Health Care Integration Committee

Thursday, April 20, 2017
8:30 a.m. to 12:00 p.m.
Holiday Inn San Jose-Silicon Valley
1350 North 1st Street, San Jose, CA 95112
Salon E

Time	Topic	Presenter or Facilitator	Tab
8:30 a.m.	Planning Council Member Issue Requests		
8:35 a.m.	Welcome and Introductions	Robert Blackford, Chairperson	
8:40 a.m.	Review and Approve Meeting Highlights from October 2016, January/March	Robert Blackford, Chairperson	A
8:45 a.m.	Discussion of Target Population of HCI Committee	Robert Blackford, Chairperson	
8:55 a.m.	Review and Approve HCI Cmte Year-End Summary re: Alternatives to Psychotropic Medication	Deborah Pitts and All	B
9:00 a.m.	Review and Approve Statement to CHCF's Policy Brief re: Mild to Moderate	Jane Adcock and All	C
9:10 a.m.	Overview of Whole Person Care and Health Homes Projects	Sara Eberhardt-Rios, MPA, Assistant Director, San Bernardino County Dept. of Behavioral Health	D
10:10 a.m.	Break		
10:25 a.m.	Review and Develop 2017 Work Plan	Robert Blackford, Chairperson	E
11:00 a.m.	California Association of Health Plans	Jennifer Alley, Legislative Advocate and Athena Chapman, VP of State Programs	F
11:35 a.m.	Discussion of Senate Bill 323 re: Reimbursement for Drug Medi-Cal services for an FQHC or RHC under Medicaid	Liz Oseguera and All	G
11:50 a.m.	Public Comment	Robert Blackford, Chairperson	
11:55 a.m.	Wrap up: Report Out/ Evaluate Meeting	Robert Blackford, Chairperson	
12:00 p.m.	Adjourn		

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

Committee Members:

Chair:
Robert Blackford

Chair-Elect:
Deborah Pitts

Members:

Patricia Bennett
Josephine Black
Vera Calloway
Catherine Moore
Dale Mueller
Gail Nickerson
Liz Oseguera
Terry Lewis
Cheryl Treadwell
Daphyne Watson
Veronica Kelley

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

_____ **INFORMATION** **TAB SECTION** **A**

__**X**___ **ACTION REQUIRED** **DATE OF MEETING** **04/20/17**

MATERIAL PREPARED BY: Jane Adcock **DATE MATERIAL PREPARED** 3/19/17

AGENDA ITEM:	Review and Approve October 2016, January and March 2017 Meeting Highlights
ENCLOSURES:	• HCI October 2016 Meeting Highlights • HCI January 2017 Meeting Highlights • HCI March 2017 Meeting Highlights
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

Committee members will Review and Approve Meeting Highlights.

CMHPC
Health Care Integration Committee

October 20, 2016
Meeting Summary

Ontario Airport Hotel
700 N. Haven Ave
Ontario CA 91764

Members Present:		
Terry Lewis, Chairperson	**Robert Blackford, Chair-Elect**	
Peter Harsch	Steven Grolnic-McClurg	
Dale Mueller		
Vera Calloway		
Patricia Bennett		

- Meeting Commenced at 8:30 a.m.

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
1.	**Review and Approve Minutes**		Motion made by Patricia Bennett and seconded by Dale Mueller: June Minutes were approved as written.	No Abstentions	
2.	Presentation: Beacon Health Options	Laura Grossman, Program Director, Beacon Health Options spoke about psychotropic medications and the impact on youth and families. She addressed the following questions: Our request was related to persons who are the Health Plan's enrollees/members with payors connected with the CA Department of Healthcare (MediCal and CHIP). 1. What if any monitoring processes/analysis do they have for the use of psychiatric medications	Staff will send the PowerPoint presentation and the 18 diagnoses that qualify for County Specialty Mental Health services to members.	All	

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
		by Pediatrician for Children and Adolescents? 2. What monitoring processes/analysis do they have for use of psychiatric medications prescribed by Psychiatrists? 3. Do their Psychiatrists need to be board certified in Child Psychiatry to see children and adolescents? If not do they have a credentialing process for General Psychiatrist to treat Children and Adolescents? 4. If a child or adolescent falls into the category of Serious Emotional Disturbance (SED) how is care coordinated between the Pediatrician and the Psychiatrist? 5. Are there other treatment providers that are used prior to medication being prescribed for children with behavioral health issues? If so, what disciplines are they? 6. Do they use standardized screening tools for determining Behavioral			

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
		Health diagnosis for children and adolescents?			
3.	**Review CMHPC HCI Alternatives to Medication Chart: Explore health effects of psychotropic medications on children and alternatives to medication.**	Staff reviewed the chart drafted by Deborah Pitts that outlines different alternatives to psychotropic mediactions for children. The committee looked over what approaches are being taken, resources identified, and considered potential invitees to the committee over the next several meetings. (LMHPs with expertise in some of the psychosocial interventions, occupational therapist with expertise in sensory processing interventions, an organization leadership representative that has implemented a workforce development effort in trauma informed care for this population.) Alternatives to medication could be clustered/categorized in to four (4) broad areas: ✓ <u>Policy level</u> initiatives to address systematic challenges to delivering care, addressing	Members discussed inviting the following for a panel presentation in January: 1. Nurse Practitioner 2. Mental Health Plan in San Diego County (Robert Blackford offered to reach out) 3. School district Members and staff will add to this chart as time progresses	Staff	Members will discuss panel further at the November meeting

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
		child to staff ratios for example, or define what type of providers should be on a team or practices that should occur prior to medications being introduced. ✓ Workforce development approaches that improve/strengthen skill sets of providers to address behavioral and psychosocial needs typically targeted by medications. ✓ Psychosocial interventions offering targeting particular psychiatric conditions, and often delivered by licensed mental health providers ✓ Neuro-science informed therapeutic approaches, including sensory processing approaches in occupational therapy. ✓ Alternative and complementary medicine ✓			
4.	**Review HCI Report: Medi-Cal coverage of Mild to Moderate Mental Health Conditions**	Jane Adcock advised that she is reviewing the draft report by staff and that that the data requested by the committee regarding mild to moderate hospitalization rate data within the health plans (and mentioned in the	Jane Adcock will follow up with her source to determine if the specific data the committee is seeking is available.		

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
		report recommendations) may be available through DHCS. Steven Grolnic-McClurg responded that the California Health Care Foundation and the HCI Committee were both unable to extract the data. The mild to moderate data in the health plans is not accessible. The committee will double check to make sure the data is not available now. Grolnic-McClurg advised that the document by the committee was meant to be a companion document (an introduction) to the report written by the California Health Care Foundation.			
5.	**New Business**	Deborah Pitts requested that the HCI committee take a look at the CCBHC application. If OTs are not explicitly included it would be an opportunity to take action on our work plan in this regard by advocating to get OTs included as members of the core CCBHC team in California's application.	Members discussed this request and preferred to make this decision at a later date after reviewing the information.		

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
4.	**Discussion: Next Steps/ Develop Agenda for Next Meeting**	Members discussed inviting the following for a panel presentation in January: 1. Nurse Practitioner 2. Mental Health Plan in San Diego County (Robert Blackford offered to reach out) 3. School district	Members will discuss further at the November meeting.	All	
5.	**Public Comment**	None	N/A	N/A	N/A
6.	**Wrap up: Report Out/ Evaluate Meeting**	Members provided thoughts on the meeting.	Terry Lewis would like time carved out on the agenda for members to speak.	All	N/A

CMHPC HCI Committee Meeting Minutes
January 19, 2017 8:30am

Present: Robert Blackford, Chair, Deborah Pitts, Chair Elect, Dale Mueller Gail Nickerson, Cheryl Treadwell, Daphyne Watson
Absent: Terry Lewis, Josephine Black, Veronica Kelly, Pat Bennett, Vera Calloway

Item	Discussion	Action
Approve Minutes from October 2016	Due to lack of quorum of committee members, the approval will be delayed until the April meeting.	Include the October 2016 minutes in the April 2017 meeting agenda.
Presentation by Dr. Laura Vleugels	Committee member received a presentation from Dr. Laura Vleugels, Supervising Child and Adolescent Psychiatrist for Children, Youth and Families at the Dept. of Behavioral Health Services for the County of San Diego Health & Human Services Agency. Dr. Vleugels started by indicating we should not be asking why anyone would give psychotropic medication to a child but rather we should ask why a child would need such medication. She went on to explain that children can have big problems such as stress, physical health, trauma, separation, mental illness and substance use. Children can hurt themselves and others and cause trouble through their behavior. So, why not other treatments? Symptoms can interfere with treatment. Medications don't cure but they can quiet the symptoms to facilitate treatment. Common symptoms for this population that need treatment include aggression, tantrums, sleep difficulties and impulsivity. CA guidelines limit the number of medications for children by age. Over recent years, legislation has passed to address the areas of concern identified in a 2011 review of Medicaid claims by the Office of Inspector General which found often the medications were prescribed for children too young, for too long, were given wrong dose or for the wrong treatment. Additionally, it was found that there was often poor monitoring, too many drugs prescribed and not enough oversight on side effects. New requirements issued around authorization requests for psychotropic medications for youth receiving Medi-Cal and then for all foster youth. San Diego has instituted some local controls including having county programs staffed by Board-Eligible/Certified Child and Adolescent Psychiatrists, reviews of authorization requests by the psychiatrists, ongoing medication monitoring and the availability of second opinions as well as consultation services for Primary Care.	Include information from Dr. Vleugels in committee documents regarding the use of psychotropic medication by children and youth.
Revised Work Plan	Members of the committee reviewed and discussed each of the six Goals outlined in the 2015-16 Work Plan. Goals #1, #2 and #4 were determined to be sunset. Goal #3 would be completed with committee member review and approval of HCI Committee Statement to CHCF's Policy Brief at the April 2017 meeting. Goal #5 was deemed no longer viable since California was not awarded a Certified Community Behavioral Health Clinic Grant. Goal #6 will be brought forward and completed with the committee member review and approval of the HCI Committee Year-End Summary at the April mtg.	Continue development of new 2017 Work Plan in future meetings.
Literature Review of Psychotropic Medication	Committee member pointed out that the summary was not presented in the format created by Deborah Pitts. Staff will look for correct format. Additionally, this information will be included in a year-end report by the committee of the work done, information gleaned and best practices identified for use of psychotropic medication	Committee members will review report prior to meeting, and come prepared to approve or request edits @ April meeting
Barriers to Integration: Health Plus	Liz Oseguera, Senior Policy Analyst at Health Plus Advocates provided an overview of barriers to integration identified by her organization which will eventually result in legislation for correction. Health Plus Advocates works with the California Primary Care Association (CPCA), a non-profit representing community clinics and health centers (CCHC) serving 6 million	Formatting questions will be directed to CMHPC staff, final review of report will be

