CalAIM Proposal Description	Timeline	Recommendation to DHCS
Person-centered care	2.1 Population health management program The proposal did not mention the consumer voice.	23-37	The population health management program requires managed care plans to submit a program description to the state annually. Descriptions should include how to use a person-centered and family-centered approach for care planning.	January 1, 2021	Provide client-centered services with consideration to families in client care. Ensure that consumers have a voice in the decision-making process.
Behavioral Health System Integration	2.6 Full integration plans 3.9 Administrative integration of Specialty Mental Health (SMHS) and Substance Use Disorder (SUD) Services	53-55; 80-85	2.6 - Full integration plans would combine physical health, behavioral health, and oral health under one contracted entity for managed care. The goal is to improve health outcomes by eliminating fragmentation, duplication, and the need to navigate multiple systems. This proposal also aims to simplify administrative processes and improve access to data sharing among providers, plans, and DHCS. 3.9 - DHCS is proposing to integrate SMHS and SUD services into a single behavioral health managed care plan structure, resulting in a single prepaid inpatient health plan in each county or region. This will streamline state and federal requirements and reduce administrative burden to counties.	Full integration plans will have stakeholder workgroups in 2020, build contract and request for proposal in 2021, post RFP and award contracts in 2022, engage in readiness planning and activities in 2023, and go live in 2024. Administrative SMHS/SUD	Improve care coordination and reduce administrative burden and confusion of navigating multiple delivery systems. Potential options: <ol style="list-style-type: none"> 1) Medi-Cal managed care plans (MCPs) manage behavioral health and physical health care 1) County mental health plans (MHPs) deliver all mental health and SUD care (mild to moderate and SMI) 2) County mental health plans manage physical and behavioral health for individuals with SMI

Systems and Medicaid Committee Recommendations to CalAIM Proposal (DRAFT)

Topic	CalAIM Proposal	Page	CalAIM Proposal Description	Timeline	Recommendation to DHCS
			<p>3.9 - Clinical integration:</p> <ul style="list-style-type: none"> • Integrated 24 hour access line to screen, triage, and refer individuals to SMHS and/or SUD services • Integrated screening to initiate an integrated treatment path for individuals with both SMHS and SUD needs. • One, integrated MH/SUD treatment plan for individuals with co-occurring disorders rather than separate treatment plans for each. • One standardized assessment for both MH and SUD. • One handbook for MH/SUD <p>3.9 – Prepaid Inpatient Health Plan (PIHP) and Fee-for-Service (FFS) Functions Integration:</p> <ul style="list-style-type: none"> • One contract in each county to cover SMHS and SUD services • Data-sharing: explore barriers due to regulations around data-sharing to determine if counties can 	<p>integration - 2026</p>	

Systems and Medicaid Committee Recommendations to CalAIM Proposal (DRAFT)

Topic	CalAIM Proposal	Page	CalAIM Proposal Description	Timeline	Recommendation to DHCS
			<p>integrate, assessments, treatment plans, and electronic health records (EHRs).</p> <ul style="list-style-type: none"> • Record design to integrate EHR • One cultural competency plan rather than separate plans for MH and SUD <p>3.9 - Administrative Integration:</p> <ul style="list-style-type: none"> • Consolidated quality improvement plan, have a single quality improvement committee, and develop a comprehensive list of performance measures for SMHS/SUD services • Combined External Quality Review Organization (EQRO) process and report for each county • One compliance review with an integrated protocol with focus to reduce duplicative documentation requirements • One certified network for SMHS and SUD for each county • Streamlined licensing and certification requirements, 		

Systems and Medicaid Committee Recommendations to CalAIM Proposal (DRAFT)

Topic	CalAIM Proposal	Page	CalAIM Proposal Description	Timeline	Recommendation to DHCS
			<p align="center">processes, and timelines across the behavioral health system</p>		
Behavioral health payment reform	<p>3.7 Behavioral Health Payment Reform</p> <p>2.4 Shared Risk, Shared Savings, and Incentive Payments</p>	71-74; 48-50	<p>3.7 - Behavioral health payment reform would change the reimbursement structure from Certified Public Expenditure (CPE) methodologies to other rate-based/value-based structures that use intergovernmental transfers (IGT) to fund the county non-federal share. Rates will be set by peer grouping counties with similar costs to deliver services.</p> <p>Two phases:</p> <ul style="list-style-type: none"> • Transition SMHS and SUD services from Healthcare Common Procedure Coding System (HCPCS) Level 2 coding to Level 1 coding. Counties will also be required to use Current Procedural Technology (CPT) codes for services provided by physicians. • Establish reimbursement rates and methodology for updating rates for the updated codes with non-federal and state share being 	<p>DHCS will work with counties and stakeholders on timeline. Earliest transition date is January 2021.</p>	<p>Move from fee-for-service to alternative payment methods e.g. value-based payments</p> <p>Enable a flexible reimbursement system for county mental health plans and behavioral health providers.</p>

Systems and Medicaid Committee Recommendations to CalAIM Proposal (DRAFT)

Topic	CalAIM Proposal	Page	CalAIM Proposal Description	Timeline	Recommendation to DHCS
			<p>provided by counties from CPEs to IGTs.</p> <p>2.4 - DHCS is considering potential incentives and shared savings/risk models to build infrastructure to support integration of long-term services, enhanced care management, and in lieu of services. These models are to encourage Managed Care Plans and providers to invest in service delivery and systems infrastructure, build appropriate care management and capacity, and achieve improvements in quality performance. Incentives include:</p> <ul style="list-style-type: none"> • Blended capitation rate for seniors and individuals with disabilities and long-term care beneficiaries • Prospective model of shared savings/risk incorporated in capitation rate development • Incentives based on quality and performance improvements and reporting on areas such as long-term services and supports and other cross-delivery system metrics 		

Systems and Medicaid Committee Recommendations to CalAIM Proposal (DRAFT)

Topic	CalAIM Proposal	Page	CalAIM Proposal Description	Timeline	Recommendation to DHCS
Childrens' Services	<p>2.7 Long Term Plan for Foster Care</p> <p>3.14 Enhancing County Oversight and Monitoring: CCS and CHDP</p>	55, 98-100	<p>Children and youth in foster care often have complex medical, behavioral, oral and developmental health problems and frequently navigate multiple systems of care. DHCS will hold workgroups to determine if there is a need to develop a new model of care for children and youth in foster care.</p> <p>DHCS intends to provide enhanced monitoring and oversight of counties by developing a robust strategic compliance program for the California Children Services (CCS) and Child Health and Disability Prevention (CHDP) programs. DHCS will develop auditing tools, identify gaps, update oversight policies and procedures, and implement best practices.</p>	<p>Long term plan for foster youth - Workgroup discussions in 2020.</p> <p>CCS/CHDP oversight- Jan 2020-October 2022</p>	Ensure that children are receiving quality services and are not forgotten as part of the conversation.