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ADVANCING BEHAVIORAL HEALTH POLICY & LEADERSHIP

January 30, 2015

Mari Cantwell, Acting Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, California 95899

SUBJECT: The Steinberg Institute and Key Behavioral Health Stakeholders' Comments on Behavioral Health Integration Proposals for the 1115 Waiver

Dear Ms. Cantwell:

On behalf of the Steinberg Institute and key behavioral health stakeholders who were members of the Mental Health and Substance Use Disorders Integration Task Force and the 1115 Waiver Work Groups, including Molly Brassil, County Behavioral Health Directors Association of California (CBHDA), Rusty Selix, California Council of Community Mental Health Agencies (CCCMHA), Al Senella, Tarzana Treatment Center and California Association of Alcohol and Drug Executives (CAADPE), Brad Gilbert and Peter Currie, Inland Empire Health Plan (IEHP), and Jennifer Clancy, California Institute of Behavioral Health Solutions (CIBHS), we offer recommendations on key strategies to support behavioral health integration in the 1115 Waiver.

On November 10, 2014 the California Department of Health Care Services (DHCS) convened the Mental Health and Substance Use Disorder Services Integration Task Force, a meeting that brought together leaders from California's County Mental Health (MH) and Substance Use Disorder (SUD) treatment systems, Legislature and Medi-Cal Managed Care Plans. The meeting resulted in a Summary Paper that identified a significant number of behavioral health integration proposals. These were shared with all of the 1115 Waiver Work Groups to ensure the strategies were informed by broad feedback and perspectives. The Steinberg Institute organized the key behavioral health stakeholders from the 1115 Work Groups to translate a disparate and high number of integration strategies into a comprehensive Four Part Plan that offers focus for the DHCS 1115 Waiver Renewal Behavioral Health Integration objectives. Please find summarized below the Steinberg Institute and key behavioral health stakeholders' recommendations for assuring the 1115 Waiver effectively promotes the integration of behavioral health.

Steinberg and Key Behavioral Health Stakeholders Recommended Integration Strategies

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Research has well established that the high healthcare costs and poor health outcomes associated with individuals with mental health and substance use conditions are primarily due to significantly higher rates of chronic health conditions in this population, such as diabetes, heart disease, and chronic respiratory diseases. There are many factors that contribute to the poor physical health of people with mental health and substance use disorders, including the more obvious such as lifestyle factors and medication side effects. However, there is increasing evidence that disparities in healthcare provision contribute to poor physical health outcomes. These inequalities have been attributed to a combination of factors including systemic issues, such as the separation of mental health services from other medical services, healthcare provider issues including the pervasive stigma associated with mental illness and substance use, and side effects of treatment.

The following recommendations are a comprehensive four part plan that offers focus for the DHCS 1115 Waiver Renewal Behavioral Health Integration objectives. These objectives include strengthening primary care delivery and appropriate access to behavioral health services for all Medi-Cal beneficiaries (in this letter behavioral health refers to mental health and/or substance use disorders); avoiding unnecessary institutionalization and improving health outcomes for individuals with serious mental health and substance use conditions ; addressing the social determinants of health; and using California's sophisticated Medi-Cal program as an incubator to test innovative approaches to whole-person care.

1. First, support the Medi-Cal Managed Care Plans and County Behavioral Health entities to do the systems infrastructure planning needed to build a coordinated system by funding the MCO-Provider Incentives Work Group Straw ***Proposal 2: Shared Savings for Medi-Cal Managed Care & County Behavioral Health Entities.***

2. Second, support the transformation of the primary care and behavioral health delivery systems by developing and implementing the MCO-Provider Incentives Work Group Straw ***Proposal 6: Shared Savings for Physical and Behavioral Health Providers for Team-Based Care.*** Funding should be made available for both the 6A and 6B parts of the proposal, as they address different populations. In addition, build out the full array of Health Homes for Patients with Complex Needs (HHPCN), in particular Behavioral Health Homes.

3. Third, provide funding to ***Promote Data Infrastructure Development*** because behavioral health integration requires all payers and providers to establish a

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means of electronic communication and sharing of cost, quality, and clinical data via technology. This is particularly true as CMS continues to support population health and standard sets of performance measures for various target populations used by all payers and providers to measure whether their efforts are achieving the desired results.