Advocates re: Same Day Billing Barrier	patients. CPCA conducted a behavioral health survey which showed that 80% of CCHCs provide mental health services and 72% are fully integrated. Working with Senator Mitchell on a bill to allow Drug Medi-Cal services to be offered outside of the Prospective Payment System (PPS) and ensure FQHCs are able to enroll as Drug Medi-Cal providers. The PPS reimbursement only allows one visit per day per patient which creates barriers to health care access. Additionally HIPAA restrictions make it difficult for providers to share patient information but recent changes in rules will make it easier to share SUD records between SUD providers and primary care doctors/clinics. Who is an allowed billable provider and provider shortages continue to make it hard to delivery services. Payment reforms and changes in PPS provider restrictions could improve this challenge. Ultimate goal is a collaborative continuum of care that allows patients to have health home that includes full array of specialty mental health, Drug Medi-Cal and behavioral health care for mild and moderate needs as well as primary care.	conducted by HCI Chair Elect and CMHCP staff for review by full committee @ April meeting.

CMHPC HCI Committee Meeting Minutes
March 10, 2017 [3:30pm]

Present: Robert Blackford, Chair, Deborah Pitts, Chair Elect, Patricia Bennett, Gail Nickerson, Cheryl Treadwell, Liz Oseguera, Vera Calloway
Absent: Terry Lewis, Josephine Black, Dale Mueller, Daphyne Watson, Veronica Kelly, Melen, Vue, Catherine Moore, Jane Adcock

Item	Discussion	Action
Revised Work Plan	Members of the committee were complimentary of the formatting and getting the work plan down to two pages. HCI Chair Elect has done this work and noted that it is still a work in progress. The Work Plan will be reviewed at the April meeting in San Jose.	Complete final review and approval of 2017 of HCI Work Plan @ April meeting
HCI Committee Report on Mild to Moderate	Jane Adcock was not present at the meeting neither was the past Chair and the previous chair that established this project/report therefore this agenda item will be reviewed at the April Meeting in San Jose.	Committee members will review report prior to meeting, and come prepared to approve or request edits @ April meeting
Review Draft Report on Alternatives to Psychotropic Medication	There were questions that arose that could not be answered by the Chair as they were pertaining to staff. HCI Chair will bring up these issues with staff next week. Specifically, why was this report not in the same format as the report on Mild to Moderate, why was it not placed under tab 3 and why is it still in the edit mode.	Formatting questions will be directed to CMHPC staff, final review of report will be conducted by HCI Chair Elect and CMHCP staff for review by full committee @ April meeting.
Next Meeting	The agenda for April meeting was reviewed. The two presentations at the meeting will be: a. Jennifer Alley and Athena Chapman from the CA Health Plan Association will attend the meeting in April in San Jose. The primary purpose of their attendance is to establish a relationship between HCI and CMHPC. Previously the CMHPC HCI committee has only dealt with carve out behavioral health plans such as Beacon. This relationship is critical to the council in that over 70% of the Medi-Cal population with Mental Health Issues are treated by Providers of the Health Plans. While this is the mild to moderate population and the type and amount of intervention is significantly less than the SED and SMI population treated by the County Mental Health Plans, it still reflects a large number of persons and a system that manages both Mental Health and Physical Health. Committee members should submit any questions they have to Robert Blackford at least one week prior to the April meeting. Robert will confirm their attendance and pass them over to Tamera and/or Cece for purposes of meeting logistics. b. Sarah Eberhardt-Rios who is the Assistant Director for Behavioral Health for San Bernardino County. Sarah is actively establishing the Whole Person and Health Homes model and will be presenting an overview of the new program. Jane Adcock previously suggested that someone from the Department of Healthcare Services also present, however, they cannot travel out of Sacramento which means they will have to wait to do a presentation in October in Folsom. This is important in order to understand the new program from both the provider/manager of care and the CMS Contract Holder. The other agenda items are as follows a. Support for SB 323 (Same Day Billing) b. Review and Approve Revised Work Plan c. Review and Approve report related to the Alternatives to Psychotropic Medications for Children and Adolescents Revised HCI Charter- Prior to today's meeting, Robert sent out some modifications to the charter to ensure it is current. Members are asked to review the document and come prepared to discuss at the meeting in April.	CMHPC staff and HCI Chair will follow-up regarding confirming guest speakers for April Meeting. HCI committee members will finalize travel arrangements for upcoming meeting with CMPHC staff.

_____ **INFORMATION** **TAB SECTION** **B**

__X___ **ACTION REQUIRED** **DATE OF MEETING** **04/20/17**

MATERIAL PREPARED BY: Jane Adcock **DATE MATERIAL PREPARED** 3/19/17

AGENDA ITEM:	Review and Approve HCI Cmte Year-End Summary re: Alternatives to Psychotropic Medication
ENCLOSURES:	• Draft Year-End Summary
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

Committee members will Review and Approve Health Care Integration Year-End Summary re: Alternatives to Psychotropic Medication.

Year-End Summary Report re: Alternatives to Psychiatric Medication

Submitted by the

Health Care Integration Committee

for the

California Mental Health Planning Council

April 2017

DRAFT

The California Mental Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. Our majority consumer and family member Council is also statutorily required to advise the Legislature on mental health issues, policies, and priorities in California. The Council has long recognized disparity in mental health access, culturally-relevant treatment and the need to include physical health. The Council has advocated for mental health services that will address the issues of access and effective treatment with the attention and intensity they deserve if true recovery and overall wellness are to be attained and retained.

The Council is committed to advocating for those living with mental illness and/or emotional disturbances and shining a light on positive changes to California's public mental health system.

DRAFT

California Mental Health Planning Council[1]
Health Care Integration Committee
Year-End Summary Report re: Alternatives to Psychiatric Medication

Introduction

During fiscal year 2016 the California Mental Health Planning Council focused on the needs of children and youth, and each committee identified an area of concern for its annual work plan that aligned with that theme. The Healthcare Integration Committee chose as its' focus the health effects of psychotropic medications on children and alternatives to medication. This emerged as a key concern given the recent California Department of Social Services and Department of Health Services development of the California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care
http://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/QIP_Guidelines.pdf .

Key Perspectives from Quarterly Meeting Guest Speaker Presentations

APRIL 2016

Matthew Gallagher, a transition age youth (TAY) with the California Youth Empowerment Network (CAYEN), discussed his experience in the foster care system. He indicated that his behavioral health treatment plan was very individualized and he felt he was able to consent and participate in every aspect. He believes early intervention can work and recovery is possible. Mr. Gallagher is now medication-free and is able to manage his illness. After he left the hospital, Mr. Gallagher did not have a discharge plan or any resources. He only had his diagnosis and recommended medications with discharge papers indicating he would not cooperate. He believes that advocating for an Individual Education Plan in college would have helped him but he would have been required to reveal his mental health conditions and may have been stigmatized. There was a time when he felt he was on the road to abusing his medication. His doctor was hesitant but supportive of his discontinuing medication. Mr. Gallagher suggested doing a WRAP (Wellness Recovery Action Plan) immediately for youth entering the system; having a peer advocate assigned immediately; and allowing youth to be a part of their treatment plan as much as possible.

Penelope K. Knapp, M.D., Department of Psychiatry and Behavioral Sciences, UC Davis Health System informed the committee that not everyone who writes a prescription for a child is necessarily a child psychiatrist. The main emphasis on the approach to treating youth in the child welfare system is on careful evaluation of their situation and family, and developing a broader treatment plan. Medication alone is not enough and will not change underlying problems particularly when it comes to trauma.

In the state of Texas, a practice parameter was developed for psychotropic medication of foster children and was published in 2013. Dr. Knapp is an adviser on the current revision of this document, which focuses on continuing to provide worthwhile information about the appropriate use of medications for younger children. One big concern is pre-school children receiving medication. Another focus of the revised document is to continue to

[1] Summary report prepared by Deborah Pitts, PhD, OTR/L, HCI Chair Elect 2017.

provide detail on treatment of preschool and young children, and to raise the age limit for appropriate prescription of antipsychotic medications to children. The age was three and has now been raised to 5 years old.

The Department of Health Care Services (DHCS) and the Department of Social Services (DSS) quality improvement committee spent a few years developing a very thoughtful set of guidelines for treating children with medications. That guideline has been published on both departments' websites. A huge emphasis is placed on adequate evaluation, accurate diagnosis, development of a good treatment plan, and non-pharmacological support.

Robert Horst, M.D. and Associate Professor, UC Davis Department of Psychiatry and Behavioral Sciences, advised that the problem isn't really with the Treatment Authorization Request (TAR) process (a form the pharmacies send to insurance companies to ensure payment) but rather with the JV-220 process (Application Regarding Psychotropic Medication). The concern with the TAR process is families are not getting medications when they desperately need them. When a dependent child or youth is prescribed a psychotropic medication, it must be approved by the courts. In California, a form called a JV-220 must be filed with and granted by the court in order for the child to obtain the medication.

Psychiatric Nurse Practitioners play an important role in medication management. They are usually licensed to work collaboratively with a physician. An important concept in treatment is the team concept. Within the Medi-Cal specialty mental health clinics that have child programs, there is a full team, and tasks that need to be completed in treating a child are divided between team members. Psychiatric Nurse Practitioners are key members of a mental health team.

The Pharmacy Benefits Branch at the Department of Social Services (DSS) houses a database for prescribing behavior to be analyzed. Analysis of the data should do more than just count the number of prescriptions that are filled and billed. It also should include information on how the child is functioning before, during, and after receiving medications. That requires integrating data that is outside the Pharmacy Benefits Branch. Some data may be found at the DHCS and some may be found at the county mental health plan level and may not be captured in billing data but in chart reviews.