4. Fourth, ***Expand the Use of Peer Providers through Certification and Medicaid Reimbursement*** to build skilled workforce capacity that can support integration of behavioral health in all health care settings, including hospitals, emergency rooms, primary care settings, and behavioral health clinics.

Each recommended strategy in this four part plan is explained further below.

Straw Proposal 2: Shared Savings for Medi-Cal Managed Care and County Behavioral Health Entities

California has taken tremendous strides over the last few years to improve access to care for individuals with mental health and substance use conditions – including recent expansions in coverage and benefits. Medi-Cal managed care plans and county mental health plans have increasingly begun to work across systems in order to be able to more appropriately coordinate care for shared beneficiaries. California's Cal MediConnect Program has provided a more targeted opportunity in those demonstration counties to improve shared accountability across systems for a particularly vulnerable population. California's mandatory enrollment of seniors and persons with disabilities into the Medi-Cal managed care program also provides a new opportunity to better coordinate care and improve outcomes for complex beneficiaries.

We recommend including the Straw *Proposals #2* in the 1115 Waiver because it offers California the opportunity to build on recent initiatives to further to strengthen our public healthcare system and improve outcomes for individuals with mental health and substance use conditions. Straw Proposal #2 incentivizes Medi-Cal Managed Care Plans and county behavioral health entities to jointly promote care integration and better outcomes for adults who meet medical necessity criteria for Medi-Cal Specialty Mental Health Services or Drug Medi-Cal Substance Abuse services. Incentives are earned based on performance on measures established by the Department that the Medi-Cal managed care plan and county mental health plan can jointly influence. We particularly support the proposed tiered approach that allows for a phased-in implementation. We believe that a phased approach to achieving a greater level of shared accountability and savings between managed care plans and county mental health plans makes the most sense for California. For example, in the first year,

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measures could be process-oriented, representing tangible, measurable activities that indicate collaboration and exchange of information that form the foundation necessary for integrating care. Such measures could include activities such as the establishment of care plans, health information exchange structures and emergency services and hospitalization notification. The measures would then evolve to health status improvement, system quality improvement and other outcome measures in subsequent years. Such outcomes might include reduced emergency and inpatient utilization for the enrolled population.

Proposal 6: Shared Savings for Physical and Behavioral Health Providers for Team-Based Care

A key take away from the MH/SUDS Integration Task Force was that the traditional fee for service payment system prohibits County Behavioral Health entities from testing key processes, such as whole health screening, medication reconciliation, multidisciplinary teaming and team based care planning, needed to integrate behavioral health. Both parts of Proposal 6 are crucial as they directly impact how Medi-cal dollars can pay for incentivizing high quality care that promotes behavioral health integration as compared to siloed and fragmented services. It can serve as the critical bridge to assist providers to transition to value based payment systems while learning how to redesign their agencies so they can operate in a coordinated system. In addition, the tiered structure is responsive to the varied levels of infrastructure capacity that currently exist in California's provider network and incentivizes improving all providers' capacity to offer the type of team based care that is the hallmark of well integrated health homes. Our only recommended addition is to specify that Model B can apply to stand alone substance use disorder agencies serving individuals that qualify for Drug Medi-Cal services.

While Proposal 6 is critical, it is significantly strengthened by other complementary initiatives such as behavioral health homes. The Steinberg Institute and key behavioral health stakeholders from the 1115 Waiver Groups strongly support the inclusion all *Behavioral Health Homes* in the of development of California's model for Health Homes for Patients with Complex Needs (HHPCN), Section 2703. We agree with the inclusion of individuals with serious and persistent mental illness as eligible for health home services in DHCS's proposed 2703 model and the inclusion of a substance use disorder in the definition of eligible chronic conditions. We also agree with CBHDA recommendations that do not dictate the lead entity, but instead allow for that entity to be the County Mental Health Plan, the Drug Medi-Cal Organized Delivery System Demonstration Participant, or the Managed Care Plan based on the local health care delivery system infrastructure and planning.