Dr. Horst discussed issues and barriers facing clinical systems with medication management for children and adolescents. An adequate diagnostic evaluation by a qualified child psychiatrist is important. There is a need for ongoing monitoring that interfaces with primary health care. This can be particularly challenging for foster children, and would include monitoring of background information. Background information can be lacking in children in foster care. There needs to be more availability of psychosocial treatment including family engagement and school support. There is still a stigma around seeing a psychiatrist, and this is a huge barrier.

DRAFT

June 2016

Laura Grossman, Program Director, Beacon Health Options spoke about psychotropic medications and the impact on youth and families. The Pediatric Psychotropic Drug Intervention Program (P-PDIP) is a medication management/quality management program that identifies claims-based, medication-related problems through analytics, clinical review, and health informatics. Beacon developed P-PDIP to improve medication adherence among children and youth and to support best prescribing practices among providers. The program helps both prescribers and members understand and resolve medication-related issues. P-PDIP specifically targets primary care physicians (PCPs) who do a large percentage of psychotropic medication prescribing and have limited access to psychiatric specialists. The program was designed to be complementary to traditional pharmacy-benefit management services with behavioral health focus, clinical review, and incorporates both Behavioral and Medical claims information.

The P-PDIP core clinical interventions are as follows:

Polypharmacy

- 2/3 of all psychiatric medications are prescribed in primary care settings. When individuals receive additive behavioral health treatment from non-mental health specialists, the potential for poly-pharmacy is high.
- A series of algorithms informs providers, pharmacies, and members when a member is prescribed psychiatric medications from the same therapeutic class and/or within multiple classes.

Sub-optimal and excessive dosing

- Sub-optimal dosing represents significant Medicaid expenditures without achieving clinical efficacy while excessive dosing presents the potential of physical harm to the member. While PCPs are the major prescribers of mental health drugs, they are seldom trained in appropriate dosing.

Non-adherence

- Members who discontinue antidepressant, mood stabilizer, and antipsychotic medication treatment without doctor's consent accumulate higher medical costs with potential for inpatient and other non-community based care.
- P-PDIP uses a combination of member and prescriber interventions, informed by a set of algorithms, to notify providers and members or caregivers of non-adherence to prescribed behavioral health drugs. Providers can access electronic and telephonic response systems that they can use for adherence advice and referrals.

To promote proper prescribing of psychotropic drugs for children, Beacon and the Massachusetts partners, Massachusetts Child Psychiatry Access Project, review high-risk prescribing practices when the P-PDIP algorithm identifies:

- Any child, six or under, prescribed an antipsychotic
- Any child, 15 or under, prescribed four or more medications, including antipsychotics
- Any child, 15 or under, prescribed one or more behavioral health medications by a PCP or non-behavioral health prescriber (e.g., the child has multiple prescribers for multiple behavioral health medications)

To identify concerning prescribing patterns and measure change in practice moving forward, the P-PDIP program relies on analyses of an integrated data file that includes combined prescription, medical, and psychiatric claims.

January 2017

Laura Vleugels, M.D., Supervising Child Adolescent Psychiatrist at the County of San Diego, Health and Human Services Agency informed the committee that psychotropic medications can help a person be less hyperactive, less aggressive, more attentive, less sad, less anxious, and less psychotic. The reasons a child might need medication are safety, ineffectiveness of other treatments, impaired function, and suffering. Medications alone contain none of the tools that lead to healing. Some alternatives to medication are:

- Cognitive Behavioral Therapy
- Dialectical Behavioral Therapy
- Family therapy
- Group therapy
- Multi-systemic Therapy
- Assertiveness training
- Problem-solving skills training
- Parent Management training
- School-based services
- Speech Therapy
- Occupational Therapy
- Recreation Therapy

Symptoms might interfere with these other treatments, such as hyperactivity, aggression, poor attention span, anxiety, or sadness that prevents engagement, and fatigue. This is where psychotropic medications may assist.

Dr. Vleugels discussed the California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care. Released on April 10, 2015, these guidelines discuss best practices for the treatment of children and youth in out-of-home care. The guidelines include expectations regarding the development and monitoring of treatment plans, and there are principles for emotional and behavioral health care, psychosocial

services, and non-pharmacological treatments. It also includes principles for informed consent to medications and principles governing medication safety.

Dr. Vleugels also discussed the Psychotropic Medication Protocol, also referred to as the JV220 process, is mandated by California Law Rules of Court 2014 and must be followed prior to the administration of psychotropic medications to children and youth in foster care. JV220 initiates the court authorization of psychotropic medications for dependents of the court. The JV220 documentation specifies the dosage and medication plan and includes targeted goals. This process allows the prescriber to discuss the JV220 with the child, family, and caregiver. Additional supportive collaterals are included in this discussion if requested by the family or as indicated by State requirement, such as Child and Family Teams for Katie A. class and sub-class members.

Lastly, Dr. Vleugels discussed California legislative changes. Senate Bill (SB) 543, which provides the court the authority to make orders regarding use of psychotropic medication for foster youth. This bill was passed in 2010 in response to concerns that foster youth were being subjected to excessive use of psychotropic medication. The requirements set forth in SB 543 were expanded in 2016 as a result of SB 238.

Dr. Vleugels discussed these additional California legislative changes:

- SB319: Expands the authority of foster care public health nurses to monitor psychotropic prescriptions. (Author: Sen. Jim Beall, D-San Jose)
- SB484: Increases monitoring of psychotropic medication use for youth in group homes. (Author: Sen. Jim Beall, D-San Jose)
- SB1291: Holds counties accountable for providing mental health care to foster children that include non-drug therapies. (Author: Sen. Jim Beall, D-San Jose)
- SB238: Requires monthly reporting on foster children who have received psychotropic medications; training for professionals who work with and care for foster children; and expanded input to the juvenile courts that authorize prescriptions. (Author: Sen. Holly Mitchell, D-Los Angeles)
- SB1174: Strengthens the ability of the Medical Board of California to identify and investigate doctors, with extreme cases forwarded to the state attorney general. (Author: Sen Mike McGuire, D-Healdsburg)
- SB253: Strengthens juvenile court oversight of psychotropic prescribing by requiring second reviews in extreme cases, such as three or more medications at once and prescriptions for very young children, and mandates proof of follow-up care. (Author: Sen. Bill Monning, D-Carmel)

SB 253 was vetoed by the Governor, given that legislative changes to the JV220 process had only recently been implemented in mid-2016. The Governor determined that the impact of those changes should be understood before making additional changes.

Types of Alternative Approaches

HCI Committee member, Deborah Pitts, PhD, OTR/L, conducted a cursory environmental scan[2] to identify alternatives to medications for children and youth. Several resources were identified and reviewed resulting in the identification of five (5) broad approaches to psychotropic medication alternatives (see Appendix for specific resources identified in each category).

- ✓ Public Policy Initiatives. These were federal, state and/or local public policy efforts that addressed systemic challenges to delivering 'care'. In particular, these included efforts to require improved oversight and monitoring of the use of psychotropic medication with children (e.g. practice guidelines). In addition, this included guidance regarding staff to child ratio, provider mix, location of care, commitment to trauma informed, child-family centered care, etc. as a way to reduce reliance on psychiatric medications as a tool for managing behavioral and psychosocial needs of children with psychiatric disorders.

- ✓ Workforce Development. These included efforts to strengthen the readiness of providers to use trauma-informed, psychosocial and behavioral approaches to mediate behavioral and psychosocial problems that are often the target of psychotropic medication. This included incorporating competency standards for different provider types in educational and certification programs.

- ✓ Psychosocial Interventions. These included efforts to identify and/or develop evidence-based approaches to using psychosocial approaches to address behavioral or mood dysregulation to again reduce reliance on psychiatric medications as a tool for managing behavioral and psychosocial needs of children with psychiatric disorders. Some of the specific approaches identified in this category included—*home-based behavioral therapy*, *parent training*, *classroom interventions*, *academic interventions* and *peer interventions.*

- ✓ Neuroscience Informed Therapeutic Approaches. These included efforts to utilized neuroscience understanding of arousal/emotion and behavioral dysregulation. Some of these approaches were integrated with attachment focused therapies to address arousal/emotion regulation problems experienced by children that often result in the behavioral problems that medication often targets. In particular, occupational therapy's sensory processing/sensory integration approaches were highlighted.

- ✓ Alternative and/or Complementary Medicine. These approaches included nutritional approaches addressing medical conditions that may be influencing a child's behavior

[2] Focus was on web-based and Google Scholar search using search terms "psychotropic medication", "children & youth", "foster youth", "alternatives to psychiatric medication".

Review of Key Sources

CMHPC Associate Government Program Analyst, Thomas Orrock, LMFT reviewed the resources identified during the environmental scan. In his review, he prioritized the resources that follow as the most useful and provided a brief summary of what they contained.

California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care

http://www.dhcs.ca.gov/provgovpart/Documents/PharmacyBenefits/QIPFosterCare/Clinical/Deliver/Guidelines.pdf

This was a project of the CDSS and DHCS to provide guidelines around the treatment of foster youth. The guidelines include information about treatment planning, the basic principles of care, psychiatric evaluation, diagnosis, and prescribing of medicine. The end of the document provides some nice checklists that prescribers should consider before prescribing, when prescribing, and after prescriptions have been made. There is discussion in the document about the importance of the Child and Family Team (CFT) and their involvement in the process of considering medications. The CFT is a major part of the Core Practice Model. Medications are approved for foster use through the use of a JV220, which is the authorization given by the court. I have always wondered why a judge is asked to approve psychotropic medications. Judges are lawyers, not psychiatrists. Should this approval be provided by a physician assigned by the court? What are the procedures with this?

NAMI (2004) Policy Research Institute Task Force Report: Children and Psychotropic Medications

http://www.fda.gov/ohrms/dockets/dailys/04/aug04/083104/04n-0330-ts00001-02-vol1.pdf

The nuts and bolts of this report is the four policy recommendations made in 2004. They are,

1. The National Institute of Mental Health (NIMH) should make a significant investment in research on early onset mental disorders and the use of psychotropic medications in children and adolescents.
2. Children should only be diagnosed and treated by the best qualified mental health professionals and properly trained medical professionals. Children should be protected from inaccurate diagnoses.
3. Families and all professionals that work with children should receive appropriate information and education about early-onset mental illnesses - including how to recognize the early warning signs as well as information about the latest research related to the use of psychotropic medications.
4. Legislative or regulatory consideration related to the use of psychotropic medications for children and adolescents must be guided by science. Action should be taken only after obtaining testimony and input from qualified and well-recognized medical and mental health professionals and families and on the basis of sound scientific research.

AACAP (2015). Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems

https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/AACAP_Psychotropic_Medication_Recommendations_2015_FINAL.pdf
This is a great report which gives an exhaustive description of best practices for the clinical practice of prescribing medications to youth, the monitoring and oversight of medication management, and the research needed to help us make the best decisions for treatment. There are a total of 18 recommendations made at the end of the report. The recommendations are broken down into the three categories mentioned above. Psychotropic medication has a legitimate role in the treatment of children. Prescribers should have an understanding of trauma informed care. It is also very important for prescribers to work within the framework of the family and to consider the child and families input before and while prescribing medications.

AACAP (2012) Psychiatric Medication for Children and Adolescents: Part 1-How Medications are Used
http://www.aacap.org/App_Themes/AACAP/docs/facts_for_families/21_psychiatric_medication_for_children_and_adolescents_part_one.pdf
This is a short fact sheet from the AACAP which outlines guidelines for psychiatrists and families
around prescribing of medications for youth. The article stated that psychiatrists should be
experienced in child psychiatry, explain the benefits and risks, and alternatives available. The article
goes on to list the types of disorders which are treated by psychotropic medications i.e. bedwetting,
ADHD, OCD, eating disorders, depression.

AACAP (2012). Psychiatric Medications for Children and Adolescents: Part II-Types of Medications
http://www.aacap.org/App_Themes/AACAP/docs/facts_for_families/29_psychiatric_medication_for_children_and_adolescents_part_two.pdf
This article outlines the importance of research so that psychiatrists are prescribing the medications that have achieved the best outcomes. The article lists the types of disorders experienced by children and the best options for medications to prescribe.

Children's Bureau, et al (2015) Supporting Youth in Foster Care in Making Healthy Choices: A Guide for Caregivers and Caseworkers on Trauma, Treatment and Psychotropic Medication.
https://www.childwelfare.gov/pubPDFs/mhc_caregivers.pdf
This was written as a guide for foster parents, caregivers, and others who interact with foster youth. It is a follow up guide to "Making Healthy Choices" which was a guide written for youth in foster care. The guide would help them to know about trauma informed care and the prescribing of medications. This guide assists caregivers to advocate for youth who are being considered for medications. The topics discussed in the guide are:

-Consider options besides medication
-Learn about safe medication use

-Empower youth and give them a voice
-Learn about trauma and its effects
-Honoring youth's specific ethnic, racial, cultural, and sexual identities
-Asking questions of the doctors and specialists who provide services to youth
-Realistic expectations of yourself, the young person, and your relationship

(copied from the document)

Guidance and Resources Regarding Agency-Based Trauma-Informed Care (TIC) Training— SAMHA's Trauma Informed Care & Alternatives to Seclusion and Restraint
http://www.samhsa.gov/nctic/trauma-interventions
This article provides a definition of a trauma-informed approach. It is described as a program that does the following:

1. *Realizes* the widespread impact of trauma and understands potential paths for recovery;
2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist *re-traumatization*." (copied from the document)

SAMHSA's six key principles are described which are safety, trustworthiness, peer support, collaboration, empowerment, and cultural competence.

Trauma Informed Care Toolkit
http://www.michigan.gov/documents/mdch/TI_Toolkit_Resources_484512_7.pdf
This is a collection of 50 articles on the subject of trauma informed care for youth. The last
few articles listed are provided in Spanish.

Appendix A: HCI Quarterly Meeting Invited Speakers

Thursday, April 21, 2016 [San Francisco, CA]

Jessica Van Tuinen, The Spot: Juvenile Justice
Youth Leadership Center, Clinical Services Technician

Matthew Gallagher, California Youth Empowerment Network (CAYEN)

Penelope K. Knapp, M.D., Professor Emerita, Department of Psychiatry and Behavioral Sciences,
UC Davis Health System

Hanumantha Damerla, MD - Los Angeles County Department of Mental Health
Specialized Child & Youth Svcs., Bureau

Robert Horst, MD Health Sciences Associate Clinical Professor, UC Davis Department of Psychiatry Medical
Director, Sacramento County Child and Family Mental Health

Thursday, October f20, 2016 [Sacramento, CA]

Beacon Health Plan

Thursday, January 19, 2017 [San Diego, CA]

Laura Vleugels, M.D.

Appendix B: Resources Identified During Environmental Scan Addressing Alternatives to Psychotropic Medications

Public Policy Initiatives

CDSS and DHCS (?). California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care
http://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/QIP_Guidelines.pdf

NAMI (2004) Policy Research Institute Task Force Report: Children and Psychotropic Medications http://www.fda.gov/ohrms/dockets/dailys/04/aug04/083104/04n-0330-ts00001-02-vol1.pdf

Workforce Development

Guidance Regarding Prescription Practices—

AACAP (2015). Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems
https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/AACAP_Psychotropic_Medication_Recommendations_2015_FINAL.pdf

AACAP (2012) Psychiatric Medication for Children and Adolescents: Part 1-How Medications are Used
http://www.aacap.org/App_Themes/AACAP/docs/facts_for_families/21_psychiatric_medication_for_children_and_adolescents_part_one.pdf

AACAP (2012). Psychiatric Medications for Children and Adolescents: Part II-Types of Medications
http://www.aacap.org/App_Themes/AACAP/docs/facts_for_families/29_psychiatric_medication_for_children_and_adolescents_part_two.pdf

Children's Bureau, et al (2015) Supporting Youth in Foster Care in Making Healthy Choices: A Guide for Caregivers and Caseworkers on Trauma, Treatment and Psychotropic Medication.
https://www.childwelfare.gov/pubPDFs/mhc_caregivers.pdf

Guidance and Resources Regarding Agency-Based Trauma-Informed Care (TIC) Training—

SAMHA's Trauma Informed Care & Alternatives to Seclusion and Restraint
http://www.samhsa.gov/nctic/trauma-interventions

Trauma Informed Care Toolkit
http://www.michigan.gov/documents/mdch/TI_Toolkit_Resources_484512_7.pdf
Center

Klain & White from ABA Center for Children and the Law (2013). Implementing Trauma-Informed Practices in Child Welfare

http://childwelfaresparc.org/wp-content/uploads/2013/11/Implementing-Trauma-Informed-Practices.pdf

Marsac, et al (2016). Implementing a trauma-informed approach in pediatric health care networks. JAMA Pediatrics
http://archpedi.jamanetwork.com/article.aspx?articleID=2470861

Risking Connection
http://www.riskingconnection.com/

Psychosocial Internventions
APA (2006). Report on the Working Group on Psychotropic Medications for Children and Adolescents: Psychopharmacological, Psychosocial and Combinted Interventions for Childhood Disorders: Evidence Based, Contextual Factors, and Future Directions
https://www.apa.org/pi/families/resources/child-medications.pdf

Neuroscience Informed Therapeutic Approaches
May-Benson, T.A. & Sawyer, S. (May 2016). SAFE Place: A Collaborative Sensory Integration-Based Approach to Trauma (Poster Presentation @ Spiral Foundation).

Warner, E. , Koomar, J.. Bryan, L. & Cook, A. (2013). Can the body change the score? Application of sensory modulation principlies in the treatment of traumatized adolescents in residential settings. *J Fam Viol, 28*, 729-738.

Warner, E., Spinazzola, J. Westcott, A. Gunn, C. & Hodgdon, H. (2014). The body can change the score: Empirical support for somatic regulation in the treatment of traumatized adolescents. *Journ Child Adol Trauma, 7*, 237-246.

Baroni, B., et al (2016). Use of the Monarch Room as an alternative to suspension in addressing school discipline issues among court-involved youth. *Urban Education,*

Vaughn, J. et al (2016) Neuro-physiological psychotlherapy (NPP): The development and application of an integrative wrap-around service and treatment programme for maltreated children placed in adoptive and foster care placements. *Clinical Child Psychology and Psychiatry,* 1-14.

McCullough, E., et al (2016). An evaluation of Neuro-Physiological Psychotherapy: An integrative therapeutic approach to working with adopted children who have experienced early life trauma. *Clinical Child Psychology and Psychiatry,* 1-21.

Alternative and Complementary Medicien
Complementary & Alternative Medicine for Mental Health (2016). Mental Health America. http://www.mentalhealthamerica.net/sites/default/files/MHA_CAM.pdf

_____	**INFORMATION**	**TAB SECTION**	**C**
___X___	**ACTION REQUIRED**	**DATE OF MEETING**	**04/20/17**

MATERIAL PREPARED BY: Jane Adcock

DATE MATERIAL PREPARED 3/19/17

AGENDA ITEM:	Review HCI Committee Statement to CHCF's Policy Brief re: Mild to Moderate
ENCLOSURES:	• Draft Statement
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

Review and Approve draft statement.

Statement to California Health Care Foundation's Policy Brief re: Mild to Moderate Mental Health Services

Submitted by

the

Health Care Integration Committee

for the

California Mental Health Planning Council

April 2017

The California Mental Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. Our majority consumer and family member Council is also statutorily required to advise the Legislature on mental health issues, policies, and priorities in California. The Council has long recognized disparity in mental health access, culturally-relevant treatment and the need to include physical health. The Council has advocated for mental health services that will address the issues of access and effective treatment with the attention and intensity they deserve if true recovery and overall wellness are to be attained and retained.

The Council is committed to advocating for those living with mental illness and/or emotional disturbances and shining a light on positive changes to California's public mental health system.

The California Mental Health Planning Council (CMHPC) is mandated by federal law (Public Law 106-310) and state statute (Welfare and Institutions Code (WIC) 5772) to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness; to review and report on the public mental health system; and to advise the Administration and the Legislature on priority issues and participate in statewide planning. The CMHPC has four committees: Healthcare Integration Committee, Advocacy Committee, Continuous System Improvement Committee, and Patients' Rights Committee.