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Promote Data Infrastructure Development

Behavioral Health Integration requires all payers and providers to establish a means of electronic communication and sharing of cost, quality, and clinical data via technology. There are significant challenges to integrating technology across payers and providers. Not only do there need to be appropriate and robust cost, clinical, and quality data sets within each of the providers/payers integrating care, there needs to be a technological system that can assimilate and analyze the data sets from a variety of electronic sources.

We recommend the 1115 Waiver provide funding or policy direction to enhance data system infrastructure in following ways:

- Support the development of technological systems that can ensure inter-operability or at a minimum timely data transfer between data systems (e.g., primary care clinic Electronic Health Records (EHR) and behavioral health EHRs, between hospital data systems and primary care, or between managed care plan Clinical Information Systems (CIS) and behavioral health EHRs) so that all primary care, mental health, substance use disorder treatment entities and managed care plans can assimilate and analyze the data sets from a variety of electronic sources.
- Address health privacy and data sharing issues at the State level and provide guidance to County Counsels so that there is a consistent statewide approach to HIPPA and 42CFR.
- Offer robust technical assistance to all health and behavioral health care providers to support the collection and routine use of data to guide clinical and administrative decision making.
- For Drug Medi-Cal Organized Delivery System demonstration participants, close gaps by offering financial support to those that currently do not have adequate clinical information systems, such as electronic health records, registries, and other population health management technological tools for the purpose of purchasing the hardware necessary to electronically communicate and share cost, quality and clinical data within their organization and with partner health agencies and health plans.

Expand the Use of Peer Providers through Certification and Medicaid Reimbursement.

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SAMHSA defines a peer provider in the following way: "A peer provider (e.g., certified peer specialist, peer support specialist, recovery coach) is a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency."[1]
Increasingly, peer providers are viewed as having a key role in integrated care and support clients/patients in integrated programs to improve health outcomes and quality of care. They do this in a number of ways including: educating clients/patients about service system navigation and thereby improving access and utilization while decreasing stigma, increasing clients/patients confidence in their ability to manage their chronic physical and behavioral health conditions, and educating clients about health management and serving as health and wellness coaches. A result of these services is that clients/patients are less dependent on high cost emergency room and inpatient care and more likely to access services in the community supported by their behavioral health home.

Given the fact that there are many roles that peer providers can play in supporting integrated behavioral health in a variety of health care systems, categorizing these roles based on intended outcomes and standardizing training and education through a certification process so peers can successfully fulfill these roles is critical. New York State identifies the benefits of certification as being an acknowledgement of the skills needed for peers to coach and assist others, defining standards for training and experience, promoting a skilled workforce, and, establishing the qualifications for "professional" recognition for peer providers. As of September 2012 there were 36 states that offered a certification program for peer provider specialists. [2]

Given the benefits of peer certification identified above, we recommend that the 1115 Waiver allow for the certification and hiring of peer providers. This certification process can also apply to peers who will offer services within substance abuse treatment agencies. We further recommend DHCS convene a robust stakeholder process that includes peers, family members, and behavioral health agencies to inform the development of peer certification.
We would like to thank you for taking the time to read our recommended Four Part Plan for Behavioral Health Integration in the 1115 Waiver. The Steinberg Institute is available to discuss this strategy with you further if necessary. In conclusion, we would like to note that none of the above systems transformation and piloting to support

[1] Retrieved from: http://www.integration.samhsa.gov/workforce/peer-providers

[2] Retrieved from: http://www.academyofpeerservices.org/pluginfile.php/3647/mod_resource/content/1/CPS%20Webinar%20May%202014.pdf

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behavioral health integration can occur and be effectively spread without robust learning support. We recommend that if DHCS moves forward with the Steinberg Institute and behavioral health communities' recommended integration proposals, they plan to invest in the critical tools of learning collaboratives, learning communities, coaching, technical assistance, and rapid cycle program evaluation. Learning to apply knowledge in complex patient care settings requires ongoing consultation, the ability to try new behaviors (e.g., integrated case conferencing), to apply new skills, and then get feedback and support for what works.

Sincerely,

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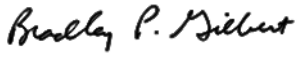

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