The Healthcare Integration Committee (HCI) is responsible for tracking, addressing, and responding to the multiple issues, including at the systems level, related to the integration of behavioral health and physical health care for persons with behavioral health needs.

The HCI promotes the inclusion of five core elements from the Mental Health Services Act to guide all its work:

- Promoting consumer and family oriented services at all levels
- Ensuring cultural competence
- Increasing community collaboration
- Promoting recovery/wellness/resiliency
- Providing integrated service experiences for clients and families

Purpose

The purpose of this HCI Committee paper is to provide background on the recent mild to moderate integrated benefit in California and to outline the committee's role in the important issue brief recently released by the California Health Care Foundation (CHCF). The HCI Committee collaborated with Catherine Teare, Associate Director, CHCF, on issues related to the implementation of expanded outpatient mental health benefits to treat mild to moderate mental health conditions, to research available data, and to map out the current landscape of coordination between the health plans and the mental health plans. With the HCI Committee's input and support, the CHCF drafted the attached issue brief entitled *The Circle Expands: Understanding Medi-Cal Coverage of Mild to Moderate Mental Health Conditions*. The issue brief provides an overview of California's public mental health system with particular focus on the implementation of expanded Medi-Cal outpatient mental health benefits to treat mild to moderate mental health conditions. The brief also provides an outline of the managed care plans'

new responsibilities, and includes a list of all Medi-Cal managed care plans and the corresponding managed behavioral health care organizations with whom they work.

Background

Prior to 2014, most Medi-Cal funded mental health services were provided through the county mental health plans and were available to those with serious mental illness. Individuals who did not meet the criteria for a serious mental illness received services from their primary care providers. In 2014, the state began a newly integrated benefit for those with mild to moderate mental health care, to be covered by the Medi-Cal managed care plans (MHSUDS Information Notice No.: 14-020). Existing Title 9, California Code of Regulations (CCR), Chapter 11 regulations, and the Department of Health Care Services/Mental Health Plan contract, require mental health plans to enter into a Memorandum of Understanding (MOU) with any managed care plan that enrolls beneficiaries covered by that mental health plan. The 2014 reforms amended MOU requirements between managed care plans and county mental health plans to assist in coordinating mild to moderate services as well as specialty mental health services. (APL 13-018 "Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans")

In 2015, the HCI Committee looked into the delivery of certain mental health services to Medi-Cal beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning through the managed care plan provider network. Specifically, the committee sought data on the psychiatric hospitalization rates for Medi-Cal beneficiaries whose care is being managed by the health plans. The Committee sent letters to the County Behavioral Health Director's Association, the Department of Managed Health Care, and the Department of Health Care Services to inquire whether the specialty mental health plans have access to this data and if so, were they able provide this data to the Planning Council. What we found is that this data is currently not available. Thus, the committee strongly advocates for the collection of this type of data. Access to data on the psychiatric hospitalization rates for Medi-Cal beneficiaries whose care is managed by the health plans, can be helpful in identifying the success of health plans in supporting the behavioral health needs of those plan members.

Committee Actions

As the CMHPC met around the state in 2015, the HCI Committee invited a number of managed health care plans to present, some of which are highlighted below.

Dr. Peter Currie, Clinical Director of Behavioral Health Inland Empire Health Plan spoke at one of the meetings. Behavioral Health Inland Empire Health Plan is a fully integrated behavioral health program that has streamlined the coordination of physical and mental health benefits. Dr. Currie provided important insights into some of the lessons learned during the integration process:

- Health Plans need to develop direct relationships with behavioral health providers in private practice, county behavioral health programs as well as community based organizations.
- Direct relationships are best: it is best to minimize the use of sub-capitated middleman with separate 1-800 phone numbers that carve out behavioral health care which can limit access.
- Health Plans must bring behavioral health expertise "In House" to ensure quality behavioral health care.
- Providers should contract directly with health plans when possible.

Abbie Totten, Director of State Programs, California Association of Health Plans, spoke with the committee regarding the importance of collaboration so that the health plans can continue to learn the mental health landscape. Building relationships and creating dialogue is key.

Dr. Clayton Chau, MD., PhD., Medical Director Care Management, Behavioral Health and Provider Continuing Education L.A. Care Health Plan also spoke at an HCI committee meeting. Dr. Chau advised that there is a critical need to build statewide partnerships in the collection of data. The local mental health commissions and boards, who are mandated by state law to "review and evaluate the community's mental health needs, services, facilities, and special programs," can be instrumental in creating these partnerships. Data exchange is imperative. Currently, only public health plans are required to post board meetings and hold them publicly. Private health plans do not have this requirement and therefore it is difficult to find meeting times for these plans. As stated, each county has their own mental health board and it is important to ask the

mental health board to invite the health plan to their meetings for open dialogue and partnership building to meet the needs of plan members and facilitate easy access to services.

Conclusion and Recommendation

The newly integrated benefit for those with mild to moderate mental health care needs is a big step towards coordinating physical and mental health care. Ongoing active collaboration and partnership is crucial for successful integration across systems. Health plans and mental health plans must continue to work together to provide access to services and to ensure a smooth transition across systems for those with mental health needs.

The HCI Committee recommends that the External Quality Review Organization (EQRO) reports include data on those beneficiaries receiving outpatient mental health care through the health plan versus those receiving care through the mental health plan.

References

California Health Care Foundation: The Circle Expands: Understanding Medi-Cal Coverage of Mild to Moderate Mental Health Conditions (2016)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CircleMediCalMentalHealth.pdf

D. (2014, May 29). MHSUDS Information Notice NO.: 14-020 New Outpatient Medi-Cal Mental Health Services Covered by Medi-Cal Managed Care Plans and Fee For-Service Medi-Cal [Letter to ALL MEDI-CAL MANAGED CARE HEALTH PLANS].

D. (2013, November 27). All Plan Letter 13-018 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans [Letter to ALL MEDI-CAL MANAGED CARE HEALTH PLANS].

Center for Health Care Strategies, Inc. (CHCS) Promising Practices to Integrate Physical and Mental Health Care for Medi-Cal Members Issue Brief (2016)
http://www.chcs.org/media/BSCF-Brief_060716.pdf

Medi-Cal Managed Care Performance Dashboard, DHCS, June 2016,
http://www.dhcs.ca.gov/services/Documents/MMCD/June152016Release.pdf

___X___	**INFORMATION**	**TAB SECTION**	**D**
_____	**ACTION REQUIRED**	**DATE OF MEETING**	**04/20/17**
MATERIAL PREPARED BY:	Jane Adcock	**DATE MATERIAL PREPARED**	3/19/17

AGENDA ITEM:	Overview of Whole Person Care and Health Homes Projects
ENCLOSURES:	• Whole Person Care Pilot Application - Second Round
OTHER MATERIAL RELATED TO ITEM:	

Whole Person Care Pilots

The overarching goal of the Whole Person Care (WPC) Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots will provide an option to a county, a city and county, a health or hospital authority, or a consortium of any of the above entities serving a county or region consisting of more than one county, or a health authority, to receive support to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. Through collaborative leadership and systematic coordination among public and private entities, WPC Pilot entities will identify target populations, share data between systems, coordinate care real time, and evaluate individual and population progress – all with the goal of providing comprehensive coordinated care for the beneficiary resulting in better health outcomes.

Health Home for Patients with Complex Needs (HHPCN)

The Medicaid Health Home State Plan Option, authorized under ACA Section 2703 (Section 2703), allows states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports needed by beneficiaries with chronic conditions. California Assembly Bill 361 (AB 361), enacted in 2013, authorized California to submit a Section 2703 application.

The Health Homes Program will serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination. Health Homes provide six core services:

- Comprehensive care management,
- Care coordination (physical health, behavioral health, community-based LTSS),
- Health promotion,
- Comprehensive transitional care,
- Individual and family support,
- Referral to community and social support services

http://www.dhcs.ca.gov/services/Documents/WPCFAQ2-22-17.pdf

http://www.thescanfoundation.org/sites/default/files/5_dhcs_handout_crosswalk_of_initiatives_f_082916.pdf

http://www.dhcs.ca.gov/services/Documents/HealthHomesForPatients_Final.pdf

Whole Person Care Pilot Program

Second Round - New Applicants

California Department of Health Care Services

January 27, 2017

Agenda

1. Welcome and Overview
2. Second Round Application Timeline
3. Application Overview
4. WPC Pilot Budget for New Applications
5. Initial Selection Criteria
6. Special Terms and Conditions (STC) Attachments
7. Questions and Answers
8. Discussion

Whole Person Care Pilots

Second Round - New Application Overview

Whole Person Care (WPC) Pilots:
5-year program (began January 1, 2016) authorized under Medi-Cal 2020 Section 1115 Waiver

Goal

- To test locally-based initiatives that will coordinate physical health, behavioral health, and social services for beneficiaries who are high users of multiple health care systems and continue to have poor health outcomes.

Activities

- WPC Pilots will identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population health progress.

Second Round Funding

- Approximately $120 million total funds are available annually.

Second Round Application Timeline

Second Round Application Timeline - 2017

- **January 13:** Revised Application and Budget Instructions released
- **March 1:** WPC Applications due
  - No extensions will be granted beyond this due date
- **March 1 – July 1:**
  - DHCS reviews applications and sends written questions to applicants as necessary
  - Applicant written responses sent to DHCS and reviewed
- **July 2:** DHCS makes final decisions and notifies applicants
- **July 12:** WPC Lead Entities provide formal acceptance to DHCS

Application Overview

Application Structure

Section 1:	Section 2:	Section 3:	Section 4:	Section 5:
Lead Entity & Participating Entity Information	General Information & Target Population(s)	Services, Interventions, Care Coordination, & Data Sharing	Performance Measures, Data Collection, Quality Improvement, & Ongoing Monitoring	Financing

Application Elements

- **Section 1: Lead Entity and Participating Entity Information**
  - Lead Entity and contact person
  - Participating entities and their role in WPC Pilot
  - Letters from participating providers and other relevant stakeholders
- **Section 2: General Information and Target Population(s)**
  - Geographic area
  - Community and target population needs
  - Communications plan
  - Target population(s)

Application Elements

- **Section 3: Services, Interventions, Care Coordination, & Data**
  - Services available to beneficiaries not otherwise covered/directly reimbursed by Medi-Cal, including housing services
  - Interventions to integrate services for target population(s), including Plan-Do-Study-Act (PDSA)
  - Care coordination activities
  - Data sharing

- **Section 4: Performance Measures, Data Collection, Quality Improvement, & Ongoing Monitoring**
  - Performance measures (universal and variant)
  - Data collection, analysis and reporting activities
  - Quality improvement activities, including PDSA
  - Monitoring of participating entity performance

Application Elements

- **Section 5: Financing**
  - Financing structure, including how payments will be distributed and any financing and/or saving arrangements
  - Diagram of flow of funds from the Lead Entity to participating entities
  - List of entities that will provide the non-federal share
  - Relationship between the pilot funding and the provision of services
  - Requested funding amount and description for each individual item; separate annual and total funding requests
  - Budget Narrative – comprehensive discussion of costs with justification

WPC Pilot Budget for New Applications

General Budget Requirements for New Applications

Total Available Funding

- For this second round of applications, a total statewide annual funding of approximately $120 million is available. WPC Pilots approved in the first round of applications may apply for expansion with additional funding.

Year 1 Funding for New Applications

- Program Year (PY) 1 (New): January 1, 2017 – June 30, 2017.
- Payments based on the submission of the WPC Pilot's approved application and baseline data.
- Payments: 75% for application and 25% for baseline data.

Exclusions

- Budgets cannot include payment for services reimbursable through Medi-Cal.
- In addition to the exclusion for Medi-Cal funded services, WPC cannot be used to fund local responsibilities for health care or social services that are mandated by state or federal laws, or to fund services for which state or federal funding is already provided.

General Budget Requirements for New Applications

- New budget requests should be based on the following 48-month budget breakdown:
  - Two 6-month periods
    - PY 1 New Applicants: January 1 - June 30, 2017,
    - PY 2 limited (Ltd): July 1 - December 30, 2017; and
  - Three additional 12-month periods
    - PY 3: January 1 – December 31, 2018
    - PY 4: January 1 – December 31, 2019
    - PY 5: January 1 – December 31, 2020
- Budgets for PY 1 and PY 2 are each 50% of the annual budgets requested for PYs 3-5

Budget Development

There are three components to the Budget submissions:

- Section 5 Financing Structure
- Budget Narrative
- Budget Summary and Detail

Budget Development

- Budget requirements are stated in the Special Terms and Conditions (STCs), FAQ, and **Revised Application**.
- The **Revised Budget Instructions** provides additional guidance regarding the level of detail needed.
- Applicant shall use the **Budget Narrative** as the vehicle to describe and justify why certain elements are included and valued in the proposal.

Budget Guidelines for New Applications

Budget requests should include:

- Information on deliverables related to infrastructure, interventions, bundled services, pay-for-reporting/outcomes, and incentives for providers
- Associated payment amounts requested for each individual deliverable for which funding is proposed
- Justification of estimated costs or value associated with each deliverable
- Details regarding all components of the requested budget to ensure costs adhere to State guidelines and requirements

Budget Guidelines for New Applications

Budget requests should:

- Include annual total funds requested (both federal funds and non-federal share) over the pilot years
- Be based on a 48-month budget: two 6-month periods and three12-month periods, starting January 1, 2017
- Show PY 1 - New and PY 2 - Ltd amounts equal to 50% of the annual budgets requested in PYs 3-5
- Relate PY 2 Ltd through PY 5 funding directly to WPC activities described in the Application and Budget Narrative
- Not include costs for services reimbursable through Medi-Cal

Budget Guidelines for New Applications

Payment:

Is based on completed deliverables - actual services provided, metrics reported, and metric outcomes achieved - as reported in the mid-year and annual reports

PY 1 New funding will be based on the approved application and complete, timely, accurate submission of baseline data in the annual report

Budget Categories

Infrastructure

- Administrative
- Delivery

Services and Interventions

- FFS Services
- Bundled PMPM Services

Reporting, Quality and Incentives

- Pay for Metric Reporting
- Pay for Metric Outcome Achievement
- Incentives for Downstream Providers

Administrative Infrastructure

Description	Examples	Level of Detail

• To build the programmatic supports necessary to plan, build and run the pilot	• Core program development and support
	• Administrative Staffing (no service-related staffing)
	• IT infrastructure
	• Program governance
	• Training
	• Ongoing data collection
	• Marketing materials
		• **E.g. Staffing:**
		  • Number of FTEs
		  • Roles and responsibilities of the staffing model for administrative infrastructure

Delivery Infrastructure

Description	Examples	Level of Detail
• To support the non-administrative infrastructure needed to implement the pilot	• Advanced medical home • Mobile street team infrastructure • Community resource database • IT workgroup • Care management tracking and reporting portal	• **E.g. Mobile street team infrastructure** • Cost for related components (e.g. vehicle cost, staffing, training, consulting, amortized use, etc.)

Services and Interventions
FFS Services

Description	Examples	Level of Detail
• New services provided in the pilot to support the WPC provided to eligible enrollees • FFS Services are single per encounter payments for a discrete service	• Mobile Care Coordination • Outreach and Engagement • Medical respite • Sobering center	• Services to be reimbursed on a per encounter or unit basis • Costs used to determine proposed service rate • Total projected cost based on the number of projected encounters

Services and Interventions PMPM Bundle

Description	Examples	Level of Detail
• New services provided in the pilot to support the WPC provided to eligible enrollees • PMPM Bundled Services, one or more services and/or activities that would be delivered as a set value to a defined population	• Comprehensive complex care management • Housing support services • Long term care diversion bundle	• Total allocated costs used to determine proposed PMPM value (i.e. salaries, services, overhead, equipment, contracted services, etc.) • Total projected cost based on the number of projected member months

Incentive Payments for Downstream Providers

Description	Examples	Level of Detail
• WPC Pilots may request funding for a defined amount associated with pilot payments to downstream providers for achievement of specific operational and quality deliverables that are critical for the pilot's overall success	• Increasing data sharing • Participating in learning collaboratives • Reducing ED utilization, and others	• Total maximum amount of funding for the incentive payments for each applicable deliverable

Reporting

Description	Examples	Level of Detail
• WPC Pilots are encouraged to propose the pay for metric reporting structure that they believe provides the most incentive, both to pilot lead organization as well as to downstream providers	• Universal and/or Variant Metrics • Reporting number of ED visits • Reporting percentage of avoided hospitalizations • Reporting individuals with follow up after hospitalization	• Incentive payments made to the Lead Entity for reporting the specific metric, including any related incentive payments made to downstream provides • Breakdown of the incentive payment on a per year/per metric basis • Attachments GG and MM requirements

Quality

Description	Examples	Level of detail

• Pay for Metric Outcomes Achievement
• WPC Pilots must include at least one pay for metric outcome achievement item in their application.
• Goals must be included that progress each PY and show improvement of at least 5% over previous PY's improvement.
	• Universal and/or Variant Metrics related to quality
	• Decrease number of ED visits by set %
	• Increased number of avoided hospitalizations by a set %
	• Increased percentage of individuals who have a follow up after hospitalization
		• **E.g. 90% of beneficiaries will have a follow up after hospitalization for mental illness:**
		  • Incentive payments made to the Lead Entity for achieving specific outcomes metrics
		  • Breakdown of the incentive payment on a per year/per metric basis
		  • Attachment MM requirements

Budget Narrative

Provides

- a vehicle for the applicant to describe the budget approach (e.g. incentive payments)
- additional information to explain and provide the rationale for an applicant's budget model, including proposed rates and/or PMPM values

Must include

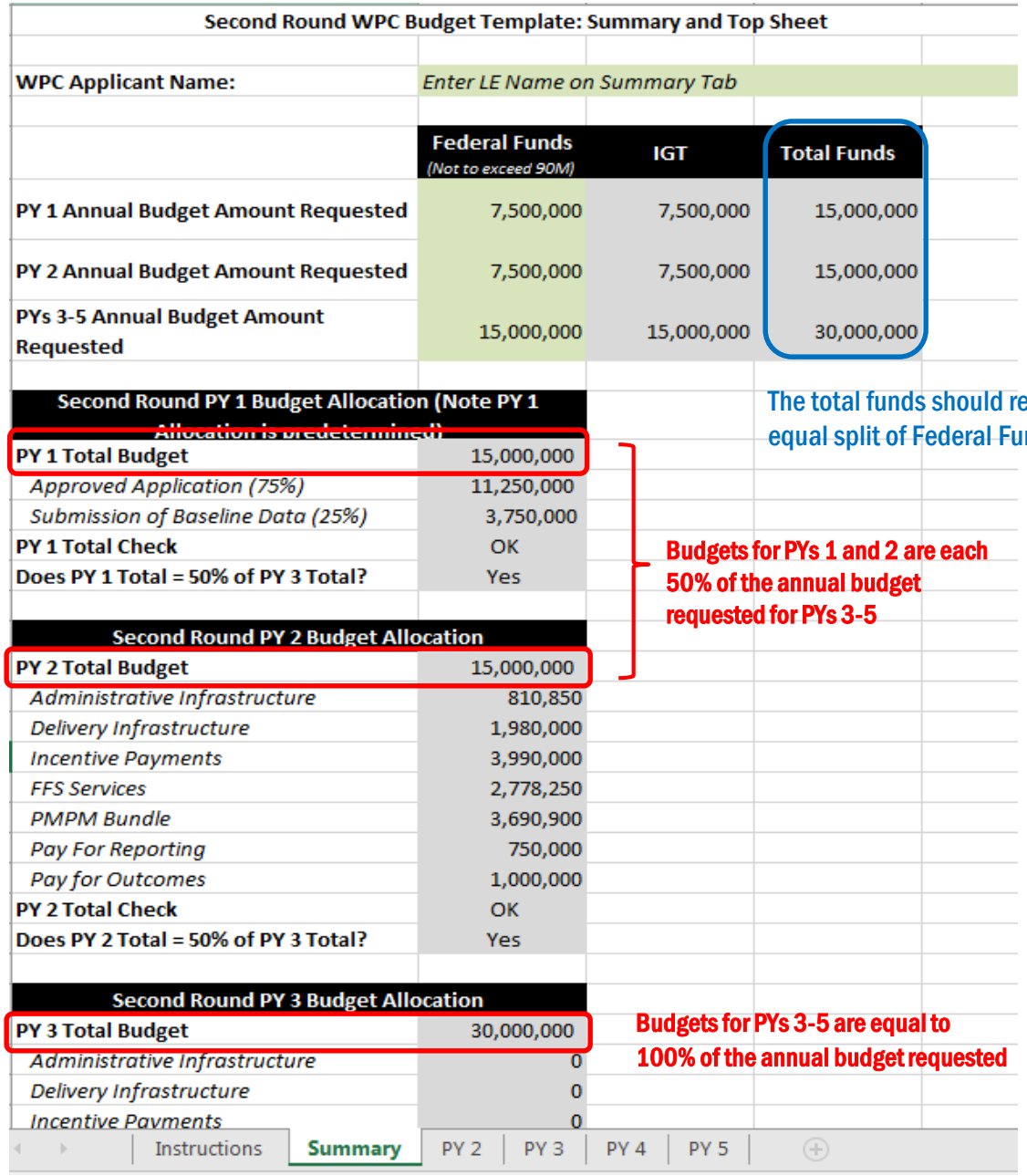
- a description of the funds requested and how their use will support the proposal
- a justification of estimated costs or value associated with each deliverable

Budget Narrative

The Budget Narrative should include the following categories
(when applicable):

- Administrative Infrastructure
- Delivery Infrastructure
- Incentive Payments for Downstream Providers
- FFS Services
- Bundled PMPM Services
- Pay for Metric Reporting
- Pay for Metric Outcomes Achievement

Budget Summary and Detail



Second Round WPC Budget Template: Summary and Top Sheet

WPC Applicant Name:	Enter LE Name on Summary Tab		
	Federal Funds (Not to exceed 90M)	IGT	Total Funds
PY 1 Annual Budget Amount Requested	7,500,000	7,500,000	15,000,000
PY 2 Annual Budget Amount Requested	7,500,000	7,500,000	15,000,000
PYs 3-5 Annual Budget Amount Requested	15,000,000	15,000,000	30,000,000

Second Round PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	15,000,000
Approved Application (75%)	11,250,000
Submission of Baseline Data (25%)	3,750,000
PY 1 Total Check	OK
Does PY 1 Total = 50% of PY 3 Total?	Yes

Second Round PY 2 Budget Allocation	
PY 2 Total Budget	15,000,000
Administrative Infrastructure	810,850
Delivery Infrastructure	1,980,000
Incentive Payments	3,990,000
FFS Services	2,778,250
PMPM Bundle	3,690,900
Pay For Reporting	750,000
Pay for Outcomes	1,000,000
PY 2 Total Check	OK
Does PY 2 Total = 50% of PY 3 Total?	Yes

Second Round PY 3 Budget Allocation	
PY 3 Total Budget	30,000,000
Administrative Infrastructure	0
Delivery Infrastructure	0
Incentive Payments	0

Instructions | Summary | PY 2 | PY 3 | PY 4 | PY 5

The total funds should reflect the equal split of Federal Fund and IGT

Budgets for PYs 1 and 2 are each 50% of the annual budget requested for PYs 3-5

Budgets for PYs 3-5 are equal to 100% of the annual budget requested

Detail needed for each budget category should be provided in budget narrative

Second Round PY 2 Budget Detail

Enter LE Name on Summary Tab

PY Error Check	
Total	15,000,000
Check	OK

Administrative Infrastructure

Item	Max Amount Per Unit	Max Units	Max WPC Fund Amount
Program Director	200,000	0.5	100,000
Quality Improvement Manager	150,000	0.5	75,000
Financial Manager	120,000	0.5	60,000
Data Analyst	65,000	5.0	325,000
Program Materials and Supplies	501,700	0.5	250,850
			-

Delivery Infrastructure

Item	Max Amount Per Unit	Max Units	Max WPC Fund Amount
Community Resources Database	1,250,000	0.5	625,000
Nurse Advice Line	750,000	1.0	750,000
Enhanced Interpretation	810,000	0.5	405,000
IT Solutions - Case Management Software	200,000	1.0	200,000
			-

Incentive Payments

Item	Max Amount Per Unit	Max Units	Max WPC Fund Amount
Hospital Incentives	100,000	5	500,000
Physician/Clinic Incentives	40,000	20	800,000
Behavioral Health Incentives	40,000	11	440,000
Community Health Worker Incentives	25,000	50	1,250,000
MCO Incentives	1,000,000	1	1,000,000
			-

FFS Services

Item	Max Amount Per Unit	Max Units	Max WPC Fund

Instructions | Summary | PY 2 | PY 3 | PY 4 | PY 5

Initial Selection Criteria

Initial Selection Criteria

- Competitive process
  - No limit on the number of WPC Pilot applications that can be received. Total awards will be limited by remaining funds available.
- DHCS will assess whether applications meet the WPC Pilot goals and requirements outlined in the Medi-Cal 2020 waiver Special Terms and Conditions and Attachments
- DHCS will evaluate applications in two phases:
  - Phase 1: Application Quality and Scope; and
  - Phase 2: Funding Decision
- A numerical score will be given for Phase 1, which will be factored into the Phase 2 funding decision.

Initial Selection Criteria

Phase 1: Quality and Scope of Application

- Scored based on specified criteria
- Minimum qualifying score is 77 points out of a total of 105 possible points
- Must receive a pass score on **all** pass/fail criteria
- Applicants that achieve at least the minimum score may qualify for bonus points for including priority program elements

Phase 2: Funding Decision

- Appropriateness of funding request and quality of application financing responses
- Comparisons to similarly-sized pilots
- Assessment of available funds relative to applications received

Application Scoring

Application Section	Maximum Points
Section 1: Lead Entity & Participating Entity Information	**5 Points**
Section 2: General Information & Target Population(s)	**25 points**
Section 3: Services, Interventions, Care Coordination & Data Sharing	**35 points**
Section 4: Performance Measures, Data Collection & Ongoing Monitoring	**30 points**
Section 5: Financing	**10 points**
Total Maximum Score:	**105 points**

Bonus Points

Priority Elements	Criteria	Maximum Points
Participating Plans	Participation of more than 1 managed care plan	5 points
Community Partners	Participation of more than 2 community partners	5 points
Innovative Interventions	Creative interventions (e.g. workforce, health IT, transportation) and financing/use of innovative payment models	5 points
	Total Maximum Bonus Points	15 points

Special Terms and Conditions (STC) Attachments

WPC Attachments

- **WPC Reporting and Evaluation (Attachment GG):** Mid-year and annual reporting requirements and evaluation process.

- **WPC Pilot Requirements and Application Process (Attachment HH):** Application submission and review process, pilot funding, termination process, and WPC Learning Collaboratives.

- **WPC Pilot Requirements and Metrics (Attachment MM):** Performance metrics (universal and variant), incorporation of Plan-Do-Study-Act (PDSA), and reporting requirements.

Universal Metrics

- All WPC Pilots are required to report on the same set of universal metrics, which include four (4) health outcomes measures and three (3) administrative measures.

Health Outcomes Measures

- Ambulatory Care
- Inpatient Utilization
- Follow-up After Mental Health Illness Hospitalization
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Administrative Measures

- Comprehensive Care Plan
- Care Coordination, Case Management, and Referral Infrastructure
- Data and Information Sharing Infrastructure

Variant Metrics

Variant metrics are specific to the WPC target population(s), strategies, and interventions.

Each WPC Pilot must report on a minimum of four variant metrics, or for WPC Pilots implementing a housing component, five variant metrics:

- **Variant Metric 1**: One **administrative metric** in addition to the universal care coordination and data sharing metrics
- **Variant Metric 2**: One **standard health outcomes metrics** (e.g., HEDIS) applicable to the WPC Pilot population across all PYs for each target population (choose one from menu in Attachment MM)
- **Variant Metric 3**: One **alternative health outcomes metric**; or for WPC Pilots utilizing the PHQ-9, report on the Depression Remission at Twelve Months (NQF 0710) metric
- **Variant Metric 4**: One **alternative health outcomes metric**; or for WPC Pilots including a severely mentally ill (SMI) target population, report on the Adult Major Depression Disorder (MDD): Suicide Risk Assessment (NQF 0104) metric
- **Variant Metric 5**: One housing specific metric specific; for WPC Pilots implementing a housing component (choose one from menu in Attachment MM)

Questions & Answers

Questions and Answers

Question: If a participating entity is a collaborative with membership of its own, does it need to submit letters of participation for all of its members?
Answer: The participating entity only needs to submit one letter of participation that includes a list of the members that are part of the collaborative.

Question: May counties add participating entities after the application is submitted and over the course of the pilot?
Answer: Yes.

Questions and Answers

Question: How should pilots approach establishing the pilot goals and outcomes?
Answer: Pilot goals should be ambitious but realistic. The outcomes should reflect the interventions that are being proposed in the application.

Questions and Answers

Question: What will happen if a WPC Pilot is not achieving the goals it set out in its application?
Answer: DHCS would undertake a multi-step process for addressing interventions that are not leading to improvements. DHCS will first work with the WPC pilot to identify strategies to improve as part of the pilot PDSA (Plan, Do, Study, Act) process. If no improvement is made, a corrective action plan will be developed.

Questions and Answers

Question: What will happen if a WPC Pilot does not achieve an outcome established in the application submission?
Answer: If pilots do not achieve an outcome established in the application, they will not receive the funding that was tied to achieving that outcome. WPC Pilots will have an opportunity to update target outcomes for the latter years of the demonstration as the Pilot progresses.

Questions and Answers

Question: If a pilot chooses a PMPM payment structure, and enrollment exceeds expectations, will payments be capped at the budgeted amount?
Answer: Yes, payments will be made up to the pilot's maximum budgeted amount for each identified PMPM item. If you have more than one PMPM item in your budget, each will have their own maximum budget amount.

Questions and Answers

Question: Can the target population grow over time?
Answer: Yes; however, payments will not exceed the pilot's annual budgeted amount per budget item. Pilots can allow for a phased-in enrollment over budget years to accommodate growth over time.

Questions and Answers

Question: Attachment GG (B)(iv) articulates, "payment in an amount proportional to the progress toward achievement of the WPC Pilot Goals based on the approved WPC Pilot application shall be paid to the WPC Pilot Lead Entity…" Does that mean that funding will fluctuate with outcomes from year to year?

Answer: Yes. The pilot will be paid based on completed deliverables, (such as services actually provided, metric reported, or metric outcome achieved). The payment for any deliverable will not exceed the DHCS approved budget amount for that item, for that budget year.

Questions and Answers

Question: What are the rules regarding the use of WPC funding for pre-existing services that could be rolled into a pilot? (Supplantation)

Answer: A goal of the WPC pilots is to address a current gap or need in the community. Items noted in the Application Selection Criteria reflect pilot priorities, including:

- Demonstrates the community need for the pilot and how the pilot will address the need
- Scope is ambitious but realistic/achievable
- Tests new interventions and strategies

Also, see the FAQ for more information on the exclusion for Medi-Cal funded services, other federally funded services, and current local responsibilities for health care or social services.

Questions and Answers

Question: Which outcome metrics need to be tied to incentive financing?
Answer: DHCS requires that pilots include at least one "pay for metric outcome achievement" item in their application. Other than this requirement, pilots have flexibility to design their funding requests and deliverables, as approved by DHCS in the application. See the Revised Budget Instructions document for more information.

Questions and Answers

Question: Can funds be used to purchase a Health Care Center for the WPC?

Answer: WPC funds may not be used to purchase, or build, a building. WPC pilot funds can support other capital infrastructure expenses when they are:

1. For items like minor rehabilitation or maintenance;
2. Allocated to the WPC enrollees during the program year in which the expense was incurred;
3. One component of a service; and/or
4. Proportional to the utility for one individual during the single encounter or PMPM payment timeframe.

Questions and Answers

Question: Can you clarify if the match for the IGT will be sent up each year or if we are expected to send the entire 5-year amount at one time.

Answer: For new applicants, Year 1 IGT and State payments are made in 2017 for the application and baseline data deliverables. Year 2-5 IGT and State payments will be made semi-annually and are based on the pilot's reported deliverables completed, such as actual services provided, metrics reported, and metric outcomes achieved.

Questions and Answers

Question: May a managed care plan (MCP) divert savings resulting from reduced ER and Inpatient Care for the WPC population to a County Housing Pool, and how would this impact their rate-setting?
Answer: The WPC pilot program does not have any specific rules for what a MCP can do with its savings. The MCP's future rates will be developed based on the usual actuarial process based on actual utilization – with no added calculation for MCP savings allocated to the housing pool. There is no DHCS/MCP savings sharing arrangement built into the WPC.

Discussion

E-mail questions to:

1115wholepersoncare@dhcs.ca.gov

Visit our website:

http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx

___	**INFORMATION**	**TAB SECTION**	**E**
___X__	**ACTION REQUIRED**	**DATE OF MEETING**	**04/20/17**
MATERIAL PREPARED BY:	Jane Adcock	**DATE MATERIAL PREPARED**	3/19/17

AGENDA ITEM:	Review Revised Work Plan
ENCLOSURES:	• Draft 2017 Work Plan
OTHER MATERIAL RELATED TO ITEM:	

ISSUE:

Discuss and comment on proposed work plan items for 2017.

CMHPC
Healthcare Integration Committee

Goal	Objectives	Action Steps	Timeline	Person(s) Responsible
Goal 1 : Reduce risks associated with psychotropic medication utilization for California's children and adolescents receiving psychotropic medications as part of their mental health treatment. **Rationale:** Results of investigation by the State of CA shows children being given inappropriate amounts and types of medications. Additionally, it is unclear how and what alternatives are offered. **Measure of Success** Resource will be identified and/or developed, be well-disseminated and utilized to educate key stakeholders. **Target Audience:** Mental Health Plans CA Association of Health Plans CA Department of Healthcare Children and Adolescent Healthcare Advocacy Organizations	A. Develop committees knowledge and understanding of issues related to use of psychotropic medication in treatment of children and adolescents B. Identify or develop resource that communicates (a) alternatives to medications and (b) best practices for medication management	Research approaches to mediating risk of psychotropic medications, including alternatives to medication Review research findings, and identify potential speakers for quarterly meetings to increase committee understanding of issue Identify possible resources that could be made available to families and advocates, evaluate quality of these resources and if appropriate select and disseminate through CMHPC network Track dissemination and use of resource.	Completed Partially completed, April 2017 Partially completed, April 2017 Ongoing	Deborah Pitts Committee, CMHPC Staff HCI Committee, CMHPC Staff CMHPC Staff
Goal 2: Older Adults will receive a screening for Behavioral Health Conditions when they see their Primary Care Physician. For those persons that screen positive they will be referred to a Behavioral Health Treatment Provider and/or be treated by their Primary Care Physician whichever is appropriate. **Rationale:** **Measure of Success:** **Target Audience:**				

DRAFT

CMHPC
Healthcare Integration Committee

Goal	Objectives	Action Steps	Timeline	Person(s) Responsible
Goal 3: Monitor any modification in Federal Funding amount and or structure that would have a negative impact on Behavioral Health consumers and/or communities and create a workplan in connection with other committees to mitigate damages. **Rationale:** The present Federal Government has indicated that they want to repeal and replace the ACA. This could result in loss of coverage for millions of Californians. **Measure of Success:** **Target Audience:**				
Goal 5: **Rationale:** **Measure of Success:** **Target Audience:**	A. Develop committee's knowledge and understanding of Depart of Health Care Services Whole Person Care Model B. Develop Committee's knowledge and understanding of California's Drug Medi-Cal Organized Delivery System			

DRAFT

_X____ **INFORMATION** **TAB SECTION** **F**

_____ **ACTION REQUIRED** **DATE OF MEETING** **04/20/17**

MATERIAL PREPARED BY: Jane Adcock **DATE MATERIAL PREPARED** 3/19/17

AGENDA ITEM:	Discussion with California Association of Health Plan representatives, Athena Chapman and Jennifer Alley regarding regulations and legislation pertaining to health care integration.
ENCLOSURES:	
OTHER MATERIAL RELATED TO ITEM:	

"The California Association of Health Plans' mission is to serve our members by creating and sustaining an environment that permits them to maintain viability and grow as organizations dedicated to coordinating or providing high quality, affordable, accessible health care to their members." (taken from website)

CAHP advocates for the interests of health plans and their members. The CAHP has a strong presence in state policy and they work to inform policy makers and regulators about the impact of their decisions on the ability of the health plans to meet their goals.

Athena Chapman and Jennifer Alley can speak to the most important legislation and regulatory issues facing health care integration.

http://www.calhealthplans.org/pdfs/About_CAHP_FS-12.13.16.pdf

_____	**INFORMATION**	**TAB SECTION**	**G**
__X___	**ACTION REQUIRED**	**DATE OF MEETING**	**04/20/17**
MATERIAL PREPARED BY:	Jane Adcock	**DATE MATERIAL PREPARED**	3/19/17

AGENDA ITEM:	Discussion of Senate Bill 323 re: Reimbursement for Drug Medi-Cal services for an FQHC or RHC under Medicaid
ENCLOSURES:	SB 323 Factsheet
OTHER MATERIAL RELATED TO ITEM:	

There are existing policies that make integration of behavioral health and physical health care difficult.

Senate Bill 323 was introduced by Senator Holly Mitchell on February 13, 2017. This bill would allow a Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC) to enroll as a Drug Medi-Cal certified provider and to receive reimbursement for behavioral health services and such costs shall not be included in the FQHCs or RHCs per-visit Prospective Payment System (PPS) rate.

Link to SB 323.

Assembly Bill 323
Senator Holly Mitchell

Revised March 1, 2017

OVERVIEW

Senate Bill 323 (Mitchell) will help community clinics provide substance use disorder treatment services to our most vulnerable communities by adding Drug Medi-Cal Program (DMC) to the types of services that federally qualified health centers (FQHCs) and rural health clinics (RHCs) may provide and be reimbursed under contract.

DMC services would join dental and pharmacy as being "carved out" of the prospective payment system (PPS) which provides reimbursement under Medi-Cal. This bill will also signal the legislature's intent to add Specialty Mental Health as an FQHC carve-out as well.

This change in law will increase access to behavioral health care in the low-income communities.

THE PROBLEM

FQHCs are required to offer medical and behavioral health care to all patients, regardless of ability to pay. The scope of these services varies among FQHCs – even different sites of a single FQHC may provide different services – because the services are designed to respond to the needs of the FQHC's local community and target population.

Under current law, health centers are reimbursed for services in Medi-Cal using a site specific per-visit bundled rate called PPS.

Most FQHCs provide behavioral health services by building the service costs into their PPS rates. A patient can come in for a medical visit or a behavioral health visit, and as long as the rules for PPS reimbursement are followed, the FQHC will receive the same PPS reimbursement no matter which type of service is provided. Building the costs of behavioral health services into the PPS rate allows FQHCs to fully integrate behavioral health into their primary care service delivery model.

However, the PPS payment system rules constrain FQHCs' ability to provide the full spectrum of DMC and Specialty Mental Health services by limiting the type of services, type of provider, and location of where services may be offered.

For example, group counseling with a certified alcohol and drug counselor is not reimbursable in PPS.

THE SOLUTION

This bill would authorize FQHCs and RHCs to elect to enroll as a DMC certified provider to provide DMC services pursuant to the terms of a mutually agreed upon contract entered into between the FQHC or RHC and the county or department, as specified, and would set forth the reimbursement requirements for these services.

The bill would prohibit the costs associated with DMC services from being included in the FQHC's or RHC's per-visit PPS rate, and would require the costs of providing DMC services to be adjusted out of the FQHC's or RHC's clinic base rate as a scope-of-service change under specified circumstances.

The bill would exempt the department from the reimbursement requirement described above for any payment received by an FQHC or RHC that contracts to provide DMC services.

The bill would declare the intent of the Legislature to authorize an FQHC or RHC to be reimbursed for specialty mental health services.

SPONSOR

CaliforniaHealth+ Advocates

FOR MORE INFORMATION

Christy Bouma/Meagan Subers: (916) 227-2666
Beth Malinowski: (916) 503-9